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.
Gary Lieberman – Analyst, Wells Fargo Securities LLC
Sheryl R. Skolnick – Analyst, Mizuho Securities USA, Inc.
A.J. Rice – Analyst, UBS Securities LLC
Joshua Raskin – Analyst, Barclays Capital, Inc.
Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone and welcome to HealthSouth's Fourth 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'll be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to 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 fourth quarter 2016 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 Encompass Home Health and Hospice, also is participating in today's call via phone.

Before we begin, if you do not already have a copy, the fourth quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website, at www.healthsouth.com.

On page two of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risk and uncertainties, many of which are beyond our control.

Certain risk, uncertainties and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates, and expectations are discussed in the company's SEC filings, including the earnings release and related Form 8-K; and the Form 10-K for the year ended December 31, 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 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

Thank you, Crissy, and good morning to everyone joining today's call. The fourth quarter was a solid conclusion to another strong year for HealthSouth. Strong revenue growth in both segments generated $198.8 million of adjusted EBITDA for the quarter and $793.6 million of adjusted EBITDA for the full year, increases of 3.8% and 16.3% respectively.

As we discussed at the JPMorgan Healthcare Conference in January, growth in the rehabilitation hospitals segment for the fourth quarter was primarily driven by pricing, while home health and hospice growth was primarily driven by volumes. And importantly, during 2016, we continued to generate strong free cash flow, which allowed us to further strengthen our balance sheet, reducing our financial leverage, while continuing and even increasing our shareholder distributions.

Throughout 2016, we've laid the foundation for our company's current and long-term success by growing our footprint strategically and providing our high quality cost effective facility-based and home-based services to an increasing number of markets.

During the year, we added four new inpatient rehabilitation hospitals, 10 home health locations, and 8 hospice locations to our portfolio, and we added 83 beds to our existing inpatient rehabilitation hospitals. As we began 2017, our development pipelines in both segments remain robust. We had 10 projects underway in the rehabilitation hospitals segment, six of which are joint ventures.

In our home health segment, we will continue our focus on increasing the number of overlap markets with our inpatient rehabilitation hospitals, and have increased our annual target for home health and hospice agency acquisitions to $50 million to $100 million.

We define an overlap market as markets where we have an Encompass Home Health location within a 30 mile radius of one of our inpatient hospitals. We ended 2016 with 59% overlap between our IRF and home health locations, up significantly from the 30% overlap, when we acquired Encompass two years ago. And we continue to make great progress on enhancing our service offering through our clinical collaboration efforts. In the fourth quarter of 2016, our clinical collaboration rate rose to 28.2%, an increase of 730 basis points over the fourth quarter of 2015.

Earlier this month, we've launched a clinical collaboration best practices initiative under our TeamWorks moniker. We expect this initiative to contribute to further gains in clinical collaboration and assist in achievement of our three-year objective of a 35% to 40% collaboration rate in our overlap markets. A major objective of 2016 was to complete the integration of the Reliant hospitals

and CareSouth Home Health location that were acquired in late 2015. I'm pleased to report this objective was successfully achieved and these assets will further contribute to our growth in 2017 and beyond.

Our operational advancements made during 2016 included the installation of our ACE IT EMR system to an additional 20 of our hospitals, bringing the year end to a total of 101. We expect to complete the final phase of the installation of our EMR system in 2017 and we'll continue in-service upgrades to the system. We also established the required interface between ACE IT and the Homecare Homebase system used by Encompass, which will further facilitate our clinical collaboration efforts.

In addition, we launched a program that utilizes predictive analytics to identify patients in our hospitals with a higher risk of acute care transfer. We believe this tool will assist in lowering acute care transfers over time. We also implemented a medication reconciliation process, which we believe will reduce medication errors both during and after a stay in our hospital.

As we shift into 2017, we will continue to develop and advance our risk-sharing and bundling strategies. We believe that in spite of the change in administration in Washington, CMS will continue to focus on value-based purchasing models that emphasize quality and cost effectiveness, two areas, where we are the industry leaders. And given that 37 of our existing hospitals are joint ventures with acute care systems, we believe we are ideally suited for these types of arrangements as we already have extensive experience in working collaboratively with acute care hospitals to improve outcomes and the overall patient experience.

Doug will discuss our risk-sharing strategies during his comments. We continue to make progress in demonstrating our value proposition to commercial payers, including MA plans particularly for conditions such as stroke and neurological impairments.

