Operator: Good morning everyone and welcome to the HealthSouth Third Quarter 2012 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. 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, Lynn, and good morning, everyone. Thank you for joining us today for the HealthSouth third quarter 2012 earnings call.

With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer; Mark Tarr, Executive Vice President and Chief Operating Officer; John Whittington, Executive Vice President, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Senior Vice President and Treasurer; and Julie Duck, Vice President of 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 Form 10-Q for the third quarter of 2012, which will be filed later today, and its previously filed Form 10-K for year-end 2011 and other SEC filings. 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 ask 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 the results of another strong quarter. Discharge growth of 4.2% along with solid pricing, produced a 7.9% increase in net operating revenues. Our hospitals continued to provide high-quality care on a disciplined and cost-effective basis, resulting in a 13.3% increase in adjusted EBITDA. Importantly, the company also continued to generate strong cash flows as reflected by the $71.6 million of adjusted free cash flow produced in the quarter compared to $32.3 million in the third quarter of last year. These strong operating results, along with lower interest expense, generated earnings per share of $0.44, including a net $0.05 per share after-tax

benefit from two non-recurring items. This compares to $0.17 per share earned in the third quarter of last year. As a reminder, last year's results included an $0.08 per share after-tax loss on the early extinguishment of debt. Excluding these items, earnings per share grew by 56% quarter-over-quarter.

On the development front, we continued the construction of our new wholly-owned hospital in Ocala, Florida, which we expect to open this December, and two hospitals we expect to open in 2013, our joint venture hospital in Stuart, Florida and our wholly-owned hospital in Littleton, Colorado. While we have purchased the land, completed the design drawing, and finalized the permitting process for our Southwest Phoenix de novo, we are delaying the start of construction on this project until growth trends in that market improve.

Two certificates of need for de novos in Williamson County, Tennessee and Middletown, Delaware, remained tied up in appellate litigation. We now expect final CON approvals for these hospitals in 2013 and openings in 2014.

On the acquisition front, we signed a letter of intent to acquire Walton Rehabilitation Hospital, a 58-bed freestanding rehabilitation hospital located in Augusta, Georgia and announced the signing of this LOI on Wednesday. We expect to close on this transaction early next year.

Lastly in September, we broke ground on a 53-bed replacement hospital in Ludlow, Massachusetts. This hospital is currently in a leased facility that is over 100 years old and as you can imagine, quite antiquated in terms of layout and design including wards with multiple patients and shared bathrooms. The lease expires in December 2013 which gives us the opportunity to build a replacement facility. The replacement hospital will be owned by HealthSouth and will be designed with our standard efficiencies and amenities including all private rooms.

These solid results underscore the strength and consistency of our business model and have contributed to very strong year-to-date performance. Through the first three quarters, discharges have grown 4.4%, net operating revenues have grown 6.6%, adjusted EBITDA has grown 9.9% and adjusted free cash flow has grown 29.6% compared to the first three quarters of last year.

We believe the disciplined execution of our business plan, protecting our balance sheet, expanding our IRF footprint through bed expansions, de novos and acquisition and investing in our operational infrastructure through enhancements to our management reporting capabilities, rolling out supply chain initiatives, installing an electronic medical record system and successfully implementing various team work initiatives, all have allowed us to produce these consistently strong results. We also believe they serve as the foundation for continued success going forward.

With that, I'll turn the agenda over to Doug for a more thorough review of the quarter.

Doug Coltharp, Executive Vice President and Chief Financial Officer

Thank you, Jay and good morning, everyone. As Jay mentioned, Q3 represented another strong quarter for our company. During Q3, we amended the partnership agreement governing our 50/50 joint venture with St. Vincent Rehabilitation Hospital. St. Vincent has been one of the three JV hospitals operated by HealthSouth that is accounted for under the equity method rather than being consolidated into HealthSouth's financial statements. The amendment revised certain participatory rights related to the governance of the St. Vincent JV entity, resulting in HealthSouth gaining control from an accounting perspective. And accordingly, the results of St. Vincent Rehabilitation Hospital are now consolidated into HealthSouth's financial statements beginning with Q3 in 2012.

This is purely an accounting determination. Our ownership interest in St. Vincent has not changed, and no cash outlay was involved. The impact of the St. Vincent consolidation on our Q3 financial and operating metrics is detailed on slide 32 and 37 of the supplemental slides filed with our press release.

Now, let's move in to the Q3 results. For Q3 2012, revenue grew by 7.9%, driven by an 8.7% increase in inpatient revenue, offset by a 2.1% decline in outpatient and other revenue. The growth in inpatient revenue resulted from a 4.2% rise in discharge volume, 1.7% attributable to same-store and a 4.4% increase in revenue per discharge. The St. Vincent consolidation contributed 130 basis points to our Q3 discharge growth, and it was treated as a new store. Our Q3 discharge volume was unfavorably impacted and conversely, our Q3 revenue per discharge was favorable impacted by the timing of patient discharges from the last week of September into the first week of October.

We experienced a modest increase in the length of stay of our September patient population which we have seen normalize in October. Because we accrue revenue on a per diem basis, much of the revenue associated with the carryover patients was recognized in Q3, even though the discharges occurred in Q4. It's difficult to be precise in quantifying the impact of this modest increase in length of stay; with that caveat, we estimate that it adversely impacted Q3 discharge volume growth and positively impacted Q3 revenue per discharge by approximately 100 basis points each.

In addition to the length of stay increase, the factors contributing to the increase in net revenue per discharge were similar to those cited for the first half of the year and included improved pricing from Medicare and managed care payers, an increase in the average acuity of our patients, stroke and neurological comprised 37.3% of our patients in Q3 212 as compared to 33.9% in Q3 2011, and a higher percentage of Medicare revenue.

The decline in outpatient and other revenue was primarily attributable to the operation of two fewer satellite clinics. At the end of Q3 2012, we operated 26 satellite clinics as compared to 28 at the end of Q3 2011. There were no closures during the quarter. As anticipated, bad debt expense increased to 1.3% of net operating revenues in Q3 2012 as compared to 1% in Q3 2011. Factors leading to the increase were the same as those we have discussed throughout the year, an increase in medical necessity reviews and a lengthening of the Medicare denials adjudication process.

