Operator: Good morning, everyone, and welcome to HealthSouth's Second 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

Thank you, Paula and good morning, everyone. Thank you for joining us today for HealthSouth's second 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, the Form 10-Q for the quarter ending March 2013, the Form 10-Q for the second quarter 2013 which we expect to file early next week. 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. Thank you for joining our call. We obviously have a lot to talk about this morning, so I'll quickly hit the quarter's highlights before discussing both the dividend and our raised guidance. We were very pleased with the results of the second quarter, which again were very solid. Total discharges grew 6.3% quarter-over-quarter with 3.3% coming from same store growth and 3% coming from new stores. Of the major conditions we treat, we saw growth in the number of neurological and stroke patients, and a reduction in the number of lower extremity joint replacement patients, a continuation of trends we've experienced over the past several quarters.

From a top line perspective, Q2 was the first full quarter of sequestration, which kept our pricing essentially flat compared to the second quarter of last year and negatively impacted the quarter's net revenues by approximately $9 million. Despite this headwind, net operating revenues grew 5.8% quarter-over-quarter.

A key building block of our business model is the ability to provide high-quality care to individuals requiring inpatient rehabilitative services and providing this care in a disciplined, cost effective manner. Our hospitals continued to exhibit this ability in the quarter, as we generated $134.5 million of adjusted EBITDA, an increase of 7.5% over the second quarter of 2012.

Since completing our turnaround five years ago, our business model has had three core elements. First the investment in an operating platform that allows us to capitalize on our preeminent position in the healthcare segment that is both growing due to aging demographics and for the most part nondiscretionary in nature.

Second, the strengthening of our balance sheet by replacing our most expensive debt with lower cost debt with well placed – well spaced maturities and targeting a leverage ratio of three times or less.

And third, the investment in growth from bed expansions, construction of new hospitals and acquisitions of other inpatient rehabilitation facilities.

The successful execution of this business model has produced consistently solid results, including growing adjusted EBITDA from $323 million in 2008 to $506 million in 2012, and growing adjusted free cash flow from $9 million to $268 million over those same five years.

While these results reinforce the strength of our business model, the action taken yesterday by our Board underscores our confidence in the sustainability of this model. When we discussed our business earlier this year, we acknowledged our free cash flow was likely to be more than adequate to fund the future growth of the company. And that in the absence of other usages for this free cash flow, we would start accumulating cash on our balance sheet. We also stated there were no compelling non-rehabilitation businesses we wanted to acquire at the current time because of the significant regulatory uncertainty facing other post-acute providers and the slow and uncertain pace of the industry's evolution toward risk-sharing payment methodologies.

To address this high-class problem of accumulating cash, we made the strategic decision to add a fourth component to our business model; returning excess capital to shareholders, and stated we would explore multiple avenues to achieve this objective. In March, we took the first step by completing a tender offer for a portion of our outstanding shares. This successful tender resulted in the retirement of 9.5% of our then outstanding shares for $234 million using a combination of cash on hand and availability under our revolving credit facility.

Yesterday, we took another step by announcing the initiation of a recurring quarterly cash dividend. We believe a dividend is a prudent way to return excess capital to existing shareholders while offering an incentive for new shareholders to own our stock. Besides providing a cash return on their investments, we also believe the dividend provides investors with a degree of downside support during times of stock price volatility that are influenced by political events in Washington beyond our control, something we've experienced in the past and inevitably will experience again in the future.

I'd like to emphasize that the initiation of this dividend in no way inhibits or limits the growth we are pursuing for our inpatient rehabilitation business. We still expect to add approximately 80 beds per year to our existing hospitals and approximately six new hospitals per year through a combination of de novos and acquisitions. And we can add more if the right opportunities present themselves.

Most importantly, we can fund this growth through our adjusted free cash flow. To understand how we quantify the sufficiency of our adjusted free cash flow let's look at some numbers. Last year's adjusted free cash flow was $268 million and our current trailing four quarter adjusted free cash flow is $311 million. As a reminder adjusted free cash flow is after interest expense, preferred stock dividends, cash taxes and maintenance CapEx. Our maintenance CapEx includes our hospital refresh and major renovation programs, the installation of our clinical information system as well as our normal ongoing maintenance capital requirements.

As we think about investing this adjusted free cash flow, we first assess debt repayment opportunities. Given our low degree of leverage with no maturities until 2018, there are no compelling debt repayment opportunities with the exception of potentially redeeming an additional 10% of our 2018 and 2022 notes. However, as we have stated before, we do have opportunities to purchase leased hospitals, and we view these buyouts as deleveraging events.

Of our 33 leased hospitals, 16 have purchase options and we expect to exercise five of these options in 2013. The remaining 11 purchase options are fairly even distributed between 2014 and 2024, averaging about one per year. And we expect to pay anywhere from $12 million to $18 million per hospital to purchase these facilities.