Currently, 99 of our hospitals hold stroke-specific certification from the Joint Commission's Disease-Specific Care Certification program. In 2017, we will seek to increase our stroke market share by further communicating the HealthSouth value proposition to acute care hospitals, physicians and commercial payers.

With these growth and operational initiatives underway, we are reaffirming our 2017 guidance, initially communicated in January. Full year guidance for net operating revenues is between $3.85 billion and $3.95 billion, while full year guidance for adjusted EBITDA is between $800 million $820 million. Full year adjusted EPS guidance is between $2.61 and $2.73 per share.

As noted on page 15 of the supplemental information included with our earnings release, there are several key factors that will influence our performance in 2017. We believe that most significant of these factors is the estimated $21 million impact of the Medicare home health reimbursement rate cut that became effective January 1, 2017.

As we've discussed previously, the 2017 home health rule will negatively impact Encompass more than other home health providers due to the impact of the case mix re-weighting as Encompass treats higher acuity patients and the impact from the change in the outlier calculation. Encompass also will be adjusting to the home health pre-claims review demonstration that is currently scheduled to begin in Florida on April 1, 2017.

This demonstration is expected to have an incremental administrative cost of between $1 million and $1.5 million in 2017. As a reminder, Encompass sold the non-strategic assets of its pediatric home health business in the fourth quarter of 2016. The pediatric assets generated approximately $2 million of adjusted EBITDA in 2016.

In our inpatient rehabilitation segment, we estimate that Medicare reimbursement rate will increase 1.9% based on the IRF-PPS Rule for fiscal year 2017. With this modest pricing increase for our hospitals and the reimbursement rate cut for our home health business, our revenue growth in 2017 will be volume dependent.

We are pleased with our rebound in volumes we've experienced within both segments since the second half of January and believe our volumes for the first quarter of 2017 will be in line with our expectations.

As a reminder, we estimate our inpatient rehabilitation hospitals' discharge growth in the first quarter of 2016 benefited by 80 basis points to 100 basis points due to the extra day associated with leap year. In addition, the inpatient rehabilitation segment's adjusted EBITDA in 2016 included the benefit of a retroactive indirect medical education adjustment of approximately $4 million at the former Reliant Hospital in Woburn, Massachusetts. And while we're not seeing widespread salary pressures across all our markets, our 2017 guidance includes an approximate 3% salary increase in both segments.

Finally, in 2017 we expect to continue to generate substantial free cash flow and continue to enjoy significant flexibility and how we allocate our free cash flow in spite of the fact we will become a cash tax payer. Using the 2017 adjusted EBITDA guidance range of between $800 million and $820 million is a starting point. Page 16 includes a schedule that estimates 2017 adjusted free cash flow of between $245 million and $370 million.

As noted on page 17 from this adjusted free cash flow, we estimate that we will invest between $175 million and $265 million to facilitate continued growth through bed expansions at existing hospitals, the construction of new hospitals and replacement hospitals, and the acquisition of new home health and hospice locations. As I noted earlier, we have increased our annual target for home health and hospice agencies to between $50 million and $100 million. We believe we can accelerate our acquisition activities in this segment in 2017 and we will continue to prioritize opportunities that create new overlap markets with HealthSouth IRFs.

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

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

Thank you, Mark and good morning, everyone. As Mark just outlined, Q4 was a solid conclusion to a strong 2016, characterized by good operating performance in both of our business segments. As we consider the comparison to the prior year period, please recall that we closed on the acquisition of the former Reliant hospitals on October 1, 2015 and we closed on the acquisition of the former CareSouth Home Health locations on November 2, 2015.

During Q4, consolidated net operating revenues increased by 8% and consolidated adjusted EBITDA rose by 3.8%. For the full year 2016, net operating revenues increased by 17.2% and adjusted EBITDA $793.6 million, was up by 16.3%. Q4 diluted earnings per share of $0.68, increased by approximately 42% over the prior year period as we benefited from lower interest expense owing to the redemption of the 7.75% senior notes. Lower income tax expenses primarily related to the impact of the Reliant and CareSouth acquisitions on our state apportionment percentages and a lower share count resulting from our stock repurchases.

During 2016, we provided further evidence of the strong free cash flow generating capacity of our business. Adjusted free cash flow for 2016 of $462.9 million, increased 19% over the prior year. We utilized free cash flow during the year to fund approximately $151 million in capacity additions to our two business segments, reduced funded debt by $155 million, repurchased $65.6 million in common stock, and paid $83.8 million in common stock dividends.

