HealthSouth

Q3 2015

Earnings Call Transcript

PARTICIPANTS

Corporate Participants

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

Other Participants

Whit Mayo – Analyst, Robert W. Baird & Co., Inc. (Broker)
Frank G. Morgan – Analyst, RBC Capital Markets LLC
Chad C. Vanacore – Analyst, Stifel, Nicolaus & Co., Inc.
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MANAGEMENT DISCUSSION SECTION

Operator: Good morning everyone and welcome to HealthSouth's Third Quarter 2015 Earnings Conference Call.

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

I would now like to turn the call over to Crissy Carlisle, HealthSouth Chief Investor Relations Officer. Ma'am?

Crissy Buchanan Carlisle, Chief Investor Relations Officer

Thank you, operator, and good morning everyone. Thank you for joining HealthSouth third quarter 2015 earnings call.

With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Mark Tarr, Chief Operating Officer, John Whittington, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; Julie Duck, Senior Vice President of Financial Operations; and Ross Comeaux within the Investor Relations Department.

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

page two of the supplemental slides, you will find the Safe Harbor statement which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risk and uncertainties, many of which are beyond our control. Certain risks and 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, Form 10-K for the year ended December 31, 2014, and the Form 10-Q for the third quarter of 2015 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 or correct these forward-looking statements. Our slide presentation and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measures are available at the end of the slide presentation, at the end of the related press release, and is part of the Form 8-K filed last night with the SEC, all of which are available on our website.

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

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

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

Thank you Crissy, and good morning to everyone joining this morning's call.

We have a lot we want to cover with you this morning. In addition to reviewing the quarter's results, we want to discuss in greater detail the factors impacting our inpatient segment, the differences in our updated full year guidance relative to our previous guidance, and some early thoughts about 2016.

While the quarter was disappointing, we were very pleased that both segments headstrong volume and topline growth. We obviously didn't get as much of this incremental revenue flowing through to adjusted EBITDA as we would have liked, but we do believe that we can manage the underlying issues going into 2016. Our home health partnership with Encompass continues to perform exceedingly well. For agencies owned by Encompass, prior to 2014, admits were up 17.1%, recertification were up 8.7%, and episodes were up 11.9% year-over-year. These growth rates include patients from 12 in-market consolidations of former HealthSouth agencies into Encompass agencies.

For agencies purchased by Encompass in 2014 and 2015, admits increased 22.8% while research were up 13.5% and episodes were up 15.6%. On the inpatient side, total discharges increased 9.6% with 5.7% coming from new hospitals. The 3.9% contribution from same-store hospitals was the highest, year-over-year same-store increase since Q1 of 2012. Segment adjusted EBITDA for home health was $20.7 million in line with our expectations.

The Encompass management team continues to execute its business plan and has acquired 12 agencies and opened four locations in 2015 while transitioning 22 of the 25 legacy HealthSouth agencies onto its operating platform. The remaining three legacy agencies involve joint ventures, one will – is expected to transition in the fourth quarter and the other two are expected to be transitioned in 2016.

The third quarter inpatient adjusted EBITDA came in at $166.2 million, up 2.9%, year-over-year, on an as-reported basis. Several factors impacted these results. The most significant was the continued deleveraging of our salaries, wages, and benefits that occurred against the backdrop of our changing payer mix. This deleveraging had two components. The first component was deleveraging as a result of continued, greater than anticipated group medical claims that resulted in us adjusting our group medical

reserves in the quarter by $4.5 million. We now expect group medical costs will continue at their current levels for the balance of the year and will negatively impact our fourth quarter results.

The second labor deleveraging component was an increase in direct labor costs. Although our productivity, as measured by employee per occupied bed, was essentially in line with last year, we utilized more contract labor and premium pay programs this quarter versus last year to accommodate the increase in the number of patients we treated. Furthermore, the licensed skill mix of new employees hired since last year has changed. We have been successful in hiring more registered nurses in lieu of LPNs or LVNs, which we believe will enhance our clinical outcomes and enable us to treat more acutely ill patients, and we've hired more occupational therapists, which gives us the opportunity to increase the amount of individual therapy we can provide.

Although the licensed skill mix change is permanent, the premium paid differential should be eliminated over time as we hire permanent staff to accommodate the increased volumes. All of these factors contributed to an increase in our year-over-year average hourly cost for an employee.

In addition to the deleveraging of our SWB, we also saw a $3.9 million or 21% sequential increase in prepayment denials that resulted in incremental bad debt expense. On our second quarter call, we stated we believe that many of our prepayment denials occurred because one of our MACs was using rule of thumb criteria to deny claims rather than criteria based solely on the law. For example, one rule of thumb, frequently used was to state the patient could have been treated in a lower acuity setting.

The MAC has consistently denied claims for lower extremity joint replacements, knees and hips, claiming claims by stating that patients could have been treated in nursing homes. Not only does this disregard the admitting physician's medical judgment as to the proper setting for his or her patients, it is not a basis for determining medical necessity under the Medicare coverage requirements for inpatient rehabilitation facilities.

Subsequent to the second quarter call, we had productive discussions with CMS officials in Baltimore and have been told they have instructed this MAC not to use rule of thumb criteria as a basis for denying claims. Although it's too early to know if this will reduce the number of denials, we will continue to monitor our denial activity to ensure the law is applied. And we'll seek to work with this particular MAC to address any ongoing concerns they may have. Finally, and perhaps most importantly, our adjusted free cash flow increased 27.8% in the quarter, compared to Q3 of 2014, bringing our year-to-date adjusted free cash flow to $305.9 million, an increase of $40 million or 15%, compared to the first nine months of last year.

