PARTICIPANTS

Corporate Participants

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

Other Participants

Whit Mayo – Analyst, Robert W. Baird & Co., Inc.
Frank Morgan – Analyst, RBC Capital Markets LLC
Sheryl Robin Skolnick – Analyst, Mizuho Securities USA, Inc.
John W. Ransom – Analyst, Raymond James & Associates, Inc.
A.J. Rice – Analyst, UBS Securities LLC
Chris Rigg – Analyst, Deutsche Bank Securities, Inc.
Kevin Ellich – Analyst, Craig-Hallum Capital Group LLC
Sarah E. James – Analyst, Piper Jaffray & Co.
Joanna Gajuk – Analyst, Bank of America Merrill Lynch

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone and welcome to HealthSouth Second Quarter 2017 Earnings Conference Call. At this time, I would like to inform all participants that their lines are in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] Today's conference call is being recorded, and if you have any objections, you may disconnect at this time.

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

Crissy Buchanan Carlisle, Chief Investor Relations Officer, HealthSouth Corp.

Thank you, operator, and good morning, everyone. Thank you for joining HealthSouth's second quarter 2017 earnings call. With me on the call in Birmingham today are Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, Executive Vice President of Operations; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations. April Anthony, Chief Executive Officer of our home health and hospice segment also is participating in today's call via phone.

Before we begin, if you do not already have a copy of the second quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website at www.healthsouth.com. On page two of the supplemental information, you will find the Safe Harbor statement, 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 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 projection, 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 quarters ended March 31, 2017 and June 30, 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, reconciliation 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 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, Crissy, and good morning to everyone joining today's call. The second quarter was another solid quarter for HealthSouth, marked by strong revenue growth in both segments and continued progress on our strategic initiatives. Inpatient rehabilitation segment discharge growth of 3.5% for the quarter reflects continued volume gains in stroke and neurological patients, areas in which we have developed significant clinical expertise. We continue to invest considerable resources into clinical and management systems and protocols that will allow us to further enhance the patient experience and provide unparalleled outcomes. Our commitment to technology includes the ongoing implementation of our inpatient rehabilitation-specific electronic medical record system known as ACE IT.

As of June 30, 2017, we had installed this system in 111 of our 125 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. We are using this system to enhance staff recruitment and retention, connect with other providers and health information exchanges, and improve patient care and safety. We've developed a predictive risk model to identify patients at risk for acute care transfer, and implement intervention strategies as part of the plan of care. We began the roll out of this model across our hospitals in the third quarter of last year, and hope to substantially all of our hospitals using this model by the end of this year. Our home health and hospice segment continued its trend of double-digit volume growth with admissions increasing 19.7% in total, and 13.3% on a same-store basis for the quarter.

We continued to invest in sales and marketing employees in the quarter, and expect to continue to generate significant admissions growth for the balance of the year. The home health and hospice team also did an excellent job in managing cost and increasing productivity, leaning to margin expansion in spite of a challenging reimbursement environment. We attribute our industry leading cost per visit to market density, daily monitoring of staff productivity, caregiver optimization and full utilization of homecare home base. The increase in our general and administrative cost in the second quarter primarily resulted from our investments in two key strategic initiatives; our recently announced rebranding and name change; and our TeamWorks clinical collaboration initiative.

Earlier this month, we announced our rebranding and name-change initiative. As the healthcare industry continues to move increasingly toward integrated delivery models, value-based purchasing and site neutrality, we believe we are well-positioned via our complementary facility-based and home-based service offerings. The research we conducted in the initial phase of our rebranding process indicated that our existing two-brand strategy was limiting the awareness and understanding of our operating strategy and value proposition with key constituencies. Our company was not being consistently recognized for the unique strengths that are shared across our businesses, specifically coordination of care across the post-acute continuum through collaboration with acute care providers and partners, leadership in delivering integrated inpatient and home-based care, and a patient-centered focus that leads to superior patient outcomes.

This led us to the conclusion that a single strong brand would more effectively facilitate the achievement of our business goals and better communicate our strategy and value proposition to key constituents. The name chosen for this one unified brand, Encompass Health, signifies our commitment to creating a seamless system where high-quality care is coordinated by clinical teams across the inpatient and home settings, while also honoring the legacy of our foundational businesses. We believe the increased awareness of our complementary service lines and value proposition will produce tangible benefits, including an enhanced pipeline of potential joint venture partners for IRF development projects, increased referrals from acute care hospitals and physicians, increased referrals and improved contracts from non-Medicare payers and increased conversion rates through a better awareness and understanding of our service offerings by physicians, patients and caregivers.

Further, we believe this change will continue to enhance our position as an employer of choice leading to improvements in employee and physician recruitment and retention. The rebranding and name change combined with our TeamWorks clinical collaboration initiative will assist in driving the clinical collaboration efforts between our IRFs and home health locations. Clinical collaboration between our two segments is a competitive advantage in the evolution towards integrated care delivery and episodic value-based purchasing models. As of June 30, 2017 approximately 60% of HealthSouth IRFs were located within a 30-mile radius of one of our home health locations, and our clinical collaboration rate in those markets was 28.6%, a marked improvement from 15.7% in the first quarter of 2015 following our acquisition of Encompass Home Health and Hospice, and a 500-basis point improvement over the second quarter of 2016.