During Q3, we continued to exhibit improved operating leverage and labor productivity. SWB for the quarter was 48.8% of net operating revenue, a decrease of 40 basis points from Q3 2011 as enhanced productivity evidenced by decline in EPOB to 3.46% from 3.53% a year earlier, more than offset our continued investment in a higher skills mix including additional CRRNs and support personnel, and outgrowth of our TeamWorks care management initiative.

Our hospital-related expenses which includes other operating, supplies, and occupancy improved by 90 basis points in Q3 2012 versus Q3 2011. This was primarily attributable to supply chain efficiencies, notably drug cost and lower occupancy expense which more than offset the increased expenses associated with the rollout of our new clinical information system. Our G&A expense, which includes stock compensation expense as a percentage of net operating revenues remained flat year-over-year at 4.3%.

The combination of strong revenue growth and improved operating leverage generated adjusted EBITDA of $125.2 million for Q3 2012, an increase of 13.3% over Q3 2011. For the first nine months of 2012, adjusted EBITDA was $377.3 million, an increase of 9.9% from the same period last year.

The St. Vincent consolidation contributed approximately $500,000 to 2012 Q3 and nine months adjusted EBITDA. As we look to Q4, please be reminded that as previously disclosed and reflected in our guidance, we anticipate the higher run rate of bad debt expense, workers' compensation cost and expenses related to the rollout of our clinical information system to continue.

Also contributing to year-over-year increase in Q4 expenses is our recent decision to replace the 2012 merit increases which normally would have taken effect on October 1 with a one-time, merit-based year-end bonus to be paid in December of this year to all eligible non-management employees. As a result, we expect SWB to increase by approximately $11 million in Q4. This is reflected in our revised guidance. Our previous guidance had assumed a merit increase of 2.25% effective October 1, 2012 which would have increased Q4 2012 SWB by approximately $5.5 million. Additionally, please recall that Q4 2011 benefited from a $2.4 million non-recurring franchise tax recovery.

Interest expense for Q3 was $23.5 million. This compares favorably to the $26.3 million incurred in Q3 2011 and represents a modest increase from the $23 million experienced in Q2 2012. The increase over Q2 2012 is attributable to our September issuance of $275 million of 5.75% senior notes due 2024. Approximately $195 million of the proceeds from this offering were used to pay down the outstanding principal balance under our revolving credit facility. An additional approximately $65 million of the offering proceeds were used to fund an optional redemption of a portion of each of our 7.25% senior notes due 2018 and 7.75% senior notes due 2022. These redemptions were completed earlier this month. We now expect Q4 interest expense to approximate $25 million.

EPS from continuing operations for Q3 2012 was $0.44 a share as compared to $0.17 a share in Q3 2011. Our Q3 EPS was reflective of strong operating results and also benefited from two items with an aggregate after-tax impact of $0.05 per share, a $4.9 million gain on the St. Vincent consolidation and a $3.5 million gain on a recovery from Richard Scrushy.

Our Q3 2011 diluted EPS included an $0.08Our Q3 2011 diluted EPS included an $0.08 per share after-tax loss on the early extinguishment of debt, related to the retirement of our 10.75% senior notes. The effective tax rate for Q3 2012 was approximately 37%, compared to approximately 45% for Q3 2011.

Q4 2012 will include a $2.7 million loss on the early extinguishment of debt related to the aforementioned partial redemption of the 2018 and 2022 senior notes. Adjusted free cash flow for Q3 of 2012, were $71.6 million versus $32.3 million in Q3 2011. The primary components of the year-over-year increase were higher adjusted EBITDA, favorable working capital flows and lower interest expense.

Working capital in Q3 2012 was favorably impacted by the shift of a $12 million interest payment from Q3 in 2011 into Q4 in 2012. This will negatively impact Q4 of 2012 adjusted free cash flow. These items were partially offset by the increase in maintenance CapEx. Adjusted free cash flow for the first nine months of 2012 was $186.8 million, as compared to $144.1 million in the comparable period of 2011. Again the increase was largely attributable to higher adjusted EBITDA, favorable working capital flows and lower interest expense. The 2011 period included a swap settlement payment of $10.9 million. Improvement in these items was also partially offset by the increase in maintenance CapEx. For the first nine months of 2012, our maintenance CapEx totaled $68 million as compared to $35.1 million for the first nine months of 2011. The increase is reflective of our planned investments in hospital refresh projects and a bed replacement program, as well as the installation of our clinical information system. We continue to expect maintenance CapEx for the full year 2012 in a range of $75 million to $85 million.

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

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Doug. Before I discuss guidance, our General Counsel, John Whittington will provide an update on the E&Y arbitration.

John Whittington, Executive Vice President, General Counsel and Corporate Secretary

Thank you, Jay. The rules of the American Arbitration Association require that all aspects of the arbitration remain confidential. So as you know, we are limited in what we can disclose to you. We can tell you that since the beginning of the arbitration in July of 2010, there have been approximately 105 days of hearings generally in four day blocks of time.

We can also provide you with this brief update. Number one, HealthSouth requested a temporary stay of the arbitration proceedings shortly after we learned on August 17, 2012 that the Alabama Supreme Court would hear on appeal a case where HealthSouth has previously prevailed on an income tax refund claim at every administrative and judicial level including the Alabama Court of Civil Appeals.

And number two, on October 12, 2012, the AAA panel entered an order temporarily staying the arbitration proceeding. We cannot predict how long the stay will remain in effect. Although this income tax case before the Supreme Court is not related to the E&Y matter, it does raise one very important legal issue which is present in the arbitration.

Specifically, whether under Alabama law, the wrongdoing of disloyal employee can or should be attributed or imputed to the employer. In particular, the State Revenue Department of Alabama argues that the Supreme Court should consider the circumstances under which a taxpayer's valid statutory refund claim may be defeated based on the misconduct of its former employees. And in turn, the circumstances under which the wrongful conduct of such disloyal employees may be attributed to or imputed to the corporation. As I've said, we think this is an important legal issue in the arbitration proceeding.