Moving onto development, we were very pleased to acquire the Reliant hospitals on October 1st. And although our access to these hospitals was very limited prior to closing, the transition to new ownership is going smoothly. As noted in our Form 8-K, the former Reliant hospitals had high EBITDA margins. This was attributable primarily to aggressive staffing levels and their focus on lower acuity shorter length of stay patients. Although this enabled them to generate high margins, it also resulted in lower average occupancy. One of our near-term objectives is to assess and where necessary upgrade the clinical capabilities of these hospitals, so they can treat a broader range of patients requiring inpatient rehabilitative care, thereby increasing the addressable markets served by these hospitals.

This also will require modest additional maintenance CapEx to some hospitals to install our electronic medical record systems and where necessary, rehab specific equipment and technology to treat these new types of patients. We have already installed HealthSouth's management reporting and billing software system at all former Reliant hospitals and will install our electronic medical record system at all these hospitals by the end of 2016.

We also are in the process of adding staff at several of these hospitals. Our first priority will be to ensure all hospitals migrate to our staffing matrices. But we also need to invest in quality reporting personnel, similar to those we've added at our legacy hospital and in therapists to ensure we provide a preponderance of individual therapy. We believe all of these investments will position the former Reliant hospitals to integrate onto our portfolio and be successful over the long term.

We expect to close on CareSouth on November 1st and are very excited about this pending acquisition. It will add another home health asset to our portfolio that complements our hospital segment. It has a proven track record of delivering high quality care and it is an excellent cultural fit with Encompass. Encompass will be the acquiring entity. The Encompass team has invested considerable time and effort preparing for this transition. CareSouth utilizes the home care home based operating system which should facilitate the integration of these agencies onto the Encompass platform. We estimate Reliant and CareSouth will contribute between $20 million and $25 million of adjusted EBITDA in the fourth quarter.

As I had mentioned, we now anticipate that elevated group medical, bad debt, and direct labor expense headwinds will persist into the fourth quarter. These headwinds were not forecasted when we provided guidance on our Q2 call.

As Doug will explain in greater detail, we viewed most of the $4 million to our group medical reserve adjustment in Q2 as an anomaly, not a trend based on the group medical claims history of the past several years. Approximately $3.5 million of the $4.5 million Q3 adjustment, coupled with an increase in our Q4 medical accruals account for approximately $7 million to $8 million of the second half headwinds that were not anticipated earlier this year.

Similarly, while we anticipated some increase for our bad debt expense resulting from prepayment denials, we did not anticipate it would be a 21% increase. This accounts for another $1 million to $2 million of incremental unanticipated second half bad debt expense. As a reminder, these claim denials typically are received by our hospitals, three-plus weeks after the patient has been discharged and the bill has been submitted to the MAC. The balance of the miss is attributable to the direct labor cost increases I discussed a moment ago.

Taking into consideration, the contribution of Reliant and CareSouth and continuation into the fourth quarter of these expense headwinds and pricing trends we've experienced through the first three quarters, we are updating our full-year adjusted EBITDA guidance to a range of $675 million to $685 million. Our updated EPS guidance range is now $1.94, to $1.99 per share.

This range includes financing cost and transaction fees related to the Reliant and CareSouth acquisitions, depreciation and amortization associated with these assets and approximately $2 million related to the loss on early extinguishment of debt for the redemption of a portion of the 22 notes.

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

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

Thank you, Jay, and good morning, everyone.

As Jay mentioned, the third quarter was again characterized by a strong revenue and volume growth at both of our business segments. On a consolidated basis, revenues for Q3 increased 30.4% over Q3 2014, aided by the acquisition of Encompass. Consolidated adjusted EBITDA increased 18.1% as EBITDA flow through was impacted by IRF segment headwinds as Jay just described.

We continue to generate high levels of free cash flow. Adjusted free cash flow for Q3 2015 increased approximately 28% over Q3 2014. And for the first nine months of 2015, adjusted free cash flow was up approximately 15%.

As I begin my discussion of the IRF segment performance, you may find it useful to turn initially to slides nine and 10 of the supplemental slides accompanying our Q3 earnings release.

IRF segment revenue for Q3 increased 10.5% over Q3 of last year, driven by discharge volume growth of 9.6%. Discharge growth was strong in both same stores at 3.9% and new stores at 5.7% and was also

strong across all major payor categories with Medicare up 8.3%, managed care up 11.5%, Medicare Advantage, also up 11.5% and Medicaid up 25.2%.

The acquisition of Cardinal Hill, which I will remind you is a very large hospital with 158 licensed inpatient rehab beds and 74 licensed skilled nursing beds, impacted discharge growth in all payor categories accounting for approximately one fifth of the increase in Medicare, one fourth of the increase in managed care, one half of the increase in Medicare Advantage and one third of the increase in Medicaid.

We believe the strong volume trends we have exhibited thus far in 2015, are indicative of the growth in the Medicare beneficiary demographic cohort as well as the increased enrollment in Medicaid and commercial exchanges. These factors all point to an increase in the addressable market for inpatient rehabilitation services.

Similar to our discussion in Q2, IRF segment pricing growth was lower than anticipated in Q3 with revenue for discharge increasing 1.2% over Q3, 2014. As we discussed in Q2, the shift in our payer mix caused by the proportionally higher growth in the non-Medicare payer categories as I just described, impacted our pricing as did a modest decrease in the average acuity of patients we treated. We also experienced a mix within the mix shift in our managed care book of business as growth during the quarter was higher in some of our lower-paying contracts, at least a portion of this owing to the commercial exchanges.

As a reminder, our managed care rates average approximately 70% to 75% of Medicare rates. Our Medicare Advantage rates average approximately 88% to 92% of Medicare rates and our Medicaid rates average 67% to 72% of Medicare rates. As we discussed in our Q2 call, Medicaid and managed care rates vary considerably from hospital to hospital. We analyzed our Medicaid and managed care rates on a per-hospital and per-contract basis and determined that in nearly all cases, these rates are sufficient to cover our estimated variable cost. But in many cases, the resulting contribution margin is quite thin. We are utilizing this information in our negotiations with our managed care payers.

