Operator: Good morning and welcome to the HealthSouth Second 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 second 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 second 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. Thank you for joining this morning's call. The strength of HealthSouth business fundamentals was again evident in the second quarter as we achieved strong volume, revenue, earnings and cash flow growth. Total discharges grew 3% with same-store hospitals contributing approximately 2/3 of this increase. Pricing, as measured by net revenue per discharge, increased 3.2%, and on an absolute basis, was consistent with the first quarter pricing. Our strong inpatient results grow top line growth of 5.6% while our disciplined operating platform allowed us to leverage this growth to generate $125.1 million of adjusted EBITDA, an increase of 8.5%. Earnings per

share from continuing operations was $0.39 for the quarter compared to $0.14 in the second quarter of 2011. However, as a reminder, last year's EPS was impacted by two items, which we have a highlighted on Pages 5 and 12 of our supplemental slides, that reduced last year's EPS by approximately $0.11 per share.

Finally and perhaps most importantly, our quarterly cash flows remained very strong. Cash flow from operating activities was $114 million, while adjusted free cash flows was $70 million. Year-to-date numbers are $195 million and $115.2 million, respectively. One of the strengths of our business model is our ability to invest our significant cash flow across a range of strategic alternatives.

In the second quarter, we invested our free cash flow in the following manner. First, we continued our de novo growth strategy with the ongoing development and construction of four new hospitals: a 40-bed wholly-owned hospital in Ocala, Florida; a 34-bed joint venture hospital in Stuart, Florida; a 40-bed wholly-owned hospital in Littleton, Colorado; and a 40-bed wholly-owned hospital in Southwest Phoenix. Ocala will be operational by the end of this year, while the remaining three hospitals are scheduled to be operational in 2013. We also received CON approval in the quarter to build a new 50-bed hospital in the Orlando market and expect to open this facility in the first quarter of 2014. And as a reminder, we have two additional CONs to build new de novos in Williamson County, Tennessee, and in Middletown, Delaware. Both of these CONs are currently tied up in appellate stages of litigation, but we hope to have them resolved in both hospitals under construction by year-end.

Second, we invested in two acquisitions. We purchased 12 rehab beds from a hospital in Andalusia, Alabama and we'll transfer and add these beds to our Dothan, Alabama hospital. We also executed an LOI to purchase a 34-bed rehab unit from CHRISTUS Health in San Antonio. This in-market acquisition was completed on July 16, and we have already consolidated this business into our existing 108-bed Rehabilitation Institute of San Antonio.

Third, we, along with our joint venture partner, exercised an option to purchase a leased property, both land and building, in Fayetteville, Arkansas. This investment gives the joint venture control of the assets and eliminates an ongoing above-market lease expense for that partnership.

Fourth, we repurchased 21,645 shares of our convertible preferred stock for approximately $22 million, which when combined with our first quarter purchases, will reduced our annual dividend payments by $3 million and our diluted share count by 1.5 million shares. And finally, we repaid $25 million on our revolving credit facility, which brought our leverage ratio to 2.6 times. With that brief overview of the quarter's highlights, I'll turn the agenda over to Doug for a more thorough discussion of the quarter's results.

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

Thank you, Jay, and good morning, everyone. As Jay mentioned, Q2 represented another solid quarter for our company. As it is our practice, in just a moment, I'll review in detail the key components of our quarterly financial performance, but I thought it might be useful to deliver the punch line upfront.

Our adjusted EBITDA growth of 8.5% in Q2 2012, as compared to Q2 2011, was primarily a result of further increases in our discharge volume and revenue per discharge, which also contributed to improved operating leverage. As you shall see within the various expense categories, we had items that impacted us both positively and negatively for the quarter with a net of these items being essentially an offset. For example, Q2 2012 benefited from a decrease in our general and professional liability insurance reserve, but this benefit was largely offset by the combination of increased workers' compensation cost, higher bad debt expense and the expenses related to the rollout of clinical information system. I offer this commentary on the frontend so that we don't lose the forest for the trees as we review the details on the quarter.

Now moving into those details, for Q2 2012, revenue grew by 5.6%, driven by a 6.4% increase in inpatient revenue, offset by a 3.3% decline in outpatient and other revenue. The growth in inpatient revenue resulted from a 3% rise in discharge volume, 1.9% on a same-store basis, and a 3.2% increase in revenue per

discharge. The 3% discharge growth for the quarter should be viewed in the context of a 6.1%, comp from Q2 2011. For the first half of 2012, discharge grew by 4.5% with 3.4% same-store growth.

The factors contributing to the increase in net revenue per discharge were similar to those cited last quarter and included the 1.6% increase in our Medicare reimbursement rates and an increase in the average acuity of our patients. Stroke and neurological comprised 37.2% of our patient mix in Q2 2012, as compared to 33.6% in Q2 2011.