Pending the stay, no additional hearing dates are presently scheduled and at this time, we are uncertain when the arbitration proceedings might resume. We do know, however, that the Alabama Supreme Court has set oral arguments on this case for November 7, 2012. We would expect a fairly prompt ruling from the Supreme Court after that oral argument. Meanwhile, we remain confident in our claims and we are committed to aggressively and diligently pursuing them.

And with that, I'll turn it back to Jay.

Jay Grinney, President and Chief Executive Officer

Thank you, John. As Doug mentioned in his remarks and as we have stated in our press release, the company's fourth quarter results will be negatively impacted by the decision to replace 2012 merit increases with a special merit-based year-end bonus for all non-management eligible employees. Management salaries also will be frozen and management will not be eligible for this special year-end bonus.

At the same time that we announced this special bonus, we announced that the company would absorb the full cost of medical plan benefit increases for employees in 2013 so as to minimize any negative effect on their take-home pay. We believe this action will partially offset the effects of sequestration in 2013 and more importantly, it rewards our employees for their contributions to the company's success this year. The response from our hospitals has been positive. We have had open communication throughout the year about how healthcare in general and HealthSouth in particular would be negatively affected by sequestration.

The feedback we've received indicates our employees understand the rationale for the action we've taken and appreciate that while their base salaries are not increasing, their efforts are being recognized with the special bonus and their take-home pay is not being reduced through health benefit increases.

As Doug mentioned, the one-time cost of this special bonus is approximately $11 million and will be included in salaries and benefits in the fourth quarter of 2012. Our previous full-year adjusted EBITDA and EPS guidance assumed a 2.25% merit increase effective October 1. So the net effect of this bonus, vis-à-vis our guidance, is approximately $5.5 million.

Even after absorbing the cost of this special bonus, we are able to narrow our full-year adjusted EBITDA range and raise our EPS guidance range as follows: 2012 adjusted EBITDA is now expected to be in the range of $490 million to $495 million, while 2012 earnings per share is now expected to be in the range of $1.49 to $1.53 per share. Some of the key considerations for this updated guidance can be found on pages 15 and 16 of the supplemental slides that we provided with the press release.

With that, Lynn will open the lines for questions.

QUESTION AND ANSWER SECTION

Operator: Thank you. Your first quarter comes from the line of Colleen Lang with Lazard Capital Markets.

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

Operator: Colleen, your line is open.

<Jay Grinney – HealthSouth Corp.>:
Let's move to the next question and then we can fit Colleen in when she gets back on.

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

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Everyone, good morning, couple of questions, as you look at the business, clearly you're making preparations for what could be a challenging year from a reimbursement perspective in 2013. And I have to say that if I were a HealthSouth employee I would feel quite a sense of loyalty to management for having taken the steps you've taken to communicate the thanks, the appreciation and the care that you have. And in addition, the other details are welcome in terms of management pay freezes and the like. Could you outline at this point what other steps you'd think, and I would imagine it'd be in broad terms at this point, you would take, if necessary, if the 2% sequestration cut ends as being the best case scenario for next year?

<A – Jay Grinney – HealthSouth Corp.>: You know, it's really a broad range of different initiatives. Obviously we have spent a lot of time on our non-labor costs; we've invested quite a bit into our supply chain initiatives. And we believe that we'll continue to see improvement there. I think that the – and then of course, on the labor side, we're always looking for efficiencies as we bring on new volume and we will be looking to continue to take market share in 2013. We believe that those additional patients can be served on a high quality basis and without having to add a dollar of cost for each dollar – additional dollar of revenue. From a global perspective, looking at it from a company standpoint, if we were to find ourselves in a situation where the reimbursement environment was worse than sequestration, we have the ability to turn off some of the capital spend, so as to preserve the integrity of our balance sheet moving forward. Now, we don't envision that having to occur, but we're certainly prepared to do that. And as we've stated over the last probably 18 months, one of the beauties of our growth strategy as it relates to de novos and frankly even acquisitions is the ability to turn that switch on and off pretty quickly without incurring additional capital outlays that would obligate us for an extended period of time.

So, that's kind of how we're looking at the business and, again, believe that the underlying demand for inpatient rehabilitation is such that we will be able to continue to treat more patients, not only just through the organic growth but also through taking market share.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: You're of the few companies actually that I deal with that has got the contingency plans in place, so I applaud you for that. And then speaking of the volumes, you clearly continue to excel in that regard. And I almost hesitate to ask this because last quarter when I did this the stock went down. But I'll give you another shot at it, Jay. So clearly, LifePoint is a disaster this morning. Other companies have reported at best, we'll call them weak, if not awful volumes. Are you seeing – but there's clearly a change in the mix of patients that's being seen and it seems like it's shifting more towards Medicare. Why are you seeing slow down from the upstream providers? And if you could speak to it as qualitatively or by patient type because I have a sneaking suspicion that while there may be fewer heads in the beds, more of those heads may be a kin to what you treat i.e. stroke et cetera given the diabetes and the blood pressure issues, et cetera in the country, than the surgeries that are the meat and potatoes of the hospital sector and I'm wondering if you're beginning to observe that?

<A – Jay Grinney – HealthSouth Corp.>: We have seen that and I think it really is a reflection of some of that discretionary business that you see in acute care hospitals is probably where they see a lot of that slowdown. As I mentioned a minute ago, the fact that the over 65 cohort is continuing to grow and inevitably, the older we get even those of us who don't want to acknowledge this, the more susceptible we are to the kinds of conditions that we ultimately treat in our hospitals.

So, what we are seeing is a pretty steady demand – increase in the demand for our services. If there's anything that we might see upstream it might be a little bit in the orthopedic but as you know, that is a very small part of our business. They're – those cases are not compliant cases for the most part and so, really, we're not seeing that much of an impact on our volumes.

And I think it's worth reminding those who may be fairly new to the story that it's really impossible to do a one-to-one correlation between what's happening in the acute care world and what's happening in our world because a very small number of patients being discharged from acute care hospitals need in-patient rehabilitative care and most of those are Medicare patients. So, it's somewhere in that 3%, maybe 4%, 5%. So as you think about the acute care denominator, that could go down a lot and still not really affect the kinds of patients that need rehabilitative care and that we're able to treat in our hospitals.

