Operator: Good morning, everyone, and welcome to HealthSouth's Fourth Quarter 2012 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. You will be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Mary Ann Arico, Chief Investor Relations Officer. Please go ahead.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Maria, and good morning, everyone. Thank you for joining us today for the HealthSouth fourth quarter 2012 earnings call.

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

Before we begin, if you do not already have a copy, the press release, financial statements, the related 8-K filing with the SEC and the supplemental slides are available on our website at www.healthsouth.com in the investor section.

Moving to slide two, the Safe Harbor, which is also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements, which are subject to risks and uncertainties, many of which are beyond our control. Certain risks, uncertainties and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates, and expectations are discussed in the company's SEC filings, including the Form 10-K for 2012, which will be filed later today. 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 measure is available at the end of the slide presentation or at the end of the related press release, both of which are available on our website and as part of the Form 8-K filed this morning with the SEC.

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

With that, I will turn the call over to Jay.

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Mary Ann, and good morning to everyone participating on this morning's call. We obviously have a lot to cover this morning. So let me begin by addressing yesterday's announcement of our stock repurchase authorization. Last Friday, our board of directors approved an increase in the common stock repurchase authorization from $125 million to $350 million, and as we stated in the release, we intend to pursue a tender offer for our common stock for up to the full amount of this authorization, the timing and parameters of which will be dictated by market conditions. Any such tender offer would be funded with a combination of cash on hand and availability under our $600 million revolving credit facility. Even if successful at the full amount authorized, any such tender offer would modestly impact the company's

leverage ratio, with the resulting ratio remaining within our target range. We believe this announcement and the contemplated tender offer is consistent with the company's strategy of deploying financial resources towards long-term shareholder value-creating opportunities.

With respect to our year-end operating results, we are very pleased to report that HealthSouth ended 2012 with another solid quarter. Demand for our services remains strong as discharges increased 5.4% compared to the fourth quarter of 2011, with same-store growth at 3%. Recently released UDS data indicates that fourth-quarter discharges at non-HealthSouth facilities declined by 1.8% compared to last year's fourth quarter, suggesting our hospitals continue to gain market share.

In-patient pricing increased 2.4% on a per-discharge basis and was driven by our modest Medicare and commercial payment adjustments, higher acuity in our patient mix and a higher percentage of Medicare patients.

Quarter-over-quarter, the number of neurological and stroke patients increased by approximately 18%, while the number of hip fracture and lower extremity joint replacement patients declined by approximately 2%. This is consistent with recent trends and is attributable to our focus on clinical programs and technology investments that are specifically designed to meet the needs of patients with neurological conditions. We're very proud of the fact we currently have 86 of our hospitals designated as a Stroke Center of Excellence by the Joint Commission. This is even more impressive when you consider that HealthSouth accounts for approximately 80% of all Joint Commission accredited Stroke Centers of Excellence nationwide.

Although outpatient revenues were down in the quarter compared to last year because of reduced outpatient visits resulting from the imposition of Medicare therapy caps and the closure of two outpatient clinics, consolidated net operating revenues were up 6.7%.

A major tenet of our business model is to provide high-quality care on a disciplined, cost-effective basis. Our hospitals continued to deliver on this value proposition as we generated adjusted EBITDA of $128.6 million in the quarter compared to $122.9 million in the fourth quarter of 2011. For the year, HealthSouth's adjusted EBITDA was $505.9 million, an 8.5% increase over prior year.

The company's cash flows also remain very strong. Cash provided by operating activities was $109.3 million for the quarter and $411.5 million for last year – for the year. Last year, cash provided by operating activities was $129.5 million in the fourth quarter and $342.7 million for the full year. This strong cash flow allowed the company to continue to support maintenance CapEx needs of our hospitals, while at the same time ramp up the implementation of our electronic clinical information system and refurbish several of our older hospitals. We believe the investment in our electronic clinical information system will further differentiate our hospitals from other post-acute providers as the healthcare delivery system evolves to a system characterized by enhanced clinical coordination, integration, and shared patient data. Even with this planned increase in maintenance CapEx, adjusted free cash flow for the year was a very strong $268 million compared to $243.3 million in 2011.

Before Doug provides a more detailed review of the quarter and year-end results, I'd like to discuss 2013 guidance. For those with a copy of the supplemental slides that went out earlier today, I will be referring to pages 15 and 16.

Our initial guidance for 2013 adjusted EBITDA is a range of $506 million to $516 million and is predicated on the following considerations as highlighted on page 15. First, discharge growth of between 3% and 4%. Although we have experienced a very strong start to the quarter, as is our practice, we are taking a conservative view on full-year volume growth as we begin the new year, owing to the importance of this metric as a driver of our overall operational and financial results.

You'll note our 2013 discharge range is higher than the 2.5% to 3.5% range we have used in the past because it includes the acquisition of Walton Rehabilitation Hospital, which we expect to close at the end of the first quarter.

2013 revenue per discharge is expected to increase by a range of 2.3% to 2.6% before sequestration and incorporates a Medicare market basket update in the fourth quarter of 2013 reduced by the Obamacare pay fors, and a 2% to 4% increase in our managed care pricing. These assumptions produce revenue growth before sequestration of between 4.9% and 6.2%, and adjusted EBITDA growth of between $39.6 million and $49.6 million, again before sequestration.

As shown on page 15, the net effect of sequestration will be to reduce adjusted EBITDA by approximately $25 million, by far the biggest headwind we will face this year. We assume the President will sign the sequest order in March, which will reduce Medicare payments made after April 1. Since the length of stay of our patients is approximately two weeks, we are assuming payments for patients admitted in the second half of March will be subject to this sequestration order.

As depicted on page 15, we faced two additional headwinds in 2013: $4 million of incremental expenses related to the continued implementation of our clinical information system and approximately $5 million of additional non-controlling interest expense related to structural changes at two of our joint venture hospitals, which Doug will discuss in just a moment.

