2016 J.P. Morgan Healthcare Conference

San Francisco, CA
January 12, 2016

PARTICIPANTS

Corporate Participants

Jay F. Grinney – President, Chief Executive Officer & Director, HealthSouth Corp.

MANAGEMENT DISCUSSION SECTION

Unverified Participant

Good morning. We're going to go ahead and get started. It's my pleasure to introduce HealthSouth Corporation, one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home health-based post-acute services in 34 states. 2015, the company completed a $750 million purchase of Encompass Home Health and Hospice. The firm's network today includes 120 inpatient rehab facilities, 179 home health locations, 23 hospice locations with annual revenues of approximately $3.5 billion, and we have the President and Chief Executive Officer, Jay Grinney, today.

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

Thank you, [ph] Gary. (0:47) Good morning, everyone. I want to apologize for somewhat a weak voice. We did spend last evening watching the Crimson Tide beat Clemson, and I must admit I was cheering for many of the plays and very happy about the outcome.

We're delighted to be here at the JPMorgan Conference. With me today are Mark Tarr, the company's Chief Operating Officer; Doug Coltharp, the Chief Financial Officer; Crissy Carlisle, who is our Chief IR Officer. She's also a very strong Alabama fan, and we started the night off with shots of Fireball, so that was courtesy of Crissy. And then April Anthony, who is the CEO of our partner, Encompass Home Health and Hospice, which [ph] Gary (01:41) mentioned a moment ago and I'll talk about in a little bit.

As [ph] Gary (01:46) said, HealthSouth is one of the largest providers of post-acute care in the United States. We offer both facility-based, post-acute care in our inpatient rehabilitation hospitals. We currently have 121 IRFs scattered throughout the United States as you see predominantly in the eastern part through the Southwest and then we're growing our presence in California and in other markets.

One aspect of our portfolio that is somewhat unique and it's a component that is growing is the fact that 33 of our inpatient rehabilitation hospitals are in a joint venture with acute care hospitals, be they academic medical centers or large acute care systems. What we're finding in the market is that with all of the changes that are going on, there is an interest, a growing interest, I might add, from the acute care hospital space for post-acute providers who can come in and operate the post-acute services that they currently have and to do that at a higher level ensuring not only high-quality care but to provide that care on a cost-effective basis.

We're finding that many of the acute care hospitals and systems understand that they need to focus their resources and their attention on those services that they are particularly good at in medical-surgical business, and in those areas particularly in the post-acute realm where they may not have that expertise and may be a tertiary or a quaternary concern for them that are looking for partners. And we've been very pleased with our success rate in securing partnerships, and we'll talk about that in just a moment as well.

In addition to the inpatient rehabilitation hospital platform through our partnership with Encompass Home Health and Hospice, we also offer home care post-acute services and 179 agencies throughout the United States. We also offer some limited pediatric home health as well as hospice care.

One of the things that we've been trying to do over the last year, once we acquired an interest in Encompass, was to identify opportunities to expand that platform that we had with both the inpatient rehabilitation as well as the home health presence. And today we have about 59% of our markets of what we characterize as being overlap markets, where we have both an inpatient rehabilitation hospital and an Encompass agency, and one of the objectives that we will be pursuing over the next several years is to build out that portfolio and to increase that percentage to 100% to the extent that we can get there.

Last thing I will say about this slide and something that we are very, very proud of is that both HealthSouth and Encompass were recognized by Modern Healthcare last year as being one of the top 100 Places to Work in Healthcare. And the reason we think that that's important is because as we go forward and to the extent that the labor market does tighten, we think that having an environment that is seen as a positive environment, where employees want to stay and potential employees want to come to work, will differentiate us from our competitors.

Back in 2008 when we completed our repositioning, we put a strategy in place that was designed to drive value over the long term. We wanted to first make sure that we had a strong and flexible balance sheet. We wanted to be able to use that capacity in a disciplined way by first growing out our inpatient rehabilitation platform and then, ultimately, and at the opportunistic time with the appropriate acquisition, to expand that inpatient portfolio beyond the limited post-acute services that we're offering to be able to provide both facility based and home based.