The strength of our balance sheet was also evident as we ended 2016 with a leverage ratio of 3.8 times as compared to 4.6 times a year ago. We've no significant debt maturities prior to 2020 and had approximately $415 million in unfunded availability under our revolving credit facility at year-end.

Turning to our business segment results. IRF revenues increased by 5.7% in Q4, driven by stronger than expected pricing and modest volume growth. Net revenue per discharge for Q4 increased by 4.8%, resulting from our patient mix, specifically, an increase in stroke and the integration of the former Reliant hospitals, which had historically exhibited a lower average acuity. Discharge growth was 1.4% in Q4, with 0.1% attributable to same-store. For 2016, total discharges increased 10.8%, with same-store up 1.7%. As was previously disclosed, discharge growth for the fourth quarter was impacted by certain market specific conditions and as Mark stated, we are pleased with the rebounded volumes we have seen thus far in Q1 2017.

IRF segment adjusted EBITDA for Q4 increased by 4.1% as increased SWB expanses partially offset revenue growth. SWB in Q4 was 50.3% of revenue, as compared to 49.6% in the same period last year, owing to the ramp up of new stores and staffing increases at the former Reliant hospitals.

As you consider Q1 2017, please be reminded that our payroll taxes are typically higher in the first quarter of each year due to the vesting of employee restricted stock awards and the payment of annual incentive bonuses.

Bad debt expense of 1.7% for Q4, improved 10 basis points from the prior year period due to a recovery of certain aging-based reserves related to the administrative payment delays at Cahaba. The administrative payment delays were unrelated to prepayment claims denials. Regarding prepayment claims denials, as can be seen on slide 20 of the supplemental slides, we saw a modest uptick in new denials as compared to Q3 and we see no evidence of any progress in addressing the substantial and growing backlog of claims awaiting adjudication by ALJs.

Moving to the home health and hospice segment, Q4 total segment revenue increased by 18.8%. In Q4, our home health business again exhibited strong volume growth with admissions up 22.1%, 14% in same-store and episodes up 15.4%, 12.4% same-store. As Mark noted in his comments, we continue to make progress on the clinical collaboration between our inpatient rehabilitation hospitals and home health agencies.

Approximately 23% of the same-store admission growth at home health was attributable to clinical collaboration. Revenue per episode increased 0.6% as a favorable patient mix shift related to an increase in therapy mix and the continued integration of CareSouth more than offset the Medicare reimbursement cuts.

As a reminder, although the 2017 home health rule and the pricing cuts embedded within it, did not take effect until January 1, it impacted Q4 because it applies to all episodes concluding after January 1. Home health and hospice segment adjusted EBITDA for Q4 increased by 5.7% as operating expenses as a percent of net operating revenue increased by 280 basis points as compared to Q4 last year.

The increase in operating expenses as a percent of net revenue resulted from the Medicare price cuts, a higher cost per visit, which was driven by an increase in therapy mix, SWB increases and CareSouth integration expenses. As Mark suggested in his comments, I'd like to provide a brief update on the development of our risk sharing strategies.

As we discussed in our Q3 comments, our initial focus has been on developing a proposal to serve as a collaborator with certain acute care hospitals on the fracture DRGs in certain CJR markets. As

we had previously stated, our near-term goal is to approach 20 to 25 acute care hospitals located within 18 to 20 CJR markets with such a proposal by the end of Q1 2017, with a further objective of having four to six collaborator agreements in place during the first half of 2017. The materials supporting these discussions underscore our value proposition by objectively laying out our cost and quality metrics for fracture patients as compared to the other post-acute providers in the subject market.

We also described in these materials, our abilities and the specific approach we intend to take, to serve as the post-acute care network coordinator for the CJR patients and more broadly if requested in these markets. We have thus far conducted a handful of these discussions with select acute care hospitals and many more meetings have been scheduled. Perhaps not surprisingly, we are discovering the speculation that HHS Secretary, Tom Price will convert the CJR pilot from mandatory to voluntary, has decreased the sense of urgency of many acute care hospitals to enter into collaborator agreements.

Nonetheless, we're finding a receptive audience and are using the meetings to bust the myth that SNFs are always cheaper than IRFs and that outcomes between the two settings do not differ. In at least one case, we have transitioned our discussion from a collaborator agreement to a non-risk sharing preferred provider agreement and we believe other opportunities to transition the discussion in this manner, will present themselves.