Our Q3, 2015 pricing was also impacted by modestly lower average acuity than we experienced in Q3, 2014, predominately from Medicare and managed care patients. In both cases, we exhibited a corresponding shorter length of stay and improved discharged community for these patients. The modest lowering and acuity notwithstanding, our CMI indicates that we continue to treat a high percentage of medically complex patients.

I'll refer you to next slide 11 through 13 of the supplemental slides. IRF segment SWB for Q3, 2015 was 50.2% of revenues as compared to 48.3% in Q3 of 2014. Approximately two thirds of the SWB rate differential is attributable to the adjustments in our insurance approval. In Q3, 2015, we increased our group medical reserve by $4.5 million over our anticipated increase of approximately 7%.

Conversely, SWB in Q3 2014 benefited from approximately $3 million in self-insurance accrual adjustments. You'll recall that in Q2, we increased our group medical accrual by $4 million and ascribed this to both a single large claim and an increase in specialty pharma utilization. At that time, owing to the unusual nature of the large claim, we expected only a portion of the increased group medical cost to persist in the second half of 2015 then assuming that about 30% of the increase attributable to specialty pharma would continue.

From Q3, we have instead witnessed an increase in the number and severity of large medical claims defined as those in excess of $100,000 each and a sustained increase in the utilization of specialty pharma, defined as an excess of $1,000 per month, per drug, per recipient. This heightened claims experience is occurring in spite of the fact that there have not been any significant changes to our group medical programs over the past several years. In fact, we have been preserving our status as a grandfathered plan under the Affordable Care Act.

As we have done further analysis on our claims trends with the assistance of our outside consultants, it is evident that the increase in high dollar claims is coming from a relatively small percentage of our

population. And the suddenness of the increase appears to be an anomaly. That said, we expect the trend to continue through Q4 before beginning to normalize albeit at this new base level beginning in 2016. Our rationale for this belief is based in part on a comparison of a recent historical experience to our peer group that can be seen on slide 12.

From 2011 through 2014, we experienced favorable claims trends as compared to other self-insured healthcare companies with our average cost per employee during this period approximating 76% of the peer group average. With the current claims experience trend, we expect this gap to close to approximately 85% to 90% of the peer group average for 2015. This is an important issue, so let me elaborate a bit more on why we think our group medical expenses are normalizing in 2015 and will not continue on the same trajectory in 2016 and beyond.

Break the source of accelerated increase into its two components: large medical claims and specialty pharma utilization. Beginning with the large medical claims, as we reported in Q2, we incurred our single largest claim this year of approximately $2 million. In 2014, our single largest claim was $800,000. There is no reason to expect the $2 million claim occurrence every year. From 2011 through 2014, incidence of large claims we experienced as a percentage of our covered lives was lower than the peer group average. The higher incidence of these claims this year as a percentage of our covered lives population is approaching the peer group average.

We can identify no reason program design, demographics of covered lives et cetera why we were able to enjoy a lower incidence of these claims in the four preceding years. Conversely, we can identify no reason why we should expect to become an outlier on the high side of the peer average. What we are experiencing in 2015 is a painful reversion to the mean. On the specialty pharma, there are two things happening: an adoption phase and front-end cost loading.

In the past two years, there’s been a surge in the introduction of new specialty drugs deemed highly effective at curing or treating some mixed diseases. As these drugs are introduced, and effectiveness proves out to the physician community, those eligible within the covered lives population migrate relatively quickly to an adoption phase. We are not an outlier with regard to the incidence of these diseases within our covered lives population. And there is no reason to believe these incidence rates will continue to ramp up. That said, other new drugs for mixed diseases may be in the pipeline.

It is also the case that some of these more popular drugs like Harvoni are front-end loaded and we should start to anniversary those costs in the back end of 2016. The balance of the SWB deleveraging in Q3 related to an increase in direct labor cost, resulting from three factors: first, the ramp up in new hospitals. Our new hospitals are performing well, but have not yet achieved peak labor efficiency; second, an increase in our licensed skills mix.

This increase relates to our continued focus on improving patient quality outcomes, and we have tangible evidence of that improvement in the second quarter. Third, expenses related to managing to the higher level of volume growth. The higher than expected volume experienced in the quarter required us to pull levers such as increased premium pay for example, shift to bonuses and a higher utilization of contract labor to achieve desired staffing levels. Please note that the labor productivity was essentially flat, year-over-year with EPOB of $3.47 million for Q3 2015 versus $3.46 million for Q3 of 2014; a modest differential here is attribute to the new stores.

I’ll refer you now to slide 14. As Jay mentioned, we were again frustrated in Q2 by the continued increase in ADRs primarily from a single MAC as well as the persistence of lengthy delays and the adjudication process. The approximately $22.5 million in new ADRs for Q3 represented approximately 4.8% of IRF segment Medicare revenue for the quarter. As Jay discussed in his comments, we are optimistic that these discussions will lead to a reduction in rule of thumb claims denials by this MAC, but it is too early to tell.

Fortunately, none of the recently acquired Reliant hospitals fall within this MAC’s jurisdiction. Substantial delays in the claims adjudication process continue with the backlog in excess of three years. Our backlog

at the end of Q3 was approximately $98 million. And for those claims that make it to the ALJ hearing level, we have historically experienced 73% success rate.

IRF segment bad debt expense in Q3 was 1.6% of revenues as compared to 1.4% in Q3 of 2014. Bad debt expense for Q3 of this year benefited by approximately 20 basis points from a revision to our reserves to reflect more recent collection activity that is the aforementioned 73% success rate. Other operating expenses for Q3 2015 increased to 14.7% of revenues from 14.6% a year earlier, primarily based on the planned investments in our operating platform as well as the ramp-up of new hospitals.