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

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

<Q – Gary Lieberman – Wells Fargo >: Thanks, good morning. Maybe just going back to the comments that John made around the Alabama Supreme Court, just to make it really easy for us to understand. So, is it – am I understanding it correctly that if the Supreme Court reverses the prior decisions then that would be negative for you guys and if they uphold it and that would be – that would essentially be positive?

<A – John Whittington – HealthSouth Corp.>:
That's correct. I think you've got it exactly right.

<Q – Gary Lieberman – Wells Fargo >: Okay, good. And then, earlier this week, or I guess last week, there was a settlement announced between a couple of provider groups and CMS that would allow therapy to be provided to patients even if there wasn't the likeliness that their function would improve. Do you guys see any potential benefit to you off on that?

<A – Jay Grinney – HealthSouth Corp.>: You know, Gary, I – we do think that there's a benefit. I think it's sort of hard to quantify exactly how that will directly impact us. We do believe that there will be a very direct benefit with respect to the adjudication of the denied claims. As you know, we've talked about this fairly consistently, there is only one fiscal intermediary or MAC, that's the one here in Birmingham, it's Cahaba; and we're for the next short period of time until the MAC conversion is completed, at which time only our hospitals in Alabama, Tennessee, and Georgia will be under the MAC, and currently we have like 70 hospitals. So at some point, we'll be out from under this sort of arbitrary fiscal intermediary, but we do believe that it bolsters, frankly, a lot of our claims that these patients that we treated whose physicians have said they need the care, will benefit from the care, and deserve that care will be able to look to this ruling, we believe, as further evidence and substantiation that those patients should've been in our hospitals.

So, we do hope that there will be that benefit; whether or not it will result in new patients coming in, I think that's a lot harder to really pin down. But I do think net-net, this is a favorable ruling for patients who need and deserve in-patient rehabilitative care.

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

<Jay Grinney – HealthSouth Corp.>: Hello, Ann.

<Q –Ann Hynes – Mizuho Securities USA, Inc.>: Hi. So I actually want to ask you about the presidential election, Jay. I guess from a business perspective, which outcome do you view as best for HealthSouth?

<A – Jay Grinney – HealthSouth Corp.>: Oh, Ann. I don't think we heard that question. That's a tough one. I think that frankly the – who's in the White House while that's very, very important. I believe that more important is what's the composition of Congress. I mean, there's no doubt that we're at gridlock, there are huge problems that need to be addressed, they need to be addressed in a comprehensive manner.

And so, I don't know that there's anyone that really is going to benefit us in terms of the White House, one way or the other. I would say that from an overall business perspective, having Romney win would be better because frankly, the biggest challenge we face right now is just this huge amount of uncertainty because of the gridlock. And that uncertainty that we feel in our little company is felt throughout healthcare, it's felt throughout the entire community, business community. And there are all kinds of reports about capital decisions being deferred, growth decisions being deferred because of the enormous uncertainty coming out of Washington coupled with all of these regulations that keep pouring out of the administration.

So, I would say from that perspective, it would clearly be better to have Romney win versus the President staying in.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: All right. Okay and my second question has to do with the Supreme Court case. If it goes against you, would you be at risk of having to repay some of the tax income that you received in the past?

<A – John Whittington – HealthSouth Corp.>: No. Actually, no. First of all, let me say the amount of the tax refund is a relatively small amount.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: Okay.

<A – John Whittington – HealthSouth Corp.>: I think it's under $500,000. But no, we would not have to pay it back. We're trying to get a refund. We paid it, and now we're trying to get it back.

<A – Jay Grinney – HealthSouth Corp.>: Yes, so it only relates to income taxes here in Alabama. And frankly we've been successful elsewhere in getting those refunds. It's ironic that our own state is fighting this, but the state is in pretty dire straits from a financial standpoint. So we suspect that they're – they feel obligated to try to defend this. And we'll know once the Supreme Court hears the case here in November.

Operator: Your next question comes from the line Colleen Lang with Lazard Capital Markets.

<Jay Grinney – HealthSouth Corp.>: Hi, Colleen.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Hi, good morning. Can you hear me this time?

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

<Q – Colleen Lang - Lazard>: Okay, great. Sorry if I missed it, just had a question on the cash flow. Just given how strong the free cash flow generation has been year-to-date as well as the solid position of the balance sheet, can you just talk about your expectations for use of cash particularly either you're doing – using it for buybacks or potentially a dividend?

<A – Doug Coltharp – HealthSouth Corp.>: Yes, sure. It starts with the fact that we will have – we already have had in Q4, $65 million outflow related to the call on the 2018 and 2022 notes. We also announced this week the acquisition of the Walton Rehabilitation Hospital in Augusta, Georgia, that will be a cash outlay. And we also discussed in our call today the fact that we're building a replacement hospital in Ludlow, Massachusetts, and that obviously is an additive use of cash as well.

With regards to buybacks, you saw through the first half year that we made some repurchases of our convertible preferred stock. We did not make any purchases in the third quarter, but there's a remaining authorization outstanding under that and we have an outstanding authorization that has not yet been utilized for common stock repurchases.

With regard to a dividend, I think it's safe to say that at this point, we have no immediate plans to initiate a dividend, either ongoing or one time. That's something that we continue to evaluate as cash accumulates. But frankly, as we continue to face a period of uncertainty, we think it's prudent to have a little bit extra liquidity on the balance sheet.

<A – Jay Grinney – HealthSouth Corp.>: And then the opportunity to buyout some of the leases.

<A – Doug Coltharp – HealthSouth Corp.>: Yes. And we've talked before. And really, Ludlow is an example of this, about the ability to move from a leased real estate portfolio to more of an owned real estate portfolio. You saw us through the course of 2011 take that action on a couple of properties. That's not only an effective deleveraging, but it also reduces the ongoing operating cost for the company and gives us much better control over the real estate moving forward, as well as putting us in a position to control things like the bed license and the certificate of need.

We've got a number of properties where we believe we may have the opportunity to move from leased to owned in 2013 and 2014. And where those opportunities arise, we'll make a potential determination as to whether or not that's a compelling use of the cash.

<Q – Colleen Lang - Lazard>: Thanks so much.

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

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

<Q – Whit May – Robert W. Baird>: Good morning. Jay, I wanted to go back and follow up on your comments about Cahaba since there has been some discussion in the past few months about some potential coverage determination changes and I think it was mostly proposed for lower extremity joints, and is there just any material change that you've seen or I guess, said another way, anything that you're paying attention to that we need to be paying attention to?

