HealthSouth Q2 2016 Earnings Call

July 29, 2016

Corporate Participants

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

Other Participants

Sheryl R. Skolnick – Analyst, Mizuho Securities USA, Inc.
Whit Mayo – Analyst, Robert W. Baird & Co., Inc. (Broker)
Gary Lieberman – Analyst, Wells Fargo Securities LLC
Frank Morgan – Analyst, RBC Capital Markets LLC
John W. Ransom – Analyst, Raymond James & Associates, Inc.
A. J. Rice – Analyst, UBS Securities LLC
Joanna S. Gajuk – Analyst, Bank of America

MANAGEMENT DISCUSSION SECTION

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

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

Crissy Buchanan Carlisle, Chief Investor Relations Officer

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

Before we begin, if you do not already have a copy, 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 2 of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risk and uncertainties, many of which are beyond our control.

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

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

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

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

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

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

Great. Thank you, Crissy, and good morning to everyone joining today's call. The second quarter was another very strong quarter for HealthSouth, with revenues of $920.7 million, adjusted EBITDA of $204.3 million, adjusted earnings per share of $0.69, and adjusted free cash flow of $115.3 million.

We believe these solid results reflect the strength and sustainability of our business model with growth from recent acquisitions complementing our organic growth. Same-store discharges in our in-patient segment grew 1.9% in the quarter, which was consistent with both the leap year adjusted growth in Q1 and the long term same-store growth expectations embedded in our long term business model.

To determine if we are growing our market share, we compared our discharge growth to growth from other IRFs participating in the UDS reporting system. And as a reminder, the UDS information is available on one quarter lag basis. Based on the UDS Q1 results, it appears that our commitment to providing high quality rehabilitative care continues to differentiate us from our competitors.

HealthSouth's reported same-store growth of 2.8% in the first quarter compared favorably to a 0.3% increase in discharges from non-HealthSouth IRFs in the UDS database. This growth in market share is consistent with the trend we have witnessed for several years and is in part a result of our focus on meeting the needs of patients recovering from strokes and those suffering from a wide range of debilitating neurological conditions, conditions that are more prevalent in older adults.

We began to reorient our clinical programs toward these conditions and invest in supporting equipment and technology when the 60% rule was re-implemented in 2004 and many of the orthopedic patients we treated historically were no longer considered compliant under this new rule. We believe this strategic repositioning has paid off.

HealthSouth currently has 100 hospitals that have earned Joint Commission Disease-Specific Certification in stroke rehabilitation. This has been an important part of our effort to reduce the percentage of our patient with non-compliant orthopedic conditions in favor of stroke and neurological patients. We also believe this strategy will yield additional future benefits as physicians, case managers, and managed care companies adopt the clinical practice guidelines released by the American Heart Association and the American Stroke Association in May of this year.

As noted on page 27 of our supplemental information, these guidelines strongly recommend that stroke patients be treated at an in-patient rehabilitation facility rather than a skilled nursing facility. Importantly, these clinical guidelines have been endorsed by the American Academy of Physical Medicine and Rehabilitation, the American Society of Neurorehabilitation, the American Academy of Neurology, and the American Congress of Rehabilitation Medicine, all of which gives these guidelines significant credibility within the physician community.

Our expertise in treating stroke patients is also contributing to the growth in the number of Medicare Advantage patients we treat in our hospitals. As mentioned on previous calls, M.A. plans are beginning to recognize the value of in-patient rehabilitative services, especially for patients recovering from strokes. In the second quarter, our same-store Medicare Advantage discharges grew 5%, with most of this growth attributable to stroke patients.

On page 26 of the supplemental information, you will note the overall payer mix of our discharges has stabilized, and it's generally in line with the payer mix we've had over the last three quarters.

We also saw continued market share gains in our home health segment. Same-store home health admissions at Encompass agencies increased a very solid 11.1% in the quarter with approximately 210 basis points attributable to clinical collaboration efforts with HealthSouth Hospitals. A key strategic rationale for partnering with Encompass was to enhance the continuity of care for patients requiring home health services following discharge from our hospitals.

In the second quarter, Encompass cared for 3,191 patients who had been discharged from HealthSouth Hospitals in overlap markets, compared to 2,037 patients in the second quarter of 2015, an increase of approximately 57%.

And as noted on page 17 of the supplemental information, these patients represent approximately 14% of all second quarter home health discharges from HealthSouth Hospitals and approximately 24% of home health discharges in our overlap markets. We believe we can continue to enhance the clinical collaboration between our two segments, thereby continuing to increase the number of patients cared for by Encompass agencies over time.

A medium-term goal is to discharge 35% to 40% of our home health patients in overlap markets to Encompass agencies. Longer term, we would hope to discharge 60% plus of home health patients in our overlap markets to Encompass agencies. Under risk sharing alternative payment models, this number could conceivably be higher.