We also looked at introducing an electronic medical record system. We think that that was something that has helped us from an efficiency standpoint, but also allows us to be positioned for participation in collaborative care models and integrated delivery system evolution.

As you can see, that strategy that we put in place has generated very solid results over the last several years, 6.5% revenue growth, 9% compounded annual growth rate from an EBITDA standpoint, adjusted EPS of 16%, and very strong free cash flow generation of 14.5%. You'll notice that in 2013, there was an increase of the free cash flow. That was really a timing issue of some maintenance CapEx, and that's why that growth seems a little lumpy.

With over 80% of our revenues coming from Medicare, perhaps the most important tailwind for our company is the fact that the patient population that we serve, the Medicare population, is growing at a very strong 3% growth rate. That demand profile is something that I think is extremely important because the demand cannot be outsourced and it cannot be replicated through the use of technology.

What we do in our hospitals is intensive therapy, physical therapy, occupational therapy, speech therapy, the services that are provided by Encompass and Home, again, skilled nursing, therapy, medical social work, very hands-on, very patient-centered services for a population that is growing, and the inevitable consequence of the aging process is that we increasingly need the services that we are providing in our hospitals in our home health agencies.

So, I can't emphasize enough how important we see this demographic tailwind for the future of the company. And as you look at the Census data in the bottom left-hand side, you can see that that continues for the next 10 years and 15 years with the growth continuing to be driven by the aging of the baby boom generation.

So, as we appreciate the fact that most of our patients are Medicare, obviously, it's important to then see what's happening in the Medicare payment system. Up until this year, I think a lot of focus was on the doc fix and whether or not post-acute providers were going to be the pay for for the doc fix, whether or not we were going to have to pay a disproportionate amount to correct that problem. That has now been resolved.

And I think people now are starting to focus on, all right, what do all of these changes to the delivery system mean, bundling, ACOs? We'll try to quantify that a little bit for you as we go into this presentation and to demonstrate to you that at least in the very near term, over the next three to five years, we think that impact is going to be fairly de minimis for our company.

Nonetheless, CMS has set out some very aggressive goals as you can see from the chart in terms of the amount of payments that would be tied to quality and the amount of payments that will be tied to integrated delivery models like ACOs and bundling.

We believe that that evolution will continue. We are not certain that the timeframe that CMS has established is necessarily achievable. We're not saying that it isn't. We just think there's a lot of work that has to be done if the system is going to change, and there isn't a lot of evidence that would suggest that the evolution of the delivery system is going at such a pace that these objectives are a slam dunk.

So, what does it mean for us and at HealthSouth? Currently, the post-acute sector is a highly fragmented sector where we have long-term acute care hospitals, inpatient rehabilitation hospitals, nursing homes, home health agency, hospice agencies, all of which are under different payment systems for Medicare. And many of those payment systems will dictate the kinds of patients that can be treated and the degree to which those patients can stay in this particular setting or that particular setting.

And that's really a reflection of the old payment system for Medicare where they look at each setting and came up with rules and regulations that would dictate what each of those settings would get paid and the kinds of patients that could be seen in those settings.

As we think about the evolution, as we think about it moving into an integrated delivery system, clearly, many of those arbitrary rules and regulations policies that set payments for providers historically would be obviated. There's no longer a need. For example, if we are in an integrated system, if we're in a bundled payment system or an ACO system for the so-called 60% rule in inpatient rehabilitation setting, a rule that

dictates that 60% of all patients have to come from a specific list that CMS has promulgated. We'll then integrate it and that was designed to then determine whether or not that setting qualified to be paid as an inpatient rehabilitation hospital.

Well, in an integrated or a fully coordinated system, Medicare is no longer going to be focusing on payment-specific rules and regulations. They're going to be focused on outcomes, quality and patient satisfaction. And in that kind of future state, many of those rules and regulations become unnecessary and obsolete.

So, as we look back on 2015, we are very pleased with many of the things we were able to accomplish. As we look out over the delivery system, beginning in 2010 with the passage of the Affordable Care Act and the mandate for changes, we recognized that there was a need for us to move beyond our inpatient portfolio, and we're very pleased to acquire a partnership interest with Encompass Home Health and Hospice. We consider them to be really the platform for home health in the United States, great management team, great culture.