<A – Jay Grinney – HealthSouth Corp.>: Nothing that we haven't been paying attention to all along. We do believe that there are some unique circumstances there at Cahaba. We are planning to share our concerns with them because we don't see this kind of behavior from other medical directors of other fiscal intermediaries. And our take on this proposed coverage determination was that it was a huge, huge overreach. And frankly, it was sort of the – we think a big power grab that fortunately the rest of the industry agreed with us and there was so much commentary I think that they had to step back and rethink it.

But there's one guy over there and he's had a burr under his saddle for a long time against this company and we're going to be approaching that and trying to address that. We're very concerned and it's one individual so, I think we'll able to address it. Whether or not it changes the behavior, I don't know.

The good news is, right now, we're sort of – we're a little bit at Cahaba's mercy and we made the decision. When the MAC configuration was announced, we had the opportunity to either put all of our hospitals under Cahaba or go to a more regional orientation where the hospitals would be under the MAC that had the – that won the contract for that region. And we made the decision to go the regional route. So at some point when the MAC transition is completed nationwide, we will be able to pull all but a handful of our hospitals out from Cahaba and that will certainly be a big relief that we'll be dealing with other fiscal intermediaries that don't have quite the same kind of internal problems that Cahaba does.

<Q – Whit May – Robert W. Baird>: Yes. I guess just to be clear, your understanding is that they have rescinded this... Okay. Okay.

<A – Jay Grinney – HealthSouth Corp.>: Oh, yes. Absolutely. They definitely have. Now, whether or not it's over, who knows. I mean, this guy is very hard to predict, but you can be very, very confident that this is something that is on my radar. I've gotten to the point where I sort of got to the tipping point and said enough is enough. And we are going to be talking with the leadership over there. If need be, we'll talk to leadership in Baltimore. But this is a situation that we think is really out of control.

<Q – Whit May – Robert W. Baird>: Got it. Okay. That's helpful. And my second question just relates to your Cerner clinical IT initiative right now. I just was hoping maybe you could remind us where you are in that conversion – and I can't remember if you were planning to deploy CPOE this year or if it's next year.

But I guess just in general, I was wondering how satisfied you are with that conversion and any signs of benefits that you can see from that investment at this point?

<A – Mark Tarr – HealthSouth Corp.>: Hi, Whit. This is Mark. The conversion or the transition has gone quite well. By the end of this year, we'll have total of 13 hospitals converted over to the Cerner platform. Next year we'll add another 20 to 23 hospitals, so we're very pleased with the way it's going so far. I think it's definitely too early to identify benefits as you had mentioned there earlier but for sure, there are going to be quality-oriented benefits, just if nothing else, better communication, coordination among the treatment teams. So we're pretty pleased with how it's gone so far.

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

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

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Good morning, everybody, I had a question and then I just want to follow up on the wage merit increase as well. But my question is just – as it relates to Medicare Advantage, I know it's only about 7% or 8% of your revenue, but I guess I wanted to hear from you how the pricing model and just the pricing agenda is going with MA plans. We've seen from some other post-acute providers really in the home health space, sort of a devaluing of their services. So I'd be curious to see your thoughts on how you think MA plans are thinking about your services. Is there anything to note there and what you're overall pricing outlook is, in both MA and on the managed care side?

<A – Jay Grinney – HealthSouth Corp.>: Yes. I'll try to address that and then we'll ask Mark for some commentary as well. I think that overall, the vast majority of the Medicare Advantage plans recognize the value of in-patient rehabilitative care. Now, there will be from, time to time, differences of opinion between the plan and the admitting physician about whether or not the patient should be in our hospital; typically those end up being some of the orthopedic cases with comorbidities. But for the most part, we feel that the plans understand that we can bring value to them by getting the patient into our hospitals, rehabilitated, back to the homes and not cycle back into an acute care setting. So we are – we have, over the last several years, worked pretty hard at educating and providing the data to the medical directors of the Medicare Advantage plans to help them get to that point.

With respect to the pricing, I'll make a general comment then I'll turn it over to Mark for more specifics. But the one trend that we are seeing that we think is favorable is the movement away from per diem pricing to case rate pricing. And often times, those case rates are very close to, if not, equal to the CMGs that we get from traditional Medicare. So, those two things working in concert I think really is sort of a good sign as we think about the next 5, 10 years if Medicare Advantage really starts taking off.

<A – Mark Tarr – HealthSouth Corp.>: Darren, I feel good about the work in progress that our managed care team made over the past several years. We probably have catch up to do if you look back where we were several years ago in terms of working through the contracts and building relationships with the payers. As you can imagine, we're a pretty small portion of what the payers have to consider out there but as Jay has said, we have worked to design our contracts to more of a CMG type of per discharge basis instead of a per day. And we've had some luck doing it. We're out there every day talking about our value proposition where the quality and our outcomes come into play. So, I would say overall, it's been very positive.

<A – Jay Grinney – HealthSouth Corp.>: And the only other thing I would say about that, Darren, is as we move into an environment where quality and outcomes matter, and it is not just a matter of a per day price which really is reflective of the past. Everybody was focused exclusively on one part of the value proposition and that was how much does it cost per day. And there's no question on that basis, nursing homes are always going to be able to provide – win that debate because they don't have the resources. They don't have the kind of nursing capabilities. They don't have the therapy capabilities. They don't have the investment and technology. They're not licensed as a hospital.

So, you go forward and all of a sudden, now we're starting to see Medicare, we're starting to see the commercial plans acknowledge that there's a big difference between providers. And there's a big difference in outcomes and quality and the value proposition is becoming more comprehensive and we think that that

really plays to our strength. And if you then couple that with the investments that we're making in our infrastructure, specifically in our electronic medical record system and the ability to integrate our patient data with those of other providers and it's an investment that to our knowledge none of the other post-acute providers are doing. They maybe waiting for some government largess to help them get there. We say we're going to do it because we think it positions us very, very well for the future and where this whole industry is going.