We're also pleased to report the integration of our recent acquisitions continued essentially on track in the quarter. Our in-patient clinical information system has been installed at six former Reliant hospitals and will be installed in all former Reliant hospitals by year-end. The planned enhancements to the clinical skills mix at the former Reliant hospitals will be completed in Q3. Most of the equipment has been ordered, and we are transitioning hospital teams to our sales and marketing, care management, and patient experience operating platforms

Additionally, on July 20, we announced the closure of our legacy hospital in downtown Austin and its consolidation with one of the two former Reliant hospitals in that market, a strategic move contemplated when we evaluated the Reliant acquisition. This leaves us with two very well-positioned hospitals serving the Austin market.

The integration of CareSouth is also generally on track, although staffing turnover in Georgia has contributed to delays in implementing Encompass' core programs such as placing care transition coordinators in referring hospitals to facilitate the discharge process and ensure timely admissions. This in turn has impacted admission and episode growth in these markets. These positions are being filled, and Encompass management is confident these markets will be back on plan by the end of the year.

The second quarter was also a very strong quarter from a development standpoint. We announced that we will add hospitals in two new states, North Carolina and Oklahoma, and expand our presence into existing markets. Our 51%/49% joint venture with St. John Medical Center in Broken Arrow, Oklahoma will own and operate a 40-bed, freestanding hospital and operate St. John's existing 22-bed unit during the construction of the new hospital, which is expected to open in the third quarter of next year.

On July 15, we announced the formation of a 50/50 joint venture with Novant Health in Winston-Salem, North Carolina to build and operate a 68-bed freestanding hospital in that market. The opening of this new hospital will be depend on when we receive the final CON.

In addition to these new markets, we announced the filing of a CON with BJC HealthCare, our partner in the St. Louis market, to open a 35-bed satellite facility on their St. Peters, Missouri Campus. We received final CON approval to build a 34-bed hospital in Shelby County, Alabama, a market that is immediately south of Birmingham, and formed a joint venture with Midland Memorial Hospital for our existing hospital in the Midland/Odessa market, which we plan to expand by 20 beds.

As noted on page 19 of the supplemental information, we currently have 11 new facilities under active construction and development. That, along with bed additions at existing hospitals, are expected to add approximately 820 incremental beds over the next two to three years, beds that will contribute to future growth for our in-patient segment.

Encompass also added to its portfolio in the quarter with the acquisition of two home health and two hospice agencies in the Greater Atlanta market and the opening of one home health agency in the New Port Richey, Florida, market. And we're only halfway through the year. Our development pipelines for both segments remain robust, and we anticipate announcing additional growth projects throughout the second half of the year.

One of HealthSouth's strengths is our ability to generate significant free cash flow and to invest this cash in a variety of value-enhancing ways. In addition to funding the growth I just mentioned, and consistent with our stated cash flow deployment strategy, in the quarter, we also reduced our long-term debt by $30 million, repurchased approximately $11 million of shares of our common stock, and paid a quarterly cash dividend of $0.23 per share.

Based on these very solid results, we are raising our full-year guidance ranges as follows. Net operating revenue is being raised to a range of $3.6 billion to $3.7 billion. Adjusted EBITDA is being raised to a range of $775 million to $795 million. And adjusted EPS is being raised to a range of $2.44 to $2.56 per share.

Before turning the agenda over to Doug, I want to provide our perspective on the new bundling initiatives, given the level of interest this topic has generated over the last several days. Let me begin by reiterating what we have said before. We believe alternative payment models that allow providers to share risks and rewards, which the two mandatory bundling models do permit, will be a net positive for HealthSouth.

It's important to remember there are two goals of these alternative models. The first is to ensure Medicare beneficiaries receive high quality care that is coordinated across all providers. The second is to reduce Medicare spending per beneficiary. Importantly, this second objective is measured over a 90-day episode, not simply on a cost per day basis, something we've stressed for some time is the correct way of assessing the value proposition of post-acute providers. By considering total 90-day expenditures, quality factors such as readmission rates, correct discharge status, and ensuring patients are returned safely to their homes all become important.

With this in mind, we believe alternative payment models play to our strengths for the following reasons. First, in many of our markets, our hospitals are the 90-day low cost provider for the hip conditions included in these bundling initiatives, and we believe we can exploit this advantage to gain market share.

Second, in those markets where we don't currently enjoy a cost advantage, we believe we can address the cost disparity by reducing acute care transfers and discharges to SNFs.

Third, robust IT capabilities that enhance clinical collaboration among providers are essential in these models, and we are the only post-acute provider that will have all of its patients on an electronic medical record system by the end of 2017. This makes us an attractive post-acute partner for acute care hospitals participating in mandatory bundling models, or we will create additional incentive for acute care hospitals to partner with us by rolling out a risk-sharing model by year-end.

And finally, our partner Encompass has established a very solid track record of treating complex patients in their homes through their specialty programs, two of which focus on cardiac and post-surgery patients. So they are uniquely positioned to gain market share in all of their markets as these models are implemented.