That allowed us in turn to acquire CareSouth because we had the operating platform, which we acquired in the fourth quarter. That gave us an expanded presence in home health in many states, Florida, Virginia, expanded our presence there, and got us into new markets like South Carolina, Tennessee and Georgia.

We also expanded our inpatient rehabilitation platform. We acquired the Cardinal Hill Hospital in Lexington, Kentucky, a very successful hospital. We acquired Reliant Hospital Partners, gave us expanded presence in some Texas markets, Dallas, Houston, Austin, gave us a new presence in Abilene. We expanded our presence in Ohio, in Massachusetts with that acquisition. And that as I mentioned before, we also consummated quite a few joint ventures with acute care hospitals to provide inpatient rehabilitative services for those systems, and you can see those listed on the right-hand side of the slide.

In addition to focusing on growth, we also maintained our commitment to returning excess cash to shareholders. I think everyone knows here, we do have a dividend that we are paying on a quarterly basis. We increased that last July, bringing it now to $0.23 a share. We also bought back $47 million worth of common stock in the fourth quarter, taking out about 1.4 million shares from our share count.

That all has allowed us to have a very solid year from a financial standpoint. As we see here, we're maintaining our guidance for 2015 with adjusted EBITDA between $675 million and $685 million. We're very pleased with the volume that we saw in the fourth quarter. Pricing came in pretty much where we thought it was going to be. We haven't closed the books yet, but we anticipate that we'll have a very strong end to the year. 2016, we're looking for top-line growth of between 12% and 15%, EBITDA growth between 13% and 15%, and adjusted EPS growth between 3% and 6%.

As we look at the guidance for next year, there are a couple of things to keep in mind. In terms on the inpatient rehabilitation side, we are going to need to fully integrate the Reliant Hospital. That will mean bringing those hospitals up to the HealthSouth operating standard. And in fact, as we've said on our call, our third quarter call, that will involve adding some staff at some hospitals. They were staff for predominantly orthopedic book of business. We will be looking to provide services primarily on a neurological basis, which will require some additional staff, not significant, but that will be a factor.

We do think that there's going to be a continuation of the change in our payer mix, more Medicaid, more exchange patients, but we don't anticipate based on data that we're seeing that those increases are going to be to the same extent that we saw in 2015.

Our pricing on the Medicare book of business on the hospital side is about 1.6% net of all of the Affordable Care action, [ph] at (17:50) reductions, and then we think our bad debt is probably going to level off going into 2016.

On the home health side, Encompass needs to fully integrate the CareSouth acquisition, bring those agencies to the Encompass operating model. We're very pleased with both the integration of Reliant and CareSouth thus far, but we need to fully operationalize those into 2016.

As we look at the free cash flow generation capacity of the company, it is very strong. You saw with the ranges for 2016 from the adjusted EBITDA standpoint. And as you can see, we're listing here ranges for what we expect to use some of that for to get to an adjusted free cash flow between $360 million and $445 million.

So what are we going to do with that cash? How are we going to put that to work? We're going to continue to focus on growth. That's one of our key objectives. It's something that has helped us achieve the results that we've achieved over the last eight years. We're going to continue look at opportunities in

the inpatient and the home health space, but we're putting a pause on any large acquisitions. We want to integrate what we have. We don't feel compelled to go out. Where there frankly are no really compelling opportunities, we feel that it's prudent to let 2016 be a period of digesting and integrating the major acquisitions.

However, we are going to be looking to deploy $30 million to $40 million on one-off acquisition in the home health space, and we'll be deploying $70 million to $90 million to build out many of those joint ventures and to pursue new joint ventures. If there are going to be acquisitions in the IRF side, frankly, they're going to be very limited, and they'll be typically sort of one-off acquisitions.

Our growth pipeline is very strong and we're very, very pleased with it. We have a disciplined approach as we look for opportunities on the joint venture side, as you think about why we may be attractive to a potential joint venture partner. We've outlined what we're hearing from those partners, as we hear them explain post-transaction why they were so happy to get involved with us and to have us as their inpatient rehabilitation partner.