So, I think that all of that really sort of speaks to the fact that as the industry moves, in any direction, be it more Medicare Advantage, more traditional Medicare, it's going to be defined by a larger value proposition than what we've seen in the past. And we think we're uniquely positioned to do very, very well in that kind of environment.

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Yes. And just, Mark, if I could, just to understand, what portion of your overall book of business at this point is on case rates, just give us a sense for that. And then my other follow-up question that I had was just in thinking about the fourth quarter action with regard to the one-time merit, is it right to think about that as essentially offsetting for next year by doing what you're doing in the fourth quarter? Around two-thirds of sequestration, is that sort of the rough math?

<A – Jay Grinney – HealthSouth Corp.>: Well, first of all Darren, I think that what we'll do is when we present our 2013 guidance, I think we'll be able to provide some of the color commentary because there's a lot of moving parts. Obviously, we took this action as a way to help prepare the company for sequestration with the goal obviously of looking to continue to grow and that's clearly our objective going into next year. We want to grow EBITDA, we expect that we're going to be able to do that. We're putting the budgets together. They're not finalized but taking the action this year was really a way of saying we have one extremely important resource in this company and that's our employees. Without our employees, we are nothing. They provide the care. They're the ones that have the hands-on, direct contact.

We did not believe that it was in the best interest of the company to increase our cost basis on a permanent basis going forward knowing that: A, we've got sequestration; and B, the risk of additional cuts down the road.

On the other hand, we wanted to reward our employees for their contributions when we had the resources to do so. So, we paid or we're going to be paying this one-time bonus to non-management, really in recognition of what their contributions have been.

It will be a part of the mitigation but to quantify is, is it going to be a third, or two-thirds, or a half or a quarter? I mean at this point, I think that that's very premature. I think what you can take confidence in, though, is that, this along with other measures that we're taking are all designed to create a foundation upon which we can grow EBITDA into 2013 and we'll provide that commentary when we report fourth quarter results in February.

<A – Mark Tarr – HealthSouth Corp.>: Darren, on these case rates, I would say that I don't have a specific number for you but for the last year and a half, all the contracts that we have negotiated from the MA side has been more focused towards the CMG or case rate and it's to the point now where the majority of that is coming from a case rate basis.

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

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

<Q – A. J. Rice – UBS Securities>: Morning. Just two quick things here. Can you just comment – we had two quarters where the discharge on a same-store basis has been about 1.9%, 1.7%. You're given guidance for the fourth quarter of 2.5% and 3.5% on a consolidated basis. I guess, A on that is the 1.3% of St. Vincent's consolidation, is that in that 2.5% to a 3.5% in the fourth quarter? And is sort of that 1.7%, 1.9% type of rate sort of the same store discharge growth numbers that you're expecting now sort of settle into?

<A – Jay Grinney – HealthSouth Corp.>: Well, yes the St. Vincent's is included in that. And if you do the math, that implies that there's some conservativism in our volume forecast going into the fourth quarter. But as we've said, every year when we approach the fourth quarter, it is the most difficult quarter to predict from a volume standpoint because of the holiday period from Thanksgiving through the end of the year. It just – it's very, very difficult to predict.

But as you can infer from Doug's comments, the fact that we had discharges spilling into October, certainly suggests that we're off to a very strong start in the quarter. It's just we want to be conservative, we want to be respectful of the fact that there is a lot of unpredictability in knowing precisely what kind of volume we're going to see in the holiday period. Having said that, I think people can look back over the last five years and can see we do well. We just don't want to get ahead of ourselves and – so we're kind of sticking with that 2.5% to 3.5%.

<Q – A. J. Rice – UBS Securities>: Sure, I understand.

<A – Doug Coltharp – HealthSouth Corp.>: A.J. I think it's important to note as well that the discharges that we realized in the beginning part of October, which were from the carryover patients from September and October, certainly our attitude towards Q4 discharge volume growth.

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

<A – Doug Coltharp – HealthSouth Corp.>: Firstly, because much of the revenue associated with those discharges was included in the third quarter, it will weigh somewhat against the net revenue per discharge in Q4.

<Q – A. J. Rice – UBS Securities>: Right. Just another data point, you referenced obviously the length of stay in September being unusual. Obviously for the quarter, you were only variants of about 2/10 of one, or 0.2%, I guess. Was – can you give us a flavor for how big this length you dealt with in September and then did you drill down, and was there anything unusual happening or was that strictly just a one-month anomaly?

<A – Mark Tarr – HealthSouth Corp.>: I'd tell you, it's related almost totally to the fact that the quarter ended on a weekend.

<A – Jay Grinney – HealthSouth Corp.>: Yes, Mark, explain – just to give you a little commentary on that.

<A – Mark Tarr – HealthSouth Corp.>: Yes, A.J. It's far from exact science, our forecasting of our discharges. Each one of our hospitals have discharge calendars so that project out over the course of a patient stay when they would expect that discharge to take place. There's a lot of factors going into it, the level of progress that a patient is making in their care, the discharge plans for the discharge home, the families have a say in that, the – of course, the attending physician.

In this case, the months ended, the last three days of the month were Friday, Saturday, and Sunday. Friday is usually a large discharge date for us. Saturday and Sunday are light. It was a little bit lighter – those last three days were a little bit lighter in the month than what we had forecasted. And ultimately, those discharges then were moved over into the first week of October.

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

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

<Q – Kevin Fischbeck – Bank of America; Merrill Lynch>: Good morning. I wanted to go back to the wage increase commentary. I guess in the past you had talked about sequestration being a headwind and being able to freeze rates to labor as being one of the levers that you could pull to do that. So this is basically you just implementing that – it sounds like, I guess A, but then B, there was some commentary in this slide deck around updating the prospective wage adjustments when you talk about 2013, or I guess in

early 2013. What is that referring to? Are you saying that you might adjust your forward view of wages in 2013 and 2014 or – I wasn't sure if that commentary was meant?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. You're right on both accounts. So we have said in the past that one of the ways that we can protect the company and ensure that we're positioned to deal with the uncertainty of sequestration or even additional cuts should they come would be to look at ways to be flexible on how we invest in our employees. And so by giving them a merit while we have the resources, absorbing the cost of the health benefit increase to protect their take home pay was one way to do that.