While all of this suggests attractive long-term opportunities for HealthSouth in terms of gaining incremental market share, the downside risks are modest. Because home health is envisioned to be the net beneficiary of both of these bundled payment models, we see no downside for Encompass, only upside and lots of it.

With respect to our in-patient segment, we have previously disclosed that the potential impact of the CJR model is relatively immaterial. Specifically, as found on page 56 of the May 23 Investor Reference Book, we estimate less than 1% of our Medicare discharges would be at risk under the CJR model.

We have also analyzed the new bundle model and believe the downside risks of this, too, are modest. As a reminder, this proposal is 900-plus pages and was published just this week, so our analysis is preliminary at this point.

But let's first consider the hip fracture component. Using the same methodology we use in assessing the impact of the initial CJR model, i.e., recognizing that we have minimal risk in losing patients in those markets where we have a cost advantage, we estimate the inclusion of these additional hip fracture-related MS-DRGs would have a potential negative revenue impact of between $8 million and $9 million, with a corresponding estimated adjusted EBITDA impact of roughly $2.5 million. And as noted, this does not assume any market share gains in markets where we have a cost advantage.

The potential impact of the cardiac portion of this new model is harder to size because CMS has not disclosed the 98 markets that will be randomly chosen to participate, which means we don't know where may have a 90-day cost advantage.

So for purposes of estimating a potential downside scenario, we assumed our hospitals would be in these 98 markets on a pro rata basis. We then assumed we would not retain any of the 15 cardiac related MS-DRG patients. Under these assumptions, we estimate the revenue hit would be approximately $7 million to $8 million with an adjusted EBITDA hit of approximately $2 million.

Obviously the most challenging aspect of discussing these bundled models is that at this point it's all speculative. The CJR model just started in April so it's too early to know its impact, and the new cardiac and hip fracture model doesn't begin until next July. While nobody knows for certain how all of this will play out, what we do know is that our nation is aging and that the demand for healthcare services in general, and post-acute services in particular, will continue to grow.

And we also know somebody is going to have service this demand. We believe we have the assets including human capital, strategy, discipline, and financial strength and flexibility to play a leading role in the provision of this care under any payment models.

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

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

Thank you, Jay, and good morning everyone. As Jay just outlined, we had another very solid quarter with good performances in both of our business segments. During Q2 our net operating revenues increased by 20.4% over the prior-year period, and adjusted EBITDA grew by 20.5%.

Adjusted EPS for Q2 was $0.69 per diluted share, increased by 16.9% over Q2 2015 as some of the benefit of adjusted EBITDA growth was offset by a higher interest expense related to acquisition financing and increased depreciation and amortization resulting from acquisitions and capital investments.

We continue to evidence the strong cash flow generating capacity of our business with adjusted free cash flow in Q2 of $115.3 million, up 22% over Q2 2015. Adjusted free cash flow for the first half of 2016 of $244.8 million increased by 40.8%, benefiting from the year-over-year increase in adjusted EBITDA, as well as favorable working capital changes primarily related to the timing of payroll liabilities. Consistent with our established priorities, we used this free cash flow to support first half discretionary capital expenditures of approximately $57 million, an approximately $85 million reduction in funded debt and the repurchase of approximately $22 million of common stock, and the payment of approximately $42 million in cash dividends on our common stock.

Last week, we declared a quarterly dividend of $0.24 per share, an increase of a penny per share to be paid in October. As a result of our strong first half performance and taking into consideration updated assumptions for cash interest expense, cash taxes, and maintenance CapEx, we now expect adjusted free cash flow for 2016 to be between $395 million and $465 million as compared to our previous estimate of $360 million to $445 million.

Our assumptions for 2016 adjusted free cash flow can be found on page 21 of the supplemental slides. Please note that based on the timing of certain working capital changes and maintenance capital expenditures, we expect Q3 adjusted free cash flow to decline from Q3 2015 and then to increase again in Q4.

We continue to strengthen our balance sheet in the second quarter. The combination of increasing adjusted EBITDA and a reduction in funded debt resulted in a leverage ratio of 4.1 times at the end of the second quarter, down from 4.6 times at the beginning of the year.

We've recently issued the redemption notice for the $76 million outstanding balance of our 7.75% senior notes, and we'll complete that transaction in September at the stepped-down call price of 102.583. Our progress on de-levering has been acknowledged by Moody's, which revised its ratings outlook for the company to stable from negative.

I'll turn now to the segment results beginning with in-patient rehabilitation. First segment adjusted EBITDA for Q2 was $204.1 million, an increase of 19.7% over Q2 2015. First half adjusted EBITDA for the IRF segment of $401 million also increased by 19.7% over the prior-year period. The growth in Q2 adjusted EBITDA was driven by a combination of revenue growth and expense leverage.

