Operator: Good morning, everyone, and welcome to HealthSouth's First Quarter 2013 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.

Mary Ann Arico, Chief Investor Relations Officer

Good morning, and thank you, operator. Thank you for joining us today for the HealthSouth first quarter 2013 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, Treasurer; Julie Duck, Senior Vice President, 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.

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 and the Form 10-Q for first quarter 2013, 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 last night with the SEC.

Before I turn it over to Jay, I would like to remind you 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.

And 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, everyone. We are very pleased to report that the first quarter was a very strong start to the year. As the company's key operating and financial metrics, discharges, revenues, adjusted EBITDA, earnings per share and adjusted free cash flow, all demonstrated solid growth compared to the first quarter of 2012.

Discharges grew 4.1% despite a challenging prior year comp of 6% and an extra day last year due to leap year. Net operating revenues were $572.6 million, an increase of 6.3% and were driven by the quarter's solid discharge growth, pricing adjustments, higher patient acuity, and a increase in the percentage of Medicare patients we treated.

On the expense side, our hospitals continued to provide high quality care in a highly efficient manner, which resulted in the company generating $139.3 million of adjusted EBITDA, an increase of 9.7%.

Finally, our solid operating results produced diluted earnings per share of $0.48 and adjusted free cash flow of $85.7 million compared to $0.40 per share and $45.2 million respectively in the first quarter of last year.

We were especially pleased that our strong cash flows allowed us to continue investing in future growth. Construction of three new hospitals, our joint venture hospital in Stuart, Florida, our wholly-owned hospital in Littleton, Colorado and our replacement hospital in Ludlow, Massachusetts, all continued on schedule. The Stuart and Littleton hospitals will be finished this quarter, while the Ludlow facility should be completed by year end.

We also acquired land for a new 50-bed hospital in Modesto, California and we'll be filing our design and construction plans with California's Office of Statewide Health Planning and Development in the third quarter of this year. Reviews by OSHPD, as it is known, can take 12 to 15 months, so construction on this hospital isn't expected to start until the third quarter of 2014 with completion by late 2015.

Finally, we devoted significant resources during the quarter to ensure a smooth transition to HealthSouth ownership of our 101st hospital, Walton Rehabilitation Hospital of Augusta, Georgia. We closed this transition on April 1, and are pleased to welcome Walton's employees and medical staff to HealthSouth.

Doug will now provide a detailed walkthrough of our results, a recap of our recent tender offer and an explanation of the agreements with the IRS that we announced yesterday. I'll then conclude with some comments on guidance before opening the lines for Q&A.

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

Thank you, Jay, and good morning, everyone.

As Jay highlighted, Q1 was a strong start to 2013. Revenue increased 6.3% over Q1 2012, driven by inpatient revenue growth of 7.3% partially offset by a decline in outpatient and other revenue. The increase in inpatient revenue stemmed from discharged growth of 4.1% and the 3.1% increase in revenue per discharge.

The discharge growth was comprised of 2.2% same-store growth which was negatively impacted by the comparison to leap year in Q1 2012, and the closure of 41 SNF beds in Q1 2013, and new store growth of 1.9%, the majority of which related to the consolidation of St. Vincent beginning Q3 last year. The increase of revenue per discharge was attributable to pricing adjustments from Medicare and managed care payors, higher patient acuity, and a higher percentage of Medicare patients. Our Q1 2013 revenue metrics include the effect of sequestration for Medicare patients admitted, but not discharged in the quarter.

Bad debt expense for Q1 was 1.3% of revenue, a 10 basis point increase over Q1 last year and consistent with our Q4 2012 result. During Q1, we again experienced improved operating leverage and labor productivity. SWB for Q1 2013 was 48% versus 48.5% in Q1 2012. Q1 SWB benefited from the foregone merit increase in anticipation of the onset of sequestration, as well as improved labor productivity, as evidenced by Q1 2013 employees per occupied bed, or EPOB, of 3.31%, down from 3.34% in Q1 2012.

Our hospital-related expenses, which include other operating, supplies and occupancy cost were 20.3% of revenue in Q1 2013, an improvement of 50 basis points from Q1 2012. In Q1, continued supply chain efficiencies and leverage of occupancy costs more than offset the impact of higher expenses associated with the ongoing implementation of our clinical information system.

G&A for Q1 2013, which excludes stock-based compensation, was flat in dollar terms to Q1 2012 and decreased 20 basis points against revenue as we again leveraged the costs associated with our corporate office.

Adjusted EBITDA for Q1 2013 was $139.3 million, an increase of 9.7% over Q1 2012, driven by the combination of strong revenue growth and improved operating leverage. The growth in adjusted EBITDA was net of a $2 million increase in non-controlling interest expense primarily attributable to the consolidation of St. Vincent and the previously disclosed ownership changes at two of our joint venture hospitals, Jonesboro and Memphis.