I'll conclude by noting that last month, we had the final disposition of the approximately 8.2 million warrants issued as a part of the 2003 consolidated class action suit, brought by the company's stockholders and bondholders. The warrants were exercisable at a price of $41.40 per share by means of cash, or cashless exercise at the option of the holder and expired on January 17, 2017.

As can be seen on slide 31 of the supplemental slides, more than 1 million of the warrants expired unexercised. Of the balance, 6,475,449 were exercised on a cashless basis, and we issued 54,970 shares in settlement thereof. 644,376 shares were exercised on a cash basis, and we issued 644,376 common shares and returned for $26.7 million of cash in settlement thereof. The impact on our share count of the total of 699,346 shares issued in settlement of the warrants was more than offset by our repurchase of 1.1 million shares in open market transactions during Q4.

And we will now open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] And again, as a reminder, you'll be limited question and one follow-up question. Your first question comes from Whit Mayo of Robert Baird.

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

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Hey. Good morning. Thanks. Mark, can you go back and elaborate on the comments you made about TeamWorks best practices that you have within the clinical collaboration strategy. I mean other initiatives that you've implemented over the years with TeamWorks have played out pretty well, so any flavor for what you're doing and the benefits you hope to see would be helpful? Thanks.

<A – Mark Tarr – HealthSouth Corp.>: Yes. Whit, as you recall, TeamWorks is the moniker that we've adopted over the years, essentially this is our standardization program where we will work with our subject matter experts in our hospitals. In this case, we're collaborating with KPMG from a process standpoint. And what we hope to do is take some of those best practices that we see from a clinical collaboration standpoint where our hospitals and our Encompass Home Health agencies have worked particularly well with the care transition coordinators, take a look at those processes that they're using, ultimately develop a program tool that lays out these standardized processes and then rule that out to our entire platform. This we would that will contribute to the 35% to 40% collaboration rate where we'd like to see over the next three years.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Okay. That's helpful and maybe one for April. CMS recently proposed a new group or model for home health, which presumably disadvantages some of the heavy therapy providers and benefits the non-therapy providers. I'm just curious to hear your thoughts around the topic and what you think develops on this front over the next year or so, and maybe if you can just touch on your pre-claim preparation plans? Thanks.

<A – April Anthony – Encompass Home Health & Hospice>: Sure, Whit. So the Home Health group or model was not a fairly proposed, but basically a white paper by [indiscernible] (27:18) associates that was put out a couple of months ago, presents some pretty major changes to the reimbursement structure within the home health industry, changing from 60-day episodes to 30-day episodes and frankly, realigning the payments structure, so that there is less emphasis on additive payments associated with therapy provision.

We think that the model frankly is a bit sketchy at this point and the amount of detail and information that's been shared. So it's hard for us to assess a full impact of the proposal or model that they're suggesting. We've been working with CMS, members our Encompass team has been in a couple of different scenarios. We've been meeting with CMS to really talk about this. We're beginning to gather some data to try to do some analytics around the information that we do have. And so it's just hard to predict at this point in time the full impact of it, but certainly it would be a major change to the reimbursement structure, but just too early to know and there are too few details to really respond to you at this stage.

Relative to pre-claim review, we anticipate based on the guidance that that will begin April 1. We remain hopeful that comp price could intervene and delay the implementation of that in the state of Florida. But at this point, we are fully preparing for an April 1 kick-off date. We believe that we have the resources internally available to assign to this project.

Our research from those who are dealing with this program in the state of Illinois suggests that each packet, both start of care and research that has to be reviewed, takes somewhere in the range of 45 minutes to an hour to actually prepare, submit and then work all the way through the

back and forth tracking process to ultimate affirmation. So we're prepared for that sort of [ph] hour of (29:07) packet approach that time is split between clinical support members RNs that would be reviewing and gathering data for the packet and administrative support members who would actually be doing some of the detailed documentation submission process.

We're working with Palmetto through our vendor Homecare Homebase to create an interface that we think would cut that administrative time down dramatically. Palmetto is being a bit slow in delivering that interface. And so at this point, we think, we'll have to continue on April 1 with the manual process. But believe that that we're not too far away hopefully within 60 days of that date, we would be able to automate in the non-clinical portions of that review process. So we think that we can manage through that pretty successfully and that we've got the team, the resources and the technology solution to manage that successfully.

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

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

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning. Hey. How are you?

<A – Mark Tarr – HealthSouth Corp.>: Great.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: I'll be interested in some more detail about the decision to accelerate the acquisitions in the home health business?