The second thing we assess is how much CapEx is required to grow our core business through bed additions, de novos and acquisitions. As we have frequently stated, the highest return on our growth capital comes from adding beds at existing hospitals. As we look out over the next several years, we estimate we will add approximately 80 beds per year at a total cost of somewhere between $25 million and $35 million per year.

From a de novo perspective, the CapEx required to buy land, construct, and equip a new 40-bed hospital has been running between $17 million and $22 million per hospital. While we are targeting to add approximately four de novos per year, which using this range would utilize between $68 million and $88 million of our adjusted free cash flow.

And finally, while the purchase price of acquisitions has varied significantly, a reasonable go-forward assumption is that we will spend approximately $30 million per year on acquisitions. If you add up all of these discretionary capital expenditures, it's obvious HealthSouth can both continue to fund the company's core inpatient rehabilitation growth agenda and accommodate a cash dividend with its adjusted free cash flow.

Furthermore, implementing a dividend also should have no meaningful impact on our ability to explore longer-term growth opportunities outside our core business. We anticipate maintaining a low degree of leverage that will continue to shrink as our adjusted EBITDA grows and having significant liquidity through our revolver. Accordingly, we expect to have more than enough balance sheet capacity to pursue any appropriate strategic acquisitions.

Finally, it should be noted that by initiating a dividend, we are not ruling out other shareholder distribution strategies in the future. As I said on our first quarter call within the context of the tender, this was not a one and done transaction. We will continue to evaluate all shareholder distribution alternatives in our ongoing strategic dialogue with our Board.

Let me now briefly discuss our revised guidance. Doug will provide commentary on second half considerations in his comments but from a discharge perspective, we're projecting growth for the second half of between 3% and 4%. This is a combination of continued solid first half results from our same store hospitals supplemented by the continued ramp up of our new hospitals offset by tougher second half comps.

Taking everything into consideration, we feel comfortable raising our adjusted EBITDA guidance to between $520 million and $530 million, and our EPS range to between $2.87 and $2.93 per diluted share.

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

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

Thank you Jay and good morning everyone. As Jay highlighted Q2 was another strong quarter for HealthSouth, particularly in the context of sequestration. Our second quarter financial results include a number of puts and takes related to factors, such as the impact of three newly opened hospitals. These

factors are enumerated in the supplemental slides which accompanied our press release and are available on our website.

I encourage you to reference these slides for further detail of the results I'll discuss this morning. Revenue increased by 5.8% over Q2, 2012 driven by inpatient growth of 6.5%, partially offset by a decline of 3.4% in outpatient and other revenue. Inpatient revenue growth was comprised of a 6.3% increase in discharges and a 0.3% increase in revenue per discharge.

Discharge growth included same store growth of 3.3% and new store growth of 3%. The new store growth included 130 basis points related to the consolidation of St. Vincent in Q3, 2012. Revenue per discharge for the quarter was positively impacted by Medicare and managed care pricing adjustments, higher patient acuity and a higher percentage of Medicare patients.

These benefits were largely offset by sequestration and the opening of three new hospitals which you may recall are subject to Medicare certification requiring each new hospital to treat a minimum of 30 patients prior to being eligible for Medicare reimbursement.

The Q2 revenue impact attributable to sequestration was approximately $9 million. The decrease in outpatient and other revenue for the quarter was primarily attributable to a decline in outpatient visits. We ended the quarter with 22 outpatient satellite clinics open as compared to 26 at the end of Q2, 2012. There was one satellite closure during the quarter. Outpatient and other revenue for Q2, 2013 benefited from the receipt of approximately $1.6 million in state provider tax refunds.

Our bad debt expense for Q2 was 1.2% of revenue, flat to last year. SWB as a percentage of revenue for Q2 increased by 20 basis points to 48.5%, as compared to 48.3% in Q2, 2012. The SWB percentage was negatively impacted by sequestration and the previously discussed opening of the three new hospitals, which were administering services without reimbursement during the Medicare certification process.

Labor productivity remains a key focus, and employees per occupied bed, or EPOB, exclusive of the impact from three new hospitals was flat to Q2, 2012. Our hospital-related expenses for the quarter were 20.9% of revenue, as compared to 21.1% in Q2, 2012.

During Q2, we benefited from continued improvements in supply costs, further leveraging of occupancy costs, as well as a favorable adjustment to our general and professional liability reserves, stemming from our semi-annual actuarial review. These benefits were partially offset by sequestration and the ramp-up of the three new hospitals, as well as increased expenses related to the continuing implementation of our clinical information system.

G&A, which excludes stock-based compensation for Q2, 2013 was 4.1% of revenue flat to Q2, 2012. Adjusted EBITDA for Q2, 2013 was $134.5 million, an increase of 7.5% over Q2, 2012 in spite of sequestration. For the first half of 2013 adjusted EBITDA was $273.8 million, an increase of 8.6% over 2012. The impact of sequestration on adjusted EBITDA, which is net of minority interest, was approximately $8 million for Q2 and $9 million for the first half.

