

Operator: Ladies and gentlemen, thank you for standing by and welcome to the HealthSouth Corporation's Fourth Quarter 2011 Earnings Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. As a reminder, today's call is being recorded. Thank you.

I would now like to turn the conference over to Mary Ann Arico, Chief Investor Relations Officer. You may begin your conference.

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**Mary Ann Arico, Chief Investor Relations Officer**

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Thank you, Paula and good morning, everyone. Thank you for joining us today for the HealthSouth fourth quarter 2011 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; Andy Price, Senior Vice President and Chief Accounting Officer; Ed Fay, Senior Vice President and Treasurer; and Julie Duck, Vice President of Financial Operations.

Before we begin, if you do not already have a copy, the press release, financial statement, the related 8-K filing with the SEC and the supplemental slides are available on our website at [www.healthsouth.com](http://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-K for year-end 2011, which we filed yesterday 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 this slide presentation or at the end of the related press release, both of which are available on our website 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.

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**Jay Grinney – President & Chief Executive Officer**

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Great. Thank you, Mary Ann. Good morning, everyone. We appreciate you joining us this morning for the call. The fourth quarter was a strong finish to another solid year for HealthSouth. Total discharges grew 2.1%, while same-store discharges were up 1.7%. These were healthy results given the 5.9% growth achieved in the fourth quarter of 2010.

Our growth compares favorably to the rest of the industry. As shown on page 24 of our supplemental slides, discharges from non-HealthSouth hospitals reporting through the UDS reporting system were down one-half of

a percent in the quarter. This suggests our superior outcomes, focus on high-quality patient care and our Teamwork Sales and Marketing initiative continue to drive market share to our hospitals.

Our volume growth, coupled with the continued shift of our patient mix toward more Medicare patients, the continued shift of our program mix toward more patients with neurological conditions, a modest Medicare pricing update, in-line managed care pricing increases and the sustained benefits from our Care Management initiative generated \$518.1 million of net operating revenues, an increase of 5.5% compared to last year's fourth quarter.

As a reminder, our Care Management initiative was designed to standardize best practices at all our hospitals in the areas of preadmission screening, post admission care coordination and discharge planning. These best practices have resulted in fewer acute care transfers which in turn have resulted in fewer partial Medicare payments.

We were especially pleased that our efficient operating platform allowed us to leverage this top line growth to achieve \$122.9 million of adjusted EBITDA and generate \$99.2 million of adjusted free cash flow in the quarter. We chose to invest this excess cash in strengthening our balance sheet by paying down approximately \$73 million of debt and purchasing the assets of one of our joint-ventured hospitals whose lease had expired in Morgantown, West Virginia. This debt repayment brought our year-end leverage ratio to 2.7 times, well within our 3 times target.

Finally, our earnings per share for the quarter was \$0.50 per share. Unfortunately, this number may create some headline noise because it reflects an effective tax rate of 22%. While most analyst models use a 40% tax rate, a 40% rate would have yielded \$0.39 per share. As a reminder HealthSouth does not pay federal taxes because of our substantial NOLs. Our cash taxes for the quarter were \$2.3 million.

Doug will now provide a more thorough review of the quarter and the full year results.

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

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Thank you, Jay, and good morning, everyone. I'll focus my comments on the fourth quarter, but also highlight certain results for the full year and elaborate on a number of the assumptions underlying our 2012 guidance.

As Jay mentioned, Q4 represented a strong finish to a strong 2011. Revenue increased 5.5% in Q4, driven by inpatient revenue growth of 6.1%. Inpatient revenue benefited from both volume and pricing increases. Beginning with volume, our discharges increased 2.1% in Q4 2011 over Q4 2010, inclusive of 1.7% same-store growth. As a reminder, we were up against a tough comparison having generated discharge growth of 5.9% in Q4 2010. For the full year 2011, we grew discharges by 5.2%, 3.3% same-store, demonstrating our ability to continue to gain market share.

Moving to pricing, our revenue per discharge for Q4 increased by 4% over Q4 2010. As anticipated, we realized a 1.6% increase in our Medicare reimbursement rates. Our Q4 revenue per discharge was also aided by a shift in our payer mix, 72.8% Medicare for Q4 2011 versus 71.6% in Q4 2010 and a shift in our patient mix. Neurological cases comprised 17.5% of our mix in Q4 2011 versus 15.4% in Q4 2010, stroke was unchanged 16.4% and replacement of lower extremity joints declined from 9.8% in Q4 2010 to 8.6% in Q4 2011.

Our outpatient and other revenue declined 1.6% in Q4 2011, primarily as a result of the closure of six satellite clinics during the course of 2011. At the end of 2011, we continued to operate 26 outpatient satellites. Please be reminded that the vast majority of our outpatient revenue comes from our hospitals and not from the satellite clinics.

Our continued focus on expense control combined with the 5.5% revenue increase resulted in a 110 basis points of incremental operating leverage in Q4 2011 versus the prior year quarter. SWB as a percentage of net operating revenue rose by 10 basis points in Q4 2011 to 48.5% as enhanced labor productivity, EPOB, improved 3.46 in Q4 2011 versus 3.50 in Q4 2010, was offset by the ramp-up costs of our two new hospitals, Cypress and Drake, also by modestly higher group health benefits and workers' compensation expenses and our decision to provide all of our employees with an extra half day of paid time off as a form of holiday bonus. Please recall that Q4 2010 included a \$3.3 million favorable adjustment related to workers' compensation accruals. Although Q4 2011 workers' compensation was higher than the prior-year period, it also included a beneficial adjustment. At this time, we are expecting workers' compensation expenses to normalize in 2012, resulting in a year-over-year expense increase of approximately \$5 million.

Hospital-related expenses for Q4 2011 were 21.6% of net operating revenues, a decline of 120 basis points from Q4 2010. This category of expenses was favorably impacted in Q4 2011 by an adjustment to our general and professional liability insurance accruals and a non-recurring franchise tax refund of \$2.4 million, which we do not expect to repeat in 2012. Partially offsetting this benefit was an increase in bad debt expense in Q4 2011 compared to Q4 2010. As we had anticipated, bad debt expense as a percentage of net operating revenues increased to 1.2% in Q4 2011 as compared to 0.3% in Q4 2010, an increase of \$4.5 million. This was based on both an increase in medical necessity claims reviews and a decline in prior period recoveries attributable primarily to a reduction in the pool outstanding claims.