<A – Mark Tarr – HealthSouth Corp.>: Well, as we stated part of our strategy is to create as many overlap markets as we can. We think that positions us well, not only from the continued growth that we see in the home health business, but also helps to continue to position the company for an integrated platform that we see going forward. As Doug mentioned in his bundling strategy comments, we think long-term that having a footprint in both facility-based and home-based segments and expanding these markets through the acquisition of home health to backfill in and create these overlap markets, positions us extremely well for the long-term.

<A – Doug Coltharp – HealthSouth Corp.>: Just to elaborate on that a little bit, Gary. In 2016, we've spent $49 million on home health and hospice agency acquisitions. So the low end of the new range is not inconsistent with the level of spending that we had in 2016. It's also the case, as Mark reported on in his comments, that April and her team have successfully completed the integration of CareSouth, which was an important milestone, we were looking to accomplish in 2016. So the platform and the infrastructure is there, supporting the incremental growth.

The strategy is really twofold because it's home health and hospice. As Mark stated, we do have a priority strategy of increasing the overlap markets and we're fortunate that there is a pretty good pipeline out there of opportunities to do so. We also would like to increase our footprint in hospice with a focus on adding hospice locations to those places where we have an existing Encompass Home Health agency, but don't currently have hospice.

To give you kind of breakdown, it's not a hard and fast number, but we would estimate that probably two-thirds of whatever we spend on acquisitions in this business segment in 2017 will be on home and health agencies and the balance would be on hospice.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Got it. That's helpful. And then maybe a follow-up, it sounds like yourselves not in consistent with your peers, feeling little bit of pressure on the labor front, can you maybe discuss how good you feel about that on being able to control that?

<A – Mark Tarr – HealthSouth Corp.>: We feel pretty good. I mean, from the nursing perspective, that seems to be the area that we've seen certain markets, it's not across the entire platform, historically, we've done extremely well on our ability to recruit and retain therapists. On the nursing side, we continue to do well on recruitment and retention. But overall, when we have markets that are seeing a little bit of labor pressure, it is in the nursing ranks. We've done a lot regarding our overall clinical education to retain and both, recruit our nurses, we've done a lot of leadership training with our nurse managers, so they can better manage their staff and as a part of the retention efforts. But that is the area that where we have markets that are experiencing a little labor fluctuations is primarily on the nursing side. April, do you want to elaborate on labor market conditions in home health?

<A – April Anthony – Encompass Home Health & Hospice>: Sure. On the home health side, we have various markets that are more difficult than others and that's kind of always the case. I'll use Boston, Massachusetts as an example of the market where we are always sort of the challenged in our recruiting process. It takes us more days to fill up a physician. But in general, we've really not seen significant challenges, our days to fill have actually been declining over 2016 open positions and with the organic growth rate that we've experienced, we've been able to maintain that growth and staff to support that growth in patients since – so we're not seeing that be a major issue, we think at the Encompass business, building kind of a reputation as a Best Place to Work is something that we've been able to do and leverage to our benefit to maintain a solid and consistent staffing level.

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

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

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Good morning. Congratulations, Mark. Well done and you too, Doug. And I guess the rest of the team because the fact that you're now a cash tax payer and the warrants were done means you're done with the past. And that's a big statement. So it took a few years, but it's done. The second – the real thrust of my question is this. I'm a little bit concerned at the above average closure of the home health business to the outlier payment reductions.

And while we've all kind of lived through an event in the past and while we try not to be covered by what other companies do, there are some striking similarities here with the argument that you treat higher acuity patients, and that's why you have the outlier. So, can you walk through a little bit what the model is for patient selection that allows you to enjoy on the one hand higher acuity and presumable strong margins and growth versus the argument that perhaps your patient selection expertise is a bit to refined, and there might be some risk here? Thank you.

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

<A – April Anthony – Encompass Home Health & Hospice>: Yeah, absolutely. So Sheryl, first let me sort of set in context a little bit about the outlier population. Out of the total episodes that we serve at any given time, our average outlier population represents about 4.5% of our total population and so it is still a very small segment. If you roll back all the way to the early days of the PPS system, many of our competitors really from the earliest days looked at the outlier payment mechanism and said, gosh, we just can't serve these high needs patients because the relative revenue per visit. If you looked at those episode types, was significantly less than with other episode types. In a high cost market, that made it very difficult to service those patients. To put it in perspective, an average patient might have revenue per visit of about $160 per visit, these outliers pre-2017 would run about $90 per visit. So it's a significant depression.