Consistent with our expectations and guidance, both interest expense and depreciation and amortization increased in Q1 2013 over Q1 2012. The $900,000 increase in interest expense was primarily due to the issuance of the $275 million in 5.75% senior notes last September.

Please note that our assumption for full year 2013 interest expense has been increased by $2 million due to the funding of the common stock tender we completed in Q1. The $2.6 million increase in D&A stems from our recent increase in capital expenditures, including our de novo activity, hospital refurbishments and the continuing rollout of our clinical information system.

EPS from continuing operations for Q1 2013 was $0.48 a share as compared to $0.40 a share in Q1 2012. The effective tax rate was approximately 39% in both periods. Again reflecting the impact of the tender offer completed in Q1, we have increased our EPS guidance for 2013 to $1.61 to $1.68 per share. It was previously $1.50 to a $1.56 per share. The assumptions underlying our EPS guidance may be found on page 16 of the supplemental slides. Please note that the tax benefit associated with our recent IRS agreements, which I will describe more fully in a moment, is not yet incorporated into our EPS guidance.

Adjusted free cash flow for Q1 2013 was very strong at $85.7 million versus $45.2 million in Q1 2012. The year-over-year increase related primarily to the aforementioned increase in adjusted EBITDA, as well as a significant working capital benefit owing to higher payroll-related liabilities in Q1 2012 and the timing of certain interest payments. You may recall that Q1 2012 included a $16.1 million decline in payroll liabilities primarily attributable to tax withholding payments related to the vesting of a 2009 restricted stock grant to our employees.

As it relates to our adjusted free cash flow assumptions for 2013, I would direct your attention to slide 18 of the supplemental slides and note that the 2013 assumptions remain unchanged with the exception of the aforementioned $2 million increase in interest expense related to the funding of our common stock tender.

Specifically, we continue to expect working capital to increase in a range of $10 million to $20 million and maintenance CapEx of $80 million to $90 million for the full year 2013. Regarding CapEx, our maintenance CapEx for Q1 was $18.9 million, in line with the $19.1 million spent in Q1 2012. The maintenance spend in Q1 included major renovations underway at two of our hospitals, as well as the continuing investment in our clinical information system.

Our discretionary CapEx in Q1 2013 was $30.3 million versus $15 million in Q1 2012. Q1 2013 included the continued investment in our de novo hospitals and our replacement hospital in Ludlow, Massachusetts, as well as a significant portion of the purchase price for our acquisition of Walton Rehabilitation Hospital, which closed on April 1. Our assumptions regarding the discretionary CapEx for 2013 are depicted on slide 19 of the supplemental slides.

Turning to the balance sheet, we ended Q1 with total debt of approximately $1.378 billion, up roughly $124 million from 2012 year-end, with the increase attributable primarily to $122 million draw on our revolver to fund a portion of the common stock tender and the acquisition of Walton Rehabilitation Hospital. As a result, our leverage ratio increased modestly to 2.7 times, but remains well within our target range.

During Q1 2013, we launched and completed a tender offer for our common shares, resulting in the repurchase of approximately 9.5% of our outstanding shares at a price of $25.50 per share. The tender was funded with approximately $152 million of cash on hand and $82 million drawn from our revolving credit facility. The tender demonstrates our ongoing commitment to utilize our substantial free cash flow generation and balance sheet capacity to enhance shareholder value via an array of investment and capital return alternatives.

I'll conclude with a discussion of the agreements with the IRS we finalized yesterday, resulting in a substantial increase to our federal NOL. We have been working in close cooperation with the IRS to resolve a number of issues that remained outstanding from the prior restatement of our financial statements. These agreements were executed yesterday. The execution of these agreements effectively closes the books on matters related to restatement and otherwise for 2008, it will result in an increase of at least $260 million to our gross federal NOL balance which stood at approximately $906 million at the end of Q1 2013.

As a result of these agreements, we expect to record a net federal income tax benefit of at least $91 million in Q2 2013. These estimates may increase as we continue to analyze certain attributes, including the implications to our state NOLs. This is obviously a significant positive event for our company and I'd like to give special recognition to Andy Price, our Chief Accounting Officer and Rob McCallum and Ted Langley in our Tax Department for their hard work and perseverance in reaching these agreements with the IRS.

With that, I'll turn it back to Jay.

Jay Grinney, President, Chief Executive Officer & Director

Great. Thank you, Doug. Although we had an excellent first quarter, our approach to guidance remains unchanged. We continue to believe it prudent to complete at least two quarters before considering any changes. Having said that, our strong first quarter coupled with a decent start in April, gives us the ability to guide to the top end or higher of our adjusted EBITDA and EPS ranges.