However, the success of clinical collaboration within our overlap markets varies widely, and necessitates the identification and standardization of best practices to facilitate continued progress on clinical collaboration rate increases. We launched the TeamWorks clinical collaboration project in February of this year and have completed the assessment and design phases. We began piloting the redesigned clinical collaboration process in July, and we expect full implementation across our overlap markets by the end of 2017. Our clinical collaboration rate goal is 35% to 40% over the next three years. We also continue to make progress in our development efforts in both segments. In the first six months of 2017, we added joint venture hospital locations in Gulfport, Mississippi, a new State for us; and Westerville, Ohio.

We've also expanded the capacity of our existing hospitals by 44 beds, and continue the development of seven previously announced IRF projects that will come on line over the next two years. Our home health and hospice segment also has added to its portfolio in the first six months with the acquisition of six home health locations, as well as the opening of one de novo home health location, and two de novo hospice locations. The pipeline for both segments remains filled and active with exploratory opportunities.

I'd like to turn now to the regulatory environment and what's happening in Washington. Yesterday, CMS released the final rule for 2018 IRF-PPS. Although, we are only beginning our analysis, the pricing update is in line with our expectations, and changes from the proposed rule appeared generally positive. We are appreciative of CMS' refinements to the 60% Rule presumptive methodology contained in the final rule. And we believe the unintended consequence of the conversion to ICD-10 was to deny consistent access to care for certain Medicare beneficiaries who require IRF-level care. We also appreciate CMS' measured response to the stakeholders' comments regarding proposed removal of certain ICD-10 codes from presumptive methodology, as this, too, would have been an adverse impact on consistent access to care. We will continue to work constructively with CMS, both individually and through our industry trade groups on matters of this nature.

Next, I'd like to turn to the subject of bundles. Earlier this year, CMS delayed the implementation of the cardiac bundle and the expansion of CJR to January 1, 2018. Neither this delay nor any potential movement of bundles from mandatory to voluntary programs changes our strategy or

desire and willingness to participate in alternative payment models. We continue to believe healthcare will continue to migrate to episodic payment models. In regards to the home health pre-claim review demonstration, recall that at the end of March this year CMS decided to pause the Illinois Pre-Claim Review demonstration and postponed its expansion to Florida. As we stated previously, we're pleased with the pause and believe it will allow the industry to work collaboratively with CMS to more effectively identify and prevent fraud.

Finally, the proposed 2018 home health rule was released on July 25. Upon initial review, it appears the proposal for calendar year 2018 would decrease rates by 0.4% for episodes ended on or after January 1, 2018, which is in line with our previous expectations. We had assumed the expiration of the rural add-on would be included in proposed rule, and it was. But Congress could elect to extend this provision by year-end. Doing so we changed the rate impact in proposed rule from a decrease of 0.4% to an increase of 0.1%. In addition to the payment update for 2018, CMS is proposing major reform to the home health reimbursement to begin 2019 in the form of a new reimbursement model referred to as the Home Health Groupings Model or HHGM.

A significant element of the change is a shift to 30-day periods from 60-day episodes. As currently written, the Home Health Groupings Model would not be budget neutral, and would substantially redistribute revenue between agencies in a manner that would likely result in significant disruptions and access to care from the Medicare beneficiary population. Further, we along with others in the industry, question whether CMS has a unilateral authority to make non-budget neutral change without action by Congress.

At this time, I'll ask April Anthony to comment on the industry's efforts to work with CMS to address this proposed payment model.

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

Thank you, Mark. We are pleased to be engaged members with the Partnership for Quality Home Healthcare, and have been working with a partnership to advance the understanding and analysis associated with the new HHGM proposal. We believe that in addition to the questions of statutory authority that Mark raised earlier, there are also a number of substantive technical flaws in the HHGM proposal, which create a significant redistributive effect among provider types and geographic regions throughout the country.

Based on our analysis, we believe that such redistribution is highly likely to create access to care issues in numerous markets across the country. For example, our analysis shows that there are number of counties across the U.S. where 100% of the home health providers located in those counties would go from positive to negative margins in their home health segment, under this proposal, and that would be an unacceptable answer for seniors residing in those counties.

Furthermore, we believe as it relates to a payment shift away from therapy services that this proposal reflects a disregard to the changing dynamics in the healthcare delivery system that have resulted in a migration of patients away from higher-cost skilled nursing facilities and into the home with the support of home-based therapy services. In addition to this shift, which has been prompted by the advent of initiatives such as the BPCI, ACOs and CJR, we have also seen a shortening of acute care hospital lengths of stay resulting in patients coming home sooner and sicker with higher demand than in years past for skilled therapy service in the home. These realities are presently not accounted for in the HHGM methodology, and they result in significant redistribution of funding away from therapy-based services.

These realities must be thoroughly considered in the final version, and we look forward to sharing our perspectives in this regard with CMS. As a member of the partnership, we look forward to working with our industry peers to bring these technical flaws and concerns of legal authority to the forefront at CMS. We're encouraged by the spirit of cooperation and openness that we have seen

from CMS under this new administration, and believe that as we did with PCRD, we will be able to work with CMS in the coming months to address these valid issues and produce a better solution for the industry and the patients that we serve, as well as the Medicare program as a whole.

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

Thanks, April. We'll continue to work with the Partnership for Quality Home Healthcare to further analyze the proposed rule and provide comments and recommendations to CMS and Congress in the weeks and months to come. Before turning the call over to Doug, I want to touch base on guidance. Our previously provided full year 2017 guidance included $1 million in anticipated consulting fees related to improving brand awareness. It did not include the balance of the $6 million to $8 million in operating expenses related to the name change. In the first two quarters of 2017, we incurred $2.2 million in branding and name change-related expenses.