At any given time, we're working 40 projects to 50 projects. In the pipeline, we may be actively engaged with 10 projects to 12 projects. And then because [ph] either due (20:43) to CON regulations, oftentimes we get a lot of time involved with valuing the assets of the contributed assets of the joint venture partner and then you just have the complexities of those partnerships. We believe four to six per year is a very doable target.

On the home health side, again deploying that $30 million to $40 million, typically those are smaller acquisitions, revenues of $5 million to $10 million, maybe $15 million, so those are much more manageable. Again, April and her team have done a magnificent job since their inception of being able to grow and to use their operating platform to bring these new acquisitions on a highly, highly profitable basis.

And we're also going to continue to deploy the excess free cash flow to the benefit of our current shareholders. We have continued authorization on common stock repurchase, and we have the ability to go after some of the 2022 notes.

We also will be focusing in 2016 on two important initiatives. One is establishing clinical care protocols that will integrate the care provided to patients that are coming into acute care hospitals, or in some

instances, perhaps in the physician's office, between the inpatient rehabilitation platform and the home health platform, establishing the needs upfront, getting the home health team involved in the care and the discharge planning in our inpatient rehabilitation hospitals, and then looking for opportunities to discharge those patients directly home, skipping what is now often an intermediary step into nursing homes.

Not necessarily because the patients need the care in a facility setting as much as it is that the patients often feel that they don't have the capability of being safe in their home with their traditional home health partner. We believe through the partnership with Encompass, we can get those patients back into the home with the world best home health provider and to obviate that need for patients who feel like they have to go into an inpatient skilled nursing facility.

Finally, I just want to talk about the bundling. We are going to be participating and are participating. The exposure for us is very small. As you can see, a lot of knees and hips in the Model 2 bundling. Most of those, 40% have some serious comorbidities. They're not going to be able to be treated in a nursing home. Many of those patients are on a lot of medications. They need 24-hour, seven-day-a-week nursing care, services that are frankly just not provided in a nursing home environment.

We also have had some experience with bundling in the home health space with Encompass, but again very limited. So, it goes back to what we were saying before which is we believe that this evolution is going to continue, but we think that the pace is going to be a little bit more moderate than what some people are expecting.

So, finally, as we think about HealthSouth, we think we've got a very strong business proposition and value proposition. We are in very attractive sectors of healthcare, sectors that are growing at 3% plus from the demand standpoint. We have industry leading positions both in the facility- based inpatient rehabilitation as well as the home-based through Encompass. We have a very cost-effective platform in both segments. We own the vast majority of our real estate from a hospital standpoint. We've got a great strong financial platform, and then we have very exciting growth opportunities in both spaces.

So with that, that concludes my presentation. Our breakout session will be in the Olympic Room, and we look forward to joining you there.

HealthSouth Corporation (Q&A)

HealthSouth Corporation presentation delivered at the 34th Annual J.P. Morgan Healthcare Conference on 01/12/2016.

PRESENTER: We'll start the breakout for HealthSouth. It's a small table, so I'm going to sit here. I've got plenty of questions to carry it, but I'll let you direct the Q&A. I won't be able to see behind me. Any questions for [inaudible 0:14] ?

AUDIENCE MEMBER: Thanks. I had a question about slide 19 in your slide deck that shows the percentage of your discharges exposed to the CJR. It's a little confusing to me. I was hoping you could elaborate on what this is showing, kind of like apples to apples.

If this is meant to show that you have less exposure to this, apples to apples, versus the industry because the acuity of their patients might be different. What exactly this is showing with regard to the exposure to the bundle?

JAY: We've been asked to repeat the question, since it's being webcast. The question is on page 19 of the deck that we just presented and wanting clarification around the numbers. Is that fair?

AUDIENCE MEMBER: Yeah.

JAY: As you know, there are four different kinds of bundling projects, initiatives, and we have an appendix that lists what those different bundles are. Bundled model 2 is where the acute care hospital is the convener of the bundle. There are at least two, right now, that are underway.

In the top line, there's 122 acute care hospitals. Those are acute care hospitals or systems in the country that have voluntarily bundled payments for certain DRGs.