Net operating revenues increased by 16.6% over Q2 2015 driven by discharge growth of 13.6% and a 2.6% increase in revenue per discharge. The $5 million retroactive SSI adjustment for 2013, incurred in Q2 2015, led to approximately 90 basis points of the increase in revenue per discharge. As Jay mentioned, the Q2 payer mix was in line with that exhibited in the preceding three quarters, and patient acuity was essentially flat with Q2 2015. The $5 million retroactive SSI adjustment for 2013 negatively impacted expense ratios for Q2 last year and thus contributed to the expense leverage realized in Q2 of this year.

SWB for Q2 2016 was 48.6% as compared to 49.2% last year. SWB this year benefited from a $2.4 million contractual rebate from the pharmacy benefit manager for our group medical program. A substantial portion of this rebate stems from the increase in specialty drug utilization we experienced in 2015.

Looking at labor productivity, EPOB for the quarter was essentially flat with the second quarter of last year.

We also realized expense leverage in supplies stemming from continued supply chain initiatives, including patient pharma and medical supplies. As a reminder, the increase in occupancy expense as a percent of revenues is primarily attributable to the Reliant acquisition, in which we assumed existing real estate leases on all of the acquired hospitals.

Consistent with our expectations, bad debt expense for Q2 was 1.9% of revenue, up 30 basis points from Q2 2015. As can be seen on slide 18, the rate of new prepayment claims denials declined from the level we had experienced in the three preceding quarters. However, virtually all of the decline occurred in the first month of the quarter, and the level of denials experienced in the final month of the quarter suggest a run rate for the back half of this year consistent with that exhibited in Q1.

We also saw no appreciable progress in the claims adjudication process during the quarter, and so the administrative backlog continues to lengthen. We are continuing to press our dialogue at seeking resolution with both CMS and Cahaba. Towards the end of Q2 we did see some minor progress on clearing the administrative payment delays reported to you in Q1, and we hope that progress will accelerate throughout Q3.

As Jay mentioned in his comments, the Reliant acquisition is tracking to plan and our previously provided estimate of $2 million to $3 million in transition and integration costs per quarter still holds.

Moving now to our Home Health and Hospice segment. we posted another strong quarter as segment adjusted EBITDA of $26 million for Q2 increased by 36.8% over the same period last year. Segment adjusted EBITDA for the first six months of 2016 of $48.6 million increased by 35.4% over the first half of 2015. The growth in Home Health and Hospice segment adjusted EBITDA for Q2 was attributable to a 41.1% increase in net operating revenues driven by higher volumes.

Admissions for the quarter increased by 52.7%, 11.1% from same-store growth and episodes increased by 43.9% with 12.4% from same store. The effect of the volume growth on revenue growth was partially offset by the anticipated pricing decline. Revenue per episode for the second quarter declined by 1.6%, largely owing to the Medicare rate cuts that became effective at the beginning of the year, but also impacted by the relatively lower revenue per episode at CareSouth due to patient mix. The higher percentage of patients requiring therapy visits had a favorable impact on Q2 pricing.

Segment operating expenses for the quarter increased by approximately 100 basis points over Q2 last year, due primarily to the pricing decline against which we incurred merit and benefit increases, and the expenses related to the integration of CareSouth.

As may be seen on slide 17 and as Jay discussed, during Q2 we made continued progress on the clinical collaboration between our facility-based and home-based service offerings. We believe this provision of a continuum of care resulted in better patient outcomes and satisfaction, as well as improved cost effectiveness. These attributes position us for success in alternative payment models, including bundled payment initiatives as Jay addressed in his remarks.

We'll turn now to our 2016 guidance. The increase in our 2016 guidance for net operating revenues, adjusted EBITDA and adjusted EPS can be found on slide 13 of the supplemental materials, and the updated considerations related to this guidance are included on slide 14.

I'd like to spend a few moments and elaborate on some of the items we expect to impact our performance in the second half of the year. Beginning with the IRF segment, we estimate that the impact to HealthSouth of the 2017 proposed rule will be a Medicare reimbursement rate increase of approximately 1.7% to be effective October 1, 2016.

Please also recall that our annual merit cycle begins on October 1, and we are anticipating a merit increase this year of 2.5% to 3% which will largely neutralize the Medicare reimbursement rate increase in Q4.

Within the IRF segment, we also anticipate that the second half openings of Broken Arrow, Bryan and Modesto, together with the impact of converting Midland to a JV, will create a net expense of $1.5 million to $2 million spread over Q3 and Q4.

On the home health and hospice side, our receipt and analysis of the 2017 proposed rule has led us to estimate the impact to HealthSouth as a reimbursement reduction of 3% to 4%. This updated estimate may be found on slide 20 of the supplemental materials. This is larger than previously anticipated, owing to two provisions within the proposed rule.

In addition to the expected reductions related to rebasing, coding intensity, and the outlier fixed-dollar loss adjustment, the proposed rule also includes changes to case mix weightings and the outlier payment methodology. These incremental changes are positioned as budget neutral in the aggregate, but we believe they would have a disproportionate impact on agencies trading higher acuity patients, which has been the focus of Encompass.