Consistent with our expectations, both interest expense and D&A increased in Q2, 2013 over Q2, 2012. The increase in interest expense stems from the issuance of the 2024 senior notes last September as well as the revolver borrowings related primarily to the tender offer and Walton acquisition. The increased D&A expense results from our continuing investment in capacity additions, hospital refurbishments and the clinical information system.

EPS from continuing operations for Q2 was $1.66 a share as compared to $0.39 a share in Q2, 2012. In addition to the aforementioned increase in adjusted EBITDA EPS for Q2, 2013 included the tax benefit related to our previously disclosed settlement with the IRS, which increased our gross federal NOLs by approximately $265 million and the lower share count owing to the common stock tender completed in Q1.

We continue to convert a high percentage of adjusted EBITDA into adjusted free cash flow. For the quarter, adjusted free cash flow was $72.5 million as compared to $70 million in Q2, 2012. In addition to the

increase in adjusted EBITDA, adjusted free cash flow for Q2, 2013 benefited from lower maintenance CapEx, $16.8 million in Q2, 2013 versus $31 million in Q2, 2012. This benefit was offset by a year-over-year change in the timing of interest payment. You may recall that we discussed this timing change as a benefit during our Q1 earnings call.

Our adjusted free cash flow for the first half of 2013 was $158.2 million, a 37.3% increase over the first half of 2012. The year-over-year increase is primarily attributable to the increase in adjusted EBITDA and lower maintenance CapEx. The lower maintenance CapEx in the first half of 2013 is purely a timing issue and our estimate for the full year remains at $80 million to $90 million. The key assumptions regarding adjusted free cash flow for 2013 may be found on slide 19 of the supplemental slides.

During Q2, we continued to invest in the capacity additions and facility upgrades. Discretionary CapEx for Q2, 2013 was $43.8 and included the completion of the Walton acquisition, investment in de novo projects and continued work on our replacement hospital in Ludlow, Massachusetts.

Discretionary CapEx for the first half of 2013 was $74.1 million. Our balance sheet and liquidity remains strong at the end of Q2. Total debt, was $1.33 billion and our leverage ratio stood at 2.52 times. The total debt included $73 million outstanding under our $600 million revolving credit facility. During the quarter, we completed an amendment to our revolver which served to extend the maturity date to June 2018, and enhance our capacity to make restricted payments.

Prior to the amendment, our ability to make restricted payments was governed primarily by an aggregate dollar basket with an annual grower provision. The amended revolver allows for unlimited restricted payments provided our senior secured leverage ratio remains at or below 1.5 times. To the extent this ratio rises above 1.5 times, restricted payments will be primarily limited by the previously existing basket. And please be reminded that separate provisions governing restricted payments are contained in the indentures governing our senior notes.

The strength and consistency of our cash flow generation, our relatively low financial leverage and the flexibility of our debt obligations allow us to augment the value created via the returns generated on our operating investments with other shareholder friendly actions. Such as the common stock tender executed in Q1, and the initiation of the quarterly cash dividend as authorized by our Board yesterday.

Before I close I'd like to provide some context around our revised guidance. Beginning with volume, please be reminded that we faced challenging comps in the second half with discharge growth having increased 4.2% in Q3, 2012 and 5.4% in Q4, 2012. In Q3 we will also anniversary the consolidation of St. Vincent.

Turning to adjusted EBITDA we faced at least three headwinds in the second half; sequestration with an estimated second half impact of $16 million, the continued rollout of our clinical information system resulting in higher expenses of $2 million and an increase of $3 million in non-controlling interest related to the JV ownerships at Jonesboro and one of our Memphis hospitals. These items, which approximate $21 million, will be partially offset by a return to a normal merit cycle in Q4 in lieu of the special bonus paid at the end of 2012.

At this time I'll ask the operator to open the line for questions.

QUESTION AND ANSWER SECTION

Operator: Your first question comes from Frank Morgan of RBC.

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning.

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

<A>: Good morning Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Hey, congratulations on a great quarter, certainly your operating plan is working very well, good results, certainly – I had really a two-part question. As we consider the longer term prospects for the business, where do you really see the changes coming, either from a business line standpoint? I mean you avoided some areas of post-acute so far, but maybe if you could kind of reflect on it, any reevaluation you've had with looking at new segments for the longer term.

And then secondarily any changes or any preparations you're making longer term from a reimbursement model perspective like for post-acute bundling, and are you seeing any kind of early demonstrations with bundled demos? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: Okay. Let me first say that from the longer term perspective, our view really has not changed. And that view can be summarized as following: first, we don't feel we have to move into any other post-acute segment. We feel that there may be some opportunities and benefits in doing so, if the evolution of the reimbursements particularly from Medicare shifts into some kind of coordinated care, accountable care, bundled type of payment system. Our view is that those changes are occurring very, very slowly.

Irrespective of what's mandated in the Affordable Care Act I think that the some of the recent results from some of the Pioneer ACOs suggests what we have been saying for quite some time, and that is these are not proven methodologies, they're not proven models. It's going to take a while to get those things perfected. And even – even if they are and we're a little skeptical that they will be. But let's say they are, it's going to take a long time for that to be embraced and adopted within the industry.

