PARTICIPANTS

Corporate Participants

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

Other Participants

Whit Mayo – Analyst, Robert W. Baird & Co., Inc.
Frank Morgan – Analyst, RBC Capital Markets LLC
Sheryl Robin Skolnick – Analyst, Mizuho Securities USA, Inc.
Kevin Ellich – Analyst, Craig-Hallum
Chris Rigg – Analyst, Deutsche Bank Securities, Inc.
Dana Hambly – Analyst, Stephens, Inc.
Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to HealthSouth Third 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 speaker's remarks, there will be a question-and-answer period. [Operator Instructions] You'll be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I'll now turn the call over to 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 third 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, the third quarter earnings release, supplemental information, and related Form 8-K filed with the SEC are available on our website at www.healthsouth.com.

On page 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 risks and uncertainties many of which are beyond our control. Certain risks, uncertainties, and other factors that could cause actual results to differ materially from management's projections forecasts, estimates, and expectations are discussed in the company's SEC filings, including the 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 subsequent quarters. 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 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, Crissy. And good morning to everyone joining today's call. Third quarter was another strong quarter for HealthSouth with good performance in both segments. In spite of the disruptions from three hurricanes, there were positive trends in volume and pricing, discharge growth of 3.8% in our Inpatient Rehabilitation segment and admissions growth of 15.5% in our Home Health and Hospice segment drove top-line growth of 7.4%.

Our company's success is a direct result of the skills and dedication of our employees. The most recent example of this was demonstrated when Hurricane Harvey, Irma and Maria impacted Texas, the southeastern portion of the U.S. and Puerto Rico. Our main priority throughout these storms was the safety and well-being of our patients and employees. Our employees stepped up in this time of need, working around the clock to care for patients and each other. Many of our hospital employees remained at the hospital for days at a time. Our Home Health and Hospice staff continued making home visits and caring for patients in the affected areas when conditions were safe.

The accounts of selfless compassion and leadership exhibited by these employees are numerous. I can't begin to express my appreciation to and admiration for our employees, who put the care of their patients ahead of themselves throughout this stressful and exhaustive experience. Our company is extremely fortunate to employ industry-leading clinicians and professionals, who provide a high level of care to our patients and are supported by the service-oriented professionals in our home office. I thank you all for your compassion, professionalism, and perseverance.

21 of our hospitals, 34 of our Home Health agencies, and 4 of our Hospice agencies were impacted by these storms. We have completed our preliminary assessment of the financial impact of these hurricanes. We estimate these storms had a negative impact to discharges from our inpatient rehabilitation hospitals of 200 to 250 discharges, or approximately 50 basis points to 60 basis points of same-store growth in the third quarter of 2017.

Similarly, we estimate these storms had a negative impact to admissions to our home health locations of 325 to 375 admissions, or approximately 120 to 140 basis points of same-store growth in the quarter. In addition, we incurred approximately $3 million in Hurricane-related expenses for staffing, increased supplies, temporary lodging, and other costs.

In addition to this volume and earnings impact, we incurred a modest amount of damage to our physical facilities in the impacted areas. All of our hospital buildings and contents are insured. We also carry insurance for additional expenses and business interruption incurred as a result of a property event.

We are still in the process of evaluating the scope of claims to be filed under our various insurance coverages and any recovery will occur in subsequent periods. Hurricane Harvey's most significant effects were on our Houston hospital, known as The Vintage, and our hospital that was under construction in Pearland, Texas.

On August 28, we evacuated patients at The Vintage to other HealthSouth hospitals due to flooding concerns. We incurred property damage at The Vintage of approximately $3 million. The hospital accepted its first post-storm patient on September 22. The new 40-bed hospital in Pearland was originally scheduled to open on October 1, but due to water damage incurred during the storm, it is now scheduled to open on October 30.

Hurricane Irma did not result in significant property damage, but we did evacuate our hospital in Miami on September 7 due to the expected path of the storm. The Miami hospital began admitting patients again on September 12. The effects of Hurricane Maria on the Island of Puerto Rico have been devastating, and the effects on our operations in Puerto Rico are ongoing. With our two hospitals on the Island incurred only modest property damage, they struggled with power and communication outages and fuel shortages.

Our hospital in San Juan, which remained operational throughout the storm is for the most part back on the power grid and is accepting patients. The power grid associated with our Manati hospital has been down since the storm, leaving us solely-dependent on backup generator power.

We discharged or evacuated all patients from this hospital on September 26, and we will not accept patients at this hospital until we are comfortable; the hospital has a safe and stable source of power, including an auxiliary power source. We continue to pay employees of this hospital and incur lease expense associated with the building. If this hospital were to remain closed for all the fourth quarter, we estimate it would negatively impact our Q4 2017 adjusted EBITDA by approximately $2 million to $3 million.