Now, turning to page 16 of the supplemental slides. Our initial EPS guidance range is between $1.50 and $1.56 per share. As noted on this page, depreciation and amortization will increase by approximately $12.5 million next year, reflecting our recent investments in de novos, acquisitions, and bed additions, as well as our investment in our electronic clinical information system.

Page 16 also depicts non-recurring items in 2012 and 2013. In 2012, we realized approximately $8.4 million of non-recurring gains and incurred approximately $20.1 million of nonrecurring expenses. In 2013, we anticipate incurring approximately $5 million of professional fees primarily related to ongoing non-E&Y legacy litigation. These unusual or non-recurring items, along with the $0.16 per share after-tax effect of sequestration, need to be considered when assessing year-over-year EPS growth.

With that, I'll now turn the agenda over to Doug, and following Doug's comments, we'll open the lines up for Q&A.

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

Thank you, Jay, and good morning, everyone. I'll focus my comments on Q4 2012, but also highlight certain results for the full year and elaborate on a number of the assumptions underlying our 2013 guidance. I'll be reiterating some of the ground Jay just covered in his opening comments and I'll go into just a bit more detail.

As Jay mentioned, Q4 represented a strong finish to a strong 2012. Our revenue increased 6.7% in Q4, driven by in-patient growth of 7.9%, offset by a decrease in outpatient and other revenue. The increase in in-patient revenue was driven by a 5.4% increase in discharges, 3% attributable to same-stores, and a 2.4% increase in revenue per discharge. Approximately 120 basis points of the new store discharge growth for Q4 resulted from the consolidation of St. Vincent Rehabilitation Hospital beginning in Q3 of 2012.

Our discharge growth for Q4 was also favorably impacted by the timing of patient discharges from the last week of September into the first week of October. This was the offset to the negative impact discharge growth in Q3 that we discussed during the third quarter earnings call and it resulted in a modest decline in our Q4 length of stay.

As I stated on the Q3 call, it's difficult to quantify with precision the impact of this length of stay change, but with that caveat, we estimate it added approximately 100 basis points to our Q4 total discharge growth. Now, as this was a timing issue, it had no impact on full year 2012 discharge growth, which was 4.6% including 2.9% in same-store growth.

The increase in revenue per discharge in Q4 2012 versus Q4 2011 was attributable to pricing adjustments from both Medicare and managed care payors, an increase in the average acuity of our patients, neurological and stroke comprised 39.2% of our discharges in Q4 2012 versus 34.3% in Q4 2011, and a higher percentage of Medicare patients, offset by the unfavorable impact of pricing related to the aforementioned timing of discharges from September into October.

The $3.2 million decline in outpatient and other revenue was impacted by the closure of two additional satellite clinics during Q4 2012 and the implementation of therapy caps on all hospital-based outpatient programs beginning October 1, 2012. At the end of Q4 2012, we operated 24 satellite clinics versus 26 at the end of Q4 2011. Revenue growth for full year 2012 was 6.7%, driven primarily by a 4.6% increase in discharge growth.

As anticipated, bad debt expense for Q4 2012 increased by 10 basis points to 1.3% of revenue as compared to 1.2% in Q4 2011. As we have previously discussed, this increase was attributable to the increase in medical necessity denials experienced throughout the year, as well as a slowdown in the adjudication process. We did see the rate of new denials slow in Q4.

During Q4, we continued to exhibit disciplined expense management. Expenses for the quarter did include a number of items, both favorable and unfavorable, that we expect to be non-repeating. I'll call those out as we review the components of our operating expenses. SWB for Q4 2012 was 48.7% versus 48.5% in Q4 2011. Q4 2012 SWB was unfavorably impacted by our previously disclosed decision to pay a one-time bonus to non-management employees in the fourth quarter in lieu of merit increases. You will recall this decision was made to reward our employees for a successful 2012 without permanently adding this expense to our cost structure in the face of sequestration in 2013.

SWB as a percentage of revenue for Q4 2012 was also unfavorably impacted by a decrease in the benefit related to year-end workers comp insurance adjustments and the costs related to the implementation of our clinical information system. These items were offset by a favorable adjustment in our group medical accrual. Netting the effect of these items would have resulted in SWB as a percentage of net revenue being essentially flat in Q4 2012 versus Q4 2011.

Our continued focus on labor productivity was evidenced by Q4 2012 employee per occupied bed, or EPOB, of 3.46, which was flat with Q4 2011.

Our hospital related expenses, which includes other operating, supplies and occupancy, increased to 20.8% in Q4 2012 from 20.4% in Q4 2011, primarily as a result of the inclusion of a $2.4 million non-recurring franchise tax recovery included in Q4 2011. In Q4 2012, continued supply chain efficiencies and leverage of occupancy cost more than offset the impact of increased clinical information system implementation cost.

G&A, which excludes stock-based compensation, improved to 4.4% of revenue in Q4 2012 from 4.6% in Q4 2011 as we gained leverage against the cost associated with our corporate office. The combination of strong revenue growth and disciplined expense management resulted in adjusted EBITDA for Q4 2012 of $128.6 million, an increase of 4.6% over Q4 2011.

For the full year 2012, we generated adjusted EBITDA of $505.9 million, an increase of 8.5% over 2011. Our 2013 guidance for adjusted EBITDA is $506 million to $516 million. Owing to the increased number of considerations factored into our 2013 guidance, we have added a 2012 to 2013 adjusted EBITDA bridge as page 15 of the supplemental slides. Jay referred you to this slide in his comments, and I encourage you to review this slide very thoroughly.

Our adjusted EBITDA guidance reflects modest growth resulting from the onset of sequestration, the continued investment in our clinical information system, with implementations scheduled for 18 of our existing hospitals in 2013, the absence of some of the favorable accrual adjustments, such as group medical, experienced in 2012 and an increase of approximately $5 million in non-controlling interest expense due to changes in the structure of two of our joint venture hospitals.