Looking forward to 2012, we expect bad debt expense to approximate 1.3% of net operating revenues versus 1% for 2011, based on the aforementioned factors as well as an expected lengthening of the Medicare denial adjudication process related to a mounting administrative backlog. This anticipated increase in bad debt expense would create a headwind of approximately \$6 million to adjusted EBITDA and EPS growth in 2012.

Remaining on the 2012 operating expense outlook for a moment, please recall that we are now in the midst of a system wide roll-out of a new clinical information system. This roll-out will occur over an approximate five-year timeframe. It's expected to result in an incremental \$4 million of operating expenses in 2012. We anticipate approximately 70% of the total cost of the CIS roll-out will be capitalized in the balance expense.

Turning back to 2011, Q4-adjusted EBITDA of \$122.9 million represented 9.6% growth over the same period in 2010. For fiscal year 2011, adjusted EBITDA of \$466.2 million represented an increase of 13.8% over 2010. While we are obviously very pleased with the strength of these operating results, most notably with the discharge volume growth, we recognize the beneficial impact of the expense items we just discussed and the corresponding hurdle they create for adjusted EBITDA growth in 2012. We continue to believe that our business model should generate a 5% to 8% adjusted EBITDA CAGR over the three-year period covering 2012 through 2014. Interest expense for Q4 2011 of \$23.1 million compared favorably to \$34.2 million in Q4 2010 and was reflective of both our declining leverage and the improvements we have made to our debt capital structure.

As Jay mentioned previously, we reduced debt by an incremental \$73 million in Q4 2011, bringing the total reduction for 2011 to \$257 million and resulting in a year-end leverage ratio of 2.7 times. The benefits of our reduced leverage and approved capital structure will be increasingly evident in 2012 as we anticipate full-year interest expense of approximately \$96 million versus \$119.4 million for 2011.

Year-over-year earnings per share comparison continues to be primarily impacted by fluctuations in our effective tax rate. Diluted earnings per share for Q4 2011 were \$0.50 per share compared to \$7.15 per share for Q4 2010. Earnings per share in Q4 2010 included a large income tax benefit, primarily attributable to the release of a substantial portion of the valuation allowance. On a full-year basis, earnings per share for 2011 were \$1.42 per share as compared to \$8.20 per share in 2010. Again, EPS for 2010 included a large income tax benefit, primarily related to the valuation allowance release. You will find a detailed comparison of our Q4 and 2011 EPS for the prior period on slide 10 of the supplemental slides.

Our federal NOL balance December 31, 2011 was approximately \$1.3 billion and the remaining valuation allowance at the end of the year was approximately \$50 million. Cash income taxes for 2011 were \$9.1 million and are anticipated to be \$7 million to \$10 million in 2012.

Let's move now to free cash flow and I'd direct your attention to slide 16 of our supplemental slides. As we discussed at the beginning of our Q3 earnings call, we anticipated strong adjusted free cash flow growth in Q4, aided in part by the shifting of approximately \$16 million in interest payments into Q3. During Q4 2011, we generated adjusted free cash flow of \$99.2 million, resulting in full-year 2011 adjusted free cash flow of \$243.3 million, an increase of 34.1% over 2010. This was driven by our higher adjusted EBITDA and benefited from lower cash interest payments and swap-related payments. Our adjusted free cash for 2011 was net of \$50.8 million in maintenance capital expenditures. As we have stated on several previous occasions, we expect 2012 maintenance CapEx to increase to \$75 million to \$85 million based primarily on the rollout of our clinical information system and two substantial hospital renovation projects. We expect to continue to generate a significant level of adjusted free cash flow in 2012, but the year-over-year growth is anticipated to be slower in large part owing to the 34% increase in 2011.

Although we will reap further benefits from reduced cash interest expense and cessation of swap-related payments, these items are likely to be offset by the aforementioned increase in maintenance CapEx and an anticipated \$30 million to \$40 million increase of working capital.

Let me elaborate for a moment on the anticipated increase in working capital. There are two primary components to this. First, we anticipate an increase in our accounts receivable balance, spending from both a higher volume of medical necessity claims reviews, an additional CMG has been added for 2012, and the previously mentioned lengthening of the adjudication process related to the amounting administrative backlog.

The second component is an expected increase in payroll liabilities, primarily related to one of the tranches of our long-term incentive plan or LTIP. The shares awarded under the 2009 LTIP were earned at a high level, based on the strong performance of the company in 2009 and 2010. Those earned shares will fully vest in 2012. As restricted shares vest, we offer our employees the option to have shares withheld to cover the related payroll tax. When employees choose this option, which most do, the Company retains the shares, but must remit cash to the IRS to cover the payroll taxes.

We expect such cash payments to approximate \$10 million in 2012. This payment will have no effect on our 2012 adjusted EBITDA or earnings per share, but it does flow through working capital as a reduction in the accrued liability and as a result, impacts adjusted free cash flow. Similar to my comments on adjusted EBITDA, we continue to believe that our business model should generate an adjusted free cash flow CAGR of 12% to 17% over the three-year period extending from 2012 to 2014, but annual results maybe outside of that range. As we have previously disclosed, there was no activity under our \$125 million share repurchase authorization during Q4 2011.

I'll wrap things up with total CapEx, which was approximately \$114 million for 2011. In addition to the previously discussed \$50.8 million in maintenance CapEx, this included approximately \$63 million in growth CapEx. Our growth CapEx in 2011 included the following, approximately \$12.5 million in capacity expansions, two de novos, Cypress which opened in Q4 2011 and Ocala which will open in 2012, our acquisition of Drake and the purchase of two hospital properties Morgantown and Lakeview, previously operated under long-term leases. This is consistent with our belief the control of our real estate adds to our competitive advantage.

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

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**Jay Grinney, President & Chief Executive Officer**

Great. Thanks Doug. Before we take questions, I'd like to discuss in a little more detail our initial 2012 guidance and highlight some underlying assumptions and considerations. This information is summarized on

pages 13 and 14 of our supplemental slides. Discharge growth remains the most important performance metric.

Our 2012 guidance is based on the assumption discharges will increase between 2.5% to 3.5% compared to 2011. Same store discharge growth is expected to be approximately 2% to 3% with the balance coming from our two new hospitals, Cypress and Drake. Our hospital in Ocala is not expected to open until December. So its contributions to discharges and earnings will be seen in 2013. We also have several other projects in our development pipeline that will come online in 2013.