The proposed rule is in the comment stage, and we do not know if these incremental changes will be sustained. Although the 2017 rule does not go into effect until January 1, the reimbursement reductions would apply to all episodes concluding after December 31, 2016. As such, we have estimated an incremental Q4 impact of the proposed rule in its current form of approximately $1.5 million, and that is incorporated into our revised guidance.

Finally, we were very pleased to see the proposed home health pre-authorization demonstration replaced with a pre-claims review demonstration. Although the demonstration includes only five states, three of those states, Texas, Florida, and Massachusetts, comprise nearly 50% of Encompass Medicare claims.

While we are highly confident in our ability to fully comply with all provisions of the demonstration, we will need to begin investing in additional administrative resources in advance of the demonstration effective dates.

And now we will open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] You first question comes from the line of Sheryl Skolnick of Mizuho.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: My goodness. Okay. So let's, if we could, this is a ton of information and all of it very high quality and very helpful.

<A – Jay Grinney – HealthSouth Corp.>: Hey, Sheryl. Excuse me. We're having hard time hearing you.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Okay. Let me try something else. Just bear with me.

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Okay. This should be better.

<A – Jay Grinney – HealthSouth Corp.>: Yup. It is.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Sorry. Okay. So ton of information, really high quality, fabulous job. You gave us a great heads up in the first quarter telling us that you're upping your guidance when you never do. This is what management teams should do.

Now, I want to try to dive into something that you mentioned. So you said in particular, you called out strength in your Medicare Advantage business inside the IRFs. And I'm going to ask this question in the context of transformation of payer and upstream provider thinking about the IRF as a high quality ultimately low cost setting. What's behind that? Is it a shift in the demographics of your market into Medicare Advantage, which may be happening? Or do you think you're making strides with the private sector Medicare business that you'll then be able to translate into the public sector Medicare business? And then I have a follow-up.

<A – Jay Grinney – HealthSouth Corp.>: So the answer is the latter. We're making strides with the plans and getting them to understand and appreciate that value proposition on an episode basis. And they're seeing it, as I mentioned in my comments, particularly in the area of stroke rehabilitation.

<A – Mark Tarr – HealthSouth Corp.>: And Sheryl, this is Mark. In some cases we've seen where hospitals have improved what we called conversion rates. So we – in many markets we have always gotten this types of referrals from physicians in the past but were unable to convert to an admission because the Medicare Advantage plan would not approve the admission.

Over the years, as Jay said, we've been able to go out and articulate our value proposition, highlighting the outcomes, particularly with stroke patients, and that has subsequently led to an increase in this what we refer to as the conversion of referrals to admissions in many of our markets.

<A – Doug Coltharp – HealthSouth Corp.>: And we believe that the stroke guidelines, as Jay mentioned in his comments, that came out just the beginning of May are going to further that trend.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Right. I would agree. And so that sort of leads me into the sort of second part of this as part of movements to alternative payment mechanisms, which I would agree can really overall only benefit you. But it seems that Wall Street is having trouble understanding that just because you're – got hospital attached and therefore a high per diem, you can actually be cost effective over a 90-day episode.

And so when we hear these numbers that CJR might cost you a couple of million dollars of EBITDA on a pretty big base of nearly $800 million this year and growing next year, and then the cardiac, very back at the envelope, sort of worst case another couple of million. But wouldn't you think that with the strides you're making and given that cardiac and stroke are still closely related that there's an opportunity for the

company to offset that through the same kinds of progress you've made with Medicare Advantage on stroke with...

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: ...cardiac? And then actually moving HealthSouth and other high quality IRFs into a position of site of care of choice?

<A – Jay Grinney – HealthSouth Corp.>: Absolutely. And the numbers that I mentioned were unmitigated numbers.

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

<A – Jay Grinney – HealthSouth Corp.>: I mean that, as I said, we do believe there are market share gain opportunities in those markets where we have a cost advantage. We think we can gain share in markets where we don't have a cost advantage today by moving those hospitals to best-of-class status with respect to acute care transfers and discharges to SNFs. And then additionally, as I mentioned in our comments, we are developing a risk-sharing model that we will be rolling out at the latter part of this year. And sort of apropos of the first part of your question, Sheryl, this initial wave is to go to the acute care hospitals in the bundled markets and to offer this risk-sharing model to them so that we can essentially take the post-acute management risk of these patients off of their plate. We believe that that same model can be ultimately used with the Medicare Advantage plans.

And so I think that the trend toward, A, looking at quality and outcomes as an important consideration, and B, looking at cost from a 90-day episodic basis all really play into the strength of our facility-based and home-based services.

And as we look at this, frankly, the one post-acute service that we believe is most at risk are the nursing homes. Virtually every kind of care that's provided in a nursing home can be provided either in an IRF or in a home health. The same can't be said for nursing homes being able to take the patients who are currently treated in our hospitals because those patients all require hospital-level care.