And then you're referring I think on the supplemental slides to page 25 where we say that the merit increase assumptions will be updated in early 2013. That really is to look at the 2014. If we were to say today is the 2.25% to 2.5% makes sense out in 2014, we probably say that's a little bit heavy. And so, we just wanted to give our – we wanted to give everybody a heads up because we know people look at these slides and we appreciate that they do. Just give them the heads up that hey, when we're out there announcing Q4 and year-end and we start giving guidance for 2014, you may see some difference in these numbers. We're just alerting you to that ahead of time.

<Q – Kevin Fischbeck – Bank of America; Merrill Lynch>: Okay.

<A – Doug Coltharp – HealthSouth Corp.>: And bear in mind, the decision that we've made for the bonus in lieu of merits is for the period that runs from October 1, 2012 to October 1, 2013. What we're really saying here is we have not yet made a determination about what, if any, the merit increase will look like beginning October 1, 2013.

<Q – Kevin Fischbeck – Bank of America; Merrill Lynch>: Okay, that makes sense, I guess, given the uncertainty around rates which leads me to my second question which is what are you hearing, if anything, around things that might impact IRFS as far as either the doc fix, adjusting sequestration, or the next step ceiling and I guess in particular, there's some rumblings that we may see at the lay of sequestration but it kind of feels to me like it's just a delay rather than eliminating sequestration and any delay may come with additional cuts to fund. I guess it's a one-year delay of sequestration might cost an extra $100 billion plus to fund. So, I guess any delay comes with additional cuts somewhere else. So, I wanted to hear what your thoughts were around your positioning there and I guess – and do you believe that delaying sequestration is a good thing or a bad thing because it might lead to further cuts?

<A – Jay Grinney – HealthSouth Corp.>: Well, first of all, we think that delaying sequestration is – frankly it's kind of a smokescreen unless there are some real substantive changes that replace it. Remember that sequestration was put in effect through the Budget Control Act in a modest effort to reduce our federal budget deficit. So if sequestration is overturned, all that does is it then increases the budget deficit and makes the debt ceiling that much more vulnerable to be breach. So, it's kind of typical Washington, we'll let's just do away with sequestration. Well, okay, we'll do away with sequestration. But all that does is add to the budget deficit and that's the core problem that has to be addressed sooner or later.

So, as far as I'm concerned, sequestration was never a great fix. It was – I mean, it was a default position. It wasn't anything that people should be proud of. The missed opportunity was to come up with a plan that was really going to substantively address the huge fundamental serious financial problems that this country faces. So we're looking down the road and our view is as follows: From a reimbursement standpoint, there is a lot of continued uncertainty, A, because sequestration is the law of the land today, B, because even if it goes away, the budget deficit is continuing to grow. The budget ceiling is going to be breached, and additional actions, sooner or later, we're going to have members of Congress and somebody in the White House is going to roll up their sleeves and say we've got to get this thing under control and we have to do it now. Or we're just going to tumble into a situation like Greece and Spain and everybody else.

So whether or not that happens initially in 2013 or it happens in 2014, we don't know, but we are preparing ourselves and have been for that kind of environment. The flip side is that we think we're very well positioned to deal with that because of our cost structure, because the fact that we don't have a lot of debt on our balance sheet, we've got a lot of flexibility in how we invest the cash that we're generating. And we

are fortunate to be in a segment where the demand is inexorably increasing because of the aging population.

So, I don't know if that addresses all of that Kevin and I apologize for getting on a bit of a soapbox. But it's amazing to me that we are here in October and people in Washington are just finally it seems like taking this fiscal cliff and sequestration seriously. I mean, my God, it's what? Two and a half months before the end of the year and they're just now sort of thinking about, oh what are we going to do. It's really just – it's so frustrating and it's so debilitating for our industry, for our company. We really just need some clarity and we need to get going, and we need to do it sooner rather than later. So I'm off my soapbox.

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

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Good morning, follow-up. Jay I would just say that if you ran HealthSouth the way our federal government is run, we wouldn't all like you so much. So, the clarity is appreciated and the soapbox is understood. Because it is, it doesn't heed the ability to make plans for the business and that's one of my key strategic concerns about healthcare generally, is I don't know how you make strategic plans for 2013, but that's not my question.

My question is this, I apologize, but I was somewhat distracted when Doug was going through the cash flow commentary, so if you could just help me out on a couple of things. First, could you give us pro forma cash balance for the 9/30? You gave us the pro forma debt, but I maybe missed it, didn't see the pro forma cash, assuming the pay down.

And two, could you just refresh for me what's your commentary might be about the fourth quarter cash flows and whether they might be approximately in the neighborhood of the third quarter adjusted free cash flow because my thinking is that you're not going to get the cash for the end of September discharges until the fourth quarter so, while you recorded the revenues and there'll be a depressing effect on net revenue per adjusted discharge, there might a be timing difference and a positive effects on cash flow. So can you help me think through the implications of fourth quarter cash flow from operations and adjusted free cash flow?

<A – Doug Coltharp – HealthSouth Corp.>: Yes. Start with – in terms of adjusting the pro forma cash number, what's really not included in there is that although the call on the 2018 and 2022 notes was initiated in September, it was actually funded on October, so that use of cash moved over into Q4, and that was approximately $65 million. With regard to the impact of those carryover discharges, that's really factored into our working capital assumption and that for the full year is included on one of our supplemental slides.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Yes, 30 to 50.

<A – Doug Coltharp – HealthSouth Corp.>: Yes. So that is in that number. The other thing that's happening again between Q3 and Q4 is this – the shifting in timing on $12 million interest payment. It had a favorable impact on working capital in Q3, it flips the other way based on when the coupon (dropped in Q4.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. So, just to summarize then the pro forma guesstimate for cash at the end of September would have been around $98 million?

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

<A – Jay Grinney – HealthSouth Corp.>: Just about right.

<A – Doug Coltharp – HealthSouth Corp.>: That's a good approximation.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: And then, you have the shifting of the interest and that's in the working capital. Was the working capital assumption terribly different from the prior assumptions because I don't recall what it was?

<A – Doug Coltharp – HealthSouth Corp.>: We tightened it down a little bit.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. All right. That's fair enough. Okay, I think that's it. Thank you very much.