As you look at those bundled DRGs and go downstream into determining how many of those ultimately end up in an inpatient rehabilitation hospital like ours, you can see that in those markets, it's a fairly small number.

That 2.9 represents about 2.9 percent of the Medicare discharges in those 79 markets where acute care hospitals, 122 acute care hospitals, have voluntarily participated in the model 2 bundling. That is the number of patients that we're currently getting. If you then look up what does this mean, the 45 percent in the LEJR, that means that 45 percent of them are lower-extremity joint replacements.

The second section of that page now addresses the CJR project. That's a mandatory model 2 where CMS has said, "In these 67 markets, acute care hospitals have to participate in a bundled payment for two DRGs, 469 and 470, which are knees and hips."

In our markets, in those 67 markets that have been identified by CMS, we have about 1.8 percent of our Medicare patients, 1.3 percent of our total patients.

The other thing that's important to note, and I mentioned this in my remarks, is that 40 percent of both categories, 40 percent of those patients, have comorbidities or complicating conditions that require inpatient rehabilitation care. They are on multiple medications, they need 24-hour, seven-day-a-week nursing care.

The purpose and the intent here is really to help put into some perspective a concern that we have heard out there from some potential shareholders about the disintermediation that's going to occur in the industry and how exposed we might be to CJR and to bundling.

The reality is that exposure is very, very small.

AUDIENCE MEMBER: The one point, how does that compare to the industry, that 1.8 percent? Do you know what percentage of the industry's discharges are in these?

JAY: No, I don't know. Keep in mind that if you go upstream to the acute care hospitals and you just look at how many 469 and 470s are being discharged today, the knees and hips today, not all of those today are getting into an inpatient rehabilitation hospital.

In fact, the 60-prcent rule limits, severely limits the kinds of patients, lower extremity joint replacement patients, that can get into an inpatient rehabilitation hospital. There's already a governor, if you will, that limits the amount of patients that can come into a rehab setting.

Then, if you look at the next page, 20, the story shifts a little differently when we talk about exposure to bundling from our home health partner. April, you want to mention...?

APRIL: We've certainly participated voluntarily in a number of bundled payment programs. In our case, we're a model 3 provider, meaning that we accept risk from the time the patient enters the home health episode and for a period 90 days forward from that date.

The opportunity in home health is really with the CJR program. So often now with these forced bundles through CJR, we're going to see hospitals taking a much keener interest in where those patients are discharged and the surgeons themselves.

If they can bypass those higher-cost SNF days and instead get that patient successfully into the home, then we think that produces a huge opportunity for home health care. In particular, Encompass has had a longstanding specialty program in the orthopedic, hip, knee, as well as spine programs.

We feel like we are really well-positioned, not only as an industry but specifically as a provider, to address that CJR opportunity and turn that into an increased bandwidth of discharges directly to home care for those patients. We have some great outcomes to prove our success with those patients.

PRESENTER: I think the low exposure to disintermediation on the IRF segment that Jay pointed out and the great opportunity for home health that April just mentioned is really highlighted on slide 26 of the presentation. There, you see the discharge destination for CJR patients out of acute care facilities.

Again, less than 10 percent of those patients going into an IRF setting. A very substantial portion of those

with significant comorbidities that would prevent them from being able to skip a stay in a specialty hospital.

By the same token, we believe that a substantial portion of that high percentage that are going into SNFs could be a candidate for some kind of disintermediation into the home setting.

JAY: Other questions?

AUDIENCE MEMBER: I have a couple. Maybe just follow up on that. Given that ETCI started, I believe, in the summer, CCJR, I guess, JM1 got delayed.

JAY: April, yeah.

AUDIENCE MEMBER: Versus the overall exposure, what has been the actual experience? I'm not actively following the stock, so maybe this is obvious to other people. Is the actual experience that some of these have ramped up that you've really been able to maintain what you thought you would maintain?

JAY: The question is what's the impact been to date. If you go back, from a bundling standpoint, to that slide 19, HealthSouth has chosen to participated in the model 3, where we are the convener. Then, we have responsibility for patients for a 60-day episode.