The decline in outpatient and other revenue was primarily attributable to the operation of three fewer satellite clinics. At the end of Q2 2012, we operated 26 satellite clinics, as compared to 29 satellite clinics at the end of Q2 2011. There were no closures during the quarter.

As anticipated, bad debt expense increased to 1.2% of net operating revenues in Q2 2012, as compared to 1% in Q2 2011. The factors leading to the increase where those we have identified on prior calls: an increase in medical necessity claims reviews and a lengthening in the Medicare denials adjudication process.

During Q2, we again generated improved operating leverage and labor productivity. SWB for the quarter was 48.3% of net operating revenue, an increase of 50 basis points from Q2 2011. The increase was primarily attributable to the anticipated increase in workers' compensation cost and the continued investment in our skills mix, which includes additional Certified Rehabilitation Registered Nurses and support personnel for our Case Management department, which is an outgrowth of our TeamWorks initiative. Our labor productivity did, however, continue to improve in Q2 as EPOB, which is an acronym for Employees Per Occupied Bed, declined to 3.41 from 3.47 a year ago, and as a reminder, when we look at that ratio, lower is better.

We experienced 140 basis points of improved operating leverage in other hospital-related expenses for the quarter. As a reminder, this category includes other operating expenses, supplies and occupancy.

Within this category, and as I mentioned at the start of my comments this morning, the benefit of a decrease in our general and professional liability insurance reserve was partially offset by the expenses related to the rollout of our clinical information system.

Flat G&A expense, which includes stock-based compensation and increased revenues, resulted in 30 basis points improvement in G&A as a percent of revenue. The combination of strong revenue growth and improved operating leverage generated adjusted EBITDA of a $125.1 million for Q2 2012, an increase of 8.5% over Q2 2011. For the first six months of 2012, adjusted EBITDA was $252.1 million, an increase of 8.3% over the first half of 2011. As we look to the second half of the year, please be reminded that as previously disclosed, we anticipate a higher run rate of bad debt expense, workers' compensation cost and expenses related to our new clinical information system to continue. Additionally, please recall Q4 of 2011 benefited from a $2.4 million non-recurring franchise tax recovery. Interest expense for Q2 2012 was $23 million, as compared to $34.9 million in Q2 2011.

For the time being, we seem to have settled into a run rate of about $23 million per quarter, and that assumption is baked into our revised EPS guidance for 2012. The substantial decline in interest expense from 2011 is attributable to the year-over-year decline in total debt, as well as the improvements we have made to our capital structure. You may recall that the 10.75% senior notes still comprise a significant component of our debt capital in Q2 2011.

Diluted EPS from continued operations for Q2 2012 was $0.39 per share, as compared to $0.14 per share in Q2 2011. As Jay mentioned earlier, our EPS for the second quarter was reflective of the strong operating results and lower interest expense I just reviewed, and included an effective tax rate of approximately 39%. EPS for Q2 2011 included a $10.6 million gain on a recovery from Richard Scrushy and $26.1 million loss on early extinguishment of debt arising from our voluntary call of a portion of then outstanding 10.75% senior notes. The net after-tax impact of these two items on EPS for Q2 2011 was approximately $0.11 per share. Adjusted free cash flow for Q2, 2012 was $70 million, an increase of approximately 10% over Q2

2011. The year-over-year increase stems primarily from our higher adjusted EBITDA and lower interest expense, partially offset by the anticipated increase in maintenance CapEx.

Our maintenance CapEx for the Q2 2012 was $31 million, as compared to $13.2 million in Q2 2011. Year-to-date maintenance CapEx of $50.1 million compares to $22.3 million for the first six months of 2011. We continue to anticipate maintenance CapEx for all of 2012 in a range of $75 million to $85 million. Obviously, this means that our 2012 expenditures have been skewed towards the first half of the year, and that is primarily attributable to the implementation of our planned bed replacement program.

Please recall that we also include the capitalized components of our new clinical information system, within the maintenance CapEx category. As Jay discussed in his opening comments during the quarter, we also repurchased 21,645 shares of our preferred stock, bringing our year-to-date total to 46,645 shares at a cost of approximately $46.5 million. These repurchases have the benefit of eliminating the 6.5% then outstanding 10.75% senior notes. The net after-tax impact of these two items on EPS for Q2 2011, was approximately $0.11 per share. Adjusted free cash flow for Q2, 2012 was $70 million, an increase of approximately 10% over Q2, 2011. The year-over-year increase stems primarily from our higher adjusted EBITDA, and lower interest expense, partially offset by the anticipated increase in maintenance CapEx.

Our maintenance CapEx for the Q2, 2012, was $31 million, as compared to $13.2 million in Q2, 2011. Year-to-date maintenance CapEx of $50.1 million compared to $22.3 million for the first six months of 2011. We continue to anticipate maintenance CapEx for all of 2012 in a range of $75 million to $85 million. Obviously, this means that our 2012 expenditures have been skewed towards the first half of the year, and that is primarily attributable to the implementation of our planned bed replacement program.