That would motivate us, that evolution toward some kind of coordinated care or accountable care organization type of payment methodology would incentivize us to at least look beyond inpatient rehabilitation for other services that would be synergistic with our rehab services. And that would allow us to come to the table, if you will, with a broader range of services, a more integrated post-acute system.

Within that context, what makes the most sense for us would be some type of home care services. Because in that model, and we've talked about this in the past, in that model this future state whatever that we want to call it, there would be a need for facility-based post-acute care services and home-based post-acute care services. We believe that in that future state, the differentiations that exist today, which are all payment driven, the only thing that really differentiates long-term acute, skilled nursing and inpatient rehabilitation in terms of what can be provided within the four walls of each of those entities is how we are paid.

And all of the myriad of Medicare regulations that exist to differentiate how we are paid. But if you think about it and then just for a minute take all of those regulations and eliminate them, and just think about what kind of care can be provided inside the four walls of a post-acute entity. We could easily offer all of those services that are offered within a long-term – I mean an LTAC rehab and skilled nursing. So we don't need any more boxes longer-term is what I'm saying.

So where the opportunity would be, would be to look at whether or not offering a broader range of home care services makes sense. But, I will caution every time I say this, and we talk about the longer-term. Our view of the longer-term is that it is years down the road and we have been cautious about home care and we've said this for several years, a) because of the re-basing and I think everyone would agree that the proposal out there is not particularly good for home care providers, and then b), the whole notion that there may be a co-pay assigned to home care, which we've been suggesting may happen for quite some time. So, those two together we think continues to put a lot of risk around getting into home care today.

As far as the reimbursement changes, I think I just touched on that Frank, are we participating in the formation of models that would be available to start testing, bundling and ACOs, yes. Is the industry moving at breakneck speed to embrace these and to test these? Not in our markets. It's a very, very slow evolutionary process. And so, we see that also sort of taking years to really play out. So, I hope that, that's a long-winded answer I'm sorry about going into so much detail, but we just don't feel that there's anything today that just forces us to say, hey, let's get out of our core business. I mean we're doing great, and we see no reason to do that, we see nothing in the environment that is compelling us to change that strategy.

<Q – Frank Morgan – RBC Capital Markets LLC>: So, even if rates are under pressure, there's nothing in your view that stops the volume story that you haven't helped out?

<A – Jay Grinney – HealthSouth Corp.>: No. I mean that's exactly right. I mean that one of the advantages of our business is that we provide care primarily for an aging population. The hardcore reality is the older you get, the more susceptible you are to strokes and a whole wide range of chronic debilitating neurological conditions, most of which, there aren't any cures for. It's just the inevitable process of aging, we've got this huge baby boom cohort that we all think we're invincible, but the reality is we're all getting older.

And this huge cohort is moving in to that 65 plus age group, so we're expecting the Medicare population to be growing at about 3% per year for the long foreseeable future. So, the demand is going to be there. Somebody has got to meet that demand and we're absolutely confident that we're as well positioned as anybody in the industry to be there to provide those services that really those Medicare beneficiaries deserve.

<Q – Frank Morgan – RBC Capital Markets LLC>: Thank you.

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

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Good morning, everyone. You do such a great of being so transparent in explaining so many of the questions that we have, it makes it very difficult to ask you a really good insightful question. That's a good thing.

So, forgive me if what I am going to ask is the little bit more pedantic, but it's been on my mind. The first part of this is this, you obviously are continuing to find markets in which you can expand services, build new facilities, primarily the markets in which you are building the de novos. So there's clearly unmet need that develops and has the population ages, presumably there are even more of those markets. So, if feeds on itself until we've all aged to an appropriate level. I think that's right.

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: But what we're also hearing is that some of your acute care brethren are rather than hearing what we've heard in the past exiting acute rehab inpatient care, are now beginning to enter it. We've heard that for a couple of quarters from HCA, perhaps some of the other for-profits are getting in, perhaps some of the other larger not-for-profits are getting in. Do you see yourself competing in markets today with either an existing HCA or other large system – for-profit system hospital of new capacity? Or are these – are they avoiding you and are you kind of outside of them, what's that dynamic like?

<A – Jay Grinney – HealthSouth Corp.>: There's definitely competition. Most of the acute care providers who are getting into rehabilitative services that are moving in and HCA's a great example, are doing it where they have enough market concentration that they can support rehab services. There aren't a lot of systems out there that have that ability. But sure, we compete as you know and as a reminder even if there is very stiff competition, ultimately the patient, the Medicare beneficiary has the right to choose where they want to go and get their inpatient rehabilitative care.

So, maybe an acute care system will make it, can make it difficult for our liaisons to get into the hospitals and that's a tactic that is used, that's been used for years and years. But they can't prevent us from going in and talking with the physicians and meeting the physicians' needs and the needs of the physicians' patients in their offices and elsewhere.