As Doug just noted, our earnings per share guidance has been updated to a range of $1.61 to $1.68 per share to reflect the slightly higher interest expense and lower share comp resulting from our successful tender, but has not been updated to reflect the tax benefit related to the IRS agreements.

The assumptions underlying our guidance are as follows. Discharged growth of between 3% and 4%; revenue per discharged growth of between 2.3% and 2.6% and revenue growth before sequestration of between 4.9% and 6.2%. We expect sequestration to reduce net revenues by approximately $28 million and reduce adjusted EBITDA by approximately $25 million. Finally, we assume our operating expenses, as a percent of net revenues, will be generally consistent with, or in some cases lower than, the final three quarters of 2012.

With that, operator, we're ready to take questions.

QUESTION AND ANSWER SECTION

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

<Q – Colleen Lang – Lazard Capital Markets LLC>: Hi. Good morning.

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

<Q – Colleen Lang – Lazard Capital Markets LLC>: Just on the volume growth, it was much better than what we and the Street were looking for this quarter, especially given the leap day or calendar comp. Can you talk a little bit about how volume trends were versus your own internal budget? And what were some of the drivers of the strength, especially just given the weakness we've seen throughout healthcare services so far this earning season?

<A – Jay Grinney – HealthSouth Corp.>: Sure. The growth was generally in line with what our expectations were. And I think the difference between our volume growth, and that of the acute care hospitals needs to be understood within the context of the differences in our mix. I mean we get only about – and when I say, we, inpatient rehabilitation hospitals get about 3% of the Medicare patients that are discharged from acute care hospitals. And they tend to be, as we all know, patients who have had a stroke.

They're suffering from some kind of debilitating neurological condition, really conditions that we have characterized in the past as being non-discretionary in nature.

In the acute care hospital world, as we all know, there's a lot of somewhat discretionary volume that goes in. There's a lot of managed care volume that goes in. So, you would not expect to see a one-to-one correlation between acute care volumes and downstream post-acute volumes, specifically inpatient rehabilitation. Having said that, I do believe the focus on our – at our hospitals on quality continues to drive volume to those hospitals.

The decisions that are made day in and day out by referring physicians, by patients and their family members is often driven by their desire to put the patient or the loved one in a hospital where they believe they have the best chance of getting a recovery and being able to resume their normal lives. So, we haven't really seen anything different in terms of admission patterns. Our hospitals continue to focus on the quality, on responsiveness to physicians and to case managers and we think that that's one of the core tenets, if you will, of our business model and has allowed us to generate very solid and very consistent volume growth quarter after quarter.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Great. Thanks. And then just a quick housekeeping one. What drove the closure of the SNF beds in the quarter and do you expect to have any additional bed closures later this year?

<A – Mark Tarr – HealthSouth Corp.>: Hi, Colleen. This is Mark Tarr. We had a few markets where they had a very specific approach to managed care where it made sense to try some SNF units over the years, so that we would be able to take patients that needed a very low intensity type of care plan, in addition to those that needed a higher intensity. Over the years as it has kind of worked it's way through the process, it made little sense to have those there any longer. They weren't profitable, so we closed two units, one in Toms River, New Jersey; one in Sandy, Utah. We will remain with one unit in our Harmarville Hospital in the suburb of Pittsburgh.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Thanks so much.

<A – Mark Tarr – HealthSouth Corp.>: You're welcome.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Good morning, everyone.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Good morning. And yet another great job. I like how boring this gets. Thank you. So I have a number of questions, but I'll limit them to one and a follow-up. Can you go through with us the impact of the sequester on the quarter, because you said that it affected essentially cases in progress, so for less than 15 days in the end of the quarter. But can you just detail that? And then I have a question about Medicare Advantage rate flow through to your business for next year and how you think about that?

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

<A – Doug Coltharp – HealthSouth Corp.>: Sheryl, this is Doug and I'll start off on the impact of the sequester. Again, the way that the sequester hits us is it doesn't begin until April 1 and it's on discharge basis. So it's really impacting the patients that were admitted into our hospitals given the average length of stay in the second half of March. Now, we operated on an accrual basis, so we made an allotment for that and the impact during the quarter was roughly $750,000. The previous estimates that we had given for the year, which were $28 million to revenue and roughly $25 million to EBITDA, remain intact.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. So, a very small percentage of your cases presumably at the end of the quarter were impacted?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah, again, it was just the timing issue because it's...