From a de novo perspective, we have three new hospitals that will begin construction in 2012, a new 34-bed hospital in Martin County, Florida, with our joint venture partner, Martin Health System; a new 40-bed hospital in Littleton, Colorado and a new 40-bed hospital in southwest Phoenix. These hospitals are expected to be opened in 2013, but the exact timing will be dependent on securing appropriate permitting in a timely fashion this year.

We're also defending appeals against two our certificates of need, one in Williamson County, Tennessee, the other in Middletown, Delaware. In both instances, we have land under contract and have begun the design phase to enable us to move quickly once we have successfully litigated these appeals.

Finally, we're completing due diligence and market assessments of two additional de novos that we expect to announce in the next 90 days. We anticipate these projects will be under construction by year-end. In addition to these de novos, we're exploring several potential partnerships and acquisitions that if consummated also will contribute to earnings in 2013.

Getting back to our 2012 guidance, we're factoring in a 2% to 2.5% pricing increase on a revenue per discharge basis. This incorporates the modest Medicare update we received October 1 and managed care increases that are a little north of 3%.

The closure of several of our unprofitable satellite outpatient clinics and a 4% reduction in our home health Medicare pricing will result in total revenue growth of approximately 4% to 5%. There also are two factors that will create slight headwinds for us next year. First, as we've previously disclosed, we plan to install our new clinical information system in 12 of our hospitals in 2012. This will add incremental operating cost of approximately \$4 million. As a reminder, rehabilitation hospitals are not eligible to receive high-tech payments. So, there will be no offsetting revenues to apply against these expenses. Secondly, we anticipate a continuation of widespread reviews of an expanded number of diagnosis codes by certain fiscal intermediaries.

As Doug said, we expect this will cause bad debt to increase by approximately \$6 million in 2012 compared to 2011 and will bring bad debt as a percent of net operating revenues to approximately 1.3%. Taking these factors into consideration, our initial 2012 adjusted EBITDA guidance is between \$475 million and \$485 million.

In performing year-over-year comparisons, it should be noted that certain non-recurring items benefited adjusted EBITDA in 2011. These were a \$1.5 million net benefit resulting from state provider taxes, \$2.4 million from a non-recurring franchise tax recovery and a \$3.8 million reduction in self-insured worker compensation cost, primarily due to revised actuarial adjustments from better than expected claims experienced in prior years.

From an earnings per share standpoint, the most important distinction between reported 2011 EPS and 2012 guidance is the difference in the effective tax rates. The effective tax rate in 2011 was approximately 19%. In 2012, we're assuming a 40% effective tax rate. It should be noted our 2012 cash taxes are expected to be between \$7 million and \$10 million. With this in mind, our initial 2012 EPS guidance is between \$1.32 and \$1.39 per basic share.

As we begin the new year, I think it's important to consider what we've been able to accomplish since turning around the Company at the end of 2007. In 2008, our first full year as a focused post-acute company, we generated \$9.3 million in adjusted free cash flow. Four years later in 2011, we generated \$243.3 million in

adjusted free cash flow. We believe our strong cash flow generating capacity is the real success story for HealthSouth.

The strategies we've deployed have allowed us to achieve these results while positioning the company to enter 2012 with a strong balance sheet and a business model that has a proven track record of generating significant operating cash. As outlined on pages 16 through 19 of the supplemental slides, we are fortunate to have multiple opportunities for investing this cash flow for the long-term benefit of our shareholders. First, as we have discussed earlier, we will install an electronic clinical information system in all of our hospitals, despite not being eligible for high-tech payments. This investment is crucial to being a good partner with our referring acute care hospitals and positions HealthSouth to participate in the evolving ACO and bundling environment.

Second, we have the ability to invest in our existing portfolio through two major hospital renovations and several major refresh programs in 2012, all of which will facilitate future growth in these markets and at these facilities. Third, we will continue to invest in bed additions at hospitals with exceptional demographic and market share gain profiles, ensuring we keep up with the demand for our services in these markets.

Fourth, we will add new hospitals to our portfolio by building de novos, acquiring competitors or partnering with acute care systems. And finally, depending on relative risk return dynamics and other exogenous factors, we will consider opportunistic share repurchase, dividends, and/or debt repayment.

We're very proud of what we've accomplished in 2011 and look forward to the year ahead. The fact that we have de-levered our balance sheet, continue to generate strong cash flow, and have a proven track record of achieving strong financial and operational results, positions us to be able to continue to grow, to continue to adapt to external events, and to continue to create value for our shareholders in 2012 and beyond.

With that, Paula, we'll open the lines for Q&A.

## QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question comes from the line Ann Hynes of Mizuho Securities.

**<Q – Mizuho Securities>**: Good morning.

**<A>**: Good morning, Ann. We're having hard time hearing you.

**<Q – Mizuho Securities>**: Okay, can you hear me now?

**<A>**: Yes.

**<Q – Mizuho Securities>**: Okay, great. So my two questions, one I want to focus on cash flow. Obviously, you're generating a lot of it and you have been clear about your cash flow and deployment opportunities. But I really want to focus on short-term cash deployment over the next 12 to 18 months since the Presidential elections do create some uncertainty in Washington. So besides the bed adds and de novo projects you've already outlined, could you actually rank and prioritize the short-term cash deployment over the next 12 to 18 months, acquisitions, debt repayment, share repo or dividend.

And my second question is on the clinical information rollout. I assume going hi-tech will create a lot of efficiencies at the hospitals over time; do you actually have a estimate for hospital potential savings once everything is rolled out? Thanks.

**<A>**: Yes. I'm going to take the second question first. We have not included any savings in the presentation that we delivered to the Board on the clinical information system and quite frankly the reason is when we went out and we looked at other healthcare systems that installed these similar electronic clinical information systems, we really didn't see a lot of demonstrated cost savings. And frankly we're not going to simply take the

projected savings that the various vendors were throwing around because, it's easy to put a number out there, it's another thing to actually achieve those savings.

We see this as an investment in our business and an investment in our future. And I think everybody would agree that today it's not a matter of should you put in an electronic clinical information system. It's rather, when are you going to put in an electronic clinical information system? And you think about establishing tighter connections with our referring hospitals and you think about the potential or moving into some kind of ACO environment or potentially going into bundled payments, the transfer of clinical information electronically is absolutely the way the industry is going and we don't want to be left behind.

We don't think we are investing too late, we think the timing is perfect. The only regret that we have is that we're not eligible for the high tech payments. The good news on that for all of the analysts on the call, that you don't have to try to figure out if we got real earnings or high tech facilitated earnings. Our numbers are going to be a lot easier to figure out, than those who get the high tech payment.