So, yes, it's a competitive issue, but frankly, Sheryl, that's been there forever. What we are seeing is that a lot of our development pipeline is being populated at an increasing pace of healthcare systems, primarily

the not-for-profit systems who recognize that they cannot offer a high quality level of inpatient services on their own.

And so, what we're seeing is we're seeing large systems, usually local systems, that have a pretty dominant position in their marketplace. Maybe they have like 20, 30, 40 bed unit that's 40% occupied, realizing that they're not doing their patients a service by providing the same level of care. They can increase that and improve upon that, and they're inviting us in to talk about joint venturing their services. So, that's an interesting opportunity. And frankly, we think it creates a longer runway, and we've certainly seen that as our development pipeline starts to build.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Yeah. I would have imagined, and thank you for that, that is very interesting. I would have imagined that you would be seeing more of that, because you've been taking share way from somebody for a while in addition to absorbing the growth in the population. And you've got to take it from some place, presumably it's some of these facilities, because of the quality that you can clearly demonstrate. But that makes a lot of sense and that just opens up the opportunity for you to continue to bring quality care to those markets. That makes – that's good sense. And the HCA part of it, my guess is you're both like two big dogs with a full plate of food. They're going to do what they do in their markets, you're going to do what you do sometimes in their markets and sometimes elsewhere, but they're probably big enough markets where there's room for more than just one 40 bed facility.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I mean the reality is as – and I have as you know because of my tenure at HCA I have tremendous respect for that organization and every single person there and always have. And I'll always have sort of a soft spot in my heart for those guys. And they're fabulous competitors. But they don't have 100% of market share in any market.

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

<A – Jay Grinney – HealthSouth Corp.>: So, there is always, there is always the non-HCA facilities and there's a lot of growth that is available I think for everybody. And I think ultimately those of us who can ensure that the quality of care is superior and better than the competitors and we can offer that on a cost effective basis, we're going to do fine.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: All right, great. Thanks so much.

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

Operator: Your next question comes from Colleen Lang of Lazard Capital Markets.

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

<Q – Colleen Lang – Lazard Capital Markets LLC>: Good morning. Congrats on another solid quarter and thank you for all the commentary on the dividend and cash flow deployment, we really appreciate it. I just had a quick housekeeping question, on the guidance did your prior year outlook assume a Q4 merit increase?

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

<Q – Colleen Lang – Lazard Capital Markets LLC>: Okay, thanks. And then could you just provide us with a general update on the IT initiative and any operational benefits you've seen thus far. How much of a differentiator do you think having a strong IT system has been versus some of your competitors? And are the acute care hospitals and docs in your market attracted to the fact that you have a strong IT system?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Hi, Colleen. This is Mark. It has gone well so far. We have it in 26 hospitals. In August we'll add five for a total of 31. And we do think it's a competitive advantage for us, working both with physicians and having the ability to integrate with referring acute care hospitals. So, it's gone well so far. We would anticipate it to continue to head down that track.

<A – Jay Grinney – HealthSouth Corp.>: And Colleen, I would just say that while we are, we do believe that it does differentiate us, it really is more of a longer term investment. Because if the evolution that we're seeing in the industry continues, it will be, I think critically important to have the integration from a medical records standpoint and to be able to move data across facilities. And clearly we're just not there yet.

I mean the industry is not there yet. But, when it does get there, we are going to be uniquely positioned. Because as Mark said, we got – we're going to have a third of our hospitals on this and by the end of the year. And we just don't know of any other post-acute provider, who is making the same kind of investment.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Great. Thank you.

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

<A – Jay Grinney – HealthSouth Corp.>: Hi. How are you, Rob?

<Q – Rob Mains – Stifel, Nicolaus & Co., Inc.>: Good morning. Two questions, I'll ask them both and then I can get off and not do a follow-on. One is Doug, you mentioned a GPL adjustment in the quarter. I might have missed it in the release, but anything you talked about magnitude of that. And then Jay any comments that you have about proposals to use post-acute as at a least the partial pay-for, for an SGR elimination?

<A – Doug Coltharp – HealthSouth Corp.>: Hey Rob, it's Doug. The GPL adjustment was roughly $2 million and again that's just related to our semi-annual actuarial adjustment.

<Q – Rob Mains – Stifel, Nicolaus & Co., Inc.>: Okay. Thanks.

<A – Jay Grinney – HealthSouth Corp.>: And then with respect to the doc fix I mean I think anytime Washington starts talking about the doc fix, all providers need to be concerned. I think the antenna for all of us should be raised.

In terms of post-acute being sort of a center piece for that. That may be true for the industry, the post-acute industry, but you start breaking it down and you start seeing where has the growth occurred that has been outside of the normal expected growth. And inpatient rehabilitation is not on that list frankly. I mean we – if you look at the percent of Medicare spending on inpatient rehabilitative services as a percent of total Medicare spending. Since I think 2007 or 2008, we have been less than 1.5% and almost consistently at that 1.2%.