We were able to achieve improved leverage in supplies and occupancy cost in Q3 2015 versus Q3 2014. As a result of these factors, IRF segment adjusted EBITDA for Q3 2015 increased to $166.2 million from $161.5 million in Q3 2014.

I'll move now to our home health segment. Our home health and hospice segment continued to perform well through the third quarter, generating segment revenue of $127 million, and adjusted EBITDA of $20.7 million. The year-over-year growth in this segment is primarily attributable to our acquisition of Encompass. In Q3 2015, for those locations owned by Encompass prior to 2014, admissions increased 17.1%, recertifications increased 8.7%, and episodes increased 11.9% as compared to Q3 2014.

As Jay mentioned in his comments, these results include volumes contributed form the integration of 12 HealthSouth legacy home health agencies that were consolidated into existing Encompass locations, and we refer to these as market consolidations. We have completed the transition of 22 of the 25 HealthSouth legacy agencies to Encompass. As Jay mentioned, residual agencies are owned in JVs and remain pending. We expect one to transition in Q4.

Overall, the transition of these agencies has gone smoothly, but we have experienced some revenue in EBITDA erosion from the legacy agencies in this process. This erosion has been offset by the Encompass core business performing ahead of expectation. We continue to expand our home health and hospice footprint in Q3 with the acquisition of three home health and two hospice locations. We also opened one new home health location during the quarter. We're advancing the clinical collaboration activities between our IRFs and home health locations.

During Q3, our home health agencies, exclusive of the JVs that are still pending transition, received 1,671 admissions from HealthSouth IRFs, an increase of approximately 50% over Q3 2014. The opportunity for clinical collaboration between our business segments will expand with the acquisitions of CareSouth which will add 14 markets overlapping with HealthSouth IRFs. Upon completion of the CareSouth acquisition, we will have a home health presence in 71 of our 120 IRF markets for an approximately 59% overlap.

I'll now make a few comments regarding the balance sheet. During Q3, we engaged the number of financing activities primarily intended to facilitate the funding of both the Reliant and CareSouth transactions. These activities included amending and expanding our senior secured credit facilities, adding $350 million to our 5.75% senior notes due 2024 and issuing $350 million of new 5.75% senior notes due 2025. We ended Q3 with approximately $802 million of cash on hand, a substantial portion of which was utilized on October 1st to fund the Reliant acquisition. We intend to fund the CareSouth acquisition with cash on hand and senior debt.

Our balance sheet remains strong although our financial leverages increased primarily as a result of the acquisitions of Encompass, Reliant, and very soon, CareSouth. Our debt is well structured and cost-effective. We face no significant debt maturities prior to 2020 and have substantial unfunded liquidity under our $600 million revolving credit facility.

Yesterday, we also announced that we issued notice of our intent to call $50 million of the $226 million of outstanding 7.75% notes through 2022. These notes became callable in September of this year. We intend to fund this call with cash on hand and/or a draw on our revolving credit facility.

And now I'll turn it back to Jay.

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

Great. Thank you, Doug.

I want to conclude by saying that beginning next year, we will change the timing of when we provide initial full-year guidance. Historically, we have provided it when we report fourth quarter and full-year results in late February. Beginning in 2016, we will provide initial full-year guidance in early January and will do so next year at the JPMorgan conference.

Although we are still in the midst of the budgeting process, I'd like to provide a framework of our current thinking about the tailwinds and headwinds we believe we'll encounter next year. On the positive side, we believe the legislative and regulatory landscape will be fairly benign, given the recently announced federal budget agreement and our belief that no major healthcare legislation will pass in a presidential election year. The demographic and demand profiles of our businesses remain favorable, which should create continued organic growth opportunities, opportunities that both segments have proven track records of exploiting.

We will have the full year benefit of the new hospitals and agencies added in 2015, including the 11 Reliant hospitals and the 45 CareSouth home health locations. We anticipate bringing online at least three additional hospitals in 2016 and have an excellent pipeline of development projects in both segments that could bring online additional hospitals and agencies. And finally, we have attractive alternatives for investing our substantial free cash flow, including the continued redemption of our most expensive senior debt and shareholder distribution alternatives.

We will also need to successfully mitigate some headwinds. As Doug indicated, we expect our group medical cost will approximate other large healthcare companies group medical cost. We expect the 2016 increase to our group medical cost will be approximately 6% to 10%, not the 25% to 30%, we are now projecting for this year. We're introducing group medical plan design changes that we believe will help mitigate increases to this line item.

Aggregate unit pricing increases will lag merit increases we provide our employees. But the premium pay used to accommodate volume increases is expected to lessen as we recruit permanent employees. Our challenge, as always, will be to continue to take market share in both businesses and to provide care for these incremental patients as efficiently as possible. On balance, we believe there are many more tailwinds than headwinds going into next year and that if we execute our business plan effectively, 2016 should be a very good year.

With that, operator, please open the lines for questions.

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operating Instruction] Our first question comes from Whit Mayo of Robert Baird.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hi, thanks. Good morning.

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hi. Appreciate all the details. My hands are tired from taking notes. I just wanted, Jay, maybe to first start on the group insurance; you mentioned that there are some changes that you are looking at. I'm just trying to figure out like how you think you can really influence that trend next year.

<A – Jay Grinney – HealthSouth Corp.>: Part of that change is going to occur as Doug mentioned just by virtue of us believing, because there is no evidence to the contrary that we are, as he said, going to regress to the mean that we are going to fall in line and be – see our claims history be more in line and more reflective of what other large healthcare companies experience. And again, there is nothing that would suggest that – the makeup of our employee population is any different than other large healthcare companies. So that I think is going to be the single biggest factor that will help mitigate the impact of this going into 2016 although as Doug mentioned that base expense is still going to be there. It's not like it's going away. But we don't expect that we're going to see a continued unusual amount of activities.