In terms of the cash flow and prioritization, our first, second and third priority is to push dollars back into the business and to grow this platform of inpatient rehabilitation hospitals. And frankly over the next 24 months we see that that is the highest and best use of our cash and we're going to be trying to deploy as much as we can in a very disciplined way and very careful analysis to put dollars into that growth because, frankly in 2012, with the Doc Fix in place, we don't see any additional regulatory or Medicare payment headwinds.

Now whether or not the lamed up session does anything that's going to be dramatic, I think is anybody's guess, we're handicapping that to be probably a low probability, frankly. So 2013 then becomes an issue of what's the impact of sequestration going to be and is there going to be an additional kick the can down the road or major Doc Fix. So right now, we're saying, let's take the cash, let's go ahead, and invest in our business, you heard that we're – if you add up everything that I've talked about in terms of de novos, we're actually above that four per year clip that we've talked about previously. We had suspended the accelerated de novo project because of the regulatory uncertainty, that is now full throttle again. We're seeing some interesting opportunities in the acquisition front, again, just IRFs and potential partnerships with acute care system.

So with all of that in mind, we really think that that's the best place to put our cash in the short-term. We think that if there is going to be any long-term structural or traditional massive cuts to providers, we won't be seeing that until probably 2014.

**<Q – Mizuho Securities>:** Okay. Thanks.

Operator: Your next question comes from the line of Adam Feinstein of Barclays Capital.

**<Q – Adam Feinstein – Barclays Capital, Inc.>:** All right. Thank you. Good morning everyone. And Jay, just, as you were reflecting back and having covered the company a long time, it really has been an outstanding job, I just wanted to say that, you guys have done a phenomenal job and just seeing the leverage down where it is, it's great to see.

**<A>:** Thank you. It's very comforting to have it, rather have it at 2.7 than 5.7 or even 4.7.

**<Q – Adam Feinstein – Barclays Capital, Inc.>:** Absolutely. So maybe, Jay, you talked a little bit about the competitive landscape, I mean, clearly you guys are showing strong volume growth and so just looking at some of the industry data, obviously you guys are taking market share, but could you just talk a little about the competitive landscape in terms of other free standing rehab hospitals, hospital base units and even the competition from nursing homes with some of the reimbursement cuts they are dealing with and changes they're going through. So just curiously to get your thoughts in terms of the overall competitive landscape and how will you see that playing out over the next 12 to 24 months.

<A>: Yeah. I think that what we have said for the last maybe year and year and half is emerging as the operating environment that we're in and that is from a rehabilitation competitive landscape, the hospital units are increasingly under pressure because their acute care sponsor – the acute care hospital that they are in is under pressure from a reimbursement standpoint. They're getting less dollars from managed care. They're having to deal with the Obama care pay for, they're looking at sequestration next year. There are the various cuts that occurred as a result of the Doc Fix that could be more. And so what we're seeing is the acute care hospitals and systems that are more forward thinking and that's just looking at today.

They're looking down the road and asking themselves, can we really afford to be all things to everybody the way we have in the past and increasingly the answer is, no. So what we're seeing and it's slowly emerging is an interest on some of the more progressive healthcare systems to say okay, in the past we had owned and operated everything. Tomorrow we're going to be able to afford to do that especially if they are continued CapEx needs in our core acute care business. Okay, so that in mind what we're going to do. Either we monetize the non-core assets or we consider partnering with someone who can come in we can offload some of the risk on the post acute stage and monetize the portion of those services but still have control. And that is probably the biggest difference item between February of 2012 and February of 2011. In 2011 we said that's what we think was going to happen. In 2012 that's what we're seeing beginning to happen.

In terms of the SNFs, there is really not a big difference there. The fact that they are not getting as much or the therapy services probably is going to put a little more pressure on them to try to make it up with more patients. But they are under some pressure and so they have a very difficult situation to deal with while trying to meet this demand at the same time you see companies out there, nursing home companies talking about having to take out cost.

Well, the costs are going to be taken out primarily through labor cost and with the labor cost reductions, ultimately, you're going to put some pressure on being able to maintain any semblance of quality. So we don't see this SNF environment changing that dramatically, however, we do think that it will be more challenging for them to maintain any semblances of quality in those higher acuity patients that we treat and that could conceivably be admitted to a nursing home, if there is no IRF available or it meaning position may have a medical directorship arrangement or some other factor. Does that help?

<Q – Adam Feinstein – Barclays Capital, Inc.>: Yeah. No, that's very helpful. And maybe just one quick follow up question either for you or Doug here. Just the opportunity of purchase lease properties, I mean you guys call that out as something that you would be interested in – Doug you made some reference earlier to two recent properties. But just as you think about that, how big an opportunity is that over the next several years, I guess, can you just frame that for us?

<A>: Certainly, not as big as we would like...

<Q – Adam Feinstein – Barclays Capital, Inc.>: Yeah.

<A>: Of course, there is one lease that is up for renewal in 2012 that has a purchase option. So we'll take a look at that to see if it makes sense to either extend the lease or exercise that option. Then there is about half-a-dozen over the next several years.

<Q – Adam Feinstein – Barclays Capital, Inc.>: Okay. Great. Thank you very much.

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

<A>: Good morning Colleen.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Good morning Jay. Just on the pricing front, do you expect the mix shift towards more Medicare to continue into 2012 and if so, is that included in your guidance along with the dynamic of you treating more neural and much lower extremity fractures that you've done especially in the second half of 2011?

<A>: We haven't forecasted in a significant shift away from what we saw in 2011. Now it's hard to know what that's going to really look like in terms of the moving out of managed Medicare and into traditional Medicare, we'll probably start to see that in the first quarter and second quarter, and no, we've not anticipated any major shift in our program mix.

<Q – Colleen Lang – Lazard Capital Markets LLC>: Okay, great. And then on your comment about the evolving healthcare events Jay are the hospitals and physicians in your market ramping up discussions in that forming ACOs or ACO like arrangements or do you think that's still further down the line.

<A>: It's very mixed with the preponderance of our referral hospitals declining to participate at this time. We do have a partner in one of our markets that is looking to develop an ACO and we are in those discussions with them to participate on the rehab side, obviously they are 50-50 partner, so obviously they are very incentivized and excited about us being at the table. We're just not seeing a lot of it and I just, I keeping going back to what we said before which is I think this is really going to be an evolution, it's not going to be a revolution.