So, I don't think we're an outsized target. Are we taking that for granted assuming that nothing has going to come our way? No. We're on the Hill a lot in fact, just recently we were working with the rest of the industry. We were successful in getting Congresswoman Lynn Jenkins from Kansas to author a letter that she just recently sent to Secretary Sebelius that has 82 other original signers on to the letter basically saying going after inpatient rehabilitation facilities, especially on this 75% rule reset is not something that they would want to see happen.

So anytime you get 83 original co-signers on any letter in today's environment, I think signals that at least Congress would be pushing back pretty hard. So, it's something that we're continuing to monitor. We're not taking anything for granted. We're working with industry participants to advocate. And as you know Rob, we're not just up there saying, don't take it away. If you have to come after rehab, don't hit us at all.

What we're basically saying, if in the final analysis there has to be something from every provider segment and okay rehab you got to pony up something. What we've gone to Congress and done is said you know there is an alternative. Going after the 75% rule, resetting it from 60% to 75% does not mean that the Medicare beneficiaries who would otherwise get care in a rehab hospital are sort of miraculously cured. Those patients are still in need of care. If a threshold is set, those patients are going to be forced into a nursing home.

And there is ample evidence that the quality of care and the outcomes are significantly worse in nursing homes for the same kind of patients that we treat than they get in a rehab. So, really if you set the rule at 75% you're really harming the Medicare beneficiaries, you're putting it on their backs.

Our alternative and we've presented a lot of data to Staff and to Members is to say, why don't we look at the outlier payments. In inpatient rehabilitation, $200 million of Medicare spending per year goes to outlier payments. One half of that, $100 million, goes to 10% of the inpatient rehabilitation providers in this country. And many of those get 40%, 50% of their total reimbursement for inpatient rehabilitative services from the outlier pool and have been getting that consistently over the last several years.

So, our position to the Hill and to CMS and the others is time out, why not instead of putting the burden on the backs of the Medicare beneficiaries, why don't you change the outlier formula and the methodology or the dollar amount and put the burden on the providers, force the providers to become more efficient.

And frankly, that alternative is one that gets a lot of very favorable response. Whether or not it gets embraced in the final analysis, I don't know. But we're certainly advocating and I think we're being pretty successful in helping certain members of Congress understand, a) we're not a problem, 1.2% of Medicare total spend and that's been consistent over the last five or six years, we're not a problem. But, b) there are alternatives that don't penalize the beneficiaries and instead puts the onus on the provider community to become more efficient.

<Q – Rob Mains – Stifel, Nicolaus & Co., Inc.>: That's very helpful. Thank you.

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

<Q – John Ransom – Raymond James & Associates, Inc.>: Hey, good morning.

<A – Jay Grinney – HealthSouth Corp.>: Hi John.

<Q – John Ransom – Raymond James & Associates, Inc.>: Lot of good questions have been asked. My question is you've got your one joint venture in Florida. Just looking at the industry data they're kind of small rehab units inside of acute care wings that lose money, that would – a joint venture with you would seem like a pretty straightforward financial decision. So, on paper the opportunity is big I know not-for-profits are bureaucratic and slow to move, but is that something two to three years out recognizing the long sales cycle, could you have five or 10 of these? Or is this going to be kind of a one-off type growth strategy?

<A – Jay Grinney – HealthSouth Corp.>: It's definitely not a one-off. As I've mentioned earlier, if you look at our development pipeline, it is increasing populated with opportunities to do just what you said. And it does go back to what we were talking about a minute ago, a lot of the acute care hospitals out there are struggling. I mean we on this call and in most of the shareholder community we focus on, on those of us who are in the for-profit arena. And particularly in the acute care, you look at the HCAs and the Tenets and Community's, at Universal, HMA, LifePoint, and we look at how are they doing. And I think we sometimes extrapolate that that's what happening in the rest of the industry. Well that's 15%, 17% of the industry.

You look below that and you've got a huge number of not-for-profit hospitals. And while some of them are doing fine, there are a lot that are a lot that are struggling and there are a lot that are underwater. And the reimbursement headwinds that they face, both sequestration on the Medicaid side, and less reimbursement from managed care is putting a lot of pressure on these providers to your point. They're losing money in some of these smaller non-core units.

So, we do see an opportunity because more and more of those hospitals and hospital systems are going out, approaching us, maybe they're approaching others. But we're certainly out there aggressively pursuing opportunities to help them reposition their rehabilitative services to a profitable level, and to offload some of that reimbursement risk. And we'll take that, because we can manage those facilities very efficiently. So, yes, we do see that as an increasingly attractive part of our growth profile.

<Q – John Ransom – Raymond James & Associates, Inc.>: So, is that as profitable for you from an ROI standpoint and a total profitability as doing a standalone?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah, obviously, we wind up with the minority interest component over there.

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

<A – Doug Coltharp – HealthSouth Corp.>: So, the P&L impact can be lessened, but from a return perspective, it's still very attractive.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay. Thank you.