With respect to the increase in non-controlling interest, we have entered into an agreement to convert our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare. Following the formation of the joint venture, our ownership position in this hospital will be reduced to 56%. This is a transaction we proactively pursued, as it is consistent with our strategy of aligning with high quality, acute care hospitals in certain key markets.

Additionally, our share of profits in one of our joint venture hospitals in Memphis, Tennessee will decrease from 70% to 50%, pursuant to a provision in the original partnership agreement, which dates back to the 1990s. There are no similar provisions in our other joint venture agreements.

Interest expense for Q4 2012 of $24.3 million was in line with our expectations and represented a modest increase over Q4 2011, resulting from our September issuance of $275 million in 5.75% senior notes maturing in 2024. As a reminder, approximately $195 million of the proceeds from this offering were used to pay down the outstanding principal balance under our revolving credit facility. And an additional approximately $65 million was used to fund an optional redemption of a portion of each of our 7.25% senior notes due 2018, and 7.75% notes due 2022.

For 2012, interest expense was $94.1 million as compared to $119.4 million for 2011. Assuming no further modifications to our capital structure, we would anticipate interest expense of approximately $98 million in 2013.

Diluted EPS from continuing operations for Q4 2012 was $0.42 per share versus $0.50 per share in Q4 2011. The decline was primarily attributable to an effective tax rate of approximately 35% in Q4 2012 as compared to approximately 22% in Q4 2011.

Additionally, Q4 2012 EPS was negatively impacted by an approximately $0.02 per share after tax loss on the early extinguishment of debt related to the previously discussed optional redemption of a portion of our 2018 and 2022 senior notes. EPS for the full year 2012 was $1.65 per share compared to $1.42 per share for 2011.

EPS for 2011 included an after-tax loss of $0.25 per share on the early extinguishment of debt versus $0.03 per share in 2012. EPS for 2011 included an effective tax rate of approximately 19% as compared to approximately 38% in 2012. The company's basic and diluted EPS were the same for 2011 and 2012.

Our 2013 EPS guidance of $1.50 to $1.56 per share incorporates the aforementioned adjusted EBITDA considerations, the anticipated increase in interest expense, an increase in depreciation and amortization expense to approximately $95 million as compared to approximately $83 million in 2012 owing to our recent increases in capital expenditures, and an effective tax rate assumption of 40%.

2012 was another year of strong free cash flow generation for our company. For 2012, we generated adjusted free cash flow of $268 million, an increase of 10.2% from 2011, which I remind you had increased 34% over 2010. The increase in 2012 was accomplished in spite of an approximately $28 million increase in net working capital and a planned approximately $32 million increase in maintenance capital expenditures.

The net working capital increased in 2012, primarily related to the timing of payroll related liabilities, an increase in accounts receivable stemming from the previously discussed trends in medical necessity claims denials and an increase in accounts payable due to the timing of year-end check disbursements. We expect net working capital in 2013 to increase by less than $20 million.

Maintenance CapEx for 2012 was approximately $83 million. The year-over-year increase in maintenance CapEx was planned and has been previously discussed. It stemmed from the continued rollout of our clinical information system, and I remind you that unlike the acute care providers, we are not subsidized by the government for this investment under the HITECH program, and from a number of significant hospital refurbishment programs. We will continue with these investments in 2013 and anticipate maintenance CapEx in a range of $80 million to $90 million.

With respect to discretionary capital expenditures in 2013, and as indicated on slide 19, we anticipate increased opportunities to convert a number of our leased hospitals into owned facilities. This relates primarily to the timing of lease terminations and purchase options embedded in certain of our real estate leases.

The decision to exercise a purchase option is typically driven by economic and/or control considerations. The estimated range on slide 19 is based on five of our hospitals on which the purchase option is in play during 2013. As reflected in the breadth of this range, the timing, magnitude and ultimate outcome of these negotiations is difficult to predict.

I'll conclude with a quick review of our year-end balance sheet. We ended 2012 with debt of $1.254 billion, roughly flat with the end of 2011. Our leverage ratio at the end of 2012 was approximately 2.5 times as compared to 2.7 times at the end of 2011. Net of cash and cash equivalents, our year-end 2012 leverage ratio was approximately 2.2 times. We ended 2012 with no borrowings under our $600 million revolving credit facility and with approximately $133 million of cash and cash equivalents. We have no debt maturities of any consequence until Q3 of 2012, when our revolver is set to mature.

Now, operator, I believe we're ready to open the call for questions.

QUESTION AND ANSWER SECTION

Operator: Thank you. Our first question comes from Colleen Lang of Lazard Capital Markets.

<A – Jay Grinney – HealthSouth Corp.>: Morning, Colleen.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Hi, Jay. Good morning. Just quickly, we've seen fairly steady increases in stroke in neuro cases as a percent of your total discharges. Do you guys have an expectation of where you think these cases could go over time?

<A – Jay Grinney – HealthSouth Corp.>: I wouldn't say that there's an expectation in terms of a specific targeted percent of the total patient volume. As we all know, the incidence of strokes continues to go up, and as the population continues to age and we see that baby boom cohort moving into the 65-plus category, we do expect that there will be a continued demand for the kinds of services that we provide. But, no, we haven't said that we're going to be tapped out or maxed out at any certain percent.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Okay. Great. And can you talk quickly about the acquisition environment and what you're seeing in the marketplace of late? Are you seeing any increases in the number of freestanding IRFs looking to sell given the uncertainty in DC? And also, what are you seeing from the acute care guys in terms of what they want to do with their IRF units?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. First of all, there aren't a lot of freestanding inpatient rehabilitation hospitals. Those that are out there and are unaffiliated we're certainly in touch with and have expressed our interest in talking with them. I think that that will be maybe slower to move.