After incorporating this investment into our full year 2017 estimates, and revising our assumptions related to Medicare pricing in our home health and hospice segment to address better than expected pricing in the first half of 2017, and anticipated pricing for the second half of 2017, we are updating guidance as follows: Net operating revenues are increasing from a range of $3.85 billion to $3.95 billion to a range of $3.875 billion to $3.95 billion. Adjusted EBITDA is increasing from a range of $800 million to $820 million to a range of $805 million to $820 million. Adjusted EPS is increasing from a range of $2.61 to $2.73 per share to a range of $2.64 to $2.73 per share.

With that, I'll turn it over to Doug.

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

Thank you, Mark, and good morning, everyone. As Mark summarized, Q2 was another solid quarter with both of our business segments performing well. Our Q2 consolidated revenues increased by 6.6%, and consolidated adjusted EBITDA of $209.5 million increased 2.5% over the prior year period. Included in consolidated adjusted EBITDA were $3.4 million of operating expenses related to two of the strategic initiatives Mark discussed, $1.7 million for the rebranding and name change, and an additional $1.7 million for TeamWorks clinical collaboration.

As can be seen on slide 12 of the supplemental slides, these expenses were classified as general and administrative expenses. Adjusted earnings per share of $0.71 increased by 2.9%, benefiting from lower interest expense, a lower effective tax rate, and a reduction in our average share count. We continue to generate high levels of free cash flow as can be seen on slide 15. Adjusted free cash flow for the first half of 2017 of $254 million was essentially flat with the first half of last year in spite of higher cash taxes related to the exhaustion of our federal NOL, and the planned increase in our maintenance capital expenditures.

First half cash flows benefited from a decrease in working capital, primarily related to improve collections of accounts receivable. Our key assumptions for adjusted free cash flow can be found on slide 18, and please note that we assume working capital will increase in the second half of 2017. We continue to deploy free cash flow to fund high-quality growth opportunities in both of our business segments, devoting $76.1 million to such projects in the first half of 2017. Mark provided the specifics on this investment in his comments. These investments were complemented by first half shareholder distributions of $61.6 million and $77.3 million in debt principal payments.

In July, our board of directors declared a quarterly dividend of $0.25 per share, indicative of continued confidence in our business model. We are one of the very few companies in our peer group to have initiated and sustained a quarterly cash dividend on our common stock. During Q2, our common stock traded at an average price high enough to trigger the redemption right under our 2% convertible senior subordinated notes. We elected to exercise [ph] as par (22:55) redemption

option, and essentially all of the holders responded by exercising their option to convert the notes into common shares.

In settlement of the notes we issued 8.9 million shares of common stock, and paid $600,000 in cash. Please note that our fully diluted share count as of March 31, 2017 had included 8.6 million shares related to the convertible notes. The conversion/redemption of the convertible notes resulted in $278 million reduction in debt in Q2. When combined with the aforementioned debt principal payments, total debt reduction for the first half of 2017 was $353 million, and we ended the second quarter with our leverage ratio at 3.3 times. We continue to exhibit one of the strongest balance sheets in the health care provider universe and are positioned with significant financial flexibility.

Turning now to our business segment results, IRF revenues increased by 5% in Q2, driven by a combination of inpatient volume and pricing increases, partially offset by a reduction in outpatient and other revenue. Discharge growth for Q2 was 3.5% including same-store growth of 1.6%. IRF segment net revenue per discharge increased 2.2% primarily as a result of patient mix, partially offset by a $2 million retroactive SSI adjustment, and a $3 million year-over-year reduction in prior period cost report adjustments.

You may recall from prior years that Q2 tends to be the quarter when we experienced the most significant retroactive pricing adjustments, and this year was no exception. These adjustments typically stemmed from the true-up of the cost reports filed for our hospitals on a December 31 reporting cycle, as well as the periodic updates to the SSI factor. The reduction in outpatient and other revenue experienced in Q2 was primarily attributable to the closure of six outpatient programs in the second half of 2016, and the inclusion of a $1.4 million provider tax recovery in Q2 of 2016.

The Q2 2017 IRF segment expense ratios as compared to the prior year were negatively impacted by the aforementioned prior period cost report adjustments, SSI factor update and the provider tax recovery in Q2 of last year. SWB for Q2 was 49.9% of revenue as compared to 48.6% in Q2 2016, an increase of 130 basis points. The out-of-period price adjustments and the provider tax recovery account for approximately 40 basis points of this rate increase. An additional 40 basis points is attributable to the ramp-up of new stores, and 20 basis points relates to staffing increases in the former Reliant hospitals.

SWB increases accounted for the residual 30 basis points. Same-store EPOB, excluding the former Reliant hospitals was flat year-over-year. Bad debt expense for the quarter was 1.6% of revenues, a decrease of 30 basis points over the same period last year. The improvement was primarily attributable to the resolution of the administrative payment delays we experienced through much of the last year. As can be seen on slide 22, we did see a decline in new prepayment claims denials as compared to both Q2 last year and Q1 of this year, but as we have previously stated, one quarter does not constitute a trend.

We also experienced a modest increase in both the recovery of previously denied claims and the number of claims receiving an ALJ hearing. Nonetheless, our backlog of claims awaiting the adjudication process continues to grow, and we see no tangible progress towards a resolution. IRF segment adjusted EBITDA for Q2 was $208.4 million, an increase of 2.1% over Q2 2016. IRF segment adjusted EBITDA margin for Q2 declined by approximately 70 basis points over Q2 last year. The aforementioned retroactive price adjustments and provider tax recovery impacted the margin by approximately 50 basis points.