I'd like now to turn to providing an update on our strategic initiatives around growth and operations. Thus far in 2017, we've opened three new hospitals, all of which are joint ventures with acute care partners and we've expanded the capacity of our existing hospitals by 103 beds, with over 80% of these new beds being added at joint venture hospitals. Our Home Health and Hospice segment also has added to its portfolio in 2017 with the acquisition of 12 home health locations, as well as the opening of one de novo Home Health location and two de novo Hospice locations.

Our original estimate for 2017 Home Health and Hospice acquisitions was $50 million to a $100 million. Through September 30, 2017, we have spent approximately $26 million on Home Health and Hospice acquisitions and we closed four additional acquisitions on October 1.

While our pipeline is robust, we currently expect to be at the low end of this range, primarily due to timing. In addition to growth opportunities, we continue to devote substantial effort and resources to developing and leveraging technology to improve patient care and operating efficiencies. These investments include an installation of our rehabilitation-specific electronic clinical information system, known as ACE IT. We began the installation of ACE IT in 2012 and we expect ACE IT to be installed in substantially all of our hospitals by the end of this year. 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're also extremely excited about our formation of the post-acute innovation center in collaboration with Cerner Corporation. The post-acute innovation center will develop advanced analytics and predictive models for post-acute management. The center will work to determine the metrics and methodology of an effective and efficient post-acute network. As a provider of care, we have the clinical expertise that is critical in developing clinical decision support tools that are patient and outcome focused.

Our clinical expertise combined with Cerner's technology will allow us to assume a leading position in the development and utilization of market-specific clinical decision support tools, which will position our

company to manage in acute care hospitals, or payers entire post-acute population. We also continue to enhance the clinical collaboration efforts between our two segments.

As of September 30, 2017, approximately 60% of our IRFs were located within a 30-mile radius of one of our home health locations. And our clinical collaboration rate in those markets was 28.7%, a 190-basis points improvement over third quarter of 2016. Our TeamWorks clinical collaboration project remains on track and we expect to complete the implementation of the redesigned clinical collaboration process across all of our overlap markets by the end of 2017.

Turning now to Washington: we continue to wait for the release of the final 2018 Home Health Rule. And more specifically, whether it will include major reform to the home health reimbursement model, such as the home health groupings model that was included in the proposed rule. While it's impossible to predict what CMS will do in the Final Rule, we do know that there has been a lot of concern about HHGM throughout the home health stakeholders, including Members of Congress. Senate Finance Committee chairman, Orrin Hatch wrote a letter to CMS Administrator, Seema Verma, urging them not to finalize HHGM in its calendar year 2018 rule, until the agency can fully validate the impact of the proposed reforms will have on Medicare spending beneficiaries' access to care.

49 senators signed a similar letter to CMS leaders asking the agency not to move forward with the proposed HHGM model, until affected stakeholders can fully analyze and understand the impact of the proposed changes. Concerns highlight the significant, deleterious impact on Medicare beneficiaries' access to home health services likely to resolve from the implementation of HHGM. It will be highly disruptive to patient care models and clinical pathways that are well-established and highly effective.

The impact will extend far beyond home health providers to include all providers of inpatient care, who will likely face challenges to the timely discharge of patients and need of follow-on care, thus resulting an increase in inpatient days and expenses for the Medicare program. These letters echo the request our company individually and as part of the partnership for quality home health care, has made to CMS to work together with the provider community and other key constituencies in the development of a revised home health reimbursement model.

Moving on to guidance, based on our results for the first nine months of 2017 and our current expectations for the fourth quarter of 2017, we are updating guidance as follows. Net operating revenues are increasing from a range of $3.875 billion to $3.95 billion to a range of $3.9 billion to $3.95 billion. Adjusted EBITDA is increasing from a range of $805 million to $820 million to a range of $810 million to $820 million. Adjusted EPS is increasing from a range of $2.64 to $2.73 per share to a range of $2.67 to $2.73 per share.

Our guidance considerations are included on page 17, of the supplemental information that accompanied our earnings release, and Doug will review some of them with you in more detail during his comments. Finally, I want to remind you all that this is our last earnings call as HealthSouth Corporation.

Effective January 1, 2018 HealthSouth Corporation will change its name to Encompass Health Corporation, with a corresponding ticker symbol change from HLS to EHC. Both of our business segments will transition to the Encompass Health branding. Our staffs are extremely engaged and enthusiastic as we work together to rebrand our company and reinforce our existing strategy and position as an integrated provider of inpatient and home based care.

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 highlighted, Q3 was another very solid quarter for our company with both businesses performing well in spite of the disruptions related to three Hurricanes. I'd also like to echo Mark's comments and extend my appreciation to our many associates

who did a phenomenal job both preparing for and then responding to these storms. This episode served as an exemplar of the strong culture in place at our company.

Turning to the results for the quarter; our consolidated revenues increased by 7.4% and consolidated adjusted EBITDA grew by 3.1%. Included in consolidated adjusted EBITDA were $3.8 million of operating expenses related to rebranding and TeamWorks' clinical collaboration.