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Yeah. No, I understand, because it's on a discharge basis. I got that. Okay.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Can we talk about something then maybe that's a little bit more expansive in that sense of uncertainty. Obviously the MA – the Medicare Advantage plans are facing less than optimal reimbursement rates for next year and many of them have discussed the potential to exit markets or significantly curtail benefits as well as perhaps pressure reimbursement rates. You're already seeing an increase in your Medicare fee-for-service or traditional Medicare exposure rather than managed care exposure. So, how do you think about how this will flow through your business? Because on the one hand, it seems like your pricing and margins maybe actually be better on traditional Medicare than they are on Medicare Advantage, but on the other hand, it's nice to have a little bit more of a diversified mix. So can you walk us through what you think is going to happen?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. I think that we'll continue to see what you just described, and that is MA plans looking at their coverage on a market by market basis and in some instances, they're just going to leave those markets. My sense and I think underlying your question, you perhaps agree that this administration is trying to starve MA plans and we do better under traditional Medicare, but the differential between that and the Medicare Advantage plans really isn't that significant given that many of those MA plans are moving from a per diem reimbursement to us to a case rate reimbursement and that case rate oftentimes is identical to what we get under Medicare.

So, there are a lot of dynamics that are going on. It's really kind of hard to know long-term what's going to happen to the plans, but as we see the shift away from managed care and into Medicare, we see that as being net positive, hence the uptick in our pricing per unit in this quarter. But, as I said just a moment ago, the pricing differential has really lessened pretty dramatically over the last couple years. If you go back three or four years ago, almost all of our MA plans were on a per diem and you fast forward to 2012-2013, a significant number of them have migrated to a case rate kind of reimbursement. So, maybe the way to look at this is net-net it's probably not going to have a huge difference to us going forward.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. Great. Thank you. I'll get back in the queue.

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

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

<Q – Ben Hendrix – RBC Capital Markets>: Hi, this is Ben Hendrix for Frank Morgan. I believe that all of our questions have largely been answered. Just if you could though, to change the subject, is there any update on the OIG subpoena from earlier?

<A – Jay Grinney – HealthSouth Corp.>: I'm going to ask John Whittington, our General Counsel, to provide you some commentary on that.

<A – John Whittington – HealthSouth Corp.>: Good morning. The answer is no. There's really not much of an update. It is a process. It's a slow-moving process. Essentially what's going on is that we are producing in a cooperative manner all of the documents requested, working with the government, operating with the government, but it is a process that moves very slowly and that's really the extent of the update.

<Q – Ben Hendrix – RBC Capital Markets>: Great. Thank you very much.

<A – John Whittington – HealthSouth Corp.>: Yes, sir.

Operator: Your next question comes from Rob Mains of Stifel.

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: Thanks. Good morning.

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

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: The increase in the Medicare mix that you had in the quarter, what were the drivers of that and how sustainable do you think that is?

<A – Jay Grinney – HealthSouth Corp.>: Well, if you go back and you look at over the last, I think probably two years, eight quarters, there's been a steady increase in the Medicare percentage of patients that we've treated. And what's happening is we're seeing this change occur out of managed Medicare back into traditional Medicare. And so, I think a lot of that is going to be a function of what happens to the Medicare Advantage plans going forward.

As we just mentioned a moment ago, I think that the current administration, I believe, is looking to try to starve Medicare Advantage plans and if that continues, obviously you've got the administration, you've got the legislative body, they've got to come up with plans and rules that will govern that. But if that continues, I think that we will continue to see more traditional Medicare in our payer mix.

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: So it's more a function of kind of market pressures on the MA plans than anything else?

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

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: Okay.

<A – Jay Grinney – HealthSouth Corp.>: Definitely on that.

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: Got it. And then second question, I know that there's not a whole lot of moving parts with the 2% rate cut. I assume there have been no surprises or anything involved with this sequester?

<A – Jay Grinney – HealthSouth Corp.>: That's correct, no surprises. There was a little bit of a slowdown in payments from Medicare as they shifted over, but we've for the most part caught up on that from a cash collection standpoint – we expected that. We typically see slowdowns at year-end when they move from one payment rate to a new payment rate, but besides that, Rob, there's really not been any surprises and we've been able to accommodate the effect as we had expected we would.

<Q – Rob Mains – Stifel, Nicolaus and Company, Incorporated>: Okay. Great. That's what I had. Thank you.

<A – Jay Grinney – HealthSouth Corp.>: All right. Thank you.

Operator: Your next question comes from Matthew Gillmor of Robert Baird.

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Hey, good morning, everyone.

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

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

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Hey, I just wanted to ask a question about healthcare reform in 2014. I know you're mostly a Medicare business, so the impact should be pretty limited, but you do have some Medicaid and some commercial, so just curious if you had any sort of expectation for what coverage expansion might mean for you all. And do you have any sort of expectation as to whether healthcare reform will enhance or detract from your EBITDA growth outlook?

<A – Jay Grinney – HealthSouth Corp.>: You know we don't anticipate a significant or meaningful increase in the number of patients that we might be able to treat, at least at this point. I think a lot of it's going to be a function of what kind of plan design are we going to see at the state level. Certainly the exchanges will provide for in-patient rehabilitative care, but you really have to look at the kind of conditions that people have that find themselves needing rehabilitative care. And as you know, most of those conditions are ailments that you get, the older you get. And so, we have most of our patients being Medicare, not because we're targeting the Medicare population it's that the services that we provide tend to be services that are needed generally to a greater degree by Medicare beneficiaries.