Our home health and hospice segment exhibited strong operating performance in Q2, with segment revenue increasing 13.8% and segment adjusted EBITDA rising 26.2%. Revenue growth resulted from volume as admissions increased 19.7%, including 13.3% in same-store admissions growth. The effects of higher volume were partially offset by a decrease in pricing as revenue per episode declined by 1.5% similar to the level we experienced in Q1. As Mark discussed, our initial guidance for 2017 included an expected Medicare home health reimbursement reduction of 3.6%. The full

impact of this reduction informed the lower end of our guidance ranges, and partial mitigation was assumed at the higher end of the ranges.

As can be seen on slide 17, based on the first half results, we have revised our guidance considerations to an expectation of a 1.5% to 2% Medicare home health reimbursement reduction for 2017. Our Q2 home health and hospice segment adjusted EBITDA margin improved by 160 basis points as compared to the prior year period, attributable to lower cost of service driven by staffing productivity gains. A portion of the productivity gains relate to the maturing of prior period acquisitions, including CareSouth as those agencies fully adopt our business practices. The cost and service productivity gains were partially offset by continued investments in additional sales and marketing employees reflective of our growth trajectory.

And with that, operator, we'll open the line for questions.

QUESTION AND ANSWER SECTION

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

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

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Hey. Good morning. I'm just curious what the feedback has been in the field with operations and your development team since announcing the corporate rebranding? I mean, presumably it gives your operators an opportunity to reengage with discharge planners and hospitals, and not just new development opportunities. But just curious if there's anything to call out that you'd learned.

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Whit, this is Mark. In general, the feedback has been extremely positive. The TeamWorks initiative where you had and continue to have staff from both business segments working together collaboratively, making sure that there is a smooth transition with patients from an inpatient setting to a home health setting, they've been saying all along that would be easier to have one name and one brand going forward. As we've said, supporting two brands was preventing us to having the opportunity to advance our strategy through a one-brand process, with a one-brand name. So the feedback has been extremely positive and we think that the benefits of having this one brand going forward will be significant.

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. Just to follow up on that, Whit, one of the outcomes of the TeamWorks process with the participants not knowing that we were heading towards making this branding change, they came back with a slogan out of TeamWorks labeled The Power of One, and it really spoke to the need to unify the organization around a single brand.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. And if my notes are right, I think you guys have focused on establishing some preferred provider arrangements for call it integrated post-acute care solution. Just any update where those conversations are with hospitals or systems, how many agreements you may have in place either in active or legal review, and generally, what's your learning from those conversations.

<A – Doug Coltharp – HealthSouth Corp.>: Sure. You may recall that we had targeted initially a little over 20 hospitals that we wanted to approach in CJR markets with the idea of serving as a collaborator, as that term is defined in the CJR program. Obviously, given the whole focus on repeal and replace, and then also the deferral that Mark mentioned in some of the additions to CJR as well as the initiation of the cardiac bundle, the sense of urgency surrounding these issues with the acute care hospitals has dissipated pretty significantly. Nonetheless, we've used the opportunity to go in and to really highlight for some of the hospitals and the markets in which we operate, the value proposition of our IRFs and of our IRFs in home health segment working together.

In many instances, we've expressed the willingness to modify the collaborator agreement to a preferred provider agreement, which relates more to an agreement to shared data, and to work more closely in partnership with the acute care hospitals on certain types of patients. We have one such agreement that has now just been signed since the end of the quarter, that is in Tyler, Texas, and we'll be proceeding with, if you will, a post-acute network strategy pilot program there. And then we have other provider agreements which are currently in draft form. So they're productive discussions, but again, with regard to actual risk-sharing arrangements, I would say, that this has not been the focus, as you can well imagine, by the acute care hospitals out there right now.

<A – Mark Tarr – HealthSouth Corp.>: With these meetings are a prime example – you asked earlier about the branding strategy, and these meetings are a prime example where it helps to have one brand and one name when you walk in to meet with a group of administration of acute care

hospital or acute care system, versus having someone from HealthSouth and someone from Encompass Home Health that it becomes a little awkward to say you're an integrated delivery provider when you have two different names walking in.

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

<A – Mark Tarr – HealthSouth Corp.>: Morning, Frank.

<A – Doug Coltharp – HealthSouth Corp.>: Morning, Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Hey, just real quickly, I think you commented about the mix being on the home healthcare side as one of the reasons for changing your pricing assumption. And I'm curious, could you just give us any color around kind of where your mix stands today between rehab and what percentage of rehab, and then maybe looking at the mix between your collaboration markets and your overall markets.

<A – Mark Tarr – HealthSouth Corp.>: April, do you want to give some insight into that?

<A – April Anthony – Encompass Home Health & Hospice>: Sure. I would say, Frank, that our mix in the overlap markets is not dissimilar to what we see broadly. We've always been a company that has some niche specialty programs in the therapy and rehab area. We've been very active in coordinating with Model 2 bundled programs to become their home health solution. We've been active in working with orthopedic surgeons in the CJR bundles as well. And so overall, our therapy utilization is on the high side; north of 50% of our episodes get some level of therapy services. And so that's a measure that's consistent across all of our markets regardless of the overlap status.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. And one of my questions you actually answered in your prepared remarks about the effects of the rural add-on if that were to come back in. But just to be clear, in terms of that impact for 2018, was that specific to HealthSouth, or was that an industry number in terms of that going from a decrease to a small increase?

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. It's about 0.5% change nationally. For the Encompass
Home Health segment it'd be closer to 0.7%. So we'll have a little bit higher proportion of rural than does the national average.