And as such it's going to take a while for this to really be proven to have long-term benefit and therefore to be accepted within the industry. I mean when you think about it, it is just, it's a little bit stronger version of capitation which we saw back in the 80s and 90s. And capitation is not around is the predominant model today for a lot of different reasons that we all know about. So the question is has the landscape changed, the dynamics change, patients willingness to deal with some of the downside of being in a closed network and having the physicians paid on a capitated basis and providers paid on a fixed basis, that just – is going to take a while to play this out. The good news is we do have a third of our hospitals are in partnerships today. So to the extent that those markets start to move, as we saw on this one example into either an ACO on a pioneer basis or some other basis, we'll be able to be there at the table, we'll be able to participate. We are confident we can bring value to the ACO, but we'll also be able to learn from that as we see this thing evolve over the next 5 to 7 to 10 years.

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

<A>: Hello Darren.

<Q – Darren P. Lehigh>: Thanks. Good morning, everybody. So, Doug, you obviously commented about the use of working capital, I guess I just wanted to touch on the medical necessity reviews here, creating a lot of headaches for your guys administrative burden and obviously delay. I guess, just a couple of things to ask first, could you comment on what kind of denials you are seeing at this point and as a sort of step up the activity levels and broaden the scope of that, maybe just characterized, how that's impacting your ability to ultimately get paid. And then secondly as I understand it, I think you have an opportunity at some point to elect other Medicare Administrative Contractor (MAC) as those MAC are awarded new contracts. So what's the plan there and how might that play out?

<A>: Okay. Let me try to answer that, then I am going to ask to Doug to fill-in in terms of the collection activity. On the MAC, when the MAC structure was first unveiled, multi-systems like ours had to make a decision, either we put all of our eggs in the MAC that receives the contract for the geographic area where the corporate office was located or we led with the decentralized and every hospital then went with the MAC that won the contract for that geographic market. We chose the latter. Unfortunately, the fiscal intermediary (FI) that we have most of our relationships with today is a very difficult FI to deal with. And we've tried to improve relationships, I think we're making some progress but it's a tough environment in that particular case.

So we have made the decision. We're going with the decentralized FI or MAC configuration but as you know those things are really, they are way off schedule and so it's going to take a while for this to play out, without a decision we made a couple of years ago and what we find a day, what we see the day in terms of the issues with Cahaba all that does is reinforce that we made the right decision when we went down that direction.

In terms of the – just to comment I'll make on denials, what happened was they added an additional diagnosis code. So they've expanded the reviews the biggest issue is that there is a backlog of these claims being adjudicated because there is a shortage of administrative law judges. So what we're seeing is in-part a slight increase because now we've got more – we've got one more code if they're going to go in and quibble over and so some of those we just we win because they ask for some additional documentation and they say, okay that's good, we're going to pay it.

Then there are others that they say, well, okay, you gave us some more information but we still don't think it was medically necessary. And we say in some cases all right, maybe the documentation isn't as precise, fine, but the vast majority of them we say, you know these patients really did need it, the documentation is there and we're going fight to you on this. And so that's the adjudication process that takes literally 15 plus months to resolve.

The problem is as those things are going into the pipeline, the pipeline isn't moving because we've got fewer administrative law judges out there adjudicating these claims. Hence the bad news, the good news is we heard this, we from our internal counsel that CMS is trying to address this backlog. So they are trying to assign a different administrative law judges. They are trying to streamline the process, they're trying to make it more efficient and resolution faster, they're also trying to standardize some of the criteria used. I mean, the biggest issue right now is if we go up against three fiscal intermediaries, we'd really be dealing with three different criteria and then if we go to three different law judges, we'd have three more different criteria. So CMS to its credit is really trying to get their arms around this. They realized, they've got a problem and they are working on it. From a cash flow standpoint we'll ask Doug to respond.

**<A – Douglas Coltharp – HealthSouth Corp.>:** I'll just put a little bit of context around this recognize that although this are certainly a new since the total number of our discharges that typically windup in the denial process even with this heightened activity somewhere between 1% and 1.5%. What causes us to have the discussion are the year-over-year fluctuations in the activity because that then has an impact on our working capital.

If you think about our total bad debt, which even next year with this increase we suggest it will be at 1.3% of net operated revenues because of our payer mix and because of where we're in the healthcare lifecycle this is really the primary source of our bad debt. And even when discharges are subjected to denial process we ultimately have a relatively high degree of recovery on those.

So we're pointing this out simply because the on-again, off-again nature just hurdles the last several years' causes these rather substantial fluctuations in our balance. As this moves out over time, it's just not a big an issue to me, since frankly it's not something that consumes a lot of assets to attract more ability to focus on the core operating business.

**<Q – Darren P. Lehrich>:** It's really helpful context and if I could just follow-up with a clarification on a response you gave to Ann, this is about sort of capital, I guess you sort of hinted here now that you've got – I guess eight de novo projects in the hopper a couple, you still haven't announced and a few under appeal. But how would you just describe your M&A pipeline. I just want to get an updated thought Jay, briefly on what the acquisition pipeline looks like, because it seems like that might be the swing factor relative to guidance? There is no M&A in the guidance I believe.

**<A>:** Yeah, you're right. There is no M&A beyond – what we have in 2012 is Drake and Cypress and obviously we haven't bought anything for 2013. The M&A pipeline is certainly more robust this year than it was last year. Some of those frankly are systems looking to monetize and get out, but there is a good number looking at least initially at the possibility of entering into some kind of partnership arrangement. And again the fact that we have a third of our hospitals that are already in some kind of partnership arrangement, I think it makes us at least attractive and we should be at the table with these systems. The fact that we can demonstrate that we are the nation's leading provider of inpatient rehabilitation that helps us out as well, so we are pretty excited about the opportunities to expand our presence and provide our higher level of care to new markets and to new communities.

And so it certainly a better environment today than it was last year and that's why when I answered Ann's question, I did it the way I did, is if you go to slide 18 on the supplemental you can see what we've got in terms of bed expansion and that's a pretty good number, \$20 million, \$25 million to add another 80 to 100 beds in those high growth markets and you think about it that is another two hospitals – equivalent to two hospitals and then just looking at the \$50 million to \$70 million that we've got in there complete Ocala and start for others obviously if some of the things that we talked about earlier come to provision, that number is going to go up a little bit. So we've got a lot of opportunities to invest in the core business and we still think that that's what makes sense for the long-term.

Operator: The next question comes from the line of John Ransom of Raymond James.

**<Q – John Ransom>**: Hi, good morning. Jay, you did a conference call back in the fall, giving an idea of what Obama's proposals would do to your P&L. I guess, I'm taken up the 75% rule if that were to resurrect. Do you have any updated numbers or should we still assume, I mean if that were to happen that it has kind of similar impact as you laid out last fall?