As you can see, the number of cases that we're taking on that responsibility for is fairly diminished. Most of those started in middle of 2015. We started our participation mid-'15. What we're seeing is a steady referral source for those patients, be it a stroke, sepsis, a double knee or double hip.

We haven't seen anything that would be a negative from a buy-in standpoint. What we're doing is we're being much more selective, especially now that we have a partner in home health. We are working to make sure that the discharges coming out of our hospitals are going to quality providers.

We're very pleased that in many of these markets, we're able to link those patients directly into Encompass.

On the top, if you look at the model 2, we have a situation in one of our Texas markets where one of these 122 acute care facilities chose to get into a bundle. They did it on lower extremities, so they're part of this 45 percent of voluntary participation.

What we saw in a relatively short period of time is we had a very small amount of orthopedic business. We didn't see a huge drop-off. We saw a little bit of a drop-off, but what we were able to then do is to replace those patients with neurological, stroke, and other higher acuity.

In fact, in that case, we're now analyzing, adding additional beds into that hospital. The net result has really been a positive. Even though we've got a bundle going on in that market, it really hasn't impacted us in any kind of way.

AUDIENCE MEMBER: On your third-quarter earnings call, you talked about how your CMI moved down a tad sequentially. You attributed that to greater commercial/Medicaid mix. Is the growth in commercial and Medicaid discharges something that you're proactively seeking, or is it a reflection of greater demand

in the market?

JAY: It's a reflection of greater demand and inclusion of inpatient rehabilitation for some of these plans. As you think about the exchange patients, rehabilitation is one of those covered services.

Individuals who previously had no insurance today have that coverage, and if they need inpatient rehabilitation, they'll be eligible to be admitted into one of our hospitals. Similarly, on the Medicaid, the growth there is a reflection of the expansion of the Medicaid programs in many of these states, just opening up the patient population.

I don't want to say that we are proactively going after any particular kind of patient except from a clinical standpoint. We don't differentiate based on payer, so we're not saying, "We're only going to take you if you're Medicare." Our responsibility is to provide that care to as many individuals that need that care. Yeah?

AUDIENCE MEMBER: [inaudible 12:00] bundles. Can you talk about the potential effect that the expanding [inaudible 12:04] may have?

JAY: We're not seeing any, and don't anticipate that there's going to be any, impact on that.

AUDIENCE MEMBER: Is that because [inaudible 12:14] , it's just that the patients have higher acuity?

JAY: They are definitely higher acuity. Definitely higher acuity. I think that's a nuance that no everybody fully understands. A knee is not a knee is not a knee. If you're 85 years old, you've got congestive heart failure, maybe you're a diabetic, and you have a knee that needs to be replaced.

The care that you require from the acute care hospital into the post-acute setting and into the home is going to be very different than if you're a 67-year-old Medicare beneficiary who had a knee replaced because they've run 40 marathons in their life and have skied for 20 years. Their knee gave out, and guess what? They need a knee replacement.

The reality is a lot of us in this room will probably be in that situation. That individual, that patient, is very different than the first patient. The care that they get in the acute care hospital, where they need to go from a post-acute setting, if at all.

It's conceivable that that 67-year-old would not need to come to a rehabilitation hospital. Maybe they'd have to go to outpatient therapy, or they could be taken care of in their home. Other questions?

AUDIENCE MEMBER: Can you update us on what you think the combined earnings power, measured by EBITDA, from Reliant and CareSouth are? When you announced Reliant, you talked about $82 million. You also very clearly said that you're going to invest more resources and staffing and change [inaudible 14:09] mix there.

Help us understand that, and I'm also curious, talk about 2014 being a little over $100 million in revenue. We presume it improved more in 2015, and if you can get it up to Encompass levels, you're talking about earnings power of...

[crosstalk]

JAY: The question is asking the individual contributions from CareSouth and Reliant. This is going to be a disappointing answer, but we're not going to get into that. We're just not going to parse it down into how much from this business, how much from that business.

A lot of it, from the Reliant perspective, is very complicated in those markets of Dallas, Houston, and Austin, where there's a solid integration process going on right now among the hospitals. To parse that out, we've made the determination that that's not a really good use of time.