At Encompass, we were always able from the earliest days to continue to service that population because of our cost efficient delivery model. We utilized fair number of LPNs and LVNs in order to

provide our nursing services in the subsequent visits, those visits that can be done by regulation by that lesser cost employee. And because we had a large staff of those people, we could staff these high volume visits with a very cost efficient staff member and that allowed us to continue to have a margin opportunity on those outliers.

Now on a percentage basis, that margin opportunity was lower on an outlier episode, on average, it ran close to about 39%, compared to our overall blended gross margin percentage that was in the north of 50% range, but we nevertheless could still service those patients effectively. So what is so much about selecting those patients, as it was about not avoiding those patients and I think where some of our peers said, listen, we just can't afford to service those, we just continue to take any and everything that came our way, because our cost efficiency model allowed us to do that.

In 2017, there was a pretty significant cut obviously to that outlier population with the proposed rule. We still believe that there is margin in those episodes at least in a way that we're able to staff them with our staffing mix, although we see that margin dropping pretty significantly in 2017, which is a reflection of that significant rate cut. In spite of that drop, there is still margin to be had on these episodes. So we do not plan to discontinue the service of the patients we have. I would say, like our peers, we also will have to be a touch more selective going forward about who we accept in that category and ensure that we in fact do have the staffing capacity in order to serve those patients with that lesser cost licensed nurse discipline.

So it's a bit of a longwinded answer, but I think although these are lower margin patients and even more so in 2017 than in the past, we have a cost efficient service delivery model, you can continue to service those patients, deliver a great value to that patient and do it with still a margin, albeit less than other types of episodes.

<A – Mark Tarr – HealthSouth Corp.>: Sheryl, I'd also like to reiterate, Encompass has a very strong track record of being able to adapt and adopt business models that are extremely efficient and are flexible and in spite of a rate reduction environment. And to the extent that, they deem that they need to redeploy their resources to different patient mix then that is absolutely a potential in the future, if it doesn't seem that we can adjust accordingly to this outlier mix.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: That's very fair. And just a follow-up which is completely unrelated. Doug, you're still talking about adjusted free cash flow, do we now start talking in terms of just plain old free cash flow?

<A – Doug Coltharp – HealthSouth Corp.>: It's certainly something that we're thinking about, Sheryl. We took your comments to heart and it's something that we're evaluating. We think that and I understand the packaging is everything. The information you need to get to either one of the two metrics is fully disclosed in all of the materials that we put out there. We have a significant portion of our investor base, it's pretty vested in the adjusted free cash flow metric. So we're trying to please all of our constituents.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Do you manage to real free cash flow or adjusted?

<A – Doug Coltharp – HealthSouth Corp.>: We look at both. We are very cognizant of both measures.

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

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

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

<Q – A.J. Rice – UBS Securities LLC>: Hey, everybody. Thanks for the question. Just first on the – you mentioned that you think that CMS will stay committed, HHS to value based payments, but also you noted that HHS Secretary, Price has talked about going to more voluntary bundles. On that they've done a 30-day delay on the cardiac oriented roll-out bundle later this year as well as – I mean what do you sort of hearing about where they're at and what they're thinking and if we do go to model this more voluntary for all of these, does that change your enthusiasm about it in anyway?

<A – Mark Tarr – HealthSouth Corp.>: No. It doesn't, A.J., it's just going from a mandatory to voluntary. Longer term, we still think that the bundled environment is one that we will migrate to, where more focus is put on the episodic care of a patient, whether that is – whether the catalyst is through mandatory bundles or not, we think that's where it's going to end up. We do think what we are hearing is, Tom Price clearly is a provider from the past in his own practice. We think he is going to be more provider friendly. He is going to be a little bit less likely to have these mandatory CMMI programs for bundling, as well as, he maybe a little bit reluctant to always listen to what MedPAC has to say out there. So we think that we continue to push forward with our strategy regarding bundling and episodic care and prepare ourselves for the long-term.

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

<A – Doug Coltharp – HealthSouth Corp.>: A.J. Just to elaborate on that. We think that we're ahead of the pack with regard to lot of preparation to serve as a collaborator in the CJR markets. We base that assumption on the feedback that we've been receiving from the various acute care partners that we've been approaching with these discussion. If the CJR and other bundle payment initiatives stay as mandatory, we embrace that change and we'll move forward with the collaborator proposals. If they become voluntary and the sense of urgency continues to decrease around collaborator agreements, what we have found is that one of the most valuable aspects with CJR is the ability to get the data about outcomes over the episode for both our IRFs and for all of the post-acute competitors in a particular market. And we've worked hard to package that information in a manner that is digestible for acute care hospitals, so they can see the validity of our value proposition.