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

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

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

<Q – Frank Morgan – RBC Capital Markets>: Hey, obviously you're preparing for a difficult environment for next year and so that makes me wonder, of the other rehab operators that are out there, either unit operators instead of acute or remaining freestanding, or does this really create an opportunity for you to acquire? And do you even really want to acquire in a year where things seem to be so uncertain?

<A – Jay Grinney – HealthSouth Corp.>: I think that it does present some opportunities to acquire or to joint venture. And yes, we do have an appetite for acquiring and consolidating the space. And we feel that it is a very low-risk way to continue to grow even during times of uncertainty, and we've positioned the balance sheet to be able to do this. We're not going to have to rely on the balance sheet to grow. So the cash flow that we're generating is going to allow us to pursue these growth opportunities, and we do believe that the trends that we've seen over the last, say, two to three quarters will continue. And that trend is the acknowledgement by many acute care providers that they're – they have limited ability to continue to offer a full range of services in an environment where their reimbursement is being cut back.

And I think that a lot of these providers, acute care hospitals who are not only looking at 2013 and the effect of sequestration and Medicaid reductions, but they're going out to 2014 and saying, when the insurance companies no longer can rescind and deny and they've got to price their products less aggressively, all of a sudden, the only ability that the insurance companies and the – are going to have to manage their bottom line is to pay the providers less.

So they're looking down not just into 2013, but they're looking through 2013 into 2014 and saying, boy that's going to be a kind of tough reimbursement environment, maybe we ought to either unlock the value of our services that are non-core and we have, oftentimes, as one of those or we'll joint venture it and offload some of the risk.

<Q – Frank Morgan – RBC Capital Markets>: I got you. And then is it relates to valuations and maybe if you could use your recent acquisition as an example or use – directionally, if you can't talk about specific valuations, but directionally do you feel like valuations of your more recent transactions are starting to reflect that growing uncertainty in there for getting better valuations or is it about the same?

<A – Jay Grinney – HealthSouth Corp.>: I think that the valuations are really acquisitions-specific, but clearly we're not going to acquire something that is not accretive. And in the case of Walton, that's a great hospital. I mean, with a fabulous tradition, they have just a really spectacular reputation there in the Augusta market. I think that the board saw that the challenges going forward were such that linking with the largest provider of in-patient rehabilitative care in the country would be a good thing. I know that there were others in the auction process, we feel very fortunate and pleased that we were chosen to really be their partner.

And so, we do things if there are going to be opportunities, even for hospitals that are doing well or units that are doing well or that are looking beyond today and out into tomorrow, are recognizing that linking and having scale and taking advantage of what we can offer is a good thing for their facility.

Operator: Your final question comes from the line of Miles Highsmith with RBC.

<Jay Grinney – HealthSouth Corp.>: Miles.

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

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

<Q – Miles Highsmith – RBC Capital Markets>: I just wondered if you touched on this in a couple of prior questions but, getting back to the topic of you guys, once you factor in length of stay and percent of readmits that your total cost based on the total episode of rehab can be less than the SNFs or some alternate sites of care. That seems to be potentially pretty powerful information and data as we head into next year, coming years where we're looking at more value for healthcare and potential budget and other discussions. Have you pushed hard with CMS, Congress and the guys outside just the commercial payers on that information? And assuming so, what's been the response? Are we still in the educational phase there? Are you getting some real good validation on that front?

<A – Jay Grinney – HealthSouth Corp.>: So we've been working on that for several years, and we believe that the messaging has been very well received because the members of Congress and particularly their staff are the ones who really are knowledgeable about the need to move into a more value-based delivery system where quality and outcomes matter and we believe, long term, will help to drive down price.

So it's been – it's a fairly mature process. We've got an outstanding individual, his name is Justin Hunter. He's our Senior Vice President for Government Relations and Public Policy. He is based in Washington DC and he does a phenomenal job of constantly working with members, their staff, the committees of jurisdiction. I mean, it's just an ongoing process. And then from time to time, I get up there – in fact, I get up there quite frequently, join Justin in meeting with those same individuals. So, I think the process is going well. I think that the message is being received and we're pretty optimistic that people get that there are some real value in what we do.

<Q – Miles Highsmith – RBC Capital Markets>: Thanks. That color is helpful and just one follow up. I guess, site neutral payments have been also talked about for years now, I'm just curious in your mind, if you sense there's any energy on the part of CMS. And even if so, is it right to think that that could realistically only apply to a small number of DRGs or cases if you were to compare to alternate sites of care?

<A – Jay Grinney – HealthSouth Corp.>: Well, first of all we are not sensing that there's any momentum in DC on this site neutral. Now, does that mean that it will never resurface? I'm – I suspect that it will be something that over time will be looked at but if you think about where the industry is going and let's just assume that everything that CMS would like to see happen occurs, which is to say that we move from an episodic to a case and capitated arrangement where we have ACOs and/or bundled payments. In that kind of environment, the arbitrary distinctions between one provider, one post acute provider and another really become immaterial. I mean, why should CMS care what kind of regulations they have to define payments for nursing homes or payments for rehabilitation hospitals? There's just going to give a lump sum dollar amount to the ACO or to the provider and say, you guys figure it out. The providers then are going to look among themselves and say, okay who is best here to provide that care and to do that on a basis where the patient gets well and doesn't linger in the bed or doesn't run the risk of being returned back to the acute care hospital.

So, A, we don't see a lot of momentum; B, the direction of the industry is really moving away from these regulations that govern individual providers and into a direction where there's a lump sum payment, and then the providers look to divvy that up based on the value that they bring to that organization.

<Q – Miles Highsmith – RBC Capital Markets>: Thanks a lot guys. Nice quarter.

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

Operator: And this conclude today's question-and-answer session, I would like to turn the floor back over to management.

Mary Ann Arico, Chief Investor Relations Officer

All right. Thank you, Lynn. As a reminder, we will be filing the updated investor relations book in early November and attending the Lazard Healthcare Conference and the Citi Credit Conference in mid November. If you have additional questions, we will be available later today. Please call me at 205-969-6175. Thank you.

Jay Grinney, President and Chief Executive Officer

Thank you, everyone.

Operator: This concludes HealthSouth's Third Quarter 2012 Earnings Conference Call. You may now disconnect.