What's more important is to focus on what do we think we can grow the top line, what do we think we can grow EBITDA, and what do we think the EPS growth is going to be. How much cash are we going to generate, and where are we going to deploy that cash?

That's the way we look at the business. Obviously, we're focused on the integration of Reliant, we're focused on the integration of CareSouth, we're pleased with what we're seeing, but parsing that out into individual components, we're not going to do that.

AUDIENCE MEMBER: On a combined basis, how do you characterize the effect of purchase multiples? Even if you put CareSouth and Reliant Encompass together, what is the effective multiple you're employing that acquisition, that billion dollar-plus of acquisition spend?

JAY: What do you think that would be?

PRESENTER: Probably somewhere in the nine times. Encompass was at the higher end of that range. CareSouth and Reliant were both beneath that.

Again, it gets a little bit complicated when you need to recall that in both the Encompass transaction and the Reliant transaction, we picked up significant tax benefits there. We picked up a tax benefit with a net present value of $40 million as part of the Encompass investment.

We've picked up a tax benefit with a net present value of approximately $150 million with the acquisition of Reliant. I want to clarify that those are not additions to the NOL. Instead, those are a result of the step up in basis and the amortization, which is straight line for both of those over a 15-year period, but it's a real number.

AUDIENCE MEMBER: That's EBITDA, right?

PRESENTER: Yeah, multiples of EBITDA.

JAY: Yup?

AUDIENCE MEMBER: Maybe I just misread it, so I apologize. If I look at the guidance provided and then '16 [inaudible 17:07] acquisitions, I think it would imply a pretty decent-sized margin compression, just on legacy IRF business. Do I read that correctly, or do I have that wrong?

PRESENTER: I think the implied margin is not too distinct from what we're going to realize in 2015,

depending on which point in the revenue range and which point in the EBITDA range that you pick.

From a historical perspective, is the margin compressing from where we were, say, two years ago? The answer is yes. The primary reason for that is the mix in the business change, and that being that home health has historically today generates lower EBITDA margins than does the IRF business.

Some of that should be expected, because it's less capital intensive. You've got, depending on who you want to look at in the home health space, maybe a range of 14 to 17 percent in EBITDA margins versus a pure facility-based inpatient rehab operator that would operate with an EBITDA margin in the low-to-mid 20s.

The second piece of that that we did acknowledge through the course of this year is that much of our revenue growth was driven more by volume than pricing increases during the course of the year. Some of that was attributable to the shift in our payer mix, based on the factors that Jay mentioned before.

We did have a little bit of a change in our patient mix that was the subject of a previous question.

AUDIENCE MEMBER: I have another one. Given that the [inaudible 18:38] for your business, you were talking about demographics, the age of the population, expanding Medicare beneficiaries. Can you just touch a little bit on your relationship with MA plans, what they're doing in terms of not just pricing but criteria for IRF or pressuring length of stay? What's the dynamic?

Is increased MA penetration over time, it looks like it's clearly going to continue to play out, is that a good, bad, neutral for the business?

JAY: The question was about our participation with MA plans and the relationship there. I would characterize that relationship as positive. What we're finding is increasingly the MA plans are moving away from a highly managed, per-day basis to a case rate system that recognizes that there are certain patients that need to get into an inpatient rehabilitation hospital.

We've been pleased with our ability to see that portion of our business grow proportionally to or with the growth in the MA plans. To your question, is it a negative? It's definitely not a negative. I would see it as being more on the positive side, because it's an expanding, addressable market for us.

PRESENTER: This won't be exactly specific, but when we look out over the period three-year period, the growth nationally in the Medicare Advantage enrollment, the CAGR's been in the seven to eight percent range. The increase in our business has been almost exactly the same.

During that period, we've been able to grow traditional Medicare fee-for-service at even a faster rate.

AUDIENCE MEMBER: I'm sorry, I just had one more follow-up. The two for model 2, two lines on model 2 on the slide where you have 2.9 percent of exposure for the voluntary and 1.8 on the...Are those overlapping, where the first line says 45 percent of these discharges are LEJR? Or is that in addition to the 1.8?

JAY: If you look at that 2.9 and the 2.1...