**<A – Jay Grinney – HealthSouth Corp.>**: Yeah, there is nothing new that we would put in there for the – for that. Clearly as time goes on and as you heard us talk about the program mix towards more neurological and fewer needs and tips. That's all – our overall compliance is moving north. So we're not in a position to say anything today about what the difference might be. But I think it's very fair to say that what we put out here last quarter, would certainly be on an apples-to-apples basis for getting any additional growth would be sort of a worst case kind of scenario, because as we move into a higher overall compliance number for the company, clearly then the downside risk is eliminated.

Having said that the 75% rule, what I think is resonating with a lot of people in Congress is that we've already paid for that. That – that's coming on and I know that that there are people out there and the nursing homes love to flog the 75% rule. And if I was in their shoes I'd probably be doing the same thing because everything else looks pretty bleak. So you got to find something and I just think that that's something that doesn't have any traction anywhere except the Whitehouse. And it doesn't have any traction in CMS, it doesn't have any traction on the hill, if you bring that 75% rule, most members of Congress that have been around plenty period of time, they'll roll their eyes and say please do not, that's dead and gone, lets bury, you paid for it.

So you know it's out there and every time Obama puts out a deficit reduction plan and puts out a budget, it's going to be there. So everybody is just got to know it's going to be there. What I say, is look at the track record of how many Obama budgets have been passed, since he was brought into the administration and made President. This thing is DOA, it's not going anywhere. So we – we don't spend a lot of time worry about it.

**<Q – John Ransom>**: Okay. I know, it was kind of interesting the investor reaction the spring versus last fall.

**<A>**: Yeah, yeah.

**<Q – John Ransom>**: Second question could you update us on E&Y and any progress there?

**<A>**: Well, our general counsel is up in Delaware trying to move through the log jam in our CON. So and I'm sure he is listening in, he's about ready to cringe I'm sure. What I can say and what he told me I can say is that the process is entirely at the discretion of the administrative law judges. We continue to believe in the strength and the solidity of our claims and we are pursuing them aggressively.

What he doesn't want me to say and I always get in trouble when I say this is, I still believe that we have much more incentive to get this done than E&Y does. And so every time I say that we get a nasty letter from the E&Y's lawyers and I'm sure we're going to get another one. But that's – I believe that, that there is no incentive for them to get this thing resolved quickly. But we have a lot of confidence in the strength of our plans. We continue to press them hard, but the process and therefore the timing of resolution is completely outside of our control. It is exclusively under the jurisdiction of three administrative law – three judges, arbitrators who are

arbitrating the case and the only other thing I would mention is think about how long this has been going on or maybe you don't want to. But it's been going on a very long time. Think about how much information those judges are going to have to wade through in order to make their decisions.

So who knows, I think the takeaway for everybody ought to be and we've been saying this now for about year-and-a-half to two years, there is nothing in our growth plans, there is nothing in our business plans, either one-year or five-year, that assumes we're going to get anything, when we get something from this, if we do and we certainly hope that we will and we certainly believe we should we'll be looking at how to deploy that.

Operator: The next question comes from the line of A. J. Rice of Susquehanna Financial Group.

**<Q – A. J. Rice>**: Thanks, hello everybody. Maybe an operating question and then a philosophical one, on the operating question, I know you said, the rate increases for the wages is running about 2.5% and the half day off which gave people. Maybe can you comment more broadly on particularly therapists – what you see in terms of productivity turnover, is that's relatively stable at this point or is it crept – its turnover crept up? Any comments along those lines.

**<A – Mark J. Tarr>**: Hey, A. J. this is Mark. I could tell you that we have not seen dramatic change in marketplaces relative to therapist or nurses. We think we've been in pretty good shape. We closely monitor our retention on both nursing and therapy and we've not seen that pop up, nor have we seen a pressure on wages going forward. You've heard us talk in the past in terms of retention specifically over nurses and that essentially reinvesting in them through education and training particularly in our CRRN program where this past year we're now in excess of 800 CRRNs which is the rehab certified nursing for RN component and so having that has of certainly helped us on the retention aspect.

**<Q – A. J. Rice>**: Okay, thanks. And then my sort of philosophical question, you guys have been asked a lot about capital deployment and this is a question I don't really have to ask too many people in the services area, but your leverage is getting down to the point where you could almost argue you are starting to be a question whether you are under levered at 2.7 times debt to EBITDA. Can you just comment – I know I heard your comments about capital deployment, but what about the leverage and where are you going at this point and maybe that will drive some comments about buybacks and dividends as so forth. But you are getting down a point where your leverage is pretty low by healthcare services standards.

**<A>**: Yeah. You are right and we are aware of that. We frankly think that's healthy and we were very content with the level of our leverage today in part because we really don't know what the future is going to be like and if you – this is just a philosophical I'll venture off a little bit, but it is really no different than where we find ourselves in on a federal budget standpoint. I mean there have been times in the past where the country we spent more than we should have and now we're standing with a lot of long-term debt that we've got to deal with.

Well, as we look in 2013 and seek for aspiration we know that something is going to happen into or we believe something will have to happen in 2014 and beyond. The reality is that the course we're on as a country in terms of how much we're spending in healthcare and so on. They're just unsustainable, it is unsustainable. So there is going to be some kind of change at some point down the road and what we've tried to do is, tried to create a balance sheet that will be able to absorb whatever changes comes our way and more importantly creates an environment to then lever up if we need to for or purposes that will bring us long-term value. But right now that the real change and it's out there in the horizon that we would want to bring more debt under the balance sheet.

We've managed this very conservatively. I would much rather be in the situation we're in today, going into 2012 and looking at 2013, than as I mentioned a moment ago than be sitting there with 3.5, 4.5, 5.5 times leverage especially as you think about the rate environment going forward. I mean how many – I don't know but you guys – we don't think that this rate environment is going to be there forever. I mean it will be kind of nice if it was one hand because you borrow at low rates, I know where you invest the money but it means it's just – it's not a sustainable environment. So we're trying to make decisions that are based on the long-term.

<A>: Oh, I think it is fair to say A.J. that when we look at our total leverage, we really take consideration three factors. We look at the leverage ratio and there we are at 2.7 times which is well within our 3 times target. Second is we look at the composition of our debt capital and the fact that we have no maturities prior to 2016 well spaced diversified sources of funding gives us a lot of comfort there. And third is we look at the obligations represented by our leased properties there because we own such substantial portion of our properties, we don't have the kind of least exposure than adds to the overall leverage picture that many of our healthcare service provider appears to.