What we have seen is the openness of the acute care hospitals with rehab units to discussing some kind of transaction involving those units, be it a complete monetization, where they just because of reimbursement pressures or cost pressures that they're under, they're just making the decision to get out of that business. Other instances, they're looking to joint venture that, oftentimes with the idea that we might come in and take the unit that is currently inside the hospital and joint venture that and build a new freestanding hospital that would give them additional capacity on an acute care side. So we certainly are seeing that. And frankly, the pipeline for de novos is still very attractive. I think you probably saw that we're looking at a couple of opportunities out in California. That's a slower go because of the OSHPD process. But overall, we feel very good about the runway of growth in inpatient rehabilitation. And we're seeing it across both the de novos, the acquisitions and the joint venture avenues.

Operator: Our next question comes from the line of Ann Hynes of Mizuho Securities.

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

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: I just want to focus on your EBITDA guidance. So the $25 million sequestration impact you have in guidance -- it appears to me there's really no cost offset assumption in there. And I know that you instituted a merit rate increase freeze, which equates to about $16.5 million in savings. So is that just buffer room for you guys just in case something else negative comes down on the Medicare front, or how should we view kind of any cost savings you have in guidance to offset the sequestration?

<A – Doug Coltharp – HealthSouth Corp.>: Ann, it's Doug. I think you're absolutely right. Because it's a pricing cut, and not a volume reduction, there really aren't any immediately accessible cost reductions that go along with that. The action that we did take with regard to the bonus in lieu of merit in Q4 is factored into some of those other bars, and what we're showing with the $25 million is the gross impact of sequestration.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: All right. So your guidance probably has some buffer room with that $16.5 million. Is that a way to look at it?

<A – Doug Coltharp – HealthSouth Corp.>: I'm sorry; say that again.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: I guess the $16.5 million -- wouldn't that be incremental costs that you don't have to incur this year, so is that incorporated in guidance?

<A – Doug Coltharp – HealthSouth Corp.>: The merit structure that we are carrying moving into 2013 is embedded in our EBITDA guidance range.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: All right. And just to follow up on Colleen's question on the competition, I know there were a lot of not-for-profit hospitals who lowered bed capacity back in 2008 when you had the Medicare freeze. Do you – and not-for-profits tend to be reactionary. So if you don't – do you expect to see any unit growth given the sequestration or at least bed declines in your peers going forward? Have you heard anything in your marketplace?

<A – Jay Grinney – HealthSouth Corp.>: Not really. I think that the overarching concern among most of the acute care hospitals -- and that's going to be disproportionately weighted to the not-for-profits since they have – they represent 80% to 85% of all hospitals nationwide -- the overarching concern is with reimbursement going forward. And there's the secondary concern of 2014 and 2015 -- will they have the capacity to accommodate any new patients that might be coming to them through Obamacare? Does that get at your question, Ann?

Operator: And your next question comes from Darren Lehrich of Deutsche Bank.

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Hey, everybody.

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

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: I wanted to just ask a question around the buyback; obviously, a nice announcement to get here. Jay, I know in talking to investors over time, you've thought about the buyback as something more opportunistic. I think I've heard you describe it as potential shock absorber in the face of bad news, but it sounds like you're thinking about it a little bit differently, obviously increasing it. So I guess I just want to flesh out a little bit more about the decision and how we should be interpreting this.

<A – Jay Grinney – HealthSouth Corp.>: Well, I think I'll leave it to you on how you want to interpret it, but I certainly would agree that our thinking has changed. Previously, we saw that primarily as a kind of stopgap. We're clearly being a lot more aggressive looking at all of the levers that we can pull to bring value to our shareholders. If you think about where we were back in 2008, $300 million of EBITDA and we just posted $506 million. We were generating maybe $7 million of free cash flow and we just posted $268

million of free cash flow. We had a leverage ratio of 4.5 times, we're now down 2.5 times, and our price is still the same.

So clearly, there are other ways that we can bring value to the shareholders that potentially – or I should say previously we have not accessed. And looking at share buybacks in a more aggressive way is certainly part of that. And there are other things that we're going to be looking at as time goes on. That's – we started this year, one of the first equity conferences that we participated in, we made it pretty clear that we feel very good about the underlying performance of our company, even in the face of sequestration, even in the face of additional risks that may come forward out of Washington, but that we are also then going to start looking at other means of bringing value – long-term value to our shareholders, and so this would be an example of that.

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Yes. Makes sense. And if I could, just follow up for Doug. We've seen you bring more real estate on the balance sheet in owned fashion. We get the question sometimes just about the REITs and their cost of capital. Are you at all considering anything different with all the owned real estate that you have and is there potentially a way to monetize that differently?

<A – Doug Coltharp – HealthSouth Corp.>: There are a lot of different ways that we could monetize the value of the real estate. None of those as we've explored them are at all attractive to us, including any kind of significant sale leaseback with the REITs. The REITs do have a very favorable cost of capital. They use that to the benefit of their shareholders, and in the proposals that we have seen, they've been unwilling to share that with our shareholders and our constituencies.

We also think that as we continue to face some reimbursement uncertainty, and although, as Jay mentioned, we feel very, very good about our current operating position and our ability to navigate any of that uncertainty, that our position is further strengthened by not being subject to automatic escalators in leases.

And frankly, if you look at the price at which we've been able to access long-term debt capital in the unsecured markets, and lease exposure is debt capital, we don't see any kind of arbitrage opportunity that exists between our cost of incremental funds and that which would – could be provided through the REIT community. So that's a rather long-winded answer of saying we haven't found anything attractive in any of those alternatives, but we're certainly aware that they're out there.

