

HealthSouth Q4 2014 Earnings Call Transcript

PARTICIPANTS

Corporate Participants

Mary Ann Arico – 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.

Other Participants

A. J. Rice – Analyst, UBS Securities LLC

Josh R. Harakal – Analyst, Susquehanna Financial Group LLLP

Gary Lieberman – Analyst, Wells Fargo Securities LLC

John W. Ransom – Analyst, Raymond James & Associates, Inc.

Joshua R. Raskin – Analyst, Barclays Capital, Inc.

Dana Nentin – Analyst, Deutsche Bank Securities, Inc.

Whit Mayo – Analyst, Robert W. Baird & Co., Inc. (Broker)

Chad C. Vanacore – Analyst, Stifel, Nicolaus & Co., Inc.

Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to the HealthSouth Fourth Quarter 2014 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 Mary Ann Arico, Chief Investor Relations Officer.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Laurie, and good morning, everyone. Thank you for joining us today for the HealthSouth fourth quarter 2014 earnings call.

With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer; Mark Tarr, Executive Vice President and Chief Operating Officer; John Whittington, Executive Vice President, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President, Financial Operations.

Before we begin, if you do not already have a copy, the press release, financial statements, the related 8-K filings with the SEC and the supplemental slides are available on our website at www.healthsouth.com.

Moving to slide 2, the Safe Harbor, which is also set forth in greater detail on the first page of the earnings release. During the call, we will make forward-looking statements which are subject to risks and

uncertainties, many of which are beyond our control. Certain risks, 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 Form 10-K for 2013, the Form 10-Q for first, second and third quarter 2014, and the Form 10-K when filed with SEC. 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 or correct these forward-looking statements.

Our slide presentation and discussion on the call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of the slide presentation or at the end of the related press release, both of which are available on our website and as part of the Form 8-K filed last night with the SEC.

Before I turn it over to Jay, I would like to remind you 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.

And with that, I will turn the call over to Jay.

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

Great. Thank you, Mary Ann. And good morning to everyone joining this morning's call. We are very pleased to report that the fourth quarter concluded another solid year of growth for HealthSouth and sets the stage for continued growth into 2015. Overall, discharges grew 4.7% in the fourth quarter with same-store discharge growth at 2.2%. Normalizing for the mid-year closure of 40 SNF beds, same-store growth would have been 2.5%.

New store discharges were negatively impacted by delayed openings at three of our four new hospitals. Medicare certification visits were delayed one month at Quillen and two weeks at Altamonte Springs because of scheduling issues with the certification teams, while our Middletown, Delaware hospital opened two-and-a-half weeks later than budgeted due to weather-related construction delays. All of these new facilities are now fully operational.

Adjusted EBITDA for the quarter was \$140.8 million and was negatively impacted by approximately \$6 million of net start-up cost associated with our new hospitals, while positively impacted by approximately \$2 million related to the increase in ownership and consolidation of our Fairlawn facility. Looking forward, we believe 2015 will be another excellent year for HealthSouth with growth in our inpatient rehabilitation segment, supplemented by growth from our newly acquired Home Health segment.

On a consolidated basis, adjusted EBITDA guidance for 2015 is between \$670 million and \$680 million while EPS guidance is between \$2.24 and \$2.29 per share. This guidance assumes discharge growth of between 3.5% and 4.5%, excluding any acquisitions. As we have said when providing full-year guidance in previous years, our inpatient segment is volume sensitive, so we base guidance of volume growth we are confident we can achieve.

To put this into perspective, last year, our guidance assumed discharge growth of between 2.5% and 3.5%. And we ended the year at the high end of the range. Factors influencing 2015 discharge growth include continued market share gains, the successful ramp up of our four new hospitals, bed additions coming online as expected throughout the year and less volatility around the yearend holidays.

Forecasted revenue per discharge growth is expected to be between 2.3% and 2.6% which is slightly higher than last year's range in part because of somewhat better pricing on our traditional Medicare book

of business. It should be noted that we anticipate our hospital bad debts will track about 20 basis points higher next year owing, in large part, to the continued backlog in the ALJ process. This will create a \$5 million headwind that Doug will discuss later in his remarks.

Encompass is expected to contribute approximately \$72 million to adjusted EBITDA after non-controlling interest. You will note that this is \$3 million less than what we projected earlier. The good news is that this difference is attributable to a larger equity role into our new partnership by Encompass' management. We are very pleased with the Encompass' team's solid commitment to the Encompass HealthSouth relationship and believe it underscores the confidence they have in our long-term prospects. Encompass' adjusted EBITDA contribution includes planned acquisitions, but does not include earnings from the integration of HealthSouth's existing home health agencies.