When you look at all of those for us, it certainly underscores the fact that further debt reduction right now is not a priority for us. We've arrived at a position we'd like to be in. It gives us substantial flexibility. So we're not going to be out there particularly with our debt trading at levels substantially above par looking to reduce that further.

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

<Q – Frank G. Morgan>: Good morning. I want to just circle back on the pricing growth and that clinical mix shift that you have seen specifically in the quarter. I'm just curious, is that something that's happened consciously, has it been because of service line development in those nuros and those high acuity areas or is that just a natural phenomenon that has occurred?

<A>: No. That's been absolutely by design. This has been – this is something that we've been focusing on really ever since the new 60% threshold came out with the new conditions. As you know Frank, you don't develop clinical programs and clinical expertise and then role them out, see the benefit overnight. It's something that you have to do carefully and thoughtfully, you've got to test them and then deploy them and that's exactly what we've done.

<Q – Frank G. Morgan>: So there is a good argument to be made, this can kind of continue to perpetuate itself and perhaps this shift is not just a onetime blip.

<A>: I think that there is certainly logic for that.

<Q – Frank G. Morgan>: Okay. I think you all mentioned about remaining real estate opportunities for buybacks, but kind of on that same subject. What about on just clinic closures, anything else much left out there to clean up on the clinic slide or you're pretty much there?

<A – Mark J. Tarr>: Hey Frank. This is Mark. As you know, we continue to look at each one of these clinics every time our leases come due, but I think we probably been through the majority of the underperformers. I think that we'll continue to have a number going forward, but I think that number will decrease over time and we'll end up with a core group of high performing clinics.

<Q – Frank G. Morgan>: I got you. One question and this will go back into that philosophical category, given the low leverage here, I guess what do you got to see before you really decide to do something perhaps using your balance sheet to do it from be a real aggressive share repurchase or I guess what do you have to see before you're really willing to risk leveraging up again?

<A>: Well, there is a lot of clarity on the – in the future that we have to see. We have to see what's the election is going to look like and who's going to win. Frankly, I don't think that whoever wins the Whitehouse is nearly as important as what happens in the Senate. Think about it we – the Senate is just – is one just big roadblock for getting things done and so we need clarity there. We need to have clarity on the next debt ceiling discussion, debate, whatever you want to call it, that – I mean everything I'm hearing is, is going to happen at some point and I remember what happened last year when that issue was on the table.

So I just think that there are a lot of macro issues that present a lot of macro risks for the country and since when they are going to be looking at changes or reductions to expenditure, then they're going to be looking at

Medicare, I mean, they always look at Medicare. So we're just sitting here thinking not for what about this quarter or what 2012, we're all sitting here – we're all shareholders and we're sitting here, what do we need to do to position this company to be successful three years from now, five years from now, ten years from now. Not knowing exactly what's going to – what the landscape is going to look like but we do know some of the basic fundamentals of managing the company in difficult times and we're just – we're not going to resist – we are going to resist the temptation to just go out there and take a lot of risk.

I mean, you look at the some of our others in the healthcare space, they went out and they did a lot of acquisitions. We got criticized; land is out there, using the balance sheet to require these properties and they are at all time lows and look at where those companies are today. They are limping along, sitting they're gone wholly cow, look at the depth of the guy, look at the depth service, am I going to violate the covenant. We don't want to be there. We've gone through – you remember what it was like in our company in 2004, 2005, 2006, 2007 not too many people had to manage in that kind of environment.

We did and we learned a lot of lessons and so we're going to continue to be focused. We're going to be disciplined, we're going to be conservative and our approach to the risk that are out there and I think we feel pretty that we're going to be able to continue to post good numbers and grow and ultimately that's what we do. We're doing that for the shareholders. We're not doing that for who's trading in the stock today. We're really building this company for shareholders over the long-term.

<A>: Frank, I think it's fair to say that specifically you asked about what would cause us to redeploy significant portion of the excess cash flow towards the share repurchase. That type of decision would have to be accompanied with a substantial diminution in the prospects were compelling growth opportunities in the core of our business and right now we see that pool of opportunities increasing and not decreasing.

<A>: Okay. I liked these philosophical questions. You can off on these stands.

Operator: Your next question comes from the line of Rob Mains of Morgan Keegan.

<Q – Robert M. Mains>: Yeah, I just have one question and that's on labor efficiency. Your EPOB metric continues to improve, is there a point where you think you kind of hit us ticking point with that?

<A>: No. Frankly we don't. I mean there is – obviously there is going to be at some point – a point that you can't move beyond but you know that – I guess our thinking is we always have to find ways to improve. And we don't know today frankly what's the potential benefits of this clinical information system might yield for us. We're certainly not making this investment to trim labor cost we're making this investment to increase the efficiency so we can see more patients. And so there is always going to be – that's always going to be part of our business plan is improve productivity, improve productivity, but we're going to do that by giving our employees the technology that will enable them to do that.

<A>: Hey Rob you may have heard us talked in the past at our Beacon system where we're able to provide this field and our managers in the field with virtually real-time feedback in terms of whether the labor exist and almost to the point of to the prior shift. So as we have volume fluctuations, we're in a much better position to adjust labor to fit the volume fluctuations, that's what been our key to continue to success and buying productivity.

<A>: The other factor that'll influence EPOB over the longer timeframe is the accelerated de novo activity. In the near term because we'll have more hospitals on a ramp up phase that could put some negative pressure on. In the longer term as a higher proportion of our hospital base becomes these new hospitals which are build with a same footprint, a prototype if you will, we should see enhanced labor productivity.

<Q – Robert M. Mains>: That's a great point. Thank you.

<A>: There is more variability in the legacy base, in terms of the physical plan.

<Q – Robert M. Mains>: Right.

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

<A>: Hey, Whit.

<Q – Whit Mayo>: Hey, thanks for sliding me and we've covered just about every question I have. But was just curious if you made any comment on the commercial mix in the quarter and Jay maybe just broadly what are your contracting terms now or they meaningfully change and – this whole conversation is evolving about narrow road networks. Does it making your way through the door at this point just kind of curious on that broader topic?