<A – Jay Grinney – HealthSouth Corp.>: And, Darren, I just wanted to reiterate. There are alternatives, but we have looked at them and they are not appealing to us under any circumstance. You get a one-time pop and that's it, but you basically – you've sold the company on an installment plan. And particularly in light of what's changing in the marketplace, losing control of one's assets, I think, really handicaps providers in today's environment. I mean, you look at what Kindred is doing. I mean, they're having to walk away from hundreds of millions of dollars of revenue and tens of millions of dollars of EBITDA because of the fact that they're hamstrung with those onerous leases from Ventas. So why would we want to jump into that kind of situation? I mean, we get this question a lot, but it's something that we've looked at. It makes no sense to us and we have absolutely no interest in attempting to monetize the value and then cripple the company going forward. That just does not seem to us to make sense from a long-term perspective.

Operator: Our next question comes from the line of Sheryl Skolnick of CRT Capital Group.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Good morning. And first, Jay and Doug, I can't thank you enough for making that very firm statement about the REIT option, because I not only agree with you, but I think it's important that we know exactly where you stand and put that issue to bed.

But my question is around the question of capital and capital deployment, and I realize that you may soon be subject to tender offer rules and may not – maybe currently -- and can't talk about it, but you do have options. You clearly have laid out a capital spending plan to sustain the growth of the company and have

lots of opportunities to do that. You've got lots of flexibility. It is the cash flow story that folks thought it would be. It's substantially different than when all this started 10 years ago next month, by the way.

So I'm looking at this decision to return capital to shareholders, and I'm curious if you can share with us what your thinking was around some of the key issues here. First of all, if you buy back stock, then obviously it affects the liquidity, but it's not an especially liquid situation anyway. So help us to think through what your thought was on that. To the extent that it might be a price you have to pay, okay.

And then the second question is, as you think about it, why a repurchase versus a dividend? Why a tender versus an open market transaction?

<A – Jay Grinney – HealthSouth Corp.>: Let me try to answer the first question, and when we looked at the buyback and made the decision, recommended it to the board and got the authorization to move forward, quite frankly, it was really a matter of where is the best opportunity to invest our cash and the resources that we have. I mean, we've got plenty of opportunities to build new hospitals, acquire inpatient rehabilitation facilities, merge them with us. We have plenty of opportunities to continue to add beds. But we're still going to have a lot of cash left over. And we felt that there's no better investment than our company.

And so we felt that the stock buyback really made the most sense from a financial return perspective simply because we know this company and we know what the future potential is, and therefore, we made the decision to invest in what we think is the best investment out there for us.

In terms of the other alternatives that we looked at, it is fair to say that we have evaluated a broad range. We felt that, again, going why a buyback and not a dividend, we felt that the opportunity to buy at this time made sense to us, and to buy back, again, something that we know very well and have a lot of confidence in. And I think that it's fair to say – and we certainly signaled this back in January – it's fair to say we will continue to look at a wide range of value-creating opportunities. We haven't made any decisions, but we're certainly going to be constantly looking at that. Again, to your point, Sheryl, because we're generating such strong cash flows.

So this is not a one and done kind of situation. This is really sort of having the company embark on a new strategy that complements the other strategies that we've been putting in place over the last several years. First, it was to de-lever and to focus on operations and build a company that was – that could grow. We did that and generated a lot of free cash flow, allowed us to be to able invest in really game-changing investments like our electronic clinical information system, like new hospitals in new markets. And now, again, because of the success that we've had, we're able to explore other value-creating avenues and we will continue to do that going forward.

<A – Doug Coltharp – HealthSouth Corp.>: I think – Sheryl, this is Doug – just to then get to the issue of why did we express a preference to potentially execute this increased authorization via tender offer as opposed to another mechanism like an open market repurchase. First of all, we haven't ruled out those other modes of execution. But the preference for a tender offer really owes back to something that you identified in your question and that's the liquidity in the stock. The magnitude of the increased authorization that we're attempting to undertake here really dictates moving more towards a tender because the average daily trading volume in the stock is roughly 0.5 million shares and if we were to try to put ourselves in that Safe Harbor regarding both 10b-5 and 10b-18 applications, it would take a very long time for us to execute under this program. And while that might carry the advantage of some kind of dollar cost averaging, we do believe it would be creating some somewhat artificial trading within the stock.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Yeah. I don't disagree with that actually and at least this way you're actually, if your intent is to return the capital to shareholder, you might as well actually put the capital in their hands.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: And I appreciate that very much. And can you just in a – I can't really relate it to this – well, I guess I can. Can you just update us on the status of E&Y and General Medicine please?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. I'm going to ask John Whittington, our General Counsel, to answer.

<A – John Whittington – HealthSouth Corp.>: Thank you, Jay. On Ernst & Young, we have filed in substance an appeal. It is pending here in Alabama in the Jefferson County Circuit Court. A scheduling order has been entered, and based on the scheduling order, we would expect to have a hearing sometime in March and maybe a ruling on the appeal in the April timeframe.

With respect to General Medicine, that litigation is also pending here in Jefferson County. We have filed a motion to dismiss the case. It is actually set for hearing tomorrow afternoon and we'll give you a report on that at the appropriate time. Our view continues to be that the judgment and settlement agreement between General Medicine and Horizon is collusive and fraudulent and should not be admitted into evidence and that's what we'll be arguing tomorrow before the Circuit Court here in Jefferson County.

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 Equity Research>: Good morning. I'll ask this question because it hasn't been asked in a while. But since you are talking about opportunities with JVs and acquisitions and de novos and what to do with this excess cash, have you thought about or evaluated opportunities outside of the core rehab business lately? In the past, you've talked about other post-acute lines. I'm just curious, have you come back to that and thought about that again lately or is that just kind of off the table and it's purely focused on either more IRFs or buybacks?

<A – Jay Grinney – HealthSouth Corp.>: No. We certainly are looking at other post acute services. To be very candid right now, as we look around of those other services, there are enough risks inherent in virtually every other post-acute segment that would really make them unattractive on a current basis. The runway is very robust for inpatient rehabilitation, it's a business we know, we believe we do a pretty good job at it. There are still, obviously, some risks coming out of Washington, D.C.; that deck has not been cleared. So you think about any of the other segments and it's pretty easy to come up with a list of headwinds that are specific to those sectors.