AUDIENCE MEMBER: The 2.9 and the 1.8, I mean.

JAY: Between those two, if you look at the 1.8, that's 100 percent LEJR. Then, 45 percent of the 2.9 is also LEJR. If you go to the far left, those acute care hospitals voluntarily chose to participate in a model 2 bundle back in 2015 or 2014 and chose to do so around lower extremity joint replacement.

AUDIENCE MEMBER: I should take the 1.8 plus 45 percent of 2.9, so that's around 3 percent, those two combined, of your total LEJR are participating in either of these?

JAY: Yeah, that'd be for Medicare, and then obviously lower in the...

AUDIENCE MEMBER: The appendix in slide 26 says approximately nine percent. It says nine percent of discharges are related to LEJR for IRFs.

APRIL: [whispers] That's national status.

PRESENTER: The information on slide 16 is specific participation for HealthSouth in these pilot initiatives. The information on slide 26 is if you look nationally at all discharges for LEJR coming out of acute care facilities, where do they land? This is a small subset of the overall discharges.

JAY: Another way to think about that, and maybe an additional question, is, is HealthSouth different than the rest of the industry in terms of the number of knees and hips? The answer is absolutely.

We have a much, much less focus on lower extremity. Our average is between six and seven percent total of all of our patients are lower extremity. If you look at the industry, it's closer to 12 to 15 percent.

That's because our focus has been on establishing clinical programs and clinical competencies around stroke, neurological, and other orthopedic conditions like hip fractures, spinal cord injuries, etc.

AUDIENCE MEMBER: Regarding Encompass, with the 2016 Medicare home health rates, are you guys going to experience an industry average 1.4 percent cut, and how would you work to offset that?

Then, in terms of your acquisition, particularly with CareSouth, presumably they have a lower margin than you. Can you tell us about your integration process and how you get an acquisition like CareSouth up to your industry [inaudible 24:05] margins?

APRIL: Relative to the margin question, our rate cut will come in very similar to the national average. I think we're going to come in at 1.6 percent is our estimate, slightly impacted by wage indexes and other demographic mixes that we see. We're right on top of the national average on the cut.

From mitigation perspective, unfortunately, we are becoming masters at mitigation, because we have been facing cuts in the home care industry pretty consistently since 2010. It's really about gaining those incremental efficiencies.

If you were to compare Encompass to our other public peers, you would see that the area where we stand out most distinctively is in our cost per visit. Creating an environment that allows us to maintain low cost per visit is driven by having great tools to manage productivity to make sure that our full-time staff

are, in fact, achieving the levels of work that we expect.

Secondarily, keeping our turnover down, which is driven by a strong commitment to our best place to work culture that Jay referenced with the modern healthcare acknowledgment.

Then, the third component is that we uniquely focus on optimizing the use of LPNs and LVNs when we can, PTAs, and COTAs to bring that cost per visit. There's about a $15 to $17 per visit delta between the cost of an RN and the cost of an LPN.

When we can utilize that lower end of the discipline to effectively deliver quality outcomes, there's a huge opportunity there. That's an area that we, in particular, have been very strong at.

We've got to continue to realize those three objectives, control our cost per visit, which is where about 60 percent of all of our cost resides in home care. If we do those things well, we can continue to face that challenge.

Scale and density will make an impact in that, as well, so in the markets that we serve, being able to minimize the windshield time can drive that productivity number if we've got a lot of volume concentrated in close geographic areas. Those are some of our mitigation strategies.

Your second question was relative to CareSouth, and I would really go back to the first part of the answer. When you look at those distinctives, in home care, it really all comes down to how you manage that workforce effectively.

The most important thing we can do in our integration work here in the first six months or so of the year is to focus on realizing those same three objectives of productivity, turnover, and optimization of our skilled staff.

If we do those three things well, we will see the margins at CareSouth improve, because they had a distinctively higher cost per visit than we experienced at Encompass, because those hadn't always been their core focus areas.

I think that's the most important thing that we will do while continuing to make sure that the volumes and the scale and density that I referenced comes in. They're very similar strategies.

JAY: I think we're out of time. Thank you very much, everyone.

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