The incidence of stroke for example is certainly much great in the upper age groups than in the lower. So we don't really expect a big increase. We would certainly welcome the opportunity to provide our care to more patients and we'll certainly be looking for those opportunities, but as we look out, we have not incorporated any of that potential upside into any of our thinking long-term. So when you go back and you look at our business model and you look at the expectations for EBITDA growth and free cash flow growth and the CAGRs associated with that, we are not incorporating any meaningful increase in our non-Medicare patients in those ranges.

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Okay. Thanks. And then, Doug can you remind us on the ability to claw back some of the senior notes? At what point can you, if you wanted to, call another sort of tranche of the 35%, is that still an option?

<A – Doug Coltharp – HealthSouth Corp.>: It is. It would be – so we can get 10% of the 18's and the 22's. It's based on the amount outstanding not the original principal amount. It's at a fixed price of 103 when we're inside the lasting of the call protection. And so, think of it as an annual option that exists and we last did that late in the third quarter, early in the fourth quarter of last year. So it'd be the same time this year that, that option would come up again.

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Okay. Thanks a lot.

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

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

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Hi, good morning. This is Dana Nentin in for Darren Lehrich.

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

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Thanks for taking the call.

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

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Within the de novo pipeline, I was wondering if you could put any type of timelines around any potential projects in the work. And I guess as a follow on to that, has anything changed at all in the model? Like, how much investment you're putting into the development of the facilities? How you're sizing them and so on? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: Yeah. The pipeline remains pretty solid. We'll be able to report when we report on the second quarter. I'm confident we'll be able to report on a couple of more de novos that we'll be able to announce this year and hopefully begin construction on later this year. As we look at how much we're investing we really haven't changed our view. I will say however when we talked about de novos and/or acquisitions and we put out a target of four de novos – opening four de novos each year and two acquisitions. Those are really just targets. Those are not limitations.

So to the extent that there are opportunities to open more in markets where we believe based on our analysis, there will be – there's a needed service, but also we'd be able to generate an appropriate return,

will certainly build those out. But just as we look at it, we still think that that four and two is about the right number. Some years it may be a little bit more, some years it may be a little bit less.

As far as the size of the hospitals, we continue to think that the 40-bed model is the appropriate model to begin with as we look at the market opportunities. There are going to be some markets, Modesto, California is a great example – where the demand is actually greater than what we have found in other traditional markets. So we're not wedded – it's not sort of a cookie-cutter – it's got to be 40 bed, but we typically begin with that. We found that 40 bed chassis to be very efficient. We can expand easily on it. We build our hospitals to accommodate that future growth. And at least for the foreseeable future, we think that that's the right place to start and from time to time, we may upsize that to a 50 bed. I don't see us necessarily downsizing, but I think that that's probably a good place to be thinking about.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Okay. Great. And then, one quick follow-up to that, can you talk about the performances of some of the recent de novos that you've done?

<A – Mark Tarr – HealthSouth Corp.>: Yeah, actually, this is Mark. We've done quite well. If you look at whether it's Ocala that we opened up back in December that came online or if you go back before that and look at our Cypress, Texas, the hospitals have certainly all met our expectations. We're running in Ocala; I think last night we had 34 patients. So we're already north of 80% occupancy rate there. So we've continued to see that model do well and our bed need calculations to be spot on.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Okay. Great. Thanks a lot.

<A – Jay Grinney – HealthSouth Corp.>: And Dana, if you go to our investor reference book, there's a section in the back that talks about growth and we profile all recently opened de novos and show what the progression is in terms of volume growth and in terms of achieving sustainable positive EBITDA. And as we'd done in the past, we'll update that investor reference book as soon as we file the Q and you'll be able to see that we really have had a pretty good track record with those de novos.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Okay. Great. Will do. Thanks a lot.

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

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning, guys. Couple questions left. Maybe an update on the status of the RAC audits, the pace maybe and also the percent adjudicated in your favor?

<A – Mark Tarr – HealthSouth Corp.>: Hey, Gary, this is Mark. We've – whether you look at the ADRs or the RAC audits, we've had, I would say a minimum number of RAC audits – we certainly had some enquiries and some requests as we've continued to be able to substantiate the medical necessity of the patients in our hospitals with a strong track record there. So I would say there's been minimal request from RACs for audits, but we remain prepared for each.

<A – Doug Coltharp – HealthSouth Corp.>: And then with regard to recovery rates, I think about this in two ways; one is for any claims that are denied, we continue to see an ultimate recovery rate at roughly 58% and our reserves are booked accordingly. For those that move to adjudication, our recovery rate is almost 85%.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay. That's helpful. And then, maybe on the follow-up question as we await the IRF proposed rule, do you guys have any expectations based on what was in the budget or other things that you're hearing about what may or may not be in the proposal?