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

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

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

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

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

<Q – A.J. Rice – UBS Securities LLC>: Maybe, I appreciate all the comments about the future, but I just maybe I'll ask you more specifically about this quarter. With the sequestration headwind, that looks like it was about 140 basis point margin headwind, potentially you could have been facing. And yet you still were able to show margin gain. I'm sort of curious, because I mean you obviously have a good history of showing margin improvement, but was there any unusual steps? Is there any unusual costs reduction programs that you've implemented in the face of that? And then also maybe just comment in the context of that about therapist productivity turnover, how that market sits right now?

<A – Jay Grinney – HealthSouth Corp.>: The one thing on the sequestration, we did not put in a merit increase. So that I think helped to mitigate some of the effect of sequestration. But to answer your specific question, did we do anything unique or different or targeted, really the only thing that we did that was targeted to offset the negative headwinds on sequestration was to give employees a bonus last year in lieu of a merit increase on October 1 of last year. Now having said that, we do – we will – we've announced – we are going to resume the merit increase program in October of this year for all line employees.

<A – Doug Coltharp – HealthSouth Corp.>: And then as we mentioned earlier, A.J., we did have a benefit of approximately $2 million related to the general and professional liability accrual adjustment. That wasn't something that we had anticipated.

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

<A – Doug Coltharp – HealthSouth Corp.>: Beyond that I do think that even with the impact of sequestration, we do see good operating leverage against certain components of our expense base, most notably the expenses associated with our corporate office and the occupancy expense. And then the other thing that we would point to that's been an ongoing initiative, is really chipping away at the margin but something that we continue to concentrate on are supply chain initiatives.

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

<A – Mark Tarr – HealthSouth Corp.>: A.J., relative to your question on therapists, we've had very good success in our ability to recruit and retain therapists. Our turnover rate is less than the industry in therapists and it's usually somewhere around that 10% or less basis. But certainly there are certain pockets across the U.S. that maybe more difficult than others to recruit. But overall I'd say we've had very good success in doing so.

<Q – A.J. Rice – UBS Securities LLC>: Okay, great. Thanks a lot.

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

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

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

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

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Hey, just one quick one. I was curious if you had any takeaways from the April proposal or for reimbursement in fiscal 2014 and specifically I was curious about the code list provision. And our sense was that it wouldn't have a meaningful impact on you guys. But just any thoughts on what that might mean for some of the units and some of the other freestanding competition out there.

<A – Jay Grinney – HealthSouth Corp.>: It's hard to really assess how may impact others, because we really don't know what their – what kind of patients they've got and how they've coded them. You're right, we have already stated that we don't really see that as being a significant factor for us. Certainly in those codes where – and frankly, we think CMS is right where there are codes where the term unspecified is in and we can do a little bit better in getting and assessing is it the left extremity or the right extremity.

I mean those things, that's the industry, I think the whole industry would be able to respond to that. I think the more challenging issue is taking away some of those arthritis related and taking that out of presumptive. I just think that for the industry, that may cause some beneficiaries not to be able to get inpatient rehabilitative services. Because some of the other non-HealthSouth providers may be unable to take those patients, because their presumptive levels would drop below 60%. So, it's hard to know what the impact in the industry is. We don't think that that change, however, is good – is a good change. So we are going to be offering our comments to that effect that we don't think that targeting patients with arthritis and the various conditions really is in their best interest.

<A – Doug Coltharp – HealthSouth Corp.>: And I'd say the balance of the proposal is in line with our expectations.

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

<Q – Matthew Gillmor – Robert W. Baird & Co. Equity Capital Markets>: Okay, great. Thanks very much.

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

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

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning. Thanks for taking the question. I think most of the good ones have been asked. You talked about the use of free cash flow. I guess you did the tender in the first quarter. Could you just talk about where share repurchases sort of fall into that priority and how you would expect to go about that?

<A – Jay Grinney – HealthSouth Corp.>: Well, it falls in the priority as we've said in the past, Gary, as a very significant lever that can pull and we'll continue to evaluate that. And I think you really touch on a very good point. And that is that, if you go back a year, we really weren't talking about shareholder distribution alternatives within the context of our business model. We began that in early 2013 and we said listen, this is now an integral part of our go-forward strategy. It's an integral part of our business model and we will be

evaluating all of those levers and will continue to have that dialog with our Board. I think what you can certainly take away is that our Board is very prepared to pull multiple levers.

Did the tender early this year, we now have initiated a regular dividend and we certainly will continue to bring forward, what I think, what we think makes sense from an additional shareholder distribution perspective. So, everything is going to be on the table. And as I said after the first quarter, when we talked about the tender that should not in any way be construed as a one and done. And we're going to look at that and we certainly believe that that makes a lot of sense from our perspective. We think that this, there's a lot of value that's not being recognized in this company. And so, over time, we'll be looking at that, and may take the action as appropriate.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Great. And then as a follow-up, you mentioned the difficult comps on volumes in the second half of the year. Is there anything else going on? Has the competitive landscape changed to any degree or is it, or is that primarily the challenge in the second half?