Also included were approximately $3 million in expenses related to the hurricane activity. Please also recall that Q3 2016 benefited from the $4 million IME credit at one of the former Reliant Hospitals.

Adjusted free cash flow for the first nine months of 2017 was $376.1 million. Free cash flow in Q3 was better than expected largely due to a decrease in working capital related to improved [ph] AR collections (18:04). As can be seen on slide 18 of the supplemental slides, we have updated our assumptions for 2017 adjusted free cash flow and now anticipate a full year range of $360 million to $430 million, as compared to previous expectations of [ph] $315 million(18:22) to $400 million.

We continue to deploy free cash flow to fund high-quality growth opportunities in both of our business segments devoting approximately $115 million in such projects over the first nine months of the year. These investments were complemented by year-to-date shareholder distributions of approximately $105 million.

As previously disclosed and as outlined on slide 5; during Q3, we amended our senior credit facility, extending the maturity date to 2022, lowering the interest rate spread, providing enhanced covenant flexibility, and shifting approximately $100 million in lender commitments from the term loan to the revolver.

This transaction is consistent with our strategy of proactively managing our capital structure. Our leverage at the end of the third quarter was 3.2 times another indication of the strength of our balance sheet.

I'll move now to the segment results; IRF revenues increased by 5.7% in Q3, driven by a combination of inpatient volume and pricing increases, partially offset by a reduction in outpatient and other revenue. Discharge growth for Q3 was 3.8% including same store growth of 1.4%. As Mark stated, we estimate that Q3 discharge growth was negatively impacted by 50 basis points to 60 basis points by the hurricane activity, all of that within same-store.

Revenue per discharge increased by 2.2%, primarily owing to patient mix. The reduction in outpatient and other revenue was largely attributable to the closure of six outpatient programs that occurred in the latter portion of 2016. IRF segment adjusted EBITDA of $200.3 million for Q3 increased by 0.9% over the prior year period.

We estimate that the IRF segment absorbed approximately $2.5 million in hurricane-related expenses during Q3. And again, I'll ask you to note that Q3 2016 included the $4 million IME credit. Within the expenses, SWB as a percentage of revenues increased by 130 basis points over Q3 last year, approximately 30 basis points of the increase resulted from the impact of the hurricanes this year and the inclusion of the IME credit last year. An additional 40 basis points is attributable to the staffing model changes at the former Reliant Hospitals.

The staffing model changes at the former Reliant Hospitals were fully in place by the end of Q3 2016. So, this will not be a factor in future-period comparisons. The ramp up of new stores contributed approximately 10 basis points to the year-over-year change in SWB and the balance of approximately 50 basis points resulted from wage rate and group medical increases that although, in line with our expectations, exceeded our pricing increases.

Now, this last point will continue as a source of SWB deleveraging into Q4 as our annual merit increases became effective on October 1 and [ph] so to, due to (21:44) the 2018 IRF Final Rule, which owing to MACRA results in a Medicare price increase of less than 1%. Further pressure on Q4 SWB will result

from the delayed opening of Pearland and the suspension of new admissions at one of our hospitals in Puerto Rico, which Mark described in his comments. In both instances, we are incurring payroll expenses without corresponding revenue.

IRF segment bad-debt expense for Q3 of 1.4%, improved by 40 basis points over the prior year period. As can be seen on slide 22, the improvement was due to a decline in new claims denials. Now, although, this may sound like cause for celebration, I'll remind you that one quarter does not a trend make and I would encourage you for the time being to curb your enthusiasm regarding the sustainability of this improvement.

There are two developments that may have had an impact on the rate of new claims denials in Q3. First and as is noted in the second to last bullet on the left side of slide 22; this summer, CMS introduced the Targeted Probe and Educate, or TPE initiative in certain MAC jurisdictions. We've included the link to the CMS explanation of this initiative and the aforementioned bullet point on slide 22.

In sum, it limits the scope of initial claims requested for medical review by the subject MACs and requires them to provide education/feedback to the providers regarding the basis for denials before widening the probes. This all sounds very positive and the effective rolling out this initiative would be to at least temporarily reduce the rate of new denials by the subject MACs. However, after three rounds of the TPE process, the initiative allows for extrapolation of any perceived unresolved reasons for denials, as such the initial narrowing of the claims denial scope early in the process has the potential to give way to a broadening of this scope later in the process.

The truth is that it is just too early for us to predict what, if any, the long-term implications of TPE will be on our bad-debt experience. We will evaluate the potential impact over time as the early adopters of TPE move through the initial denials and as TPE is extended to other MAC jurisdictions.

Second and as referenced in the final bullet point on the left side of slide 22. During the quarter, CMS announced that effective February 2018, Palmetto will assume responsibility for Cahaba's MAC jurisdiction. As noted on slide 22, Cahaba currently has 75 of our hospitals within its jurisdiction.