<Q – Frank Morgan – RBC Capital Markets LLC>: Okay. Thank you.

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

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

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Thank you very much for that. Unfortunately, my phone died just as you were Mark about to talk about the various and sundry regulations, the final rule as well as the home health. But I think the final rule is pretty clear. And focusing, and I hate to focus everything on home health when the business did so nicely this quarter, it really did.

But just to understand a little bit here, so given the increasing linkage and the focus that you have and the synergy between the two businesses, obviously, with the branding initiative you're looking to go more in that direction, et cetera. To what extent – and I almost hate to ask this, but to what extent is your business model now even a little bit more at risk given this sort of surprise attack from CMS on the therapy episodes.

That would be sort of question number one. What thought are your giving to sort of a contingency plan should this prevail, while you're fighting hard against it? And two, to the extent that perhaps some of this aggressive stance against therapy utilization and home health rates in general, and payments in general, to what extent do you think that some of this might be rooted in the level of payment errors, and what is the industry and HealthSouth in particular doing to help the industry through its own error rates to get those things down so you'll be on stronger footing to argue against this?

<A – Mark Tarr – HealthSouth Corp.>: Well, I'll take that first question and then I'll ask April to answer the second one. Our strategy, long-term strategy, of working collaboratively with a facility-based and a home-based setting is directing us toward what we think is going to be an episodic environment moving forward. So we are committed to the strategy. There may be some pricing hits or some maybe regulatory pressures in the short term that we'll have to work through. If we need to adjust our near-term strategy, we can. But long term, we believe that we're headed down a path that will position us strategically for where CMS is moving with an episodic focus on overall care.

<A – Doug Coltharp – HealthSouth Corp.>: And I would just say further, the demand for these services is only going to continue to increase based both on the demographics of the population and also, as April mentioned in her comments, the movement which is already under foot to reduce the length of stay in acute care hospitals. And that means increasingly a larger number of patients with a higher acuity level are going to be moved out of inpatient institutions and into the home setting, and they are going to require home health therapy services. And if the cuts that are suggested, or the redistributions that are suggested in HHGM, were to go through, and we think that that is a huge if, because it is very early in the game, and as April addressed in her comments, there are many, many technical flaws within the model, that would result in a substantial decrease in the supply of those services in the face of the increasing demand, and ultimately that just can't be sustained.

<A – Mark Tarr – HealthSouth Corp.>: April, do you want to make some comments on what the industry is doing relative to the billing errors?

<A – April Anthony – Encompass Home Health & Hospice>: Yeah, absolutely. And I'd like to make a comment as well regarding shareholder short-term nature. So Doug and Mark mentioned sort of the long-term strategy and our confidence within the long run, episodic-based approaches in the totality of post acute are certainly going to lend themselves to the strategy that we're pursuing. In the short term, I would point you to the fact that Encompass continues to have industry-leading organic growth rates. And today, as I mentioned earlier, a lot of our sales and marketing focus has been on BPCI programs, which as you know, were heavily weighted to ortho-CJR programs, which are very ortho-oriented, and then to specialty programs with our orthopedic surgeon. That same team of assets can pivot, if necessary, to pursue a different avenue, to begin to have the same conversations we're having with orthopedic surgeons with our cardiac surgeons, and begin to make necessary shifts and adjustments.

And so I think, coming from a place of having a strong and well-established sales team that has produced, again, industry-leading organic growth rates quarter-after-quarter, is going to give us the opportunity over the course of the next 18 months as we simultaneously fight the battles with the inappropriate shifts that we think HHGM creates, it will simultaneously give us the opportunity to redirect our strong team in a direction that lends to where CMS is guiding us, as far as types of patients they'd like to see in home health. So I feel like we have both the short-term as well as the well-oiled long-term strategy, and we believe we can pursue both to the greater good.

As it relates to how much of the shift is because of the concern of improper payment rates within home health, I think you've hit the nail on the head that is absolutely at the heart of, I think, why we continue to see a steady drumbeat at CMS, the cuts and adjustments both regulatory as well as reimbursement cuts within the home health space, and as an industry, we are struggling with

frankly a flawed face-to-face regulation that Medicare put in several years ago, and if you look at those improper payment rates before the face-to-face regulation, it was in the mid-teens.

If you look at it now, post-implementation of the face-to-face rule, it's jumped up into the high 50%s. And that inconsistency really comes back to a very subjective rule in the form of face-to-face where home health providers are being asked to be responsible specifically for what physicians write on those documents. And so we are spending a great deal of time with CMS talking about that very issue, and getting some warm response that they recognize that are broadly subjective criteria is always going to be difficult to implement. And so we are at the same time that we fight against the HHGM proposal of some of the technical flaws within that, we are absolutely seeking to adjust the face-to-face regulation, so that we can create a more objective standard by which home health agencies could be measured. With that objective standard, we believe the improper payment rate drops dramatically just as it did before face-to-face came in place.

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

<A – Mark Tarr – HealthSouth Corp.>: Hello, John.

<A – Doug Coltharp – HealthSouth Corp.>: Hello, John.

<Q – John Ransom – Raymond James & Associates, Inc.>: Hey. Good morning. You guys sound chipper this morning, it's good to hear. Sorry, April gets to be the star of the show today. I think there's a lot more going on. One question I had April was the 60 days going to 30 days. You guys have a very high level of recertification. How do you think about that change? That's probably the question I get the most, and I can't really find a good way to think about it.