As noted in our earnings release, guidance for 2015 includes approximately \$10 million of incremental costs associated with the following new investments to our operating platform that we mentioned on our Q3 call. A contractual increase of our Cerner payments, the addition of staff at our hospitals to ensure compliance with new CMS quality reporting requirements, the creation of a new medical services department and cost associated with our participation in CMS' Model 3 bundling pilot. The Cerner increase is tied to the ongoing rollout of our electronic medical records system. We are targeting to have this system fully installed in 82 of our hospitals by the end of 2015 and in all hospitals by the end of 2017.

Beginning in fiscal year 2015, inpatient rehabilitation facilities that fail to completely and accurately report CMS-mandated quality metrics will be subject to a 2% reduction of their Medicare payments. Since we derive so much of our revenues from Medicare, we are adding incremental staff at our hospitals to ensure these revenues are not at risk. These additional staff also will assist with other quality-related initiatives.

We have often discussed the fact that Cahaba, the Medicare Administrative Contractor, or MAC, that processes approximately 71% of our Medicare claims, consistently denies claims, ostensibly because of medical necessity but in reality because of incomplete documentation. While we win approximately 72% of these denials once they hit the ALJ level, those we lose are typically lost because of inadequate physician documentation.

To assist the medical staffs at our hospitals in improving the completeness of their medical records, we have created a new physician-led department to train and educate physicians on the importance of timely documentation. Training from the new departments will result in fewer denials on the front end and a higher win rate at the ALJ level. This department also will explore ways to leverage our new EMR to improve the accuracy and completeness of medical records.

We have selected Dr. Lisa Charbonneau as the person to lead this new department. She is board-certified by the American Board of Physical Medicine and Rehabilitation and the American Osteopathic Board of Rehabilitation Medicine, and has served as the Medical Director of our hospital in Portland, Maine for the past 15 years. In 2012, she received the HealthSouth Medical Director of the Year Award. We believe Dr. Charbonneau has the experience, personality and leadership capabilities to lead this new department effectively.

This year also marks our foray into bundled payments. We have submitted applications for five of our hospitals to participate in the Model 3 bundling pilot beginning in April and we are investing in incremental staff and consulting resources to ensure we manage these pilots appropriately. Depending on how well these initial hospitals do, we may seek to add additional hospitals by year-end.

Finally, it's important to note that this guidance does not include our two announced but not yet closed transactions – the joint venture with Memorial University Medical Center for a 50-bed hospital in Savannah, Georgia, and the acquisition of the 158-bed Cardinal Hill Rehabilitation Hospital in Lexington, Kentucky. We anticipate closing both transactions in the first half of 2015 and, as has been our past practice, we will incorporate them into updated guidance when we report Q2 results.

In summary, I believe we're going into the new year with a stronger foundation than ever before and that 2015 will be another successful year for the company. Although we only have a month and a half under our belts, we are very pleased with how both segments are performing thus far and are excited about both the quantity and quality of their respective development pipelines.

Before I turn the agenda over to Doug, I want to mention that we will host an Investor Day in New York on June 10. The focus of this meeting will be on how the company is positioned for long-term growth and will include a presentation by April Anthony and the Encompass management team on our Home Health and Hospice partnership. Mary Ann will provide specifics about this Investor Day at a later date.

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

Thank you, Jay. And good morning, everyone. Q4 was a solid finish to 2014. The quarter was punctuated by the opening of four new hospitals and the year-end closing of our acquisition of Encompass. I'll highlight the impact of those events as I review our Q4 and 2014 financial results. As always, I encourage you to reference the supplemental slides accompanying our earnings release.

Revenue growth of 7.2% for Q4 was comprised of inpatient revenue growth of 8.1% offset by a \$2.1 million decline in outpatient and other revenues. The inpatient growth was favorably impacted by two items – approximately 210 basis points attributable to the increased equity ownership and consolidation of our Fairlawn Hospital, and approximately 150 basis points attributable to the approximately \$8 million RAC reserve we established in Q4 2013.

Discharge growth for Q4 of 4.7% was comprised of 2.2% same-store growth and 2.5% new store growth. Same-store growth was negatively impacted by approximately 30 basis points due to the closure of 40 SNF beds in Q2. New store growth benefited by approximately 190 basis points from Fairlawn with an approximately 30-basis-point offset attributable to delays encountered in opening three of our new hospitals in the quarter, as Jay reviewed in his remarks.

Revenue per discharge growth of 3.2% for Q4 was favorably impacted by price adjustments as well as the aforementioned RAC reserves established in Q4 2013. These benefits were partially offset by the ramp-up of our new hospitals. As a reminder, as new hospitals are undergoing Medicare certification, they are required to treat a minimum of 30 patients without reimbursement.

Our bad debt for Q4 was 1.1% of net revenue as compared to 0.6% in Q4 2013. During the quarter, we updated our prepayment claims denials reserves estimates based on recent collection activity and current expectations for ultimate recovery. This resulted in an increase to our expected realization rate on prepayment claims denials and a corresponding reduction to bad debt expense in Q4 of approximately \$3 million. Bad debt in Q4 2013 was favorably impacted by approximately \$4 million due to the reclassification of reserves related to RAC audits.

Looking to 2015 and, as Jay referenced in his remarks and as also can be seen on page 16 of the supplemental slides, we are anticipating bad debt of approximately 1.5% of net revenue for our IRF segment as compared to 1.3% for 2014. As Jay mentioned, that delta creates an approximately \$5 million headwind for 2015. This assumption is reflective of our expectation of additional medical necessity claims denial activity, the continued backlog in the ALJ proceedings, and the aforementioned increase in our anticipated recovery rate. I'll touch on this topic again when we discuss net working capital in just a few moments.

Two of our key expense ratios for Q4 were negatively impacted by lower year-over-year reductions in our self-insurance reserves, as well as the start-up cost of our four new hospitals. SWB for Q4 increased by approximately 150 basis points, primarily attributable to approximately \$3 million in lower self-insurance reserve reductions for group medical and workers' compensation in Q4 2014 versus Q4 2013, as well as the impact of the new hospitals.

Hospital-related expenses increased by 60 basis points in Q4, owing to an approximately \$4 million lower reduction to GPL reserves in Q4 2014 versus Q4 2013 and the impact of the new hospitals. We continue to exhibit leverage on the G&A line with Q4 2014 at 3.7% of net revenues, a decline of 60 basis points from Q4 2013, aided in part by a decline in incentive compensation.

Adjusted EBITDA for Q4 of \$140.8 million decreased by 1.1% over Q4 2013 with a negative impact of approximately \$6 million in net start-up costs for the new hospitals, only partially offset by the \$2 million benefit related to Fairlawn. For 2014, adjusted EBITDA of \$577.6 million increased by \$26 million or 4.7%, even with the \$8 million drag from sequestration experienced in Q1 and the net start-up costs related to our new hospitals.

Interest expense for Q4 of \$25.7 million decreased by approximately \$800,000 from Q4 2013, primarily owing to our Q4 debt transactions, and I'll discuss those in just a few minutes. As anticipated, D&A expense rose modestly in Q4 to \$27.5 million as compared to \$25.2 million in Q4 2013 with the increase attributable to continuing investments in our business, including capacity expansions, hospital refurbishments and the ongoing implementation of our clinical information system.

Diluted earnings per share of \$0.41 for Q4 were negatively impacted by \$13.2 million or \$0.08 per share and loss on extinguishment of debt related to the redemption of our 2018 senior notes and the 10% call on our 2022 senior notes, as well as \$9.3 million or \$0.06 per share in Encompass transaction costs. Please recall that diluted EPS for Q4 2013 was negatively impacted by \$71.6 million or \$0.81 per share related to the repurchase premium on the preferred stock exchange transaction.

In comparing 2014 diluted EPS of \$2.24 to our 2015 guidance of \$2.24 to \$2.29 per share, please note that the effective tax rate for 2014 was approximately 34% versus an assumed 40% for 2015. Please also take note of the approximately \$8.1 million delta between certain non-recurring expenses in 2014 and the assumed level of such items in 2015.

During 2014, we continued to demonstrate the strength and consistency of our free cash flow generating ability with adjusted free cash flow of \$311.3 million. This was lower than our previous estimate, primarily due to the continued growth in accounts receivable attributable to additional claim denials by predominantly one Medicare Administrative Contractor and continued delays at the administrative law judge hearing level.

As we have stated previously, we have confidence in the medical judgment of our referring and admitting physicians, and as such, we intend to continue to appeal substantially all denials. The success of our ultimate recovery is evident in the increase in our expected realization rate as I mentioned earlier. And for Jay's comments, the investments that we're making in the new department should also help in this regard. Nonetheless, the new claims denial activity, together with the continued logjam at the ALJ hearing level has caused and could continue to cause our accounts receivable balances to increase.

As can be seen on slide 18 of the supplemental slides, we are anticipating a net working capital increase of \$40 million to \$50 million for 2015. There are two primary factors underlying this assumption. First, the continuation of medical necessity claims denials and the persistence of the adjudication backlog. And second, similar to some previous years, during the first quarter, we will have performance share grants related to our long-term incentive plan vest. As that vesting occurs, we expect to experience a decline of approximately \$15 million in payroll liabilities attributable to tax withholding payments.

Turning to the balance sheet, during Q4 we redeemed all \$271 million of our 7.25% senior notes due 2018. The funding for this redemption occurred in Q3 and utilized a \$175 million add-on to our 5.75% senior notes due 2024, a \$75 million drop on our newly added \$150 million term loan commitment to our existing \$600 million revolver, and cash on-hand. We also exercised our call options to redeem 10% or approximately \$25 million of the outstanding balance of our 7.75% senior notes due 2022.

In December, we expanded our term loan facility by \$300 million to facilitate funding of the year-end acquisition of Encompass. We ended the year with a leverage ratio of 3.7 times. Pro forma leverage, with

Encompass adjusted EBITDA included, would have been approximately 3.3 times. In January 2015, we issued \$400 million of additional 5.75% senior notes due 2024 and used \$250 million of the proceeds to repay a portion of our term loan with the balance used to replenish availability under our \$600 million revolver.

Our rationale for refinancing a significant portion of the term loan addition so shortly after its implementation was simply because the notes market was not offering attractive terms in late December, but by mid-January the market had recovered. We took advantage of the attractive terms in the notes market to create a more optimal funding structure for the Encompass transaction.

The impact of this refinancing is embedded in our 2015 interest expense assumption down on slide 17 of the supplemental slides. We have not assumed any additional refinancing activity in this interest expense assumption.

Our \$290 million of 8.125% senior notes due 2020 are now fully callable at a price of 104.063% and our \$226 million of 7.75% senior notes due 2022 will be fully callable in September of this year at a price of 103.875%. We will continue to evaluate the potential refinancing and/or redemption of these notes in whole or in part.

Our balance sheet remained strong. Our leverage is within our target range. And we have significant liquidity in the form of availability under our \$600 million revolver. And now, operator, we'll open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question comes from the line of A. J. Rice of UBS.

<Q – A. J. Rice – UBS Securities LLC>: Hi, everybody. Maybe just to pursue a little further what you are doing to try to address the issue of the audits and the delays with the administrative law judge. How quick will you have the new program in place in your facilities? And anyway to quantify what that might mean in terms of being able to get these claims not flagged by this one intermediary?

<A – Jay Grinney – HealthSouth Corp.>: I think we've already begun the process, A.J. We should have it fully up and operational by midyear, certainly end of the third quarter. It is hard to quantify the impact, quite frankly. We hope to continue to work with Cahaba to see if we can't get these issues resolved sooner. Technically, they should be reviewing claims and denying them based on medical necessity, but they are indeed denying them based on inadequate documentation. So, that's an issue that we're continuing to try to resolve with them. We'll be looking for ways to do that both here in Birmingham and, if necessary, in Washington.

But the ability to get the backlog cleared up is frankly going to be significantly down the road. As you know, there's a huge backlog. The acute care hospitals were able to get a settlement. We have made some inquiries as to whether or not there may be an opportunity to have a similar settlement for inpatient rehabilitation facilities. We don't know if that's yet possible, but we're kind of working this problem from a lot of different avenues.

<Q – A. J. Rice – UBS Securities LLC>: Okay. And maybe just a quick follow-up. The new clinical information system, I think you now have it in 58 hospitals. Can you sort of tell us if you compare the performance of those facilities versus the ones that are still yet to do, what are the big things that happened when you put the new clinical information system in?

<A – Mark Tarr – HealthSouth Corp.>: Hey, A. J., this is Mark Tarr. We actually have it up and running in 61 of our hospitals now. It's still a little early to compare hospitals that are still in the paper system versus our electronic system, although we're starting to see some indication that our documentation overall by our therapists, nurses and in some cases, physicians, is starting to be more complete. It certainly gives us access to information in the future from which to pull data from for us to do some best practices and use it to be an indicator of such things as fall, risk or likelihood to be transferred back to the acute. So we think in the future there'll be a great benefit to the information that we'll have access to and be able to draw from electronically.

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

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

<Q – Josh Harakal – Susquehanna Financial Group LLLP>: Hi. This is Josh Harakal on for Chris. Just a quick question. You had start-up costs of \$6 million in the fourth quarter. How much did you have for full-year 2014? And then how much do you assume for 2015 in your guidance? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: It's about – most of that start-up cost occurred in the fourth quarter, the vast majority of it did. So I guess all-in it was, what?

<A – Doug Coltharp – HealthSouth Corp.>: \$7.6 million for the full year.

<A – Jay Grinney – HealthSouth Corp.>: Yeah. So you can see \$6 million of that was in Q4. Right now, the start-up costs that are in the guidance are fairly modest. There's one hospital that we are building today that is scheduled to open in Q4 of 2015 up in Franklin, Tennessee. And the start-up costs range anywhere from \$500,000 to \$1 million. Clearly, as I've indicated in my remarks, we have not included Cardinal Hill nor have we included the Memorial joint venture in our guidance. There may be some early

costs – not so much ramp-up, but some early costs associated with those transactions that would not be in the budget at this point.

<Q – Josh Harakal – Susquehanna Financial Group LLLP>: Thank you.

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

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

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Can you talk a little bit about the ACO opportunity? You mentioned you're pursuing it under the Model 3. Just how are you thinking about it? And maybe as you get out there, what's your hope for how large it could be?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Hey, Gary, this is Mark. It's actually the bundling Model 3 opportunity we have. We've applied for – well, back in the fall, we applied all of our hospitals to at least start the process of the application of which we were able to receive all the information that was being sent out from CMS, which is very helpful because it shows over a longer period of time cost information on patients that extend beyond the time of discharge from our hospitals, so that gave us great insight.

We've carried five hospitals on to the next level of the application process. Our entire goal on this is to get some experience, see what it's like to be able to manage it, see what we would have to do as a company in terms of establishing resources both here and the corporate office and at the hospital level. So we anticipate having five that would go live on April 1. There's another opportunity in May to apply and have more of our hospitals involved. We'll evaluate that opportunity here in the future.

<A – Jay Grinney – HealthSouth Corp.>: I think it's fair to say, Gary, that the foray, as I mentioned, into bundling is really putting our toe in the water and trying to learn where the opportunities might be. I mean, this is very new for us. I think it's very new for many in the industry. So I think it's premature to say exactly what we hope to get out of that other than get some knowledge and look for where the opportunities might present themselves.

I think that the partnership with Encompass certainly creates some interesting opportunities to bundle and to have hospitals in markets where we have an Encompass present to take that risk and to have a much higher degree of confidence in the clinical outcomes and the patient satisfaction of the patients in the bundle pilot. So, right now, it's learning and trying to assess where those opportunities may be in the future.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Great. And then maybe for a follow-up on Encompass, is there anything additional you can share what you learned in the first quarter? How's the integration of the HealthSouth facilities and Encompass going?

<A – Jay Grinney – HealthSouth Corp.>: Well, we're very, very pleased with the partnership with Encompass. I had the pleasure of attending a leadership conference; I guess it was earlier this week. Time flies. And I was just so impressed by the entire leadership team of that organization and, more importantly, with the culture of that organization. April Anthony and her senior management team have created just a truly best-in-class Home Health and Hospice operator.

The initial integration I think is going along quite well. We have not yet transitioned our existing Home Health agencies over to Encompass, but we are very close to being able to do that, and I'm very confident that the partnership between our two organizations is going to be very, very successful.

<A – Doug Coltharp – HealthSouth Corp.>: And Gary, this is Doug. Just a clarification on that; we're not going to flip a switch and transition all 25 of our agencies on one day. There is an integration process that needs to take place as those agencies transfer over to Encompass and that will be staggered. My

guess is that we'll start some of those prior to the end of the first quarter, but that activity will probably extend through Q3.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Great. Thanks very much.

Operator: Your next question comes from the line of John Ransom of Raymond James.

<Q – John Ransom – Raymond James & Associates, Inc.>: Hi. Good morning. Two quick ones; First of all, I assume we're just going to move straight to segment reporting. So, is there any reason to think that preceding the integration of the HealthSouth agencies that you'll just be a Home Health division with the Encompass revenue and approximately \$72 million of EBITDA?

<A – Doug Coltharp – HealthSouth Corp.>: John, you're right. We will move to segment reporting beginning with Q1 and actually, even though the operational integration will not have occurred beginning with Q1, the revenues from our existing Home Health agencies will be part of the Home Health segment which is going to be predominantly Encompass' numbers.

<Q – John Ransom – Raymond James & Associates, Inc.>: What does that add to the EBITDA of the unit once it gets fully put in, in revenue?

<A – Doug Coltharp – HealthSouth Corp.>: I don't have a revenue number for you off the top of my head. I think it's probably between \$25 million and \$30 million. The EBITDA contribution would be somewhere in, call it, the \$4 million to \$5 million range.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay. And, Jay, this is a hard question to answer, I know, but what is the latest on the Hill with respect to post-acute care's contribution or no contribution to the doc fix?

<A – Jay Grinney – HealthSouth Corp.>: That is a hard one. We're up there, I guess, two weeks ago. We had over 100 meetings with various members, and it was very hard to glean much from those meetings. I think as everybody has probably read in the last several days, there have been reports about a short-term doc fix, which really doesn't come as much a surprise, but no discussion on the pay-fors.

The only thing that I've heard is probably the same thing that you've heard is looking at adding additional time to sequestration and possibly looking at DSH. So, right now, we don't know the duration. We believe it will be a patch. A patch would be maybe \$12 billion depending on how long that is, say, six to nine months, maybe \$12 billion. Where they would get that, I think is anybody's guess.

I will say that when we have been on the Hill – when we were on the Hill, we talked about the issues that are near and dear to our heart, one of which is site neutral payments. And we were quite positively surprised by the fact that that did not seem to be as big of an issue with the members that we met with. And I think that that was reflective of the fact that site neutral payments were not explicitly mentioned in President Obama's budget. I'm not sure why that was excluded. I think some of the members that we met with and the staff were speculating that since the IMPACT Act was passed last year and since that Act provided a roadway for moving to post-acute payment reform and included in that reform would be exploring the concept of site neutral payments that that issue has sort of been put to bed, if you will. But going back to my initial comment, it's really just very hard to know what the pay-fors might be.

<Q – John Ransom – Raymond James & Associates, Inc.>: Thanks so much.

Operator: Our next question comes from the line of Josh Raskin of Barclays.

<Q – Josh Raskin – Barclays Capital, Inc.>: Hi. Thanks. Good morning. Just a follow-up on two of the items that you guys mentioned in the guidance, the first, the \$3 million difference on Encompass. I think you said that had to do with management roles. So just curious what happened from time of the announcement until today? And then the second item, the \$10 million of what you guys are calling

incremental investments, I'm just curious if there's some level of that type of investment on certain projects that we saw in 2014, and whether any of these costs will continue into 2016 and beyond as well?

<A – Jay Grinney – HealthSouth Corp.>: I'll take the second one first. There was modest cost in 2014, but very, very modest. We did not add anybody – we didn't add a lot of people in the hospitals. The department here in the corporate office was not started. We had some modest bundling costs and, of course, the Cerner contract had not been increased. So it was very, very modest in 2014. Virtually all of those costs are going to continue going forward.

We made the decision going into 2015, especially with the additional EBITDA contribution from our Encompass partnership, that we were in a position to be able to make an investment in the operating platform that would bring long-term value to the company and long-term value to the shareholders. So it is a cost – those are costs that we will continue to incur going forward.

In terms of the equity roll, I'm going to ask Doug to respond to that.

<A – Doug Coltharp – HealthSouth Corp.>: Sure, Josh. So we announced the transaction back in late November, and that was based on the signing of a definitive agreement. In the definitive agreement, we had agreed with April Anthony and the Encompass management team about a minimum amount of equity roll that was required for the deal to close. The management team was not required to make a decision on how much they were going to roll until the closing, which occurred at year-end.

Based on the very attractive incentive structure that we created within the equity participation, and I think based on the very positive discussions that we had both preceding the announcement and following the announcement regarding the opportunities that our two businesses would have in a combined entity, April and her management team chose to roll a number that was far in excess of the minimum required. That determination was made in the closing process at year-end, and it led to an increase in the minority interest.

<Q – Josh Raskin – Barclays Capital, Inc.>: Okay. Got you. So it's just \$3 million of minority interest coming out of there?

<A – Doug Coltharp – HealthSouth Corp.>: That was strictly – the equity roll again was about three times the minimum required. It was a very positive sign.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, and I was going to say the same thing. I mean, we see this as a very, very positive sign. As I mentioned earlier, April and her team are just truly exceptional. And having them commit their own dollars into this partnership really underscores how much confidence they have, and certainly reinforces the confidence that we have that this partnership is going to bring significant long-term value to our shareholders.

<Q – Josh Raskin – Barclays Capital, Inc.>: Got it. Does that have any impact on the purchase price or cash payments by HealthSouth?

<A – Jay Grinney – HealthSouth Corp.>: No, not the percent roll. It was something that we were including in the negotiations. We would not have done the deal had there not been an equity roll. I would tell you that.

<A – Doug Coltharp – HealthSouth Corp.>: It did reduce our required cash outlay.

<A – Jay Grinney – HealthSouth Corp.>: But it didn't impact the purchase price, but it did have a positive impact on the cash we had to put out for the transaction.

<Q – Josh Raskin – Barclays Capital, Inc.>: Right. Okay. Perfect. Thanks.

Operator: Your next question comes from the line of Dana Nentin of Deutsche Bank.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Hi. Good morning. Thanks for taking the question. Just to follow-up on the bundled payment topic, I was wondering if you could give more color on your thinking around the base case and expected impact on your business from these initiatives, maybe, if you could give a percentage range of your discharges in those hospitals that might be impacted and then also how you plan to structure it?

<A – Jay Grinney – HealthSouth Corp.>: Well, in terms of the number of discharges, it's going to be fairly small. As you know, the way the Model 3 is structured, first of all, we're going to be putting five hospitals in that those hospitals would begin in April. And then the way the Model 3 is structured, we can choose from a list of diagnoses that we would want to bundle, and we are doing four different diagnoses.

So, as you can see – as I mentioned before, this is really for us to gain some knowledge. I don't think anyone should be modeling any significant benefit in 2015 to the bundling initiative. It's really designed to give us some knowledge that we don't have right now. And so, you've got five hospitals, and in those five hospitals you've got four different diagnoses. I don't know exactly what that number is, but it's pretty small.

So, I don't know if that helps, but it's really designed to just give us that initial baseline understanding of how this bundled system would work. And more importantly, how would we be able to influence some of those downstream decisions with respect to discharge status of our patients once they leave our facilities and to what extent can we influence those downstream providers to enhance the overall outcomes of those patients.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Got it. Thanks. And then just as it relates to the claims denials issue, is there an opportunity to move to a different MAC? And if so, what would be the process to do so?

<A – Jay Grinney – HealthSouth Corp.>: That is a great question and we have wanted to do that forever. This particular MAC has been the most difficult to deal with. We don't know why we have worked non-stop, it seems like, trying to influence the process over there. It's an exception. The fact is we can't do it. It's just a – the barriers are such that we don't have any options. So, we've explored that. We've looked to try to move; we can't. So we're kind of acknowledging that reality and saying, okay, we're going to have to spend some money and we're going to have to do what we need to do to try to deal with this particular MAC.

<A – Doug Coltharp – HealthSouth Corp.>: There was a time when CMS had expressed some willingness to consider providing the option for companies providers such as us to change the MAC designation from predominantly based on the location of the headquarters facility to the jurisdiction in which the hospital resides. But I think they quickly realized that was going to create an administrative burden on them so they removed that option. Whether or not it could arise again in the future is unknown, but we're certainly not counting on it.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, and when that option was offered, we formally declared that we wanted to go down that path of having the individual hospitals be administered by the MAC with responsibility for that jurisdiction. So we were actually – two, three years ago, we were hoping we would not be in this position, but it is what it is.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Got it. Thank you.

Operator: Your next question comes from the line of Whit Mayo of Robert Baird.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hey.

<A – Jay Grinney – HealthSouth Corp.>: Hey, Whit.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hey. Just back on the bundled payment pilot program just for a second, why is 5 the right number? Why not 10 and how did you select those specific facilities? Is there any common denominator with the patients to the programs or the services? And why Model 3 versus 2 and is there any specific DRG you're most interested in?

<A – Mark Tarr – HealthSouth Corp.>: Hey, Whit, this is Mark. So there is nothing magical about 5. We wanted to choose a representation of enough hospitals to give us some accessed information and some experience. We did look at it by diagnostic category, by hospital, by our own performance against what we had estimated as being the target prices that were out there.

So there was a lot of thought that went into it. Obviously, we want to minimize our financial risk, which would be very little, but we also wanted to make sure that we had an opportunity to work with our hospitals that showed the best promise within these categories. So, we've chosen, as Jay said, the four diagnostic categories – one is stroke, one is simple pneumonia, one is sepsis, and one is double joint – so we have two hospitals that have stroke. So – and just a reminder, the Model 3 is what applies to post-acute; Model 2 is for acute only.

<A – Jay Grinney – HealthSouth Corp.>: And, Whit, the general answer to your question is this is new. And it didn't seem prudent to jump all-in with this pilot. We think we can gain a lot of information with the number of hospitals that we've chosen. As I mentioned and as Mark has said, we may go with additional hospitals later in the year, but we just think it's prudent to take this somewhat cautiously and make sure that when we participate we have a full appreciation for what it takes to manage in that kind of environment. And I'm confident that we'll learn a lot.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Great. And my follow-up is just around mix in the quarter. Doug, can you just talk a little bit about that? It looks like Medicare slipped a little bit year-to-year, maybe that's just a function of the inability to bill Medicare for the de novos. And then also if there's a good number to think about for D&A for 2015 pro forma for Encompass. Thanks.

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. So with regard to the mix; a couple things there. In terms of the overall Medicare mix, we did see a little bit of an increase in Medicaid as we commented earlier. We think that that was due to the expansion of those programs in a couple of key states like Ohio; Colorado comes to mind as well. Again, it remains a very small percentage of our overall business. We think some of that increase is sort of a one-time in nature as those programs get expanded and the enrollees come in. But, overall, not a dramatic change in the Medicare mix.

With regard to the types of conditions that we're treating, by and large, there was a lot of consistency there. We did see a little bit of a decrease in neurological. And that was the primary difference that we saw. In terms of the impact on depreciation and amortization in 2015 from the Encompass transaction, it's an increment of about \$12 million.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Okay. Thanks.

Operator: Our next question comes from the line of Chad Vanacore of Stifel.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Hey, good morning.

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

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Of the three de novos that opened up in the quarter, how many of those have actually met the criteria for Medicare certification by now?

<A – Jay Grinney – HealthSouth Corp.>: All of them have.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Okay. Good. And then...