To say that our relationship with Cahaba has been difficult would be a vast understatement. That said, we've had very limited experience on the IRF side with Palmetto to date, with just two hospitals within their current jurisdiction.

Our Home Health segment has a broader relationship with Palmetto and that experience has been cooperative and productive. We will seek the same relationship with Palmetto for our IRF segment and intend to work closely with them to ensure a smooth transition. We did see a reduction in new claims denials as compared to recent trend from Cahaba in Q2 and Q3. Whether or not any of that reduction was related to the re-letting of the MAC contract, we cannot say.

Moreover, we recently received notification from Cahaba, that due to the pending transition to Palmetto, they will not be adopting TPE. These developments introduced an element of heightened uncertainty into forecasting bad-debt expense for at least the next two quarters and that uncertainty is reflected in the relatively broad range we have cited for Q4 bad-debt and the updated IRF's guidance considerations on slide 17.

While on slide 17, I'll draw your attention to another of the IRF segment guidance considerations. As Mark described in his opening remarks, our Manati hospital on the Island of Puerto Rico has stopped admitting patients since Hurricane Maria struck. We do not know when Manati will begin admitting patients again. Manati has been a well-run hospital for us and was contributing to our adjusted EBITDA, that EBITDA contribution was included in our previous guidance and will, obviously, be foregone for the period of closure.

In addition, as Mark outlined, we are continuing to pay the staff of Manati and to pay rent on this facility. The incurrence of these expenses without corresponding revenue was not included in our previous guidance.

Our Home Health and Hospice segment exhibited strong operating performance in Q3 with segment revenues increasing 14.7%, driven by continued strong volume growth. Home Health admissions increased by 15.5% in Q3, including 8.8% in same-store admissions growth. As Mark stated, we estimate that the hurricane activity negatively impacted Q3 admissions growth by 120 basis points to 140 basis points, all within same-store.

Approximately 90 basis points of the same-store admissions growth resulted from clinical collaboration with our IRFs, the clinical collaboration rate for Q3 was 28.7%, a year-over-year increase of a 190 basis points. Slightly offsetting the revenue growth attributable to the volume increases was this 30 basis point decline in revenue per episode.

This better-than-expected pricing, resulted both from patient mix changes, and the receipt of prior period reconciliation payments from various ACOs and BPCI pilots in which we are participating. As noted in the Home Health and Hospice guidance considerations on slide 17, we continue to assume a 1.5% to 2% Medicare pricing decrease for Q4.

Home Health and Hospice adjusted EBITDA for Q3, of $34.8 million increased by approximately 35% over Q3 last year. The increase was generated primarily by the combination of strong volume growth and continued improvements in labor productivity. Segment adjusted EBITDA for the quarter also benefited by approximately $900,000 related to the true-up to the purchase price of a 2016 acquisition, which resulted from the expiration of an earn-out provision.

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

QUESTION AND ANSWER SECTION

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

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

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Hey, guys. Thanks. Can you maybe just talk a little bit about your stroke and neuro mix, how that's trended in the quarter, right? I know that that you've deemphasized joints in ortho in recent years, but just curious generally how those patient categories are growing, and maybe what newer initiatives you have in place?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Whit, we continue to see stroke and neuro continue to be a strong component of our overall patient mix in our IRFs together, they make up almost 40% of our discharges, stroke is right at 18% with the remainder of that in what's known as being the other neurological categories.

Over the past several years, we have done a lot in terms to accommodate the stroke population to handle a higher acuity patient, as a matter of fact, this last quarter, total acuity was the highest I can ever remember being for our hospitals, our case mix index was 1.38 in total and I attribute a portion of that because of our growing stroke and neuro mix.

We now have a 101 hospitals that have the joint commission accredited stroke program that I think enhances our ability to continue to grow our stroke population, as you know the American Hospital, American Stroke Association came out a year and a half ago now with the independent survey and study that showed if a stroke patient is going to be treated in an inpatient setting, they are best served by being treated in an IRFs. So, we think this continues to be a growth opportunity for us. There are still a large percentage of the stroke patients being discharged out of the acute care hospitals, that are not going to IRFs that are instead going to skilled-nursing facilities that would be better cared for in an IRF.

<A – Doug Coltharp – HealthSouth Corp.>: And Whit, just to give you some specifics on there, if you compare the patient mix in Q3 of this year to Q3 of 2016 together stroke and neuro were up about 200 basis points and knee and hip replacement was down a 100 basis points, so that reflects the shift.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. And maybe a two-part second question. Just any way maybe to potentially size the opportunity or the addressable market that you see within the stroke population? And then, if you could elaborate a little bit more on the Cerner relationship? What you're doing, what the feedback from the hospital partners has been? Just curious, if there is any additional color to put this initiative into a perspective?