<A – April Anthony – Encompass Home Health & Hospice>: Well, at this point, it's really still 60-day episodes but with 30-day assessment periods within that. So we, at this point, don't have a full assessment of the impacts that would possibly come from these reassessments that have to happen at the midpoint in the episodes. But that's something that certainly as we begin to try to plough through the details further in the next few weeks and begin to model it, we'll begin to look at potential implications of that. You have seen and if you look at the supplemental slides back in the appendix section, you've definitely seen our ratio of research continue to decline over the past six or seven quarters, and you can see that information over on slide 34 in the supplemental information. So we do think that that's becoming less and less of a concern relatively each quarter.

<Q – John Ransom – Raymond James & Associates, Inc.>: So is the 30-day assessment that you have to loop the physician in and get physician sign off, or is this just a staff kind of paperwork documentation-type thing?

<A – April Anthony – Encompass Home Health & Hospice>: Well, just like we have to do now with our recertification business, you would ultimately have to get physician acknowledgment of that recertification, and how we understand it at this point.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay. And then the other question I had is, I mean, obviously, the geographic effects are very lumpy. Have you guys done at least been able to do a flyover to say we have X percent of our agencies and states that look they are net losers in this whole deal?

<A – April Anthony – Encompass Home Health & Hospice>: We are beginning to be able to look at the data now on a state-by-state basis. We had some pre-release work done based on the technical documents that was released back in December. We're conforming now that modeling to the rule that was proposed because there were some adjustments. We'll begin to be able to look at that on a state-by-state basis. But certainly, what we see is that there are some criteria that drive utilization. What we can't yet get our arms around from a level of detail that we have is how much of that is driven specifically by the geography versus the characteristics within that geography. And so

we are working with Dobson and DaVanzo through our work with Partnership to try to really slice and dice the data. But at this point we're conforming our pre-release model to the post-release information that we have, and then we'll begin to be able to slice and dice that data, and the Partnership will be releasing specific information as it becomes available.

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

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

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

<Q – A.J. Rice – UBS Securities LLC>: Hey. Thanks. Hello, everybody. On the home health, I have down – maybe this has been updated, but you were targeting $50 million to $100 million of acquisition spend. I think year-to-date you're running about $10 million, if I get my number right. And I wondered, is anything changing in the marketplace, or you're just going to see a lot of it in the back half as these reimbursement proposals frozen the market, either for buyer or sellers.

<A – Doug Coltharp – HealthSouth Corp.>: A.J...

<A – April Anthony – Encompass Home Health & Hospice>: A.J., I'll get that. Go ahead, Doug. Sorry.

<A – Doug Coltharp – HealthSouth Corp.>: I was just going to say, we had assumed all along that the acquisition pipeline would be back-end loaded. And we feel very good about what's currently in the pipeline and remain confident that we're going to wind up somewhere in that $50 million to $100 million range. With regard to any change on what's happening out in the marketplace and so forth, because of HHGM, I'll ask April to comment on that.

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. So we did have even some closings the day after the end of the quarter. And so I think we will most certainly confidently hit that $50 million to $100 million range. And so from a standpoint, the impact that HHGM will have on the marketplace, I think certainly that it will have us looking for agencies that fits that characteristic profile that fits well under HHGM. So would we go out and buy a long length of stay, high therapy agency tomorrow under the proposal of HHGM? Probably not. We would probably direct our efforts to shorter length of stay and lower therapy utilization agencies. That being said, we do believe that there are plenty of opportunities, and furthermore with hospice service line, which continues to be a nice growth piece for us, we will continue to pursue hospice acquisitions where we're looking at more like a 2% increase. And so that can also increase our growth profile in the back half of the year.

<Q – A.J. Rice – UBS Securities LLC>: Okay. Great. And then maybe just a follow up, a similar type question directed at the IRF space. I think I had down on this one with your bed expansion outlays we're going to be about $30 million to $40 million this year. And again, I think you had $8 million year-to-date. Is that just, again, back half-loaded or is there anything going on there?

<A – Doug Coltharp – HealthSouth Corp.>: It's predominantly a timing issue. We normally try to time our bed additions so that they're coming on in the third quarter, and again just really, just a timing issue there.

<Q – A.J. Rice – UBS Securities LLC>: Is there any reason to do it in the third quarter, for curiosity?

<A – Doug Coltharp – HealthSouth Corp.>: Really just in terms of the pacing throughout the course of the year.

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

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

Operator: Your next question comes from the line of Chris Rigg with Deutsche Bank.

<A – Mark Tarr – HealthSouth Corp.>: Hello, Chris.

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Hi, good morning. Just wanted to focus on the wage inflation at this point. It sounds like it's still pretty well controlled, but I guess you guys give a range. Is it skewed to the high end, or is it sort of right in the middle at this point?

<A – Mark Tarr – HealthSouth Corp.>: We've got, for both business segments in our guidance, we have salary increase of 3%. So we think we're going to be right at that 3%. You may be referring when you think about the range to our business outlook where we had 2.75% to 3.25%, but we had 3% in our guidance.

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Okay. And that's pretty stable year-to-year, correct?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. It's a slight increase over our prior year. We continue to put a lot of focus on labor. From experience over the past years, it's better to stay ahead of the curve and make sure you're at market and not fall behind. It's harder once you fall behind to get caught up. So we do a lot of market analysis, get the competitive rates. We look to make sure that from the clinical education side, which is very important for both our nurses and therapists, that we have offerings such as those to help provide areas for interest into our hospitals and home health agencies, and we also put a lot of focus on keeping our turnover under the industry standards. So all those things go into play in terms of making sure that we have a workforce that we can recruit and retain and keep our overall costs down.