<A – Jay Grinney – HealthSouth Corp.>: No, not really. Obviously, we're keeping our ear to the ground and we'll see what comes out and as we've done in the past, we'll provide our comments. We don't expect anything dramatic. We do know that, for example, the one topic that gets thrown around a lot, it's been in

the President's past two budgets and his 2011 Living Within our Means deficit proposal – is this whole concept of site-neutral payments.

And just a couple comments on that. Number one, I think as everybody knows CMS was mandated to evaluate this by Congress, I think in 2007, 2008 timeframe. They engaged the RAND Corporation to do an analysis and to start coming up with some early ideas about how this might be effective. The RAND Corporation issued their preliminary results and study last year 350 plus pages. And it was very inconclusive. If you go back and you look at that and read the report. The bottom line is, they came back and said this stuff is really, really complicated. It's going to take a lot more work and effort to try to figure out, is there a way to justify that site-neutral payment.

Interestingly, we just were – we're going – and the process is going through a pretty significant data jump from CMS, where we have started to look at, and I believe CMS is looking at what the total payments by CMS have been to rehabilitation providers and SNF providers. And in some of the states that we've looked at, Florida, Tennessee, elsewhere – it's pretty interesting as you dive into this really, really deep in complicated database, you find out that the spending on rehab is actually cheaper than spending on skilled nursing.

So this presupposition that so many people have that site-neutral is going to be this just horrible thing that's going to happen to rehab hospital operators – we just don't see. I mean we frankly don't see. And we believe that CMS increasingly is going to be looking at the entire episode of care and will in fact incorporate things like readmission rates, things like discharge back to home and quality outcomes frankly to determine whether or not, it is better to pay for a shorter, higher quality stay in a rehabilitation hospital or a longer, less quality stay in a nursing home where there's a significantly greater probability that the patient is going to end up being readmitted back to an acute care hospital.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Great. Thanks for all the detail.

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

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

<A – Jay Grinney – HealthSouth Corp.>: Hello, John.

<Q – John Ransom – Raymond James & Associates, Inc.>: Good morning. One thing that's been a little curious to me is you guys have been out there doing very well for a long time and we haven't seen a lot of emerging players in the rehab. I know HCA has made some noise about that. Are you seeing anything else on the local level or are you guys continuing to just operate away and compete mostly against the units of acute care hospitals?

<A – Jay Grinney – HealthSouth Corp.>: We haven't seen any new entrants into this space. As we've said in the past, there certainly are a handful of private operators; most of them tend to be concentrated in Texas and in the West. As you know, Ernest Healthcare is out there. They are an owner and operator of both rehab and LTACs and they were acquired by Medical Properties Trust. You have some physician-owned and physician-started companies, but we really are not seeing many new entrants. Yes, HCA certainly has announced and we certainly see them getting into the in-patient rehabilitation business. But as you well know, John, there's HCA and then there's everybody else. I mean, very few companies have the depth of management, the balance sheet and the cash flows to be able to move into a new space and to do that well, typically you need to have an acute care hospital or system needs a fair amount of market share to be able to support a rehab unit for their hospital. And so, you don't see many systems that have that kind of market concentration that HCA has established over the years.

<Q – John Ransom – Raymond James & Associates, Inc.>: Thanks. And just two other quick ones, and I'm sorry if I missed this one. You've given in the past, statistics on where you are relative to the 75% rule if that resurrects. Do you have an update there?

<A – Mark Tarr – HealthSouth Corp.>: Hey, John. It's Mark. Overall at the company we're at 75% on our compliance percentage.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay. No, I know that's on average; is that another way of saying that if they raise the bar for you, that wouldn't be a big deal or are we over reading that?

<A – Jay Grinney – HealthSouth Corp.>: Well, I wouldn't say it wouldn't be a big deal, because – and the reason I say that is not that it would have dire financial consequences. I mean we – frankly, I think we would be able to accommodate that, however, I think that the big deal is at Medicare beneficiary level, because the notion that the 75% rule is somehow going to fix a Medicare overall payment problem is really kind of silly. I mean it's not even a rounding year in terms of the impact that it might have. But the impact that it has from a beneficiary standpoint is huge because those patients have to go somewhere. I mean, it's not as if they set the 75% threshold and all of a sudden people are all of a sudden going to stop having the conditions that require in-patient rehabilitative care. So where are those patients going to go? They're going to go, more than likely, into a skilled nursing facility.