Please recall that we also include the capitalized components of our new clinical information system within the maintenance CapEx category. As Jay discussed in his opening comments, during the quarter, we also repurchased 21,645 shares of our preferred stock, bringing our year-to-date total to 46,645 shares at a cost of approximately $46.5 million. These repurchases have the benefit of eliminating the 6.5% annual dividend obligation on repurchased shares and also reducing our diluted share count by 1.5 million shares. We are now at a run rate on the preferred dividend of $5.74 million per quarter, or approximately $23 million per annum. We also reduced our total debt by $26.7 million during the quarter, primarily by means of repaying $25 million on our revolving credit facility and thereby lowering the outstanding principal balance to $100 million at the end of the quarter.

These actions resulted in our leverage ratio declining to 2.6 times from 2.7 times at the end of last quarter. The continued strength in our operating performance and the substantial improvements we made to our balance sheet were acknowledged with upgrades to our credit ratings from both Moody's and S&P during the second quarter. Our bank facilities, which are the senior-most debt obligations in our capital structure, are now rated investment grade by Moody's. And now, I'll turn it back to Jay.

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Doug. As a result of our strong first half performance, we are raising our full-year guidance. Adjusted EBITDA is now expected to be between $487 million and $495 million, while EPS is expected to be between $1.45 per share to – and a $1.50 per share. This new guidance assumes the following when comparing the second half of 2012 to the second half of last year. Discharge growth of between 2.5% to 3.5%. Pricing growth of between 2% to 2.5%. Salaries, wages and benefits as a percent of net operating revenues generally in line with last year. A slight increase in bad debts to approximately 1.3% of net operating revenues. And a 50 basis point increase in other operating expenses as a percent of net operating revenues due to the rollout of our electronic clinical information system and last year's non-recurring franchise tax recoveries that Doug mentioned in his comments.

Although we're only halfway through 2012, it is shaping up to be another year of strong operational performance, coupled with multiple opportunities to invest our significant cash flow to create long-term shareholder value. We continue to provide high-quality care, which in turn allows us to gain market share.

We're able to leverage these volume gains against an efficient operating platform to achieve solid growth in adjusted EBITDA, EPS and cash flow. And we're investing in future earnings growth with our de novo, acquisition and other cash deployment strategies.

Finally, it's important to note we're achieving all of this while maintaining a strong balance sheet, excellent liquidity and a low amount of leverage, which gives us the capacity and flexibility to adapt to future uncertainties and opportunities in our operating environment.

With that, operator, please open the lines for questions.

QUESTION AND ANSWER SECTION

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

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

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

<Q – Sheryl Skolnick – CRT Capital Group LLC>: I have no idea how I did that. First of all, it is remarkable and quite a tribute to all the hard work that went into getting that investment grade rating on the senior secured facility. That is really quite a stunning turnaround. That's a comment, not a question. I'm curious, though, as you look out at the business and the environment in which it operates, there has been a lot of movement in blending of managed care companies with physician groups, with movements towards ACOs, whether they be Medicare or non- Medicare, and I'm wonder – and I know that you're positioning the EHR, the clinical information system, to be an efficient and effective partner in that. Has there been any movements either in your markets or at a higher senior management level of discussions in that direction as yet?

<A – Jay Grinney – HealthSouth Corp.>: No. We have – the short answer is there have been some discussions, but not a lot. We, as you know Sheryl, we've got about 1/3 of our hospitals that are in some kind of partnership arrangement that – be that with a large academic medical center, such as BJC in St. Louis; Vanderbilt in Nashville; University of Virginia in Charlottesville, Virginia; as well as with large systems such as Geisinger in Pennsylvania. And at this point, we have not seen any interest or movement among those partners into a very active participation in these new payment models. That's not to say that there isn't any; it's just that they're not racing to sign up and apply to be in this early stage. Now that we have had discussions from time-to-time. We certainly have expressed our interest in participating. We think that we have a pretty compelling value proposition to offer, but we haven't really seen any takers at this point.

<Q – Sheryl Skolnick – CRT Capital Group LLC>: Okay. That's – that's interesting and I think a little disappointing, but not surprising. And then it's' not quite a follow-up, but I'm going to ask it anyway. Your guidance, in actual, the terms of your guidance in terms of the actual numbers seems close to, if not exactly identical to what you guided to before. What's the nuance of difference? Is it the higher level of confidence? Is it just the difference in time period, nine months versus six months in the comparison that gives you the confidence now to raise the guidance for the back half of the year given that volumes are going to be what volumes are going to be and you can only influence it to the extent that you already have by positioning the hospitals the way you have?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. I think that – I think you characterized it correctly. We just have more confidence in the numbers, and I think you're right. The volume number is always going to the key metric. We saw in the second quarter some unevenness in our upstream referral volumes. I think you're starting to see that in some of the publicly-traded acute care companies that are reporting same-store admits down anywhere from 2% to 4%. We certