HealthSouth
Q1 2017 Earnings Call

PARTICIPANTS

Corporate Participants

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

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

April K. Anthony – Chief Executive Officer, Encompass Home Health & Hospice

Barbara Jacobsmeyer – Executive Vice President-Operations, HealthSouth Corp.

Other Participants

Sheryl R. Skolnick – Analyst, Mizuho Securities USA, Inc.

Gary Lieberman – Analyst, Wells Fargo Securities LLC

Kevin Ellich – Analyst, Craig-Hallum Capital Group LLC

A.J. Rice – Analyst, UBS Securities LLC

Joshua Raskin – Analyst, Barclays Capital, Inc.

Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch

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

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to HealthSouth's First Quarter 2017 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 will 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 Doug Coltharp, HealthSouth's Chief Financial Officer.

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

Thank you, operator, and good morning, everyone. Joining me on the call today are Mark Tarr, President and Chief Executive Officer; Barb Jacobsmeyer, Executive Vice President of Operations, April Anthony, CEO of Encompass Home Health and Hospice; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations. As a reminder, Crissy Carlisle, our Chief Investor Relations Officer is on personal leave for couple of weeks and is not participating in today's call. We look forward to having Crissy back shortly.

Before we begin, if you do not already have a copy, the first 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 2 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, 2016, and the Form 10-Q for the quarter ended March 31, 2017, 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 Mark, 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 Mark.

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

Thank you, Doug, and good morning to everyone joining today's call. We're off to a good start in 2017. Inpatient rehabilitation segment volume rebounded in Q1 and remained strong in our home health and hospice segment. These volume increases, combined with growth in revenue per discharge in our IRF segment, drove top-line growth of 7.1%. Our teams continue to actively communicate the HealthSouth value preposition to referral sources, patients, caregivers and payers. In the first quarter of 2017, we saw improved conversion rates from referral to admission for managed care payers, including Medicare Advantage, and we continue to see increases in the number of stroke patients sent to our hospitals.

We also continue to advance the clinical collaboration efforts between our IRFs and Encompass Home Health locations. The Q1 clinical collaboration rate, as shown on page 6 of the supplemental information accompanying our earnings release, was 28.9%, up 630 basis points over Q1 of last year. In February, we launched our TeamWorks initiative to identify, codify, and extrapolate best practices across all overlap markets.

In addition, we enhanced our use of clinical data analytics to further improve patient outcomes by minimizing preventable readmissions to acute care hospitals. This same focus on clinical collaboration has also resulted in more patients with a discharge path back home versus a skilled nursing facility. These combined efforts between our facility-based and home-based services are assisting in our quality metrics, as our discharging community was 78.5%, or 340 basis points better than the UDS expected outcome, and our discharge-to-SNF was 9.7%, or 360 basis points better than the UDS expected outcome.

While we made progress with our strategic priorities, and our top-line growth was good, we did experienced margin pressure in both segments. In our IRF segment, this was primarily due to a planned increase in full-time equivalents resulting from additional staffing year-over-year at the former Reliant hospitals, and a planned investment in additional clinical staff due to additional regulatory reporting requirements for our hospitals. These staffing increases are important for our hospitals to maintain the high-quality outcomes we expect for our patients.

Margin pressure in our home health and hospice segment was due primarily to the Medicare home health reimbursement rate cuts that became effective January 1 of 2017. These factors notwithstanding, we grew consolidated adjusted EBITDA for Q1 by 4.5%. We also continue to generate high levels of free cash flow. Adjusted free cash flow for Q1 of $147.5 million was up 5.8% over Q1 of 2016.

I'd like to turn now for a moment to provide you with our thoughts on the developments in Washington related to the Affordable Care Act, bundling pilots, and the pre-claim review demonstration in home health. First for the Affordable Care Act, while we continuously and closely monitor the legislative process in Washington around the Affordable Care Act, working both with internal and external lobbyists and the major trade associations for the industry, we do not need to take a position on any repeal-and/or-replace legislation at this time, nor does its lack of universal support in Washington cause us immediate concern. The Affordable Care Act does not directly impact key Medicare policy areas that enable us to provide care and services to our primary patient – Medicare.

Our population – our primary concern under the Affordable Care Act is connected to the reimbursement cuts to which hospitals, including our in-patient rehabilitation hospitals, are subjected. These cuts were imposed in order to help offset the cost of the Affordable Care Act's expansion of consumers' access to insurance coverage. If the Affordable Care Act's coverage expansion is substantially scaled back, then the hospital cuts intended to pay for the expansion, especially the permanent productivity adjustment cuts, should be commensurately reduced or eliminated as well.

Moving to bundles, neither delays nor any potential movement of bundles from mandatory to voluntary programs changes our strategy, or desire and willingness to participate in alternative payment models. Longer term, we believe healthcare will migrate to an episodic environment, and we embrace any movement where more focus is placed on the patient and the patient's total episode of care. As Doug will discuss in more detail during his comments, we believe, based upon the feedback we are receiving from the various acute hospitals we approached, we are well ahead of other post-acute providers in the development of strategies and capabilities to effectively address pilots such as CJR.

We packaged the information, HealthSouth's value proposition, using data specific to each market in a manner that is digestible for acute care hospitals. So whether or not bundles stay mandatory or become voluntary, we believe the progress we're making to educate the acute care hospitals will result in more collaboration with our inpatient rehabilitation hospitals and home health agencies.

Turning now to the home health pre-claim review demonstration, as you know, at the end of March, CMS decided to pause the Illinois pre-claim review demonstration and postponed its expansion to Florida. We are pleased with the pause and believe it will allow the industry to work collaboratively with CMS to more effectively identify and prevent fraud.

We're focused on the long-term success of our company. Our strategy is clear. The IRF segment is going to continue to be very attractive because of the types of patients we treat. We also believe that home health is part of any long-term post-acute solution, given its cost-effectiveness. Our combined platform of these two businesses, facility-based and home-based services, positioned us to be highly effective and partnering with acute care hospitals and treating post-acute patients over the entire episode of care. In addition, both of our segments benefit from a demographic tailwind resulting from the ageing of the baby boomers and the expanding Medicare beneficiary population.

As I mentioned in the beginning of my remarks, we are pleased with the start of the year, and we remained confident in our strategy and ability to execute on our key operational initiatives. Therefore, we are reaffirming our full-year guidance ranges of revenue between $3.85 billion and $3.95 billion, adjusted EBITDA of $800 million to $820 million, and adjusted EPS of $2.61 to $2.73 per share.

And with that, I'll turn it over to Doug.

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

Thanks, Mark, and good morning again, everyone. I'll take a few moments to walk through the details of the quarter and elaborate on a number of the concepts that Mark alluded to in his discussion. As Mark just summarized, Q1 was a solid start to the year, characterized by solid operating performance in both segments. During Q1, consolidated net operating revenues increased by 7.1% and consolidated adjusted EBITDA rose by 4.5%. Diluted earnings per share of $0.70 for Q1 increased by 14.8% over the prior-year period, benefiting from lower interest expense, a lower effective tax rate, and a reduced share count.

As Mark mentioned, we continue to generate high levels of free cash flow, as can be seen on slide 13 of the supplemental materials, Q1 adjusted free cash flow of $147.5 million increased by 5.8% over Q1 2016. We extended our track record of utilizing free cash flow to expand the capacity of our two business segments via high-quality growth opportunities, and complementing these investments and growth, shareholder distributions. As depicted on slide 17, during Q1 approximately $39 million of free

cash flow was deployed to core growth opportunities, and approximately $40 million was returned to our shareholders in the form of common stock dividends and share repurchases.

As we think about cash flow for the final three quarters of the year, please note that we have revised our estimate for 2017 cash taxes to a range of $95 million to $115 million from the previous estimate of $120 million to $175 million. This revision stems from the approval we received from the IRS for a tax accounting method change related to billings denied under prepayment claims reviews. This is good news in that we are no longer required to pay taxes on revenue that has not been received because of a prepayment claims denial. The immediate impact was to replenish our NOL by approximately $130 million, creating a tax benefit of approximately $54 million.

Please note that this results in a tax deferral, as income taxes will be payable if and when the denied claims are paid. As may be seen on slide 16, we essentially consumed the replenished NOL in Q1, and thus we estimate that cash taxes for 2017 will be ratably spread over quarters two through four.

Our funded debt was reduced by $63 million during Q1, resulting in a leverage ratio at the end of the quarter of 3.7 times. We have no significant debt maturities prior to 2020, and ended Q1 with approximately $479 million of unfunded availability under our revolving credit facility. We continue to enjoy one of the strongest balance sheets in the post-acute sector, and given our real estate ownership position, this advantage will be further highlighted with the adoption of the new lease accounting standards beginning in 2019.

Turning now to our business segment results, IRF revenues increased by 5.8% in Q1, driven by a combination of pricing and volume. Net revenue per discharge increased 3.6% owing to our patient mix, as we made further progress on treating stroke and neurological patients. For Q1, neuro was approximately 22.1% of our patient mix and stroke was approximately 18.3%, both representing year-over-year and sequential quarter increases. Discharge growth for Q1 was 2.8%, including same-store discharge growth of 1.6%. I'll again remind you that the 2.8% same-store discharge growth we posted in Q1 2016 benefited by an estimated 80 basis points to 100 basis points due to leap year.

IRF segment adjusted EBITDA of $205.4 million for Q1 rose 4.3% over the prior-year period. SWB for Q1 was 50.2% of revenues, an increase of approximately 80 basis points over the same period last year. As Mark discussed, the year-over-year increase in SWB was primarily attributable to an increase in FTEs, arising from achieving target staffing levels in the former Reliant hospitals, our planned investments in additional clinical staff due to increased regulatory reporting requirements, and also the ramp-up of

new stores. Bad debt expense for Q1 was 1.9% of revenue, down from 2.1% in Q1 2016. The decrease was primarily attributable to the resolution of the administrative payment delays that impacted collections in 2016.

As can be seen on slide 20, the level of new prepayment claims denials during the quarter was relatively consistent with that experienced over the course of 2016. As may also be gleamed from slide 20, we continue to see no evidence of progress on reducing the very substantial and growing backlog of claims awaiting adjudication.

Moving to the home health and hospice segment, Q1 revenue increased by 13.5% and adjusted EBITDA rose 5.8%. The segment growth was driven by volume, with admissions increasing 19.6%, including 13.9% attributable to same-store growth. And similar to Q4, approximately 20% of the same-store admissions growth can be traced through the clinical collaboration with HealthSouth IRFs. The effects of higher volume were partially offset by a decrease in pricing, as revenue per episode for Q1 declined by 1.4%. The pricing decline was a result of the Medicare reimbursement reductions, partially offset by a higher therapy mix, primarily related to clinical collaboration.

While we're on the topic of clinical collaboration, and as Mark mentioned in his remarks, we continue to make tangible progress on this important initiative, which is focused on improving patient outcomes over a longer episode of care, and doing so in a cost-effective manner.

As is depicted on slide 6, our clinical collaboration rate for Q1 was 28.9%, an increase of 630 basis points over Q1 2016. As Mark also discussed, we launched our clinical collaboration TeamWorks initiative in February, and our teams are actively engaged in identifying and codifying best practices to be standardized across all overlap markets.

It will take some time for these new practices to be fully implemented in all overlap markets, but based on our previous success with TeamsWork initiatives, and the enthusiastic commitment of our associates at HealthSouth and Encompass, we are confident this approach will help facilitate the achievement of our 35% to 40% collaboration rate target in the intermediate term.

As I have mentioned in the past, the progression towards this objective is more likely to be a step function than a smooth linear ascension. And I note specifically that as we move into the back half of this year, we will be comping against 2016 collaboration rates for already reflected substantial gains.

Just to conclude my comments on the home health and hospice segment, Q1 adjusted EBITDA increased 5.8% over the prior-year to $23.9 million. Operating expenses rose as a percentage of revenues due to the reduction in Medicare reimbursement rates; a higher cost per visit, which was driven by an increase in therapy patients; and salary and benefit increases.

I'll take a moment to elaborate on the therapy mix impact here. We have stated previously that more than 55% of patients discharged from our IRFs require and qualify for home health services. Not surprisingly, given the conditions we treat in our hospitals, there is a heavy component of therapy continuation embodied in the home treatment plan of patients discharged from our facilities. As compared to home nursing services, therapy services generally carry both a higher reimbursement and a higher cost per visit, resulting in a lower gross margin percentage, but higher gross margin dollars.

Please also note that the home health pre-claims review demonstration which was scheduled to expand into Florida has been postponed for a minimum of 30 days, with a 30-day notice to be provided prior to reinstatement. We believe we are fully prepared for the PCRD expansion, with the exception of hiring additional FTEs, which can be initiated when notice of reinstatement is received.

I'll close my remarks with a brief update on our risk-sharing pilot strategies. As we have discussed on these calls beginning with Q3 of last year, our initial focus has been on developing a proposal to serve as a collaborator with certain acute care hospitals on fractured DRGs in certain CJR markets. We established a goal of approaching 20 to 25 acute care hospitals located within 18 to 20 CJR markets by the end of Q1, with a further objective of having four to six collaborator agreements in place by mid-year.

As I updated you on our Q4 call, speculation that the new administration would convert CJR from mandatory to voluntary, together with the low degree of financial risk faced by acute care providers related to CJR in 2016 – as a reminder, the risk corridor is at 5% for the current year – has significantly decrease the prioritization and sense of urgency of the acute care hospitals to engage in risk-sharing on this program. The delayed implementation of the cardiac shift bundled payment program until at least October 1 has only served to endorse this view.

Nonetheless, we believe the data we have assimilated and the value proposition we have articulated in preparation for the collaborator discussions are resonating with acute care hospitals, and in a number of

instances have led to requests for preferred provider agreements specific to the CJR DRGs. As Mark stated, regardless of the timing or mandatory nature of these pilots, we continue to believe that the progression towards episodic and value-based payment models will continue and eventually accelerate.

We continue to focus on building the tools necessary to serve as a value-added partner to payers and acute care hospitals for all of their post-acute needs. This includes developing the analytical and clinical capabilities to effectively serve as a true post-acute care navigator, a role we expect to begin piloting later this year.

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 Sheryl Skolnick of Mizuho.

<A – Mark Tarr – HealthSouth Corp.>: Good morning, Sheryl, this is Mark.

<A – Doug Coltharp – HealthSouth Corp.>: Good morning, Sheryl

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Good morning, Mark, Doug, and the entire HealthSouth family. And congratulations, this is a good result and a nice first quarter for the year.

<A – Mark Tarr – HealthSouth Corp.>: Thank you.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: I do want to – and I know it's not easy, although you make it look that way. I do want to just focus, if I may, on home health and try to understand a little bit more of what's going on with the support and overhead cost here, because as I look at your cost of services from that slide 10, which is extremely helpful, but you managed to keep the expense ratio flat year-over-year for cost of services, despite the mix, and despite the increase in therapy and therapist

cost. But it looks to me more like the support and overhead costs rose as a percent, and that seems to have driven more of the operating cost increase.

So, is that something – first of all, what's going on there as – help me to understand why we're not talking about that cost increase a little bit more, rather than the cost per visit and therapy costs? That's number one. And number two is, that something that can be addressed to further offset the, what's clearly margin compression or compression of growth rate, due to the pricing change?

<A – Mark Tarr – HealthSouth Corp.>: April, would you like to give insight to that?

<A – April Anthony – Encompass Home Health & Hospice>: Sure. Sheryl, I don't think there's anything systemic happening there. I think overall you're seeing the rate pressure cause all of the categories to go up as a percentage, when we're seeing that top-line rate pressure. Our first quarter does always tend to be a quarter, from a support and overhead costs, where we'd make a few core investments, things like our annual leadership training happen in that first quarter, and as our organization grows, that as a total number continues to increase on an annual basis. And so I think there's a handful of things that are sort of unique to Q1, and if you look back over the history that tends to be true.

We generally see that improving margin as we get out away from the Q1 kind of start-of-the-year expenses that hit us. But I don't think there's anything really systemic there, I think that we're beginning to absorb the impact of that rate pressure and create the incremental volume that can help us manage through that, and I think that's really been the focus.

We did make some adjustments in sales. If you look at our sales expenses, up a little bit, and that's because we've got to really support that strong revenue growth. I don't think that's going to stay at a high level, because those people that have been added to our team in the late fourth quarter and early first quarter, obviously it takes a little while for a sales person to become a productive resource within the organization. So we see a heavier weight of their cost to the first quarter without the corresponding revenue implications. I think as we move into the second quarter, we're already beginning to see those early-year hires begin to perform. But I think we'll see improvement in that trend throughout the year, and I just don't think there's anything substantive going on in that category that concerns us.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: But you didn't answer my question, which is that it begins to abate as a percentage, and also because there are somewhat first quarter items. So, you can make some progress through the year on that?

<A – April Anthony – Encompass Home Health & Hospice>: Absolutely, and if you go back and look at last year, you'll see the same trend occurring.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Yeah. Okay.

<A – Doug Coltharp – HealthSouth Corp.>: And Sheryl, I might – this is Doug – I might point to just a couple of other things in there. One of which is a corollary to what April just mentioned, and that is, for instance, as we're adding the care transition coordinator position to all of our overlap markets, which is an important investment, some of that investment is ahead of the volume that will eventually flow from the clinical collaboration activities. And then the second piece there is that Encompass, within its group medical program, is seeing a little bit of this – the trend we experienced in 2015; they hadn't experienced it then, they're seeing a little bit now. We think we've got our arms around that, but there is a higher benefits cost that's flowing through the statement as well.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Okay. Could I just switch gears for my follow-up question? Can you explain to me on that one slide, where I think it was 20 but I'm not sure, where you went through what's going on with the backlog of payments on denied claims and the review of denied claims. So I must have misunderstood something from your press release. Exactly what were you referring to that seems to have eased, versus what's still a problem?

<A – Doug Coltharp – HealthSouth Corp.>: So we basically have two components to our bad debt expense. We have the normal, regular way aging-based reserve, where for whatever reason we see a slowdown in AR collections. Over time, we begin to accrue – we begin to reserve a percentage of that, based on the perception of uncollectibility. And then we have the prepayment claims denials, where instead the reserve is established based on our historical track record for moving those through the adjudication process and getting to a favorable resolution.

Last year, we saw an uptick in AR that was specifically related to an increase in the aging-based reserve. And the specific cause for that was an administrative payment delay at Cahaba. It had to do with staffing issues, it had to do with some software upgrades, and so forth. It took longer than it should have, but

that eventually got resolved. And when it did get resolved, we were able to take down that reserve. The activity on the second piece, the prepayment claims denials, as can be seen in the chart on the right-hand side of slide 20, has been relatively consistent with that exhibited over the course of last four quarters or so.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Okay. Now I've got it. Now I recall what was going on there. Thank you very much, I appreciate that explanation.

<A – Mark Tarr – HealthSouth Corp.>: Thank you, Sheryl.

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning, guys.

<A – Mark Tarr – HealthSouth Corp.>: Good morning, Gary.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning. Thanks for taking the question. Maybe just a follow-up on that last comment on Cahaba. Could you give us any more detail on any conversations you had over the last quarter with Cahaba or with CMS, and maybe your thoughts on if the new administration will approach it any differently than the prior?

<A – Mark Tarr – HealthSouth Corp.>: Hey, Gary, it's Mark. So, we continue to have dialogues with Cahaba, and actually they've been very open to discussions. It's – we last had our meeting, I think about a month ago now. It was still early on with Dr. Price's influence in his new role within the administration. So they didn't – weren't able to provide any additional insights, but we do continue to have dialogue, we have discussions, it's positive in nature, in terms of expressing our thoughts and in terms of how we view things. But we've not seen a lot of movement one way or the other in terms of improvement in the situation.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay. And then maybe, Doug, just going back to your comments on the increase in the collaboration rate being a step function, can you just provide some more detail around why it is a step function and not more kind of a linear increase?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. I think if you look back, we've essentially already gone through two waves with regard to the implementation of our clinical collaboration practices and protocols. You may recall that we really didn't launch at all until the second quarter, late in the second quarter, really the end of the second quarter, in 2015. And that is because, as the partnership between Encompass and HealthSouth was formed, even recognizing the opportunity, we first had to make sure that anything that we were going to be doing with regard to approaching referral sources and patients about clinical collaboration, had to be vetted by legal and compliance. And then, we also had to put together at least a baseline of standardized practices for our associates to follow.

We took the first six months following the formation of the partnership to form those, and then began rolling those out. Those were what I'll call just a real baseline practice. Over the course of the next year or so, we developed some additional learnings, we got more comfortable with what was working and what was not working, and in an informal way we began to roll out best practices. It was also during that time that we were able to increase the clinical collaboration rate based on two important staffing components that I've mentioned before.

The first is, we identified that one of the keys to success was to take the role of care transition coordinator that Encompass had historically used effectively with other referral sources, and to get one in each overlap market specifically dedicated to one of IRFs. It has taken time to go out and recruit and train and have those folks put in place and form relationships with our hospital CEOs, but as they have been doing that, we've seen the benefits in clinical collaboration from rolling that out. At the same time, we had to reorient to some extent the Encompass clinical workforce from one that had been heavily focused on nursing services to one that had a larger therapy component, and so that required recruiting a different type of field technician. And again, we've been doing that.

Those things have been largely in place and we really started to see the benefits of those types of activities beginning in the half 2016, and that's when you saw some very large year-over-year increases in the collaboration rate. The marginal utility related to those specific actions is diminishing, as you would expect to be the case. And that is why we have launched the clinical collaborations TeamWork. It's to get much more detailed and much more formalized about what best practices really mean, and then to be able to extrapolate those and make sure that if there are additional staffing changes that need to be made, that we get those in place. That's going to take a little while, and so it is conceivable

that as we move into the second half of this year, we will not see the same year-over-year rate of increase, although we do continue to, we do expect to continue to see a forward progression.

<A – Mark Tarr – HealthSouth Corp.>: Gary, it's Mark. As Doug said, we're very positive on the outlooks of TeamWorks and its ability to continue to increase the collaboration rate. We had a chance to be out in Dallas last week and address the entire group that's participating as part of this TeamWorks initiative with our subject matter experts, along with the KPMGs, helping us from a process standpoint, and I tell you, the enthusiasm in that room and the willingness and eagerness to work together in a collaborative manner between both the IRF staff and the home health staff was very, very encouraging.

<A – Doug Coltharp – HealthSouth Corp.>: And Gary, please don't interpret any of my comments as either walking back our stated goal of getting to a 35% to 40% collaboration rate in the near term, or as any diminished enthusiasm about the importance and the effectiveness of the partnership between our IRF and home health business segments.

<A – Gary Lieberman – Wells Fargo Securities LLC>: Got it. That's very helpful. Thanks a lot.

Operator: Your next question comes from the line of Kevin Ellich of Craig-Hallum.

<A – Mark Tarr – HealthSouth Corp.>: Good morning, Kevin.

<A – Doug Coltharp – HealthSouth Corp.>: Hey, Kevin.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Good morning, guys. Thanks for taking the questions. Kind of just following up on Gary's question with the collaboration, a lot of very good information, and I see the target's going to be 35% to 40% over the next few years. I guess it makes a lot of sense with the discharges. Have you guys ever quantified what the revenue and EBITDA impact could be as you get to 35% to 40%?

<A – Mark Tarr – HealthSouth Corp.>: We have, and I think the pieces are out there for really anyone to do that, because some of it – we don't put that out there because it would be a financial projection,

right? But you can – you could look for instance at the fact that – and what we've stated is, in general, each one of the patients that comes out of a, one of our IRFs and goes into home health requires about 1.2 episodes of home healthcare, and those episodes generate about $3,100 to $3,200 in revenue per episode. And then as I just mentioned in some of my remarks, they have a slightly higher cost per visit than standard nursing services, so a little bit of a lower gross margin, but it's a pretty profitable patient.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Got you, and understood that with therapy. And then the only other question I had was, what sort of impact did you expect – do you expect from the Easter holiday? Or do you expect one this year?

<A – Doug Coltharp – HealthSouth Corp.>: We're more focused in terms on the year-over-year comparison. We were a little bit more focused for Q1 on the impact of leap year. Having said that, the shift in the Easter holiday does make a difference. It's – the movement of a holiday like Easter is a lot more difficult to quantify. So we're not making any excuses regarding Q2 volume based on the shift in Easter.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Got it. Thank you.

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

<A – Mark Tarr – HealthSouth Corp.>: Good morning, A.J.

<A – Doug Coltharp – HealthSouth Corp.>: Good morning, A.J.

<Q – A.J. Rice – UBS Securities LLC>: Hey, how are you guys? A couple of question or follow-up I guess. On the payer mix trends, I see that both in the IRF and the home health side, MA continues to be up 90 basis point in IRF, 160 in home health, and then your also managed care generally higher and Medicaid, on the home health side at least, a little under pressure. Any – when you drill down what's driving those changes, and do you see those continuing to shift the payer mix?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. We would continue to see a payer mix shift, especially on the IRF side, Medicare Advantage has been growing a little bit faster rate than most of the other segments. Currently it's about 9% of our total cases and it grew about 10% in Q1, so we would continue to see Medicare Advantage. One comment on Medicare Advantage growth is that we've been successful on having more and more of our contracts now, rather than be linked to a per diem, they are linked to the CMG. So that's a trend that we've seen the last several years and we continue to see that make progress. We've also seen, as Doug pointed out, we've seen a larger increase in our stroke mix, in terms of the conversion rate when we get a stroke patient that's covered with Medicare Advantage Plan referred to our hospital, we're seeing more and more success in getting them converted to an admission. So those are all factors impacting that payer mix.

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

<A – Doug Coltharp – HealthSouth Corp.>: And A.J., to elaborate on Mark's comments, in each of the last five years we have seen the percentage of Medicare Advantage contracts that are paid on a case rate versus a per diem basis increase, and it's now approximately 55% of our MA contracts are paid on a case-rate basis. It's also the case that over each of the last five years, we've seen the delta between the Medicare Advantage payment and Medicare fee-for-service rates decrease. And in the most recent quarter, we're at about a 14% gap between them. If you roll the clock back five years, we were closer to 25%.

<Q – A.J. Rice – UBS Securities LLC>: Okay. Interesting. Maybe just quickly on the labor front, you commented on that a bunch in your prepared remarks, but interesting in the comments about some of the pressures you felt, you didn't say anything about just absolute rate increases. Are those remaining pretty steady? And maybe I've missed this from previous comments, but your comment about increased staffing around new reporting requirements, maybe I should know that, but what was that – what is that referring too?

<A – Mark Tarr – HealthSouth Corp.>: A.J., I'm going to ask Barb Jacobsmeyer to answer that.

<A – Barbara Jacobsmeyer – HealthSouth Corp.>: So I have two things. On the salary pressures, we're not feeling that enterprise-wide. We do have some particular markets that are more challenging than others, and we're addressing those as needed. To the comment on the regulatory, there was added information that needed to be put into our IRF pie, which is the document that's submitted with each of our claims. That required the additional information that the clinicians needed to be able to pull. So we

needed to add some of the clinical staff to be able to handle that. We've estimated about 40 minutes per claim has been needed for additional staffing for that.

<A – Mark Tarr – HealthSouth Corp.>: A.J., the additional...

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

<A – Mark Tarr – HealthSouth Corp.>: ...information was tied to the care tool implementation. And as Barb said, I mean, that affected all the information that's submitted, particularly from a therapy standpoint, on every one of our patients. So that had an impact about 40 minutes per patient, so that adds up.

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

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

<A – Mark Tarr – HealthSouth Corp.>: Hi, Josh.

<A – Doug Coltharp – HealthSouth Corp.>: Hi, Josh.

<Q – Josh Raskin – Barclays Capital, Inc.>: Hi. Good morning, guys. Just on the IRF update, the Medicare IRF update and macro sort of superseding the normal process with a 1% increase, I guess, two questions on it. One, how are you guys thinking about next year and offsetting a little bit of that pressure? And then as we think about 2019, I can't find it in macro, is there a potential sort of giveback or some sort of catch-up in 2019 to make up for that? Does sort of the wage component catch up, or how does that work in the next year, do you guys know?

<A – Mark Tarr – HealthSouth Corp.>: Yeah, Josh. I'm not aware of any makeup or any catch-up out there in 2019. Relative to the update that was rolled out late last night or yesterday afternoon, we're still doing our research and homework on the numbers to see the impact. The 1%, at least on first blush,

does seem to be in line with what our expectations were, and it's what we had in our Outlook slides, our business Outlook slides, so that seemed to be in line.

<Q – Josh Raskin – Barclays Capital, Inc.>: Okay. All right. That's fine. And then, just on those staffing levels at Reliant hospitals, and I appreciate the answer to some of A.J.'s questions, but are you guys now at target staffing levels at the Reliant hospitals? And then I guess, on a related note, is there any wage pressure in hiring those clinicians? Or is this just simply, we needed more bodies?

<A – Mark Tarr – HealthSouth Corp.>: We are now at our staffing metrics at the Reliant hospitals, and have been now for a quarter or two. A year ago we were still ramping up, so that's why you're seeing the increase year-over-year, but we are there now. And so, we – relative to labor salary increases, the majority of those staff that were hired were therapists, and somewhat additional nurses as well in some of those hospitals. But that's all has been factored into what we put in terms of our 3% expected increase this year in salaries.

<A – Doug Coltharp – HealthSouth Corp.>: We did have to do some salary adjustments to the Reliant staff that were remaining with us after the acquisition. But virtually all of that took place in the first half of last year, so we're already anniversaring that component, Josh.

<Q – Josh Raskin – Barclays Capital, Inc.>: Okay. All right. So it's not salaries, it's just bodies, it sounds like.

<A – Doug Coltharp – HealthSouth Corp.>: It is.

<A – Mark Tarr – HealthSouth Corp.>: That's right.

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

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

<A – Mark Tarr – HealthSouth Corp.>: Good morning, Kevin.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Good morning. So just following-up on that labor question. If you didn't have these kind of discrete items, what would labor cost have been on the IRFs side?

<A – Doug Coltharp – HealthSouth Corp.>: I think it accounted for most of the 80 basis point increase. When we look at the, what drove the year-over-year change in SWB, it was almost specifically FTE-related, because the pricing increase for the IRF segment was kind of sufficient to offset the increase in SWB, in terms of the merit increase and another increases there.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. So you would have kept it flat year-over-year if not for this?

<A – Doug Coltharp – HealthSouth Corp.>: Slight to maybe some modest leverage on top of that.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. So you would have had a little leverage, so I guess if you think about next year's rates probably being a little bit less than this year rates, labor costs should – you would still expect it to be at least flattish, is that the way to think about it?"

<A – Mark Tarr – HealthSouth Corp.>: Well, there are a lot of ifs in there. We would hope so, but it's really going to depend on whether or not there are any additional regulatory requirements thrust upon us. But it's certainly the case that our response – and this applies to both business segments, to the rapidly changing environment in healthcare – has been to invest in the business, and invest in the business in a manner that we think is producing higher-quality outcomes for our patients and underscoring our value proposition, and also preparing us better to serve effectively as a partner with payers' in acute care systems and episodic payment models.

There is going to come a time when pricing normalizes for both business segments. Right now, it looks like that's more 2019 than 2018, and there's also going to be a time when the investments that we've made in the business lead to productivity gains.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay, that's helpful. Just second question, anything in the nursing home reg last night that you thought might be good for either of your businesses? I guess that they're going to change the way that they pay for therapy in 2019. Does that potentially keep more people into an IRF, or push people more quickly into home health? I mean, is there any impact from that, in your mind?

<A – Mark Tarr – HealthSouth Corp.>: Kevin, we've not had a chance to get, to dig into the SNF update. We certainly spent the majority of our time trying to address the [ph] IRFA (45:42) rule that came out late in the game yesterday. So can't really comment on any impacts, positive or negative, from the SNF update.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. Fine.

<A – Doug Coltharp – HealthSouth Corp.>: We do believe that the trend of disintermediation that the SNFs have been experiencing is going to continue, and we know through our own efforts on home health that we're being effective in contributing to that disintermediation.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: All right, thanks.

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

<A – Mark Tarr – HealthSouth Corp.>: Good morning, Whit.

<A – Doug Coltharp – HealthSouth Corp.>: Good morning, Whit.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Hey, thanks. Just maybe a couple random ones. Can you just remind us where you are on some of your IT investments, I think you've called it ACE IT or something, and maybe how many installs you've made at this point, how many more are forthcoming? And are you seeing any noticeable benefit from these investments on ADRs or anything, or just broader update on where you are, and the benefit, would be helpful? Thanks.

<A – Mark Tarr – HealthSouth Corp.>: So, Whit, we're now – well over 100 hospitals have full implementation for ACE IT. This year, 2017, will be the final year of the initial rollout, we will have all of our hospitals have it implemented by the end of the fourth quarter. We do have two hospitals in Puerto Rico that will have it installed in Q1 or at least the first half of next year.

Relative to overall documentation or impact on ADRs, we anecdotally have gotten positive feedback in terms of the quality of our documentation that is tied to ACE IT and our ability to ensure that we have complete documented items, complete with the signatures and dates and other areas of aspect that are reviewed from a documentation standpoint. We think longer-term, it will absolutely help us on the ADR front. We think it's also helped us in our ability to position ourselves from episodic standpoint with APMs going forward.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. Imagine physician satisfaction and recruiting has been helpful too.

<A – Mark Tarr – HealthSouth Corp.>: It does.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Yeah. And maybe my second question for Doug is, on the lease accounting changes that you've referenced, I know you've seen some of the stuff we've published on it and you and I have discussed this in some detail, but I'm just maybe curious how you think it really differentiates HealthSouth versus the peer group, and really curious how your conversations with the banks are going and how the banks will actually treat this accounting change going forward? Thanks.

<A – Doug Coltharp – HealthSouth Corp.>: You know, so first, we like our position – we've always liked our position with regard to real estate ownership because of the flexibility it gives us in managing our portfolio of hospitals, and also because of the protection it gives us in a difficult rate environment against the kind of increases in your occupancy expense that can reside in a lease arrangement. I mean, at its core, a lease is a highly inflexible non-pre-payable debt obligation with an escalating interest rate. Really sounds pretty attractive.

So the fact that two-thirds of our real estate is owned is a real advantage, and when that comes onto the balance sheet and when the disclosures related to that are made, I think as the saying goes, when tide goes out, we're going to find out who's swimming naked.

In terms of the reaction from the banks, I really can't comment on that. I know it's not a factor for us in our discussions with the banks, because of the position that we hold. My guess is if we get into an environment where the debt markets aren't nearly as liquid as they have been over the last several years, and that will come because they cycle through, that it's those kinds of factors that are going to lead to a differentiation in borrowing rates and availability of funds.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. Thanks, I appreciate it.

Operator: At this time, there are no further questions. I will now return the call to Doug Coltharp for any additional or closing remarks.

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

Well, great. Thank you, anyone. If anyone does have additional questions, please send them to Travis Wilson of our Investor Relations department at travis.wilson@healthsouth.com. We ask for a little bit of your latitude and patience, in Crissy's absence, to work with us. We want to be responsive to all of your questions. The protocol that we have put in place is that Travis will work with me and other members of our executive management team to respond to your question via phone or email as quickly as possible, but initially he's going to just gather your questions up and then consult with us. So, thank you again for your time and attention today and for joining today's call.

Operator: Thank you for participating in HealthSouth's first quarter 2017 earnings conference call. You may now disconnect.