Having said that, Frank, we're always looking at what makes sense. We do believe that on a much longer-term basis, and this is not a 2013 or even 2014 or maybe even 2015 kind of timeframe. But certainly over time, to the extent that the industry migrates to a risk sharing, accountable care, bundled kind of environment, we do believe that in that kind of new world order, that the silos that limit the kinds of patients that can be treated in Medicare-designated, facility-based post-acute settings will start to go away, they'll become unnecessary. And so that then creates an opportunity for us in the four walls of what we now call an inpatient rehabilitation hospital to treat patients that otherwise might be going to other facility-based post-acute providers.

In that new world order, we think it would be attractive if we could then supplement that facility-based post-acute care with home-based post-acute care. And we certainly would be looking to do that through acquisitions, mostly likely – in fact I can't imagine. I don't know of any public company, home care company that has the kind of market synergies that we would be looking for. So what we would want to do is we'd want to look at regional players, get a couple of those that are high quality, learn a little bit more about home care, build the infrastructure just as we did on the rehab side.

But that's a long, long-term view, and I always hesitate to answer questions like that, even when they're asked about what is the long-term view, because your sense of long-term may be different than mine. But this is certainly looking at it over a 10-year horizon, not a 10-month or a 2-year horizon. So that's kind of our thinking. And frankly, there still needs to be more clarity out of Washington with respect to, a, overall

Medicare changes and then, b, sector specific changes that we all know about, be it a rebasing of the payment system, patient criteria in LPACs, home care having a co-pay added. I mean, there's a lot of risks out there, buying in or getting into those risks today makes no sense when we have such a very attractive sector that we do very well in, and where there's a lot of near-term growth.

<Q – Frank Morgan – RBC Capital Markets Equity Research>: Okay. I kind of thought you'd answer it that way, but I just hadn't heard you comment on it in a while. One other, just in terms of your – given how well you're doing with your business, the leverage coming down, have you really reevaluated your tolerance for leverage? I mean, would you considering taking leverage backups seeing that you've operated at higher levels in the past, and certainly did it very successfully then and it seems like you're in much better shape today and the cash flow is much higher? Is there any possibility that you might even reassess what your leverage target levels are? I'll hop off. Thanks.

<A – Jay Grinney – HealthSouth Corp.>: I think we signaled to some degree that we are doing that beginning again at the – at the start of this year, when we attended the JPMorgan Equity Conference. And that was in our business outlook slide, we made a subtle, but important, change in the way that we talk about our leverage target. And there we expressed our willingness to go two times, three times or higher, if we were presented with compelling shareholder value-creating opportunities.

So currently, if you look at the composition of the debt markets right now, and also of our balance sheet, it suggests that the capacity is there to take on a bit more leverage. We're going to be prudent about how we do that. As we have always talked about, when we think about leverage, we're not thinking just about absolute levels of leverage because that is certainly an important measure, but looking at the form of that leverage is equally as important. And in addition to the fact that we're currently at a very low level of leverage, particularly as you compare us versus the other healthcare providers out there, you look the structure of our debt capital, and with no maturities facing us prior to the third quarter of 2017, and that maturity being a completely unfunded $600 million revolving credit facility, those things factored into our decision to pursue the increased authorization.

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

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Good morning. Doug, you talked in your prepared comments about the denial rate slowing, but bad debt maybe up a little, which it really doesn't look like to me on the P&L, but maybe just remind us if you've gotten a change in your MAC or fiscal intermediary and if so, what's the experience then?

<A – Doug Coltharp – HealthSouth Corp.>: That is pending, but has not taken place yet, so our largest intermediary continues to be Cahaba. We have had more proactive discussions with Cahaba beginning in the fourth quarter of this year, and we're optimistic that those discussions are bearing some fruits as we did see the number of incremental denials slow in the fourth quarter.

<A – Jay Grinney – HealthSouth Corp.>: And, Whit, this is Jay. The transition from the current structure to one where every single one of our hospitals will be assigned to the MAC that gets the – wins the MAC contract for that particular geography, it's my understanding that won't be finalized until sometime in 2015. I could be wrong on that, but I think I'm right. And it's at that point that we will then move those hospitals that are currently serviced by Cahaba, and there are 70-some of those, any of them that are outside of the Cahaba MAC, and there are quite a few of them, would then go to a variety of different MACs, but it'll be a while until we see that happening.

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Okay.

<A – Jay Grinney – HealthSouth Corp.>: We've declared that, and we've let CMS know, but it's just the way the process has been structured, we don't have that ability to move ours out of Cahaba until all of the MAC contracts have been executed.

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Understood. But I guess the point is, is that the – it hasn't gotten any worse with Cahaba and it appears to be improved.

<A – Jay Grinney – HealthSouth Corp.>: They've gotten better.

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Yeah. Okay, great. And maybe one last one, Jay, just – maybe just a general update on your IT initiative and how pleased you are now and any surprises or benefits that you've been able to see or put your finger on? And do you think that the strategy in any way is assisting in some of your market share gains?

<A – Jay Grinney – HealthSouth Corp.>: I'll answer the first part and then I'm going to ask Mark to address the implementation success. I think what it has done is it makes us a little more attractive in the processes that are run when a unit or a hospital is looking to be sold or joint ventured. I know, for example, that at the – at Walton Rehabilitation Hospital over in Augusta, the fact that we had a clinical information system that we're installing, we were told differentiated us pretty dramatically from the others who showed up in the process.