As I noted in my comments, that is really resonating with the acute care hospitals with whom we are meeting. So we think with regards to whether or not the pilots become voluntary, that the progress we're going to continue to make to function in a more collaborative fashion with the acute care hospitals in the markets in which we have an inpatient rehab hospital going to increase.

<Q – A.J. Rice – UBS Securities LLC>: Okay. And maybe the follow-up related to that – partially related to that is just – have you commented and update us on your thinking on capital priorities broadly, but specific two things. One with this greater involvement in collaboration – being a collaborator could mean or whatever. Does that change your thinking about where you might look for acquisitions? Does it require any incremental? I know you guys have done a lot in IT investments, does it require any new IT type of investments? And then also slip-in that you stepped up a pace of the buyback, it looks like in the fourth quarter, is that something that signals any kind of change in priority.

<A – Doug Coltharp – HealthSouth Corp.>: I don't think there is any change in priority. On slide 17 supplemental slides, we've laid out our 2017 assumptions and I think that they are pretty consistent with what you've seen over the last couple of years with the exception of the increase in the allocation to home health and hospice per the specific parameters that I outlined earlier.

Our strategy is pretty clear. We believe that the IRF segment is going to continue to be very attractive, because of the types of patients we treat, because of the demographic tailwind that that business is fortunate enough to have. We also believe that home health is part of any long-term solution given its cost effectiveness, and we believe that the marriage between the two businesses is highly effective in treating post acute patients over a longer episode of care in our progress, in

that regard is demonstrated by our clinical collaboration rate which we hope to accelerate based on the TeamWorks initiative that Mark discussed.

We have been investing in IT over a long period of time. We think we are on the vanguard with regard to having technology enabled business processes in both of our business segments. We think that the [ph] center (46:03) EMR that has been implemented in our hospitals and installation will be completed as Mark suggested in his comments this year is really all that we need on the IRF side.

We will continue to make incremental investments in that in service upgrades as Mark suggested to enhance the capabilities. And we think that Homecare Homebase remains the state-of-the-art system serve in the home health and hospice market. And again Mark mentioned in his comments, we've successfully established the interface between those two systems. So, we really think that the focus in terms of capital investments is going to stay the same.

With regard to share repurchase, we've said all along that our philosophy is to remain opportunistic with regard to share repurchase activity. The activity in Q4 was driven by two things. One is, there was a little bit of weakness in stock and frankly we took advantage of that based on the fact that we had already accomplished our leverage target by the end of the third quarter. And then the second thing was, we anticipated that there would be some level of dilution associated with the 2017 warrants and we want to head that off. We were successful in doing so.

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

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

<Q – Josh Raskin – Barclays Capital, Inc.>: Hi, thanks. Hi, good morning. Thanks, Mark. First question, just on the home health and hospice segment, you guys have outlined a whole series of headwinds for next year, which were certainly understandable. But you've seen some growth throughout 2016 and you've got $50 million to $100 million of acquisitions, is that a segment that you think you can offset some of those difficulties just directionally, is EBITDA up or down, I guess, in 2017?

<A – Doug Coltharp – HealthSouth Corp.>: Modestly up.

<Q – Josh Raskin – Barclays Capital, Inc.>: Modestly up. Okay, all right. There is still growth there. And then just a follow-up on the same-store growth on the IRF side, I know Reliant – or it looks like Reliant and Franklin will both – will all move into same-store for 1Q 2017. Is that helpful, I mean are those facilities again directionally growing faster than the overall book, just on a same-store, would we assume that those would be helpful to that calculation?

<A – Doug Coltharp – HealthSouth Corp.>: Well, remember, Reliant moved into the same-store calculation beginning in Q4. We are seeing growth in the Reliant hospitals, as I mentioned, remember a 7 of the 11 facilities that we acquired as part of the Reliant transaction were facilities in Texas and that there is a substantial amount of overlap between those and legacy HealthSouth facilities.

And in those overlap markets, the strategy we've had from day one with regard to those acquisitions was to operate those as a market and not as individual hospitals within that market. So the focus on where you're getting the same-store in one unit versus the other becomes a little bit more cloudy. What we can tell you is, in those overlap markets, we are planning for same-store growth for the overall market.