<A – Mark Tarr – HealthSouth Corp.>: Well, if you look at the 2015 Medicare claims, there were approximately 368,000 total stroke cases in acute care hospitals, of which 67,000 of those patients that were discharged from acute care hospitals, 18% were treated in IRFs and 24% were treated in a skilled-nursing facility. So we believe the opportunity to go out and take additional market share and treat a higher percentage of the stroke patients being discharged out of the acute care hospitals is the primary focus for us.

<A – Doug Coltharp – HealthSouth Corp.>: Regarding to the Cerner relationship, one of the reasons that we moved forward with the formation of the Post-Acute Innovation Center is because as we were out speaking to our existing joint venture partners and as we were engaging in discussions with new joint venture partners about potentially entering those markets, we were getting increasing requests from those partners to take on a broader role that involved really helping them manage their entire post-acute network needs, whether it was by having more services that we were providing directly or by helping them understand and coordinate which of the post-acute providers in their markets were most effective.

So, we're going to be working with Cerner, obviously the formation of the Post-Acute Innovation Center was only announced in late August. So, we're really still very much in the assembling the bodies and then putting the priorities in place. But we have a list of priorities, which we're going to address and we're going to begin piloting some of the tools that we've developed out of the post-acute center by as early as mid-next year, probably starting with a market like Tyler, Texas, where we're working on a pilot on around hip fractures with our joint venture partner there.

<A – Mark Tarr – HealthSouth Corp.>: You've heard us talk about our predictive modeling capabilities in the past and we've been working with our medical – group of our medical directors and what we call our rehab program or initiative to help identify patients that are at a high risk for acute care transfers. We've been doing that now for a couple of years, but this partnership with Cerner will help us take that to the next level and tapping into their extensive database working with our physicians and our clinicians as a whole. We think it will put us in an extremely competitive position going forward.

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

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

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Hey, I appreciate all the color surrounding the impact of those hurricanes. I'm just curious like, for example, in this – the Manati Puerto Rico facility being closed completely. Is that something that will ultimately be covered under business interruption insurance, or just any color on that would be my first question?

<A – Doug Coltharp – HealthSouth Corp.>: Hey, Frank. It's Doug. First of all, I enjoyed your appearance on Squawk Box this morning. Yes, we do believe that much of that will ultimately be recovered through our BI insurance. As you can imagine, there's a lot of this activity going on right now and it takes time to develop the claim information. We're keeping close track of all of the expenses that we're incurring with regard to all three of the storms, we'll be filing claims under both our property and casualty in our business interruption insurance, but recoveries under those claims will be in subsequent periods, hopefully sometime in 2018, and it's too early yet to determine the magnitude of any such recoveries.

<Q – Frank Morgan – RBC Capital Markets LLC>: Okay. And I suppose when that happens, that will just all be recorded sort of as a lump sum. You know it will just all hit and – mostly hit in a quarter?

<A – Doug Coltharp – HealthSouth Corp.>: It's hard to say because you've got a lot of different insurers involved. And so you know as it comes in, we will be calling it out to the course of next year.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. Okay. Just one other and then I'll hop off. As it relates to this switch over to Palmetto from the Cahaba, well, is there any sense or any concern about any incremental cost that you may have that occurs during that process, or do you have any sense of? You know I think you made some comments that things had gotten better again the last few months, but how do you really think that relationship plays out through the final transition? Thanks.

<A – Mark Tarr – HealthSouth Corp.>: You know it's very difficult to tell on two fronts. One, again our experience with Palmetto as a MAC on the IRF side is quite limited. As I pointed out in my comments, it's more extensive on the Home Health side, and our experience on the Home Health side has been very positive. But we don't know if that will extend the IRF side, we're hopeful that it will.

The second is; this is by far our largest MAC, with 75 hospitals impacted. So, the movement is very substantial. Cahaba is based here in Birmingham. They employ quite a large number of folks who have been handling our claims as well as the claims of other providers within the jurisdiction. We don't know how many of those employees will ultimately be retained or if a facility will be retained in Birmingham, and we also don't know what kind of capacity Palmetto may have within its existing administrative areas.

So, I think there is probably less risk of a lot of additional administrative costs on our part, although some incremental costs is possible, I think, the greater risk would be a temporary slowdown in the processing of our claims, which could result in a temporary buildup in working capital, but again at this point, that's all kind of conjecture.

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

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

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Good morning, everyone. And really, really nice job. It's impressive that you reported these results including the hurricane, never mind that you took such good care of patients and each other during the difficult times there. Not everybody is doing that. So it deserves to be called out.

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: You're welcome. I wanted to focus a little bit more on – actually two things. The first is, a very simple follow-up to the Cahaba situation, given that transition do you anticipate that there could be a delay in processing of claims as a result?

And then, the second question is a question about HHGM. So if you could answer the first, [ph] give me a leave (38:35) to ask part two, I'd appreciate it?