So as we think about the future – and this is our view – but as we think about the future, the disintermediation is going to occur primarily in the skilled nursing area, not in IRF and not in home health. And our view is that skilled nursing eventually is going to go back into more of a sort of a convalescent location for the elderly and the poor. And that's just our view long term.

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hey, thanks. Good morning. I don't know if April is there, but I'm curious to hear a little bit more about the home health pre-claim review, the pros and cons of the pilot and just the work that you guys are putting forth to manage through this. And furthermore, just curious what you think the actual objective here is from CMS, just trying to size this up as a risk factor?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. Good morning, Whit. No. April is not here. I'm assuming that she is doing something that is very productive and adding value to Encompass. I will tell you our take, and we meet with April and her team on a regular basis. We just had a big meeting over in Dallas with them, quarterly meeting last week and their assessment is as follows. Number one, pre-claim review is a heck a lot better than waiting in line for the Medicare contractor to give them permission to treat the patient. So it's the lesser of two evils.

To your question what is CMS trying to achieve? Ostensibly what they're saying is they're trying to rule our fraud and abuse. Our view, and April's and her team's view, is that this is really not the correct way to do it. There are certainly much more targeted means of going after the fraud that may exist in the space. So it will be inefficient.

We are going to have to add some incremental staff. That incremental staff in the home health segment is going to have to make sure that the documentation interface with the MACs are perfect. The good news is if there are any deficiencies, if there is any area where the physician may have missed a signature or there may be some missing documentation, the good news is because of the length of the episode the providers will have an opportunity to go back and to update the file.

So we think that the net result is going to be cleaner files that are submitted for payment, and then the corollary benefit is since these have all now have been pre-approved by the MAC, the downstream auditing process of RAC audits and everything, ADRs, really should be eliminated. When you think about it, if the MACs are pre-authorizing these claims it really obviates the need for any post-payment review of any kind. So that's kind of our view on this pilot.

Frankly, the belief is that – or the hope, excuse me, the hope is that CMS will be very diligent in assessing the rollout in the initial states and will not just plow ahead, hell-bent on rolling this out across all three states that we're affected in no matter what that first rollout looks like. We really do think that there are going to be a lot of providers who are not up for the kind of addition of staff that we have here. And we think it's going to be pretty lumpy.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Okay. Great. I'll leave at that. We've got a busy morning, so I'll let others ask questions.

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

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

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

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Just maybe a little bit more on the update on the issues with Cahaba, any conversations with them or maybe more importantly any conversations with CMS on any type of broader resolution on the horizon?

<A – Jay Grinney – HealthSouth Corp.>: We do have a meeting that we are scheduling with CMS and with Cahaba in the not too distant future. This is something that was really organized with a collective agreement that it would make sense. And we hope that at that meeting we'll be able to lay out where we believe there are significant areas of ambiguity. And our approach is to see this as a problem solving opportunity. The good news is that the folks at Cahaba are very supportive of that approach as well. And the good news is that the folks at CMS are also interested in trying to see if there is a path forward where these gray areas of interpretation can be narrowed and the lines of what is and is not allowable can be more clearly drawn.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: And then in recent quarters you've discussed more effort on sort of the documentation and just making sure the documentation is as clean as possible. How is that going?

<A – Mark Tarr – HealthSouth Corp.>: Hey, Gary, it's Mark. It's going quite well. We are now up to 93 of our hospitals have the ACE IT system installed which is a critical part of this documentation process. We also have a number of physician leadership out doing presentations on-site, in-services with our physicians in our hospitals addressing the problematic areas. So we feel very good about the progress that we've made in terms of the completeness and accuracy of the documentation component in our records.

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

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

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Hey, I hopped on late. I hope this hasn't been asked already. But just looking at same-store results, the same-store volume numbers, is it of the 1.9% versus usually it's been running 2.5%, 3.5%, just curious any color there? Is that more driven by just a larger percentage of more recently added facilities the same-store, or do you think that's sort of the new norm for same-store in that, we can call it 2% range versus, say, a 3% range?

<A – Jay Grinney – HealthSouth Corp.>: Well, I do think that part of it is is that same-store denominator is certainly growing. But if you look at our business model, we've said for some time that the expectations for volume growth in the IRF segment is in that 3% plus. And obviously that's going to vary for a lot of different reasons just because things don't progress on a straight line. But in that 3%, we've always said that about two-thirds of that is going to be same-store and a third is going to be new store.

Now, clearly when you bring on the number of new hospitals that we did last year with Reliant, those numbers get skewed. So that 1.9%, 2% is what we think and have thought for a while as sort of that expected range for same-store. Now, we're not going to be comfortable with that, obviously, but we're always going to be trying to do better than that. But that's, I think, the right range for you to think about.

<A – Doug Coltharp – HealthSouth Corp.>: And Frank, this is Doug. I'd note as well we're up against the 2.8% same-store comp from Q2 of last year. And if you look at the last eight quarters, including the most recently reported quarter, our average same store growth in the IRF segment was 2.7%.