<A – Mark Tarr – HealthSouth Corp.>: Josh, you mentioned Franklin. So whether it's Franklin or the Reliant hospitals, Franklin continues to ramp up. If you recall, they came online in December of

2015, and the Reliant hospitals continue to change their program mix. Those hospitals that historically had been very dependent upon orthopedic mix, we've seen nice progress on continuing to migrate those hospitals over to more of what our program mix typically looks like on the rest of our portfolio where you have more emphasis on stroke and neurological. So yes, we're happy on both fronts relative to our opportunity to grow those hospitals and continue to add expertise to the program mix.

<Q – Josh Raskin – Barclays Capital, Inc.>: Got you. And Doug, just to clarify that comment on the market, so, what you're saying is that even if there was a little cannibalization of existing, all of it – the whole market is kind of same-store now at this point and you're seeing growth overall in the market regardless of what any individual specific facility, whether it was Reliant or legacy, is that way to think about it?

<A – Doug Coltharp – HealthSouth Corp.>: That's exactly. What the increased capacity in those overlap markets allows us to do is to offer even more convenience to the patients requiring inpatient rehabilitation care in those markets, meaning that on occasion either the legacy hospital or the Reliant hospital is going to be more convenient from a location perspective for the patient and their family. It also allows us to treat a larger number of patients. There were a number of hospitals in those Texas markets where we were bumping up against capacity issues. So we're indifferent as to whether or not the volume growth occurs in a new Reliant box versus a legacy HealthSouth box, as long as the overall market is seeing same-store growth.

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

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

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Great. Good morning. I just wanted to ask a question about the investments that you're making and what kind of return you're expecting, because in your slide, you showed that I guess since 2015, your maintenance CapEx is up about 55%, 70%, and your growth CapEx is up about 65%, 70%, and yet your IRF volume growth that you're forecasting looks like it's about the same with target about 3% plus. I mean I guess the business is up 20%, maybe 20% larger since 2015. But it seems like a lot more CapEx spending, and not a lot of extra organic volume growth. Can you help explain that a little bit?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah, somewhat what's been running through CapEx obviously is the investment in our clinical information system, and the good news is, as Mark said, and that's been in excess of $20 million a year. As Mark suggested, we'll complete the installation of that system in our existing hospitals this year. As we've noted previously, we have had over the course of the last several years and continuing into 2017, a number of significant remodels at certain of our hospitals.

The good news is, there is a finite number of those projects to be done. And we're getting closer to the end of those significant remodels and we are to the beginning. And then finally, specifically impacting the 2017 estimate for maintenance CapEx is that we have a new home office under development here in Birmingham. We are coming to the end of our lease at the existing facility, just about a year from now, the facility that we are in is not sufficient to support our needs on a go forward basis. So we are doing essentially a built-to-suit on a new home office, it will be a leased facility, but we are required to fund the tenant improvements, and the full amount of these tenant improvements were included in our maintenance CapEx for 2017.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay [indiscernible] (53:13)

<A – Doug Coltharp – HealthSouth Corp.>: We feel pleased about the returns that we're getting on the investments we make specifically, in the discretionary growth CapEx, granted right now. It's

a tough year for home health, because of the headwinds that Mark pointed out. But long run, we'd like the way that these two business segments are positioned and we think that the opportunity to continue to work together collaboratively to participate in the evolution towards these value – based payments and collaborative care models is going to be very compelling.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Do you expect maintenance CapEx to come down in 2018?

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

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. And then I guess you mentioned that the growth story is going to be more volume driven just given the rate environment this year and I guess, next year it's not going to be a much different. Is there a way to think about the volume growth that you need or maybe you think about it from a same-store revenue perspective that you need to kind of keep margins flat or when you start to get leverage on your margins within each business?

<A – Doug Coltharp – HealthSouth Corp.>: So it's tough to get there solely with volume, we need some level of pricing increase. If you can do the math and just think about the fact that, SWB is about 50% of the revenue dollar in each of our two businesses, kind of suggest that if you can get pricing increases and get north of 1.5%. You start to find yourself in a position where you can leverage the other components of the P&L. As you mentioned, particularly because of the headwinds we face in a home health, it presents some challenges in terms of margin compression for 2017, 2018 remains a bit of a challenge because of the macro basically capping the pricing at both of our two business segments, but we remain optimistic regarding what the pricing environment for both business segments looks like in 2019 and beyond.

Operator: At this time, there are no further questions. I will now turn the floor back over 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 tomorrow. Please call me at 205-970-5860. Thank you again for joining today's call.

Operator: Thank you. This concludes your conference. You may now disconnect.