<A – Mark Tarr – HealthSouth Corp.>: Sheryl, on the first one, it's hard to say obviously, because we haven't been through any kind of change in a MAC jurisdiction of the magnitude like this where 75 of our hospitals are included. I do think that there is a risk that just based on the administrative turnover, there will be a temporary slowdown in the processing of claims and a temporary increase in working capital.

But I would think that it would be fairly short lived. We do know that Palmetto is widely perceived to be a highly competent MAC and I think that's probably the reason that this contract is transitioning to them. We're going to start working with Palmetto very soon here and are going to do everything on our part to help make sure that the administrative changeover goes as smoothly as possible.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Yeah. Good idea, okay. Thank you. And on the HHGM side, so obviously no one knows what this rule is going to include and it's not helpful to speculate, although, it's probably a Wall Street analysts' job to suppose. But I want to talk a little bit about the processes that you might help us to understand that you'll go through once you do know what the Final Rule will include. And under the assumption that some form of HHGM is going to be implemented, because my concern and what I'm getting at here is, it seems to me we haven't heard from any of the companies perhaps prudently, that what the impact would be on their businesses? And I don't know if it's because you can't get at the data or you just don't want to stay until it's final.

But can you walk us through when we might anticipate you get the Final Rule, you know what the situation is, there's going to be some form of HHGM whether it's budget neutral or not 2019 or 2020. When or how long would it take you to be able to assess the impact, and then give us a view of the, what impact and potentially the mitigation that you could do?

<A – Mark Tarr – HealthSouth Corp.>: Sheryl, I'm going to ask April Anthony to answer that, her and her team have spent a lot of time in evaluating the options, and what the mitigation strategies would be. So may I ask April to comment?

<A – April Anthony – Encompass Home Health & Hospice>: Sheryl, those are all great questions and I wish I had an objective answer for you. The reality is in our efforts in Washington, we've been pursuing strategies with CMS with OMB, as well as with the Hill. And so, I do have some concern that even when

we know we may not fully know, right away. So, if the rule comes through the traditional process and it gives us all the definition that you would expect in a normal rule situation of exactly what's going to come into play, then I think that it's probably a 30-day to 60-day window to [ph] home that through (41:24).

If it ends up taking a different path or a different route and ends up having a legislative element, very possible that we will have some directional guidance, but that there will still be time given the implementation timeline of it to work through some of the details at which time we will have less opportunity to have a very pin down answer for you pretty quickly.

And so, it's really, I would hope that by the middle of next week, we will have a much better sense of where this thing is headed. But at the moment, it's very difficult to exactly estimate what that's going to look like.

From a mitigation strategy perspective though, I will say that as an industry, I do think that there has been a lot of work done to understand the implications of 30-day episodes, how that would potentially impact care models and patient care. So, I do think there's some preliminary work being done, both here at Encompass and across the industry to understand what a 30-day episode period would look like and how that would impact care of patients, communications with physicians, and the like. But we're going just have to kind of wait another couple of weeks and figure out exactly where this thing's headed before be able to firmly answer those questions.

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

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

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

<Q – Kevin Ellich – Craig-Hallum>: Good morning, guys. Thanks for taking the questions. I guess kind of following-up on the HHGM, given a little bit of an overhang, what are you guys seeing in terms of valuations for Home Health deals? And, I guess on top of that, what sort of benefit, if any, should we be expecting from value-based purchasing next year?

<A – April Anthony – Encompass Home Health & Hospice>: Yes, so I would say that we have really not seen multiples move, one way or another yet as a result of the risk of HHGM, we continue to see activity in the market, we continue to see multiples remaining pretty consistent and there are certainly some things that you would look at in light of the potential for HHGM and, say, oh that might be a higher-risk transaction, so it may cause you to sort of walk away through a few deals that maybe would have been more intriguing before this overhang was there. But so far I would say it's been a pretty minimal impact on the market.

As to your second question, I'm sorry, refresh me, I had a momentary blank on that.

<Q – Kevin Ellich – Craig-Hallum>: Sorry, sorry, April, value-based purchasing, what sort of benefit do you think we should see next year?

<A – April Anthony – Encompass Home Health & Hospice>: Yeah, very good. On value-based purchasing, it's still an early in the process, it's the 2016 experience, that is affecting the 2018 rates. I think we expect our locations that were in the nine value-based purchasing states, were recently acquired as of the 2016 timeframe. So, we expect very minimal impact maybe a very, very slight negative, of just a couple of hundred thousand dollars next year.

We do believe that as we get to 2017 activity, which will pay out 2019 that that turns back in the positive direction that our states, we were just new entrants in 2016 when that rate was impacted. We're a big believer that value based purchasing is a long-term positive for high-quality providers in the industry, and it would be a big advocate for expansion of value-based purchasing program to a nationwide approach.