The second thing we are doing is we are frankly increasing co-pays and deductibles. We're introducing a – for our employee population, we are shifting more of that cost to our employees. We have in the past on several occasions absorbed all of the cost instead of passing it onto employees. We're going to change that. So, we are going to be putting a little bit more of a financial incentive on to our employees.

And at the same time, we will be continuing to introduce a variety of wellness programs. We do think that long term, we need to help our employees, those who need the help to lead better lives and to take care of those chronic conditions that they may have. And our focus this year has been on diabetes. We're going to continue that focus into 2016. But we're also looking at employees who – or dependents, who have challenges with their weight, and we are looking at programs that will help them manage that better as well.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Okay. It sounds like this is probably and hopefully something that doesn't continue next year. And just the second question on the premium pay. What do you think is really going on, Jay? I mean, this is – you're now like the third or fourth company to report some increase in contract labor premium pay. And I'm inclined to think this is very fixable, specific to the third quarter, maybe just a bunch of summer stuff. But are nurses just demanding PTO now? Just any thoughts from you on kind of what you think is going on in the market.

<A – Jay Grinney – HealthSouth Corp.>: Yes. I'll give you my observation. Then I'll ask Mark to chime in as well. First of all, in our case, the premium pay, as you said, really was in two buckets. One is contract labor, and the other was shift bonuses and other incentive programs designed to have our full or part-time employees work extra to help accommodate the increase in patient volume.

I do think that there is a trend towards employees – full-time and part-time employees who do have PTO to take that PTO. That's more anecdotal than anything else. But certainly 20 years ago, when I was in hospitals, we could get and incentivize people to take and work extra and not take that their time off or maybe defer it. There is a different sentiment today. And I'm not saying that it's a bad. I just think it's a little bit different.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Yes.

<A – Jay Grinney – HealthSouth Corp.>: So, in the past, you could look to your full and part-time and ask them to step up and help in times of increased volumes. Increasingly today we are looking to them

and saying, hey, I've got PTO and I've got vacation planned with my family and I'm going to take that time. I am going to have that work-life balance. So I think that that is a factor.

<A – Mark Tarr – HealthSouth Corp.>: Yes, Whit, this is Mark.

As Jay and Doug both said, the premium pay was really to accommodate the increased volume. We really try to stay on the front end of issues that may involve turnover or recruitment and retention. One of the things we've done – you've probably heard us talk about it in the past is our CRRN program, where we recognize the certified rehab nurses with additional payment bump. And we encourage them and reimburse them for taking the test in general.

So we're up to almost 16% now of our direct nursing care as provided by CRRN, which we've seen a big impact on our ability to retain those nurses who have much fewer turnover among the CRRNs than we do the nursing staff as a whole. We've not seen a big increase in turnover this year versus last. We have had some market-specific turnover issues that we have gone in and addressed. But overall, we feel like we've stayed ahead of this nursing issue from a company standpoint.

Operator: Our next question comes from the line of Sheryl Skolnick

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

<Q>: Good morning, gentlemen. It's nice to be back, so – even though it's not best quarter in the world. Yes, well, it happens.

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

<Q>: And unfortunately, it happens to everybody. A couple of questions on your case mix if we would, because I am really – I'm concerned about what's happening now and also what could happen changing case mix in the future with different benefit structures out there, different payment incentives at the acute level potentially even at the physician level. So, can you talk a little bit about what's happening – I get it. Yes, we've got Medicaid coverage. We've got exchange coverage. We've got moving down the spectrum on pricing.

But what I'm really trying to get at is why are these patients coming in to HealthSouth at lower acuity with shorter length of stay? What can – and at the same time, you are correctly investing in the clinical capabilities of your facilities by going after nurses with higher levels of training and specialization. So that sets you up for a squeeze, no matter what.

So, talk to me about where these kinds of patients are coming from. Are you seeing more single joint? Are you seeing more cases that are in some way shape or form, indicative of a change – with this change in the total addressable market, a permanent change in margins for the company?

<A – Jay Grinney – HealthSouth Corp.>: I think to answer the last part of the question, yes, I do think that there is going to be a change in the margin profile of the company. The thing is as you know, we have said, for the last x number of years that ours is not going to be a margin expansion story. Ours will be an EBITDA growth story. And so there will be, I think, a change in our margin profile.

But going back to the case mix change and the acuity change, what we're seeing is not a lot of change in the Medicare. Although from quarter-to-quarter, there may be more neurological one quarter, more stroke the next, but that mix is essentially staying pretty similar. We're not seeing huge shifts in the Medicare population, where we're seeing some changes although there are some in the Medicare, it's not huge. Where we're really seeing big changes is in the managed and the Medicaid. And what's happened is in the past, we tended to get patients, particularly on the managed care side, who were really, really compromised.

These were the trauma patients, patients who had multiple problems that needed extensive rehabilitative services. They tended to be there for extended periods of time, car accidents patients and so on with very, very high acuity. And so what we're seeing now is that if you think about it in terms of numerator and denominator, that denominator is getting a lot bigger. And that denominator is now getting bigger with stroke patients and those are complex patients, but not nearly the same acuity level as what you'd expect from say a car accident or a multiple trauma.

We have neurological patients coming in. Yes, we do have some knees and hips, but not a disproportionate amount. So I think it's a little bit relative to – as we think about the acuity in 2015, it's important to take it into context of what we saw in those payer categories previously, which tended to be very medically complex, very acutely ill patients, we're now seeing more. And it's not as if we're swinging all the way to the other end of the spectrum. But we are seeing that change really being driven I think more by the fact that we are treating more patients.

<A – Doug Coltharp – HealthSouth Corp.>: And Sheryl just to elaborate a little bit, it's Doug, this is a relatively modest drop in the overall acuity. Begin with – if you look at our acuity for Q3 at 1.35 CMI, it remains very high. And we are treating a preponderance of medically-complex patients.