And as I just mentioned, you start looking at some of the CMS data, you start hearing and reading some of the reports that are coming out and you look what CMS has said in the past about the quality difference, the fact that they, CMS, back in 2011 said we don't think that sending patients to skilled nursing necessarily saves the program any money. So I think it's kind of a straw argument. You know, you read the budget proposal and it's so typical, you set up a straw argument, a problem that doesn't exist, ensure appropriate utilization of in-patient rehabilitative care as if there is inappropriate. Well, that's a bogus premise and then to solve this bogus premise, the solution is well, we've got to go back to the 75% rule.

Well, you know, I get the politics, but if you think about it from a, does it save the program money? We would argue no. And more importantly, does it compromise the ability of patients to receive care that they need? We would say emphatically it does. So whether or not it goes through, who knows? We certainly believe we could accommodate it, but that's not the point. The point is what's the impact going to be at HealthSouth? The impact – the real point is what's the impact to Medicare beneficiaries. And we think that maybe the administration doesn't focus on that, but we do know based on our advocacy on the hill, that members of Congress definitely understand and focus on what's in the best interest of the beneficiaries, many of whom vote for them on a pretty regular basis.

<A – Doug Coltharp – HealthSouth Corp.>: John, I do want to clarify that although we said the compliance rate right now is about 75%, you underscored the key term and that's on average and the compliance has to be determined on a hospital-by-hospital basis. So we are not saying that the reinstatement, the 75% rule, would not have a financial impact on our business, it would. And in addition to the immediate impact it would have in certain markets where we're not at that compliance level, overall it reduces the addressable market.

<Q – John Ransom – Raymond James & Associates, Inc.>: Right. And just finally, I know this is a squishy question, but I like asking it of you just to hear what you say. So let's assume for the sake of argument, we get a small deficit deal to patch us through the next election. Other than maybe another rate freeze for rehab, is there anything else on the menu of choice as they floated in the various summits that you think might be the most likely next thing they might consider, assuming that payment equivalency between SNF and rehab is too complicated to engineer in the short-term? Is there anything else that you think is on their menu to pull off the shelf if they need to do another debt deal?

<A – Jay Grinney – HealthSouth Corp.>: No, no, not really. I think everything that's on the shelf has been pulled off. I do think that if a grand bargain ultimately is struck, I think every single healthcare provider out there ought to be thinking in terms of everything is going to be on the table. So whether or not there's anything new, I would say no. We can't envision that there is. We certainly believe that there are other areas that will generate significantly more dollar savings, things like raising the eligibility age and means testing and so on, that will really move the needle.

But going after a $7 billion a year segment and trying to exact huge savings that will save the Medicare program, I mean, we don't see that happening, but I think everything's going to be on the table, I really do. I think if a grand bargain is struck now, if you ask, what's the probability of that? I think that's anybody's guess. But I'm certainly not being optimistic that there's a consensus in Washington that we have a debt and deficit problem. And I think there are a lot of people who do agree with that, but I am increasingly thinking that there are quite a few members of Congress and certainly this administration – and that's not a big deal. We'll work our way out of it and I – so, I don't know if there's going to be a grand bargain or even if there's a consensus that a grand bargain needs to be struck.

<Q – John Ransom – Raymond James & Associates, Inc.>: All right. Thanks a lot.

Operator: Your final question is a follow-up from Sheryl Skolnick of CRT Capital Group.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. Good. Thank you very much. A couple of questions, just to round out here. Can you give us an update on the General Medical situation as well as on the E&Y situation?

<A – Jay Grinney – HealthSouth Corp.>: Sure. I'm going to ask John Whittington to respond to those.

<A – John Whittington – HealthSouth Corp.>: Yeah, sure. On Ernst & Young, as you know we have processed in effect what is an appeal of the arbitration ruling. The appeal has been briefed and oral arguments have been presented and the trial judge has indicated that he will make a ruling in early May. So we're expecting a ruling any day on our efforts to set aside the award of the arbitrators. With respect to General Medicine, as there is an update, the trial judge has ruled that General Medicine may be allowed to introduce its consent judgment with the third-party Horizon, in any trial, but the trial judge also ruled that, that judgment is not binding nor does it preclude HealthSouth from putting on evidence that the judgment is the product of collusion or that the amount of the judgment is greatly exaggerated. With those rulings we are proceeding with Discovery. I predict that the trial will probably go forward late next year, but that could vary. It certainly will not be tried this year.

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

<A – John Whittington – HealthSouth Corp.>: Okay?

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Very good. I appreciate that very much. And I also have to ask a question, I mean, as we look at your business, it seems to me that your company is substantially different from many of the other providers of rehabilitation services, acute rehabilitation services in the market. So and in particular, as you look at the administration's position which seems to be whoever has money they want it, whoever has margin they want it, whether or not it makes sense over the long-term to go after these groups, MA plans, managed care plans or not MA providers of various types. But as you look at that one of the – there's two questions that come about. One, your margins are higher than everybody else, so does that make you potentially more vulnerable or everyone else is just so much lower that you have cover? And two, what would be the impact of a unified – what do you think would be the impact of a unified co-payment deductible strategy to simplify the Medicare benefit structure?