<A – Mark Tarr – HealthSouth Corp.>: And Kevin, just one follow-up on April's comments regarding multiples. Bear in mind that we are not paying publicly-traded company multiples for the acquisitions that we're looking at within the Home Health space, typically and we do see a wide disparity because sometimes really just buying a [ph] CON (45:08), or a license to operate in a new geography. But typically, we're more in a range of 5 times to 6 times run rate EBITDA in our acquisition activity.

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

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

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

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Good morning.

<A – Mark Tarr – HealthSouth Corp.>: What's up?

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Just hoping to get a little color on sort of the evolution of your relationship with the Medicare Advantage Plan, sorry, in the Home Health business, how that's really, if it has changed materially over the last year or so with the plans?

<A – April Anthony – Encompass Home Health & Hospice>: I think we're certainly seeing some continued progress in the Medicare Advantage world. We're seeing both progress on the front of those that are paying episodically, which is certainly our preference even if it's at a some discount to the Medicare rate for the episodic approach. But even in the per visit relationships we have in Med Advantage, we've seen our rate per visit rise consistently over the last few years, and I think that's because we've been able to really show the value of our solution. We've also been able to do some creative things with a handful of our Medicare Advantage plans and create some shared risk plans where we get paid a base rate, but then we have an opportunity to receive a premium if we're able to control costs on a bundles of patients.

And so we've got a lot of creative things going on that front. And I think it is one of the things that we're encouraged by at the moment that there is a lot of opportunity with a little better than 30% of the nation's seniors being in that Medicare Advantage world. We see this as an area for growth and expansion if we can get the right relationships and the right structures in place. And we're beginning to feel better about that opportunity, and we're seeing that grow as a percentage of our total revenue at a disproportionate pace.

<A – Mark Tarr – HealthSouth Corp.>: We've had that same experience, Chris when you look at it on the IRF side, particularly with stroke population, our value proposition, we've gone out now for several years and talked about our quality outcomes and the lower percent of patients that get readmitted back in acute care hospitals and considerations for total cost versus just Per Diem cost. And it may not stick the first time you go in and meet with the MA plans. But over time we've seen some nice progress in both of our segments.

<Q – Chris Rigg – Deutsche Bank Securities, Inc.>: Great. And then just one follow-up, on the IRF JV side, has the competitive dynamic there, or has it just gotten more competitive for to get the JVs, or is most of the time HealthSouth negotiating exclusively with the hospital partners? Thanks.

<A – Mark Tarr – HealthSouth Corp.>: I would say and we've been doing this now for many years relative to the JV business model as we evaluate opportunities for growth in our hospitals, matter of fact, a third of our hospitals are partnerships. Our business development team has done an outstanding job, particularly in last several years in going out and reaching out with the proposition and proposals from our side of it.

I would say that at least half of those times, we are in a competitive situation where we're not the only provider being considered. But I would say, it's not gotten any more competitive in the last couple of years than what it was three years or four years ago.

<A – Doug Coltharp – HealthSouth Corp.>: I'll just add a little bit more color on that. About half of our development pipeline right now is JV activity and about half of it is solo. And so, if about half of the JV opportunities are competitive situations that suggest that only about 25% of our IRF development pipeline faces any kind of competitive situation. And even in those competitive situations, we feel pretty good about the value proposition and the track record that we're putting on the table.

Operator: Your next question comes from the line of Dana Hambly of Stephens.

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

<Q – Dana Hambly – Stephens, Inc.>: Hey, good morning. Thanks for getting me in. Just on the – where would you rank the or where do you think hospitals rank the post-acute strategy in their list of priorities? And then my follow-up would be, how does your post-acute innovation center business model differ from the existing convener models that are out there already?

<A – Mark Tarr – HealthSouth Corp.>: So, I think in terms of where they rank it as a priority, it depends entirely on the situation to the hospital. So, if you've got a well-run hospital that's already doing well on a lot of its other quality metrics, its controlling, its admissions and so forth, then they probably have been more proactive in thinking about the additional improvements that they can make in a post-acute strategy. What we actually find is and it's been a very effective tool for us from a business development perspective is frequently they haven't thought a lot about the impact of just kind of randomly choosing post-acute providers is having on things like the length of stay in their hospital and on their readmission rate.

And we have developed a very effective analytical tool that goes by the acronym of [ph] PACSA (50:21) where we go in and we take all of the mark – all of the Medicare claims data that is specific to that hospital and to the other providers in the market. And we show them the effectiveness of them versus competitors in terms of moving patients out into a post-acute setting on a timely manner – in a timely manner. And ultimately what the cost and what the trajectory is of those patients in their post-acute network.

With regard to what's different between us and the conveners, it's the marriage of a very, very powerful data analytics firm in Cerner, which is able to access great amounts of information and to synthesize that data in a meaningful way with the clinical expertise of an actual post-acute operator. One of the things that [ph] remedy and Nava Health (51:11) and those other conveners do not bring to the table is the knowledge that comes from operating the largest IRF provider and the fourth largest home health provider in the marketplace, and we think it's a very powerful combination.