<A>: Our commercial pricing is still in that 3%, 3.5% range. It really hasn't changed that much. We don't see a lot of commercial patients, because if you look at our pay or mix of that 20%, a good portion of that is Medicare, managed Medicare and those patients are shifting out of managed care – managed Medicare into traditional. So if you look at – for 2011, the fourth quarter, we had about 20% – 19.5%, about 8% of that is managed Medicare. So you're talking about a fairly small amount were patients – were not a big spend for the payers. And so, what we're seeing is pretty steady pricing environment.

In terms of the more networks, I'm going to ask Mark to respond what he's seeing there.

<A – Mark J. Tarr>: We haven't seen a real change in the overall networks where all the major payers you would expect out there, make up our largest percentage. I will say that over the years, we better roll-out into just having a better cooperation, not only cooperation, but relationships and building relationships with each of these payers in all of our major markets. And that's been a key success for us because every time we go out and talk to these payers, we also bring our quality metrics and really make that value proposal to them where our quality comes into play.

<Q – Whit Mayo>: Okay. Thanks a lot.

<A>: Okay.

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

<A>: Good morning, Gary.

<Q – Gary Lieberman>: Good morning. Thanks for taking the question. You guys have done such a good job on the discharge growth for a while now that it seems like, maybe we're starting to take it for granted. Can you talk about – is there a limit, is there a point where incrementally it becomes more difficult to continue to take share or should we not really worry about it and you guys still comfortable that you'll continue to be able to do it?

<A>: Well, we appreciate the comment on – people taking things for granted because it's one thing to state something it's another thing to actually make it happen, there is a lot of the execution. We've got a tremendous focus on doing just that. I think that the market share gains will impart continue for really and definitely but remember that the underlying demand unlike acute care hospitals or other providers, the underlying demand is pretty steady and its driven by the ageing of the population and the inevitability that occurs the older you get, the more you have these kinds of conditions that we treat and as – population as a whole.

So if there is a 2% sort of fundamental underlying growth trend that is embedded simply in the ageing of the population. That gives us kind of a baseline if you will, to build our long-term expectations. And so we think that there is still lot of opportunity out there and a lot of it is going to be going up against other rehabilitation providers, but frankly a lot of it is going to be also continuing to take share from nursing home.

**<Q – Gary Lieberman>**: Okay. And then in the quarter, you guys had adjusted the guidance at the beginning of January for EBITDA to \$455 million to \$458 million you still had some nice upside in the quarter. Can you just maybe talk about, what's specifically was the – you came in at \$466 million, what was the upside to the high end of the adjusted guidance?

**<A>**: It was really going steady, it was really in the two insurance accrual items that we referenced, we had favorable outcomes regarding our yearend actuarial review on the general professional liability and then we also had a favorable outcome on the workers' comp. And heading into that investor conference where we have updated the guidance at the first week of January, we just didn't have a handle at that time on where those accruals would shake out.

**<Q – Gary Lieberman>**: Okay, great. Thanks for the color.

**<A>**: Okay.

Operator: Your final question comes from the line of Kevin Fischbeck of Bank of America.

**<Q – Kevin Fischbeck>**: Okay, great. Thanks. I guess, when you look at the EBITDA on a cash flow growth 2012, it's a little below your targets, but that makes sense given I guess the comps are obviously tough particularly on the free cash flow side. But you guys feel good about those numbers longer term and I just wanted to see if we could talk a little bit about 2013, just looking at the sequestration cut you've targeted about \$30 million. It seems like it's going to be hard to hit those longer term targets in 2013. Now you mentioned some offsets potentially gets on de novo side coming in, but I would think that would add more of revenue than it would the profit. Is there something else in 2013 that's going to come in and help offset those cuts that we should be thinking about or is it more, it might be a little bit soft in 2013, but 2014, 2015 will pick up and you feel good about the longer term growth?

**<A>**: Yeah, I mean, you're right, we shouldn't be talking about 2013. And with respect to 2012 guidance, remember what the guidance, you made it sound like, those numbers were already cast in concrete that 2012 is going to be right on those, right on the guidance. I mean, as you know there are there is really kind of two, at least two camps for how to handle guidance, some guys like to go out there and some took [indiscernible] and talk about how great the year is going to be and then they find themselves having to walk down guidance at some point down the road. We've never had to do that. We've never had to do that and we don't expect that we're going to start this year, because we tried to put out there on a realistic candid transparent way, here's is what we believe we can do and kind of in a high degree of confidence. And that's the approach we've taken.

So guidance of that and if you saw the release and heard our comments, it's initial guidance and it's based on where we ended the year and now we've got about five weeks out of 52 weeks that we have operational knowledge about today. So, it's always the discussion that we have every time we put our guidance, but again we never wanted to be in a situation where we have to walk that back down. Because getting a short-term popper or an ad-boy [ph] for a great guidance to us is meaningless.

What we do is we're building the company for the shareholders and we want the shareholders to appreciate the value that we're creating. 2013 what we said is our business model for the 2012 through 2015 timeframe that CAGR, those CAGRs are solid. We feel very good based on what we know today. So we're not going to comment on 2013. We are six weeks into 2012 and that seems a little bit of a stretch. But let's focus on 2012. We had a great year in 2011. We got a great start to 2012 and we're excited about the opportunities that are out there to continue to grow this business.

**<Q – Kevin Fischbeck>**: Yeah. I think that's a fair point that going back things were taken for granted. I guess two quick clarifications. You mentioned, I guess in the press release that regarding your volume assumption assumes some market share gains, I just want to, and you mentioned in the conference call, you think 2% is kind of what the industry is growing, so, your ability to get to 3% on a same-store basis would be – the delta there would be market share gains, is that the way to think about it?

<A>: Yeah. And the 2% is the – is what the underlying 65 plus cohort is growing at. And that, we use that as really sort of a place holder for what we think the underlying market is growing at. And so, yeah, anything above that is going to be market share gains and on top of that any new store contributions that we might have.

<Q – Kevin Fischbeck>: Okay. And then the IT expense for 2012, this is a multiyear roll out, so should we expect a similar \$4 million per year going forward, is that weighted towards one year or another?

<A>: It will increase modestly as the number of hospitals that are rolled out onto system increases in subsequent years.

<Q – Kevin Fischbeck>: Okay. All right. Thanks.

<A>: All right. Thank you.

Operator: This concludes today's questions and answer session. I would now like to turn the floor back over to Mary Ann Arico for any closing remarks.

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**Mary Ann Arico, Chief Investor Relations Officer**

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Yes. As a reminder, we will be attending RBC Healthcare Conference next week, the Raymond James Equity Conference in early March, and the Barclays Healthcare Conference in mid March. If you have additional questions today, please give me a call 205-969-6175. Thank you.

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