<A – Mark Tarr – HealthSouth Corp.>: Yeah, Whit, the rollout has gone extremely well, extremely smooth up to this point. We're now implemented in 13 hospitals. Next month we will roll it out to an additional five hospitals for a total of 18, and it's gone real well. We're able to interface with the lab and radiology systems that are out there, working particularly close with our partners, and referring hospitals. So we're very pleased with it up to this point. I think in terms of isolating benefits that it's bringing to us, still a little early to tell, but we're confident that, overall, the system is going to work well for us.

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

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

<Q – Gary Lieberman – Wells Fargo Advisors LLC>: Question – hey. With regards to the tender, would you expect it to be a Dutch tender or is there some other format that you guys are considering?

<A – Doug Coltharp – HealthSouth Corp.>: And again, we – our announcement was not that we are launching a tender offer. Our announcement was that we have increased the common share authorization and that we intend to pursue one, which means we are currently evaluating our opportunities, and within that evaluation, if we choose to launch a tender, we will then make the determination whether or not a fixed price or a Dutch auction best suits our needs.

<Q – Gary Lieberman – Wells Fargo Advisors LLC>: Okay, great. That's very helpful. And then in terms of the facilities that you are considering purchasing, do you think the fact that you're the operator gives you any kind of advantage in the purchase of the facility? And also, would you consider purchasing facilities that you don't currently operate today?

<A – Doug Coltharp – HealthSouth Corp.>: So, our presence as not only the operator but the most efficient operator in the business is a bit of a double-edged sword, because virtually all of the purchase options are subject to a fair market value determination of the price. And that is typically resolved by HealthSouth as the tenant going out and getting one appraisal and the landlord going to get another appraisal. Well, almost all instances, we tend to look at the value of the real estate as if HealthSouth were not the operator, whether another IRF were in there or another party, and obviously in most of those cases, the value of the underlying real estate is towards the low end. The landlord is not surprised when we look at it on an income basis and assume that everybody would operate it just the way that HealthSouth does, and you know he's trying to compare us with the peers that very few companies are able to achieve that level of efficiency, so it creates some tension in the process.

In terms of purchasing or moving to another facility, that really gets to another core issue that is embedded in this decision about pursuing the buyout of leased options and that's where is the control of the CON vested? Is it a CON state at all? If it's not a CON state, then it certainly makes it a lot of easier for us to consider moving to another piece of property in the same market. And in some cases, we'll choose to do that, such as in Ludlow, Massachusetts, because we had an old facility and wanted to move to a slightly better location.

But I'd say in the vast majority of situations we're dealing with, our preference would be to not disrupt the existing hospital, and to try to stay in the existing location. And the negotiation that goes on over this period of time is not only about trying to reconcile to what a fair market value is, but frequently, that opens up the door to discuss renewing the lease on terms that are more market and more favorable from our perspective.

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

<Q – A.J. Rice – UBS Securities LLC>: Hi, everybody.

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

<Q – A.J. Rice – UBS Securities LLC>: You guys mentioned a couple times in your prepared remarks that part of the benefit on pricing and revenues was the higher acuity year-to-year. Do you have any metrics on that, either case mix or something else that would tell us to what extent that helps you in the quarter and year?

<A – Jay Grinney – HealthSouth Corp.>: Our case mix index is approximately 1.35, so that's a little bit higher than what we've seen in the past, and that certainly is a contributor. And, if you recall, A.J., say five years ago, we were closer to 1.30, 1.31.

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

<A – Doug Coltharp – HealthSouth Corp.>: And obviously that CMI is going to be tied to those two significant categories that we talked about, which is stroke and the neurological. And as you may recall that in our prepared remarks, we did state that those two categories were up nearly 500 basis points in Q4 2012 versus Q4 2011. The specific percentages of those two combined, 39.2% in Q4 2012 versus 34.3% in Q4 2011.

<Q – A.J. Rice – UBS Securities LLC>: Okay. That's helpful. And then my other question would be around the D&A, that was sort of a point where I know that's non-cash below the operating income, but there was some variance relative to what we're looking at. Can you just flesh out a little bit more why the increase year-to-year in the guidance, and specifically around the investment in the IT, are you – and the way you amortize that, can you just remind us of that maybe?

<A – Doug Coltharp – HealthSouth Corp.>: There's no doubt that we said that we would look for D&A to be more in the $95 million range next year. And I don't think you're going to see the same kind of year-over-year increase in subsequent years beyond 2013, but it is a number of things. One is the rollout of the clinical information system and recognizing that although we believe that system is going to be in place for a long time, and have a very long and sustainable benefit, that the nature of the assets means that it gets written off over a shorter period of time than do our investments in our typical fixed assets. You're talking about a 7-year life on the capitalized portion of the CIS investment.

You've also added increase in refurbishment expenses and those tend to be with shorter-lived assets, and then if you couple that with the increased activity we've had under the de novos, all of that is kind of culminating in what appears to be a significant step up between 2012 and 2013. But again, I would expect that beyond 2013, the rate of increase, the slope of that increase if you will, will be substantially flatter.

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

<A – Jay Grinney – HealthSouth Corp.>: Morning, Kevin. Hello?

<Q>: Unknown Caller - Your comments – yes, hello? Can you hear me?

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

<Q>: Unknown Caller>: Okay. So yes, the – I just want to follow up on the commentary around the, I guess your outlook, on what's going on in this because I know you assumed sequestration cut in 2013, but I guess there is this idea of that the sequester might be sort of – the Congress will try to find another way and replace the sequester with something else instead. So what is your view in terms of positioning of the industry IRFs in DC, and what are the topics out there that are being discussed in terms of potential offsets for the sequester, and how you view the positioning of IRFs there?

<A – Jay Grinney – HealthSouth Corp.>: First of all, we are not hearing a lot about the – that sequestration for healthcare providers is going to be pushed back or not implemented. It's hard to know, frankly, what will happen in Washington, but we're planning on sequestration or that order being signed because we're not picking up anything that would suggest that there is movement to strike a grand bargain or to come up with an alternative plan. Because remember, the sequestration is there to help reduce the budget deficit and to limit the amount of increase in the national debt. And without that sequestration, the deficit becomes larger, the debt ceiling becomes more problematic.