<A – Doug Coltharp – HealthSouth Corp.>: Dana, it's difficult to be good at all things in health care now. And we're seeing more and more acute care hospitals figure that out and know that they can't be good at all their acute care programs and also expand into post-acute and be highly competitive in all different areas and keep up with all the changing regulations, which is very time consuming and resource consideration. So, those are all driving the effort for our development side in reaching out to all the acute care system and driving our pipeline of opportunities.

Operator: [Operator Instructions] Your next question comes from the line of Sheryl Skolnick of Mizuho Securities.

<A – Mark Tarr – HealthSouth Corp.>: Welcome back, Sheryl.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Thank you. So, I wanted to follow-up with April, about her intriguing comments about a legislative component. Would you care to elaborate on that with respect to the HHGM, please?

<A – April Anthony – Encompass Home Health & Hospice>: Well, Sheryl, just to say that we are, as I mentioned working all avenues, so we've had a multiplicity of meetings with CMS and with OMB. And as you know try to read the tea leaves, we never want to get ourselves away from having legislative opportunities as well. So, as you know, 50 senators have signed on to a letter opposing HHGM. We now have [ph] right at (52:53) 160 house members, who similarly signed on to a letter opposing HHGM. So, there are a lot of folks on The Hill who think this is a bad proposal as well. And so we are working in all avenues trying to make sure that we have all of our bases covered and can attract this issue one way or another.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Okay, because when you answered the question, I thought it was in the context of the regulation that there might be some legislative avenue and I suppose that – I understand what you're saying now, okay, rather than just sit it out there. All right. That was very helpful. Thank you. That was it.

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

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

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Hey, hey, great. Thanks. So as far as the Home Health business, you know margins improved there nicely even if you exclude a couple one-time items that you mentioned, it sounds like on labor productivity, what's the right way to think about where Home Health margins could be if we assume the stable reimbursement backdrop?

<A – April Anthony – Encompass Home Health & Hospice>: Well, I think we're doing, obviously, a very good job in margin management if you compare the Encompass margins to our peers. We, certainly, are making the most of our tools and our resources. And so you know there are just some core restrictions that you have, I don't think there is just tons of margin upside potential from where we are today. But I do think that we're in a place to be able to sustain the margins that were reflecting certainly in a flat rate environment.

And we've forgotten what a flat rate environment looks like. It's been so long since we've even had flat, but certainly there could be some upside if we could get back to that kind of environment. We're used to living in a down rate environment still having to manage margin.

So, I think it's the things that we mentioned earlier in the year as we were concerned about rate changes and reimbursement cuts. It's really about gaining efficiency with our clinical fields data, utilizing a model that has us focusing primarily on salary-based field staff, about 75% of our visits are performed by salaried employees who don't have any kind of incentive to do more visits in order to [ph] pad (55:01) their own payroll.

And so, we've been able to use that model very effectively to build great culture, to drive great quality, to control utilization. And because of the strength of our home care home-based tools, we've been able to manage the productivity of these full-time staff members in such a way that we have been able to keep our cost per visit very efficient.

In addition, our administrative costs on the back-office side, which is a growing challenge because of expanding regulation, our team continues to find ways to better leverage our tools and technologies to make that possible.

So I'm very proud of the margin that we've been able to deliver, and I think it certainly leaves the industry from a margin perspective. But it will be an everyday job to maintain that and to continue to look for opportunities to expand it over time.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: All right, great. Thanks. Then I guess we just go over the IRF side. It wasn't clear to me, you've mentioned a number of things that impacted, labor costs or SWB as a percentage of revenue this quarter and some of them are going to go away as far as Reliant specifically, but you made it some comments that it may sound like you still expect, I don't know I guess the 50 basis points is a kind of core labor pressure and health benefits pressure in the quarter. You made it sound like you expect something similar to happen next year kind of highlighting that the rates next year are going to be below inflation too, is that the right way to think about it, or are there mitigating or offsetting factors that you would point to?

<A – Mark Tarr – HealthSouth Corp.>: So again you know, Kevin we provide our regular cycle merit increases on October 1st correspond with fiscal year. And so those went in and we're very much in line with that 3% item that's in our guidance consideration. And yet the new pricing for IRFs on the Medicare side also went into effect on April 1st and based on macro that holds us to a pricing increase of less than 1%. So just by virtue of that, you're likely to see some de-levering. You know we don't think that there are opportunities to trim clinical staffing; we think that that would be a mistake.

So, yeah, I think some of that margin pressure is going to continue into 2018. I think as we start to look at 2019, and beyond and start to move out from some of the pricing offsets that are embedded in the Affordable Care Act. I think the environment gets better.

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

Operator: Thank you. I'll now return the call to Crissy Carlisle, for any additional or closing remarks.

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

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

Operator: Thank you. That does conclude today's HealthSouth third quarter 2017 earnings conference call. You may now disconnect.