Within the Medicare population specifically, we dropped by a basis point. But that basis point translates into roughly $100 per discharge. Because, obviously, pricing in the Medicare world is tiered to acuity. That $100 per discharge was really sufficient to account the difference between the initial 2.3% price increase that we expected for Medicare patients based on the 2015 rule. And 1.9% revenue per discharge increase we saw for Medicare in Q3.

Within the commercial as Jay suggested, we may in fact be a little bit of a victim of our own success. And that is – I think that we have begun to demonstrate the value proposition to the commercial payers of us treating patients with maladies such as stroke. And so we're getting more of those coming in. The investment that we've made in CRRN so forth is allowing us to effectively treat those patients with the shorter length of stay. And most of the managed care contracts are not tiered to acuity; they are based on a per diem. And therefore, when we get them out faster albeit healthy and that's reflected in our discharge community staffs, we're getting paid less. That's a tool that we think we can use to negotiate with managed care payers on a go-forward basis.

<Q>: Okay. And that's helpful and part of the reason why this is so timely is because you now also have Medicare this morning releasing new proposed rules about discharge planning and involving patient choice. So, the world above you and the upstream is changing so significantly at a time when your cost structure is being changed by your own initiative as well as things being imposed on you. It's good that you are expanding your addressable market. I guess where I'm coming from is that – follow up question being, as you see differences in discharge planning, as you see moves toward bundle payments albeit not just hips and knees, which you barely treat, but this whole big move, are you yet able to grab that volume in a more formal way, given that you have made progress with managed care, that you are still well regarded, extremely well-regarded for your outcomes? Or are you just not yet seeing that where you could literally exchange volumes for a little bit of mitigation of price in margin?

<A – Jay Grinney – HealthSouth Corp.>: Yes, not yet. We have not seen that yet. But we do believe that over the long haul, the partnership with Encompass is going to give us a unique opportunity in the post-acute space to look at the patient's episode of care both in the facility and at home. And we are – as I mentioned in the comments and Doug did as well, we are already starting that process of establishing formal clinical collaboration establishing best practices from a post-acute standpoint. Not just an IRF standpoint or from a home health standpoint.

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

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

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Couple of questions; first, kind of going back to the labor issue again – in the instances, where you saw some, I think you said in some markets, you call it an issue about turnover. Where are those people going? I mean is it competition from other care sides or any color on that?

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

The one market I referred to specifically happened to be in Vegas. And as you know that entire marketplace has come back to growth stage versus where it was a few years back, and there is a lot of growth in the hospitals out there. So, we just found pressure on – particularly our hospital in Henderson, relative to staffing needs of nurses and the acute cares, and everybody is fighting after the same group of nurses in that marketplace. So – but that's – I think that's an outlier as we look at our marketplaces and have not seen nearly as severe impact in other markets.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. I think the last question sort of touched around the BPCI and some of those initiatives. But I was just curious any more color you might have on BPCI and also in your MA book today, you do any sort of episodic-based care and reimbursement programs? Thanks.

<A – Mark Tarr – HealthSouth Corp.>: Yes. Frank, it's Mark again.

So, we remain participating in – eight of our hospitals are participating the model three bundling initiative. We – across these eight hospitals, we have five different episodes. The volume has been fairly modest. But we continue to pull away some insight as to how to manage this process and what we would need to do as a company as a whole in terms of providing resources to our hospital, should the bundling initiatives as a whole, gain traction. And take up a greater portion of the patient population.

<Q – Frank Morgan – RBC Capital Markets LLC>: And then on – any episodic payment in your MA book today?

<A – Jay Grinney – HealthSouth Corp.>: Any what? I'm sorry, Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Any kind of bundle-like payments or episodic-based reimbursement today with your Medicare Advantage payers? We hear about in the – some of the other post-acute settings that they're actually doing some of that already with Medicare Advantage. So do you actually have any kind of episodic or somewhat at-risk payment models for your care today?

<A – Jay Grinney – HealthSouth Corp.>: We don't at this point, Frank. But we would anticipate in the future that may be where it goes.

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

Operator: Our next question comes from the line of Chad Vanacore of Stifel.

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

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: Hey, good morning; all right. Just shifting back to the labor cost, why do you feel that now was the right time to increase your paid license clinical professionals?

<A – Jay Grinney – HealthSouth Corp.>: Well, we did that over time. We've been doing that since – it wasn't like all of a sudden in the third quarter we made that decision. That really is reflective of what we've been doing really pretty dramatically and pretty constantly over the last several years. Now we did see a pretty big increase year-over-year, third quarter last year or third quarter this year.

But it's really our effort as we said to enhance the quality of the patient care that's offered. The patients are coming in especially on the Medicare side. And it got a lot of comorbidities. They are not the kind of patients that we treated 10 years ago. And so we want to make sure we have the kind of staff in our hospitals that can treat those patients.

<A – Mark Tarr – HealthSouth Corp.>: The other aspect of that too is as we increase the complement individual versus group therapy in our hospitals and in order to do that, we had to bring on more licensed therapists as Jay mentioned particularly with occupational therapists.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right, thanks. And then-

<A – Doug Coltharp – HealthSouth Corp.>: That would have been a phenomenon that was new to this year. The CRRN program has been out there for a couple years. But the addition of the therapist is really something that's ramped up in the second half of this year, and again, it's in – an anticipation of more of a preponderance for individual therapy.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right. And that includes increased occupational therapists in there?

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

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right. So, have you found that it's getting more difficult to recruit skilled labor or have you experienced a higher turnover or more competitive recruiting process?

<A – Jay Grinney – HealthSouth Corp.>: We've increased turnover very slightly. Our overall recruitment retention efforts have gone extremely well. If you look at our therapists – licensed therapists versus the industry, we are well below the industry norms. Nurses were right at industry norm. So we are very pleased with where we've been able to recruit and retain both nurses and therapists.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right. And then I mean, how long does something like this typically take to moderate as far as higher expenses as far as a percentage of revenues?