<Q – Frank Morgan – RBC Capital Markets LLC>: Okay. Just one follow-up on a different question. In terms of just the updated guidance on the year, would you – how would you generally characterize that in terms of conservatism? And is it also – I mean, obviously, there was – you had a [ph] beat (49:32) in the quarter, but in terms of your view about the balance of the year, is there anything you've got built in to some of these issues you've raised on the home healthcare side that make it a little more conservative? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: No. I mean it's consistent with the approach that we've always taken, which is a pretty humble approach with respect to the patients that we treat. As you know, our business is driven by the number of patients that we serve, and we don't take anything for granted with respect to volumes and being able to execute on that. So there is nothing new in terms of the approach or the philosophy. I think we've outlined on page 14, and Doug did an excellent job of summarizing, some of the considerations for that second half.

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

<Q – John Ransom – Raymond James & Associates, Inc.>: Hey, good morning. Your volume numbers in home health this quarter, is there any way to tease out what the effects may or may have not been from CJR? In other words, are you already starting to take any share from the home – from the SNFs?

<A – Jay Grinney] : John, that's no. The answer to your question is no. There's really no way of teasing that out. In talking with April and her team, they do believe that they are getting some incremental orthopedic business. But it's really too early to know with certainty whether or not it's CJR-related or whether or not they may be other factors in the market. I think it's going to take several months for us as an industry to really understand CJR, in part because we do know in many of our markets that the acute care hospitals are just now digesting the data that has been provided, are just now really seriously looking at the post-acute spend. In some markets they're a little more ahead than others, but there's still a lot in this first year where there isn't a penalty associated with CJR.

There's still a lot of fact-finding and decision making going on, which gives us some confidence that this risk model that we're developing and should have rolled out by the end of the year can

help solidify the thinking of the acute care hospital partners and kind of line us up with them going into next year.

<Q – John Ransom]>: Great. And just to ask the requisite stupid question on the call, could you just explain a little more what the significance of the 90-day savings versus – I mean, I realized your per diem costs will be higher, but does the 90-day include readmissions? Does this include a greater mix of home health? Is there something else in there that I'm missing? I just didn't quite understand the significance of that comment you made.

<A – Jay Grinney – HealthSouth Corp.>: Yeah. So the 90-day spend includes all post-acute and acute spending after that would occur in the 90 days after the patient is discharged from the acute care hospital, so readmission rates is definitely a big factor in that number.

Discharge status is a very important number. So to give you an example, let's say a patient – you've got two patients, exactly the same conditions. One goes into an in-patient rehabilitation hospital and we are paid the CMG rate, and that patient is with us for whatever number of days. It really doesn't matter because we get paid X number of dollars. And that patient then goes home and is treated at the home for one, two episodes and remains home and fully recovers. And the total cost for that episode will be whatever is in the acute care plus all of those costs that I just mentioned.

Patient two goes into a skilled nursing facility. The skilled nursing facility is paid on a per diem. That patient may stay another week, week and a half longer than they would in the acute care hospital, sometimes even more. Often those patients then are also discharged to home health, and let's just assume that at that point the home health episodes are the same.

We would argue that they are not and in fact the Encompass folks would validate that, that oftentimes the patients that they get coming out of SNFs are much sicker and require longer episodes. But even if you took that and moved that aside, if that same patient then has a 50% greater chance of going back into the acute care hospital, where charges again are incurred that Medicare has to pay for, all of those costs then are included in that 90-day episode.

So that's why we've been saying for so many years the obsession on the per diem difference in post-acute is a narrow, shortsighted, incomplete, inadequate way of looking at post-acute spend. Quality does matter. It's not just a matter of can you get it cheaper on a per-day basis. Medicare finally – and I say finally – Medicare is recognizing that with these bundled.

And so that's why we think it really plays to our strength because we can take the patient, treat them, get them very healthy so that they can either go home without any home health, or if they need home health, the care that they get in the home is on a less intensive basis than if the same patient was coming out of a nursing home, where their rehabilitation has been much, much less sophisticated and incomplete.

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

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

<Q – A. J. Rice – UBS Securities LLC>: Hi, everybody. Just two areas, I guess, real quick. In the commentary in the fourth quarter, and I guess slide 14 of your deck, and you mentioned it, Doug, I think, the $1.5 million drag from the new home health update, is that the way to think about that? That's basically two months of an impact the way the discharge payments and all work, and so we need to add another month to sort of get the quarterly run rate for next year? Is that the right way to think about it? And is there any way to quantify the administrative costs from the pre-claims review that you're factoring into the guidance for the back half?

<A – Doug Coltharp – HealthSouth Corp.>: So, A.J, it's Doug. I think that you're looking at it the right way in terms of the pricing impact. Now, all of that is on an unmitigated basis and assumes the same patient mix moving into 2017.