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Great. Thanks a lot.

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

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

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Good morning, guys. Just a couple of questions. A lot has been asked and talked about so far. But it looks like you did a little acquisition in Illinois yesterday. I think that's your first entry in that state for home health. Are there other geographic areas that you'd like to expand into that you could call out?

<A – April Anthony – Encompass Home Health & Hospice>: Well, certainly, our priority from an acquisition perspective is to build our overlap markets. We're excited about this expansion in Illinois because it does give us access to a few more HealthSouth facilities. And so if you look at our map that's in the first page of the appendix on slide 21, if you see red dots with no corresponding yellow dots, that's the focus area for us.

<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>: Got it. And then HHGM, will you, I guess, strategically look at that and kind of parse around it in terms of the geographic areas that will be hit? I think John asked a similar question; sorry for the redundancy.

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. Absolutely. I mean, as much as we will do all that we can to work with CMS to make adaptation, it would be unwise for us to pursue regardless of the situation. We will look at HHGM as part of our analysis of acquisition. It's not to say that we wouldn't pursuit anything in those tougher markets. It's to say that we would price them accordingly to recognize the impact that's going to exist in those markets.

<A – Doug Coltharp – HealthSouth Corp.>: And just to elaborate on that, as April have suggested before, within our home health and hospice segment we enjoyed the lowest cost per visit out of any of the major international providers, which gives us a great advantage there. We have what we believe is the most highly motivated and well-trained clinical workforce being deployed, and the most highly trained and motivated marketing liaisons that are out there as well. So if these changes have a negative impact on the rest of the industry, that's going to open up opportunities for us both in terms of gaining market share where we already have a presence, and probably creating more attractive acquisition opportunities.

Operator: Our next question comes from the line of Sarah James with Piper Jaffray.

<A – Mark Tarr – HealthSouth Corp.>: Hello, Sarah.

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

<Q – Sarah James – Piper Jaffray & Co.>: Good morning. You talked about the significant benefit from rebranding, and I'm just wanting to understand the long-term context around that. So how do you see HealthSouth business mix evolving long term? Are you thinking this is more of an incremental shift, or are you talking about a meaningful shift, and how heavily does M&A play into the equation for any long-term business mix shift?

<A – Mark Tarr – HealthSouth Corp.>: We think there's substantial growth opportunities in both of our business segments. As part of our overall strategy, we're growing out IRF, we're growing out home health, and at the same time we're putting our focus, as April mentioned, on the overlap opportunities to have home health within 30 miles of any of our hospitals. Longer term, we think that CMS is moving towards more of a site neutral environment, episodic environment where you will be responsible for the overall care of a patient for a 60-day or 90-day period of episode, and we'll be positioned well for that environment with having a solid footprint in both a facility-based and home-based setting.

<A – Doug Coltharp – HealthSouth Corp.>: We would expect to continue the home health segment having a higher growth rate than the IRF segment, but it's off of a lower base, and a large part of that is again trying to fill in those markets where we currently operate in IRF but don't have a home health agency. But overall, I wouldn't expect – the name change and the rebranding was not intended to signal a significant shift in the business mix. It was intended to underscore for the market and for various constituencies, the fact that we do have these two business segments that are working very effectively together in a clinical collaboration effort.

<Q – Sarah James – Piper Jaffray & Co.>: Got it. That's helpful. And one clarification here, in the slides, it mentions that you're not sure CMS would have the authority to change the home health payment system in a non-budget neutral way. Just wondering if that's ever happened before where CMS made a non-budget neutral change without legislation.

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. I don't think we can speak to whether or not it's ever happened before. I know there have been specific situations in recent times when changes were purported to be budget-neutral, and upon implementation were deemed not to be. But this one is not even purported to be budget-neutral.

<Q – Sarah James – Piper Jaffray & Co.>: Thank you.

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

<A – Mark Tarr – HealthSouth Corp.>: Hello again, Sheryl.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Hi there. Two questions. First, just an observation, you're awfully brave for CMS to try doing something with a $1 billion cut that they don't

feel really robust about having the basis to do that. I mean, that sort of flies right in the face of Congress, at the place where the Secretary used to spend a lot of time. So forgive me if I'm a little bit cynical that maybe they might have actually done their homework there, and I'll wish you all the best in fighting this, because it does seem to be an unreasonable allocation of money.

But my real question for the follow up is this. You mentioned something interesting about bad debt and collections. From the tone of the press release, just the data that I looked at, I would have thought that you actually did make some progress, and that some of these backlog issues you experienced on pre-payment denials and the appeals process would have eased. But Doug, you're making it sound like this was just sort of a temporary reprieve and there isn't any real progress. Can you clarify that very important point as it relates to your cash flow, which, you know, always interests me?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. I wish I could offer you more optimism on that. First of all, the real positive impact in the quarter on bad debt, which drove it to 1.6%, was that last year at this time we were experiencing those administrative payment delays, predominantly at Cahaba, and those have gotten resolved through the course of the first half of this year, which caused the major swing in the receivables. It is true, as I mentioned in my comments, that we had a favorable quarter in terms of denials, new claims denials, both as compared to the second quarter of last year and the first quarter of this year, and hopefully that's sustainable. But our point there is, we've kind of seen some of these fluctuations previously only to see in subsequent quarters that it returns to historical levels, and that's kind of our assumption right now. But it was a favorable quarter in terms of a reduction in new pre-payment claims denials.