<A – Mark Tarr – HealthSouth Corp.>: I think our anticipation is that we'll begin anniversarying it as we move into 2016 and certainly would anticipate as we get into the second half of 2016, we've anniversaried this model. And some of the efficiency we're going to pick up is – again, it's been a good thing that we've had the higher volume. It came in faster and higher than we had anticipated and to the extent we can reduce our contract labor to levels that we have exhibited in the past. That's going to be beneficial as well.

<Q – Chad Vanacore – Stifel, Nicolaus & Co., Inc.>: All right.

<A – Jay Grinney – HealthSouth Corp.>: I also want to just note, we are bringing on the 11 former Reliant hospitals. And as I mentioned in my comments, those hospitals were really being run to be sold. And they had very, very aggressive staffing levels at virtually all of the hospitals. We are going to be getting in and we are already in there now; and frankly, we are going to be adding staff in some of these hospitals to bring the staffing levels up to our standards. So there is going to be some noise in some of these labor metrics and productivity metrics as we make that adjustment with Reliant.

You might expect that the fourth quarter – the metrics – I'm not talking about the dollars, I'm just talking about some of these metrics, are going to move around a little bit as we bring them on. And then as we adjust them over time, I don't think it's going to take a long time, but certainly by the end of Q2 of 2016, we should have all of those hospitals fully up and operational on to our platform.

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

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

<Q – A.J. Rice – UBS Securities LLC>: Just a couple things, to your last point, Jay, I understand there is a lot of movement. I'm sure Reliant is impacting this, so your pricing in the IRF segment was up about 1.2% year-to-year, it looks like. Is that sort of with the impact of Reliant and everything, what we should look for or do you think the pricing will be materially different going forward?

<A – Jay Grinney – HealthSouth Corp.>: Reliant was not in that number.

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

<A – Jay Grinney – HealthSouth Corp.>: And yes – so there we started operating them on October 1.

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

<A – Jay Grinney – HealthSouth Corp.>: So you will see that in Q4 numbers. And obviously that will have an impact on the year-over-year. We will have to adjust for that.

<A – Doug Coltharp – HealthSouth Corp.>: Yes, I would not anticipate A.J., that Reliant specifically will have a significant increase on our pricing for Q4. It's going to be very hard to make any real significant changes in the course of one quarter in their patients mix. I do think the fact that we're going to try to move them more up in the acuity spectrum overtime, to resemble our other hospitals, create some upside to the pricing as we move into 2016. But as Jay said, it's going to take us a little while to implement those changes.

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

<A – Jay Grinney – HealthSouth Corp.>: We do expect though that it wouldn't be out of the realm of possibilities that in Q4, that net revenue per discharge may go down, if we've got Reliant in that at the lower acuity, more ortho level in the fourth quarter of 2015. And in the fourth quarter of 2014, we didn't have them in there. So, that's some of that noise that we may see, but we'll explain that as we transition into full operations with them.

<Q – A.J. Rice – UBS Securities LLC>: That's what I thought; it might actually depress the pricing number somehow. One more broad question: I guess now you guys have three years of – you're saying the backlog – the administrative law judge level, has there been any discussion about, a potential settlement of any of these claims? Sort of what we saw with the racks in the hospitals? Has that come back?

And then I also would ask you in a similar vein, I know last quarter you mentioned you guys were sitting down with the MAC try to develop an educational process for your people that would help. Is there anything that's happened along those lines, that's resulting in any improvement?

<A – Jay Grinney – HealthSouth Corp.>: Yes, I'll take the last one first. There was an educational forum that the MAC had in August for all inpatient rehabilitative providers. And we attended that as you would expect. Couple takeaways; one, misery loves company. So, the other rehabilitation providers who were in attendance were experiencing the same issues with this MAC that we were. So, I guess we took away from that that we were not being singled out. And that this was just an interpretation by that MAC of what the rules were and what they can and cannot do.

It actually was helpful because it put in black-and-white some of these rules of thumb and some of these across the board sweeping comments that were made that were not based in coverage requirements and not based in the law. And actually it enabled us to go to CMS, which we did subsequent to that August meeting to sit down and review with some of the senior officials at CMS our concerns and to point out

what – the conflicting direction that we were getting from Cahaba vis-à-vis what was in the law. So, I think that helps.

Whether or not we will see any impact, I think it's too early to tell. But we stand ready and we've made extensive overtures and we will continue to do that. We want to have a good relationship with this MAC. We want to understand how they are looking at our world, not just HealthSouth, but inpatient rehabilitation and try to get to a level where we believe we're singing off the same page.

One thing that we do know is that some of the denials that we've experienced over the years has been a result of inadequate physician documentation in the medical record. And anybody who has been in healthcare for any period of time knows that that's just a sore spot in any facility.

It doesn't matter if you are acute care, post-acute, the physicians' office, physician documentation is something that everybody needs to look to improve. They are using that as a basis for denial. So as you know, we invested in a new medical services department in 2015, that's one of the incremental investments that we made in the business, to specifically help our physicians improve and enhance and strengthen their documentation. So, we think that we are addressing that as well. And then of course, the installation of our EMR should help with the documentation overtime.

In terms of the settlement the industry – the rehab industry has pursued that – there have been some early discussions over the last several months, but there is nothing that is pending at this point. I think that as you would imagine there is big difference between a bid and an ask. And I think that was a bridge too far.

<Q – A.J. Rice – UBS Securities LLC>: Okay, all right. Thanks a lot. That's great.

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

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

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

<A – Jay Grinney – HealthSouth Corp.>: Hi, Gary.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning. Thanks for taking the question. Just wanted to get your thoughts as the LTCHs start to deal with more restrictive patient criteria, some of the hospitals beginning October 1, do you think that's having any impact on your case mix index? Or do you have any concerns that might have a negative impact on your case mix index?