<A – Jay Grinney – HealthSouth Corp.>: So first of all, I think it's hard to predict what this administration might or might not do. We certainly are comforted in our political system and know that there are checks and balances. Thank goodness. And Congress is there as a very powerful check and balance. And in our advocacy and when I say, our, it's not HealthSouth; that really is all inpatient rehabilitation providers, indeed all healthcare providers. We're up there on the Hill constantly and I think members of Congress get that there are going to be some providers who do well, because they are efficient and they focus on efficiency and there are going to be some who don't.

And I don't think that there's going to be this, let's take it away from those who are working hard to be efficient and give it to those who are not. And if you think about, on Page 8 of our Investor Reference Book, there's a cost effectiveness slide and we show where the average payment from Medicare – the average payment for HealthSouth hospital is $17,301. So that's what Medicare has to pay to us and the other

freestanding is $18,600, $18,300. The average for the industry is $18,000. Heck, CMS should be incentivized to put all of their patients in HealthSouth hospital because we would pay them so much money. So – and that resonates on the Hill. It may not resonate everywhere in Washington, but it certainly resonates on the Hill. And I'm sorry, Sheryl, what's the second part of the question?

<Q – Sheryl Skolnick – CRT Capital Group LLC>: The second part of the question was to the extent that Congress views a unified or uniform deductible co-payment co-insurance strategy as a way to achieve a number of goals, including simplification of the Medicare benefit, what would be the impact on acute rehab?

<A – Jay Grinney – HealthSouth Corp.>: I don't know that there would be any impact.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: That's what I thought.

<A – Jay Grinney – HealthSouth Corp.>: Unless you're saying uniform where every single...

<Q – Sheryl Skolnick – CRT Capital Group LLC>: So the inpatient...

<A – Jay Grinney – HealthSouth Corp.>: I don't have that.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Yeah, no, so acute care and acute rehab would presumably have the same percentage co-pay or percentage deductible or percentage co-insurance?

<A – Jay Grinney – HealthSouth Corp.>: Okay. So not – you're not talking about combining A and B?

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Well, within – even within A, they're looking at standardizing some of these co-payments and deductibles.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, and we're downstream because we're an acute care hospital, licensed as such, typically those co-pays and deductibles get exhausted before they come to us.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Got it. That's kind of what I thought. That's what I thought the answer was. Okay.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I think you can also assume that if that were to come to fruition, that there would be a co-pay associated with all of the other post-acute settings as well. And given the nondiscretionary nature of the patients that we treat, really don't think it would impact the demand.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: You're absolutely right. An excellent point. Thank you so much, gentlemen, and Mary Ann. I appreciate it.

<A – Jay Grinney – HealthSouth Corp.>: Thank you.

Operator: We do have one more question from the line of Chris Rigg at Susquehanna.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Thanks for taking my call.

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

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Good morning. And I apologize if I missed this, but the tender offer from earlier this year was clearly successful in the sense that people didn't want to tender in the range you guys offered, but at the same time, you did fall short on the absolute dollar amount. I guess, can you give us a sense for the balance of $120 million or so? Does that just get sort of reallocated back in terms of sort of normal priorities de novo, acquisitions, then on down, or is it still sort of earmarked for shareholder enhancing activities?

<A – Jay Grinney – HealthSouth Corp.>: No, when we received authorization from the board for the tender, it was for the tender, so in a sense that the balance of the $120 million is not sitting out there in any

kind of share repurchase authorization. However, I will say that our board is constantly looking at and will continue to evaluate a wide range of value-enhancing strategies for our shareholders. And we made it pretty clear at the beginning of this year that the company had turned a corner with respect to looking at all of the levers that were available to us to complement the strong operational and financial performance of the company. And as we stated on the fourth quarter call and we're talking about the tender, we made it pretty clear: this is not a one and done. And we've said it very publicly. We'll say it again. We're going to constantly look for ways to unlock the value of this company and to take the cash flow that we're generating from this – from the company and if need be, the balance sheet to bring value to our shareholders. And so, like I said, there's not an authorization sitting out there, but as I said earlier the tender was by no means a one and done.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Okay. Great. Thanks a lot and thanks for squeezing me in.

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

Operator: This concludes today's question-and-answer session. I will now turn the call back over to Mary Ann Arico for concluding remarks.

Mary Ann Arico, Chief Investor Relations Officer

As a reminder, we will be updating the Investor Reference Book in early May and will be attending the UBS Healthcare Conference and the Deutsche Bank Healthcare Conference in the second half of May. If you have additional questions, I will be available later today. Please call me at 205-969-6175. Thanks. Good bye.

Operator: Thank you. This concludes today's conference. You may now disconnect.