It's also the case that we did see a slight increase in both the number of – or the amount of recoveries of previously adjudicated claims, and the number of hearings taking place. But neither one of those was sufficient enough in terms of their increase to overcome what was an increase in the overall amount of claims awaiting adjudication. So the backlog continued to grow in spite of the fact that both the claims processed and the recoveries increased in the quarter.

And what we haven't had is we haven't had any substantive discussions with CMS during this period about a real meaningful resolution to the overall problem. If we're just relying upon a reduction in new claims and a slight increase in the processing in the backlog, that's very helpful to us from a working capital perspective, it's not going to meaningfully decrease that $120 million-plus that's hung up on our balance sheet.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Got it. Thank you very much for that.

Operator: [Operator Instructions] And your next question comes from the line of Kevin Fischbeck with BoA Merrill Lynch.

<A – Mark Tarr – HealthSouth Corp.>: Kevin?

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Hey. Good morning. Yes. Hi. This is actually Joanna Gajuk filling in for Kevin. Thanks for taking in the question here. If I may – can you hear me?

<A – Mark Tarr – HealthSouth Corp.>: Yes, we can.

<A – Doug Coltharp – HealthSouth Corp.>: Yes.

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Great. Yes. So two questions. So one is a new topic, rather a new question and then a follow up. So the first one on your comments about the medication efforts around the current year home health Medicare reimbursement, and you mentioned there's some outlier medication that you've been successful with. So what exactly you've done, and then is this kind of a way to think about it as being sustainable into the next year?

And I guess, this is happening also in conjunction in the increased therapy mix. So just can you flush that out exactly how you're mitigating this outlier change in the current year? Thank you.

<A – Mark Tarr – HealthSouth Corp.>: April, do you want to take it?

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. Happy to. So the mix changes, when you look at a rule in July and August timeframe, and even the final rule that comes out in October, you still are having to rely on your prior year's set of patients. And you're saying, if I had the exact same cohort of patients next year that I've had in the first eight or nine months of this year, what would the rate impacts be? And when we looked at that data in the fall of last year for the 2017 rule, that's where we came up with that little better than 3% total rate cut.

As we moved into 2017, we've seen some shifts happen in our patient mix, and by definition, that's going to happen frankly daily. And so it has been somewhat a mitigation in the outlier proportion, but more so it's been just a broad mix shift across different types of patients, different levels of acuity within even the same category of episodes, so not just the shift of therapy but standard patients that are just of higher acuity than those that we had last year. So it's always hard to predict that implication.

As it relates specifically to the outlier piece, one thing that we did find is that in our attempts to model the impact on our prior year patients, we really looked at the outlier cohort of 2016, rolled that forward to be the outlier cohort under the 2017 rules, and anticipated the cut associated with those. What we failed to anticipate last year was there were a number of patients that on a quantity of visit basis did not qualify as outliers in 2016, but now do qualify as outliers in 2017 because they by nature have long duration visits. So not a high quantity of visits, but the visits they perform has a large proportion of 15-minute increments, and therefore when you look at on a 15-minute increment basis, those patients began to jump in to the outlier category.

So what we saw is our proportion of outliers actually increased, and because those patients are sort of just moving into the edges of the outlier category, their average revenue per visit was actually quite a bit higher than we had originally expected, because most of their visits were still paid at the traditional rate, only a small portion being subsidized by the outlier proportion, compared to our prior year outlier patients which were solely based on volume of visits, those patients had a much lower, on an effective basis, revenue per visit. And so we saw some shift just in the types of patients that fell into these various categories, but on balance, it's just a slightly different acuity than we had this time last year in our patient mix that has caused our estimate to be a little more favorable than we had originally anticipated.

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: All right. And if I may, on the follow up on the big topic around the proposed HHGM. So how should we think about, when CMS talks about the overall reduction to the industry of 4%, is it just that they assume that there was certain number of 60-day episodes and now there will be only one 30-day episode, and there's not going to be the incremental 30-days that would have happened before? So when we think about those estimates from CMS, should we think about there's some, I guess, cost offsets in terms of just not providing the extra visit in that 30 days?

And also on your comment about readjusting, I think, your business development, how long would it take to actually have this kind of in place, and reach out to these [indiscernible] (01:03:27) and change the clinical protocols to feed those new patients? Thank you.

<A – April Anthony – Encompass Home Health & Hospice>: Sure. So we don't believe in CMS' modeling to-date that they've made assumptions about changed durations of episodes. So we don't think that the length of stay is what's creating the non-budget neutral effect. We think that it's truly just a redistribution has not come out equal. So we will certainly have to dig a little bit further into that. But at this point, we believe the 4.7% cut is not reflecting any changes in behavior relative to

length of stay or estimates on that. So we'll need to dig into that further to fully unpack that, but that's our understanding from our first line of review.

As it relates to pivoting our business development efforts, we feel like that is something that we can begin really early next year. Obviously, we've got a lot of things in flight for this year, and we think we will continue on that glide path for the balance of this year. But as we began to build our budgets for next year, which that process has actually already begun just a few weeks ago, with our business development team, we are really directing them at that point to look at the resources that they've put toward BPCI and CJR, and to pivot those resources and say, in this new world, we may need to redirect those efforts, which is sort of counterintuitive, but we may redirect those efforts to more traditional cardiac patients, general surgery patients, other things. And so we are looking at that process right now, and expect those sort of shifts in focus to begin early 2018.

Operator: At this time, there are no further questions in queue. I will now turn the conference back to Ms. Crissy Carlisle.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, HealthSouth Corp.

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

Operator: This concludes today's conference call. You may now disconnect, and have a wonderful day.