<A – Jay Grinney – HealthSouth Corp.>: No, not anything that would be affected to the LTCH criteria. I mean really, the mix change or the acuity level change as we said in the Medicare book of business that fluctuates from a quarter-to-quarter and we are not seeing anything that is just atypical there. There was, as we said, more of the managed and Medicaid at a lower acuity level than what we've seen historically. But that was driven more by the fact that we are just treating more of those patients.

<A – Doug Coltharp – HealthSouth Corp.>: I think if you look back to, Gary, some of our historical reports, we had a steady march up in our Medicare patient acuity that really kind of reached its peak level about mid-year last year. And I think we recalled in the second and third quarter of last year, Mark even responding to a question said from this level you're not going to be able to take it consistently higher, and we're going to see it bounce around a little quarter-to-quarter. It's creating a little bit of volatility in the Medicare pricing on a quarterly basis. But again, we are at a very high CMI for our Medicare patients.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay. And then maybe just going back to some of the issues with the MAC, you mentioned you had the meeting in Baltimore. Do you have any – did you get any indication from CMS when they might communicate that to the MAC or when you would expect it

to flow through and a change of behavior from the MAC. And then maybe if you don't see that, are there any next steps for you to pursue to try to rectify the issue?

<A – Jay Grinney – HealthSouth Corp.>: We've been told that the communication has already occurred. We have not seen any impact yet. But it's too early. I mean, it just – that communication is relatively recent. And as I mentioned in my remarks, it takes anywhere from three to four weeks before we get the denial. So it's probably too early to tell. We certainly will know and have an indication by the next call.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay, great. Thanks very much.

<A – Jay Grinney – HealthSouth Corp.>: You bet.

Operator: Our next question comes from line of Chris Rigg of Susquehanna.

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

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Good morning. And I got in a little late here. Good morning, Jay. I think you just answered my question. But when we look at the claims denial for $22.5 million in Q3 that would mostly be in quarter submission, correct?

<A – Jay Grinney – HealthSouth Corp.>: That's all in quarter.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Okay. And then just on the reserve methodology, I'm just trying to make sure I understand, it seems like you are reverting to the mean you got 70%-ish of the $98 million booked as the receivable. But when you look back to the end of 2013, it was a much lower number. Can you just give us a sense for how you are thinking about that?

<A – Doug Coltharp – HealthSouth Corp.>: Yes. The game has changed a little bit just in terms of the nature of the denials and ultimately how we prevail through the full adjudication process. We previously had used a kind of a five-year rolling average on recoveries to estimate our initial reserve percentage. And that recovery rate had been around 68%. Because the game has changed, we felt it was appropriate to shorten the look back period to something more akin to two years. That's more representative of the type of activity that's taking place right now.

When we look back over the last two years, the recovery rate is 73%. And so, we've factored that into our initial reserve methodology and again, that change was made during the quarter and had a 20 basis point positive effect on the bad debt. Stated differently and this is an important point, we posted a 1.6% bad debt number for Q3. Absent that change in the reserve methodology that number would have been 1.8%. When you see the top end of our range and the guidance that has been updated is 1.8% for Q4.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Great. And then just on the medical claims, do you guys have a stop loss mechanism? Are you guys on the hook for 100%? Thanks a lot.

<A – Doug Coltharp – HealthSouth Corp.>: We do not have a stop loss program in place. We are spending some time evaluating it although our initial feel as we've looked is it's not something that makes since economically for us, again, not off the table, but not something that we are necessarily positively inclined towards right now.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Great. Thanks a lot.

Operator: Our next question comes from the line of Miles Highsmith of RBC.

<Q – Miles Highsmith – RBC Capital Markets LLC>: Hi. Good morning, guys.

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

<Q – Miles Highsmith – RBC Capital Markets LLC>: Hi Jay. I think, Doug, you mentioned the CMI of 1.35. I was assuming that was Medicare. But I was just curious if you could tell us what the industry average is. And then a follow-up question just curious on the 7.75%, why $50 million and any thoughts on the balance of that charge? Thanks.

<A – Doug Coltharp – HealthSouth Corp.>: Sure. So, I don't have the industry average right in front of me. Our recollection is that it's about 1.32. With regard to the $50 million, first of all there's a great opportunity for us to create an interest rate arbitrage by simply moving it out of the 7.75% even with the call premium under the revolver. And then it's – the cost to carry there is significantly lower, and we can prepay that debt with cash flow as we generated in the fourth quarter and beyond.

Why not do more right now? There are couple of things happening that we want to just make sure we get our arms around from a cash flow perspective that we think is going to be short-term in nature. One of them is the fact that as everybody knows, we made the conversion to ICD-10 on October 1st. Historically, we have seen those types of changes create a little bit of backlog in the processing of claims. Again, it's typically resolved in the course of a quarter. But it can create some intermittent cash flow needs. So we just want to keep an eye on that. The second is that as we bring the 11 Reliant hospitals on board, we'll have some licensure transfer issues.

And again, sometimes those can lead to short-term disruptions in the processing of claims. We want to digest both of those before we put any additional utilization on to the revolving credit facility. So that was the primary reason for targeting the $50 millions. It's a manageable number. It's not to suggest that that's the full extent of the intent to which we use, intend to use that type of refinancing.

<Q – Miles Highsmith – RBC Capital Markets LLC>: Great. Thank you very much.

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

Operator: [Operator Instructions] I'm showing no further questions at this time. I would now like to turn the call over to Crissy Carlisle for any additional or closing remarks.

Crissy Buchanan Carlisle, Chief Investor Relations Officer

Thank you. If anyone has any 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, ladies and gentlemen for participating in today's conference call. You may now disconnect and have a wonderful day.