So it's nice to talk about avoiding sequestration, and helping the middle class in doing that, but the reality is, is that Washington is going to have to come to grips with the fact that we've got a huge deficit, it's growing, and we've got a debt ceiling that is going to be breached again here in the not-too-distant future. So those can't be avoided, and they're going to be – they are going to have to be some very tough decisions. Everybody is going to have to tighten their belts a little bit, and we're assuming that that will occur through sequestration for healthcare providers.

<Q>: Unknown Caller>: Yeah. But that was exactly my point that if the sequester stays the same, but then Congress will have to address the next debt ceiling, what is your view in terms of the industry being at risk for changes to reimbursement additional or on top of sequestration?

<A – Jay Grinney – HealthSouth Corp.>: No, we're not – yeah, we're not hearing anything that would suggest that inpatient rehabilitation is at any disproportionate risk to anybody else. I mean, I think everybody is expecting that when the President finally issues his fiscal year 2014 budget, that there will be the same provisions in there, the 75% rule and the site neutral and the no market basket update, but those have been around since September of 2011. They have not been acted on because there's no momentum, there's no advocate for that outside of the political machine in the White House. So we don't see any disproportionate risk for inpatient rehabilitation providers.

We do, of course, believe that there is always going to be some risk for all providers that we will we asked to do more from a rate perspective. I think that would be more short term in nature. If Congress ever does get together and works with the President and finds a way to come up with a grand bargain, if you will, everything we're hearing suggests that the grand bargain would include major structural changes, and not just going in and tinkering with this sector or that sector, or going after across-the-board cuts. So we certainly – and I spent a lot of time up there. We've got a full-time person who lives in DC, is on the Hill constantly. And we're not hearing anything that would concern us that inpatient rehabilitation facilities and hospitals are at a disproportionate risk to other providers.

<Q>: Great. Thank you so much for the color.

<A – Jay Grinney – HealthSouth Corp.>: You're welcome. Thank you.

Operator: Our next question comes from Sheryl Skolnick of CRT Capital Group.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Hi there. Some people don't let me ask one, you let me ask two. So thank you very much. I guess that's what happens when you have nice things to say, but then again do a good job. So I'm curious about a couple of more detailed questions. One of the axioms I guess about your market positioning of your hospitals, I thought had been that it was better not to align with any one provider. Yet it looks like some of your more interesting opportunities to reposition, and perhaps breathe new life into a fully utilized facility or less than fully utilized facility may be to joint venture with some

local partners. So I'm wondering if you can talk about the conditions under which it makes sense to align with a local partner, and when it doesn't? That would be question number one.

Also related to hospitals, how many more are in line to be refurbished and how many have you done?

And then the third question related to the hospitals is, have you seen any indication to-date, whether it be in your piloting or your rollout, of a positive or a negative implications of the clinical information system on productivity and workflow and quality?

<A – Jay Grinney – HealthSouth Corp.>: All right. Yeah. In terms of the market conditions or joint venturing, typically it would be in those situations where it's a relatively small market, there are few providers in that market and aligning with an acute care hospital is really sort of an investment in the future, if you will, and in anticipation of the market evolving to one of risk sharing or some level of integration. Typically what we'll do is we will align ourselves in those kinds of situations with our largest provider, largest single referral source. So it's kind of a natural in terms of when we do that.

And keep in mind, we have a third of our hospitals that already are in some kind of joint venture arrangement with a large provider. We've got them with academic medical centers like UVA, Vanderbilt, Barnes-Jewish in St. Louis. We have it with acute care systems, not necessarily academic medical centers. So it's very market specific, but we're certainly flexible and open to doing that. In terms of the number of hospitals that we've refurbished and those that are on the docket for refurbishment in the future, I'm going to ask Mark to answer that.

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Sheryl, we first put in what we call our refresh program four, five years ago, and the whole goal is to go in and address hospitals that were, in terms of having the most need for major renovations, cosmetic and otherwise. We typically do nurses' stations, we touch all the patient rooms with wall coverings, flooring, major corridors. And in some cases, on some of the more major hospital renovations, we've had to go back in, and take care of bathrooms in each one of our patient rooms. But we've touched or completed I think somewhere between 10 and 12 of our hospitals. I would say on an ongoing basis you could expect us to do two to four hospitals a year, and some means, as our hospitals continue to age, we'll have to continue to reinvest in our hospitals on a go forward basis.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay.

<A – Jay Grinney – HealthSouth Corp.>: And then on the implications on the electronic clinical information system. On productivity, we really haven't seen any impact there yet. And frankly, when we rolled it out, and even when we sold it to the board, we didn't sell it on the notion that it was going to save us salary, wages, and benefit dollars. What we did was we said it would free up our clinicians to spend more time with the patient and that still is the primary objective. What we hope to do over time is to see that translate into improved patient satisfaction, improved outcomes, and we're confident that we're going to get that. We're seeing some early benefit of that in the hospitals where we have installed the clinical information system, certainly from an integration standpoint with physicians and making sure that the documentation is there. Those are all some of the benefits that we know are there. Whether or not they're going to translate into fewer litigation expenses and so on down the road, I think that's just going to play itself out over the next several years.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Great. Thanks.

Operator: At this time, there are no further questions, I would like to turn the floor back over to Mary Ann Arico for any closing remarks.

Mary Ann Arico, Chief Investor Relations Officer

As a reminder, we will be filing the updated investor reference book next week. The 10-K will be filed later today. If you have additional questions, we'll be available later today. Please call me at 205-969-6175. Thank you.

Jay Grinney, President and Chief Executive Officer

Thanks, everyone.

Operator: Thank you. This concludes today's HealthSouth's fourth quarter 2012 earnings conference call. You may disconnect at this time.