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

<A – Doug Coltharp – HealthSouth Corp.>: But with those caveats it would create a $10 million to $12 million revenue, and therefore EBITDA headwind as we head into 2017. We don't intend to stand still on that. I think that there are opportunities to mitigate at least a portion of that.

With regard to the administrative cost, it's difficult to say right now because the dates for the state rollouts were established as not sooner than, but we don't know specifically when they'll line up. We'll need to add resources in advance of those becoming live, but we don't want to add them too far in advance.

And I also wanted to comment, and this is an elaboration on Jay's explanation of these provisions earlier on, that although we believe that there are may be some friction cost here on the administrative side and also some potential increases in DSO and maybe even bad debt expense for a period of time as we transition to this new provision, we think that that will be temporary.

We think there is going to be some timeframe for both the MACs and the providers to transition to the pre-claims demonstration. But over time, as it relates to both bad debt and to DSO, I'll remind you of two things. One is that about 80% of our Medicare payments are under the RAP program, which is the request for advance payment. And that's where we actually get paid about 60% from Medicare at the beginning of the episode, and that is not going to change with the pre-claims demonstration. So we'll continue to have that amount coming in upfront.

And then as it relates to both the longer term implications on bad debt and also the administration costs, as Jay mentioned, if this program continues it should ultimately supplant the work that is being done by ZPICs and also on ADRs and so forth. And so both the impact on bad debt can come down or should be neutralized and the administrative costs that have been applied towards dealing with those audits will really be substituted for any of the administration on the pre-claims review.

<Q – A. J. Rice – UBS Securities LLC>: Okay. Great. And then just my follow-up. I have to ask my obligatory bundle payment question. We've been talking to providers. Obviously, some of them are starting to look at this idea of gain sharing with constituencies outside of the hospital to share in any kind of savings that you may realize having the IRF capability and the home health capability. Have you entered into any of those discussions or are we still too early on that? Maybe elaborate on whether any of that kind of thing is going on behind that scenes?

<A – Jay Grinney – HealthSouth Corp.>: Well, that's exactly what we are positioning ourselves. First of all, those discussions are going on behind the scenes. And it plays right into what I said earlier and what we mentioned on the first quarter call which is the development of this risk-sharing model that we will be rolling out and going to the acute care hospitals with towards the latter half of this year and into 2017 to do exactly what you are commenting on. And that is to volunteer and to offer to be their risk-sharing partner.

In fact, we are looking at it not so much on sharing the upside, although certainly that's going to be a part of it, but what we want to do is we want to provide that downside risk safety net for the acute care hospitals. So I think you're – what you're hearing from the market is exactly what we're hearing, and we are actively driving that in many of our situations.

<A – Doug Coltharp – HealthSouth Corp.>: And A.J., recognize that right now there's no ability for anybody to do that because at least under the bundled payment initiative for CJR because there's no risk-sharing in the first year of the program. But we're working on that, and the place that we'll start, as Jay mentioned, is to be able to go to our acute care partners and offer to serve as a collaborator on the risk-sharing, beginning in the second year of the program. We believe that ultimately the work that we do on that initiative will allow us to develop commercial bundled payment products that can be marketed to M.A. plans and other payers.

<A – Jay Grinney – HealthSouth Corp.>: And again, just to – and this is maybe reiterating a point we've said many times before, our ability to approach this type of initiative is available to us in large part because of the investment that we made in our electronic medical record system over the last several years. And I know a lot of people kind of question, well, why are you guys making such a big investment in an electronic medical record system when you're not getting reimbursed to do so? And we said consistently we believe to position ourselves to be successful in the new world order, we needed to make that investment. And I think that the returns are just now starting to be apparent.

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

<Q – Joanna Gajuk – Bank of America>: Good morning. Actually this is Joanna Gajuk on behalf of Kevin here. Thanks for taking the last question, just going back on the discussion around the cardiac [ph] before the [01:02:31] bundle and the expansion of CJR. There was also this provision that CMS came out with about the, what they call a new model to increase cardiac rehabilitation utilization. So any comment there? Is that anything that you might benefit from in terms of potential adjustments to the pressure on IRFs, if at all? Thank you.

<A – Jay Grinney – HealthSouth Corp.>: No. There won't be pressure on IRFs. That's an outpatient program. There is no pressure on IRFs.

<Q – Joanna Gajuk – Bank of America>: All right. But are you able to participate to benefit from that?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, if we wanted to. If we wanted to participate, we might do that, but that's not a current business line that we're in. Now, on the home health side, that's different, but the program that they're talking about in the bundle is for outpatient services. And, you know, frankly, the rates that are in there are not particularly attractive. So that's not something that we would look to move into.

<Q – Joanna Gajuk – Bank of America>: Great. I figured I'd just check. Thank you so much for taking the last question. Thank you.

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

Crissy Buchanan Carlisle, Chief Investor Relations Officer

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

Operator: Thank you. That does conclude today's HealthSouth second quarter 2016 earnings conference call. You may now disconnect.