<A – Doug Coltharp – HealthSouth Corp.>: They all had by the end of 2014.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Okay. And then, when you start rolling up or start reporting your Home Health and Hospice business, are you going to put the outpatient business in there as well?

<A – Jay Grinney – HealthSouth Corp.>: We will not.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Okay. Are you going to continue reporting that separately, or is that going to get rolled into inpatient?

<A – Doug Coltharp – HealthSouth Corp.>: It's going to stay as part of inpatient.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Okay. And then, you mentioned that you've got some debt refi opportunity. If you were going to issue 10-year debt today, where do you think it will come out?

<A – Doug Coltharp – HealthSouth Corp.>: I think it probably wouldn't be too far from what you saw us do in January of this year. My guess is, if I were to put a broad range out there, it would be somewhere between, on the very low end, say 5.375%, and on the high end maybe 5.625%.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right. Thanks a lot.

<A – Jay Grinney – HealthSouth Corp.>: You bet.

Operator: [Operator Instructions] Your next question comes from the line of Kevin Fischbeck of Bank of America Merrill Lynch.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: All right, great. Thanks. Just wanted to go into your guidance, I guess it includes acquisitions on the Home Health side, which I think was a spending target. I mean, how do we think of that in terms of revenue acquired? And when you do make acquisitions there, what are you buying? Are you buying licenses that you just plan to grow? Or are you buying turnarounds or are you buying well-run agencies that you just want to tuck in?

<A – Jay Grinney – HealthSouth Corp.>: All of the above in terms of acquisition opportunities. And what was the first part of your question?

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Well, I think you have an acquisition number in your slides around Home Health, but I wasn't sure how much revenue that kind of – I think that was a dollar amount spent, not a revenue target. How much are you thinking about as far as revenue?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. What we don't do is breakdown revenue and EBITDA contributions from every single acquisition. I would say that, in 2015, the overall contribution from the acquisitions is fairly modest. I mean, a lot of the growth year-over-year is a function of maturing the acquisitions made in 2014, particularly the larger one that was done in the fourth quarter down in Florida. So, what we aren't going to be doing is breaking out the revenue and EBITDA contributions of each acquisition, in part because some of these acquisitions are fairly small and they're relatively small cash outlays.

And we just think that it makes more sense to just put the focus on the guidance number. It does include some acquisitions. And the good news is Encompass is very successful at acquiring. As I mentioned, the development pipeline is very robust and they have some that are already in the LOI stages and very close to being completed. So we're pretty confident that the amount of contribution from acquisitions in 2015 is a very achievable number.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. And then, I guess in your slide, you have 2016 as being the time when you might look at other adjacencies. Can you talk a little bit about what you're thinking there and how important is it to offer a continuum of services in your markets versus just focusing on one or two business lines?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. The 2016 timeframe was only to underscore that in 2015, we are really going to be focusing on integrating the home health partnership. I think that the platform that we're creating frankly gives us the continuum that we need in this evolving delivery system. A delivery system that is characterized by coordinated care and coordinated payments.

In that coordinated payments environment, we believe that many of the arbitrary silos that have been created by Medicare that have been created exclusively to determine how providers get paid, SNFs, ERF, LPACs on the facility side and then of course home health and hospice on the homecare side. That at least the facility silos will go away. I mean, if you think about it in a bundled payment environment or in an ACO payment environment, now there's a single check.

And whether or not the patient is in a SNF, or an ERF or an LPAC, becomes immaterial. And so, our view of that new world order is that, to provide a continuum or post-acute care, you really only need facility-based post-acute capabilities and home-based post-acute capabilities. And so we believe that we have the facilities that we need and within those facilities, over time, subject to the regulatory relief that we're going to be seeking to be able to offer a full range of facility-based post-acute services. So, we think we're providing and building the foundation for that continuum as we speak.

In terms of looking at other post-acute services, that's really going to be opportunistic. And whether or not it's in 2016, 2017 or beyond, I think that's just – it's way too early to tell. Obviously, we have talked in the past that the other post-acute service that makes sense for us as providers, we've certainly seen the benefit is long-term acute care. But as everyone knows, that segment is undergoing a tremendous change with the new patient criteria, and there's a pretty wide range of views on what the impact is going to be for LPACs in that new patient criteria environment. And we're certainly going to be watching that with interest, but we're going to be very, very, very cautious about moving into that space prematurely.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay, great. Thanks.

Operator: At this time, there are no further questions. I'll now return the call to Mary Ann Arico for any additional or closing remarks.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Laurie. As a reminder, we will be attending the Raymond James Conference next week. If you have additional questions, I will be available later today. Please call me at 205-969-6175. Thank you.

Operator: Thank you for participating in HealthSouth fourth quarter 2014 earnings conference call. You may now disconnect.