<A – Jay Grinney – HealthSouth Corp.>: That's really the challenge. The competitive landscape really isn't changing, I mean it's intense, and that's why it's – once we post a quarter's numbers, we're all obviously very pleased, but, man the focus is on the next quarter. And in our company we take nothing for granted. We stay hungry every single day, Saturdays, Sundays, Monday through Friday, we take nothing for granted. And so, just think about it, you have a good discharge month, that means there are lot of beds that have to be filled to get the momentum into the second, into the next quarter. There's nothing really changing in the competitive landscape. We do have tough comps, and so we're just out there every day trying to meet the needs of the patients who need our care.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Thanks a lot.

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

Operator: Your next question comes from Chris Rigg at Susquehanna.

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

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Good morning. Thanks for taking my question. Just wanted to come back quickly on the merit increases in the fourth quarter, will that be roughly one fourth of the bonus payment from last year's fourth quarter? Is that the right way to think about the quarterly impact?

<A – Doug Coltharp – HealthSouth Corp.>: Closer to half.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Half, okay, and that will run rate pretty much at that level every quarter.

<A – Doug Coltharp – HealthSouth Corp.>: That's correct.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Okay. And then I'm pretty sure this has been largely mitigated, but I figured I'd ask it, since most other questions have been asked. Just with regard to the 75% rule, if you were to go phase up to that level what would be, if any, the impact from that change?

<A – Jay Grinney – HealthSouth Corp.>: It's really hard to predict. If you look at our average compliance today, we're at 75% so..

<A – Mark Tarr – HealthSouth Corp.>: Total company right now.

<A – Jay Grinney – HealthSouth Corp.>: So – we – I think we'd be able to move to that level if we had to. I think the problem is going to be more on the other rehab units, the non-HealthSouth rehab units. I think that's really where the biggest impact would be. But we think that we could accommodate a rule change if

we absolutely had to. But our view is that that really hurts beneficiaries and it's not something that should be done.

So we're advocating to as I said a minute ago that there are alternatives to resetting the 75% rule. And ironically – and I think you guys know this on the June 14 Ways and Means Subcommittee hearing both Mark Miller and Jonathan Blum, Jonathan Blum is a Deputy Administrator with CMS and Mark Miller is the Executive Director of MedPAC. Both of them testified in that hearing. And with respect to the 75% rule, they collectively referred to that rule as clunky, as lacking any real science, I mean those are direct quotes, crude.

So, I think members of Congress particularly on the Subcommittee were saying, "Well, wait a minute. If you guys are saying this is a clunky, crude rule that has really no science behind it, why in God's name would we want to double down on that and move the threshold from 60% to 75%. The impact is going to be on the beneficiaries."

And so, is it a possibility? You know everything is a possibility, but we still believe that keeping the threshold at 60% makes the most sense. We and the rest of the industry are advocating that on the Hill. And as I mentioned before, getting 83 co-signers on a letter to Secretary Sebelius in this environment on any topic, we think is a pretty significant indication of where at least the House Members are thinking about this rule.

<A – Doug Coltharp – HealthSouth Corp.>: And Chris, just to be clear, we're not suggesting that the reimplementation of the 75% rule would have no negative impact on HealthSouth. Because although our average compliance is right at about 75%, we do have hospitals particularly some of those in smaller markets that are at a lower level and where the reimplementation of this rule would cost us some volume in order to be compliant. What we are saying is that we believe that this rule would have a less proportionate impact on HealthSouth than it would on the rest of the industry, and most significantly that it would have a negative impact on the beneficiaries, because of their access to the appropriate level of care.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Okay. Thanks so much for the color guys.

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

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

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

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Good morning. Actually this is Joanna Gajuk filling in for Kevin today. Thank you so much for taking the question. I don't want to make this call longer because the key questions that I had were already asked. But just still a very quick one on your assumptions around de novo hospitals. So I've noticed that – I guess the dollar amount was scaled down from $55 million to $75 million to $40 million to $50 million, so is there some something around timing or because you still are saying that you still plan to do the same number of these hospitals. So is there – that you're just scaling down the projects or you just, or is there some sort of timing issue there?

<A – Jay Grinney – HealthSouth Corp.>: It's really timing. I mean the number of projects have not been scaled down at all.

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Okay.

<A – Jay Grinney – HealthSouth Corp.>: And as I mentioned before, we're pretty excited about our development pipeline.

<Q – Joanna Gajuk – Bank of America Merrill Lynch>: Great. Thank you so much. That's all for me.

<A – Jay Grinney – HealthSouth Corp.>: All right. Thank you. Operator do we have any other questions?

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

Mary Ann Arico, Chief Investor Relations Officer

Thank you. As a reminder, we will be filing the updated Investor Reference Book in early August and attending the Robert W. Baird and Morgan Stanley conferences in September. If you have additional questions, I will be available later today at 205-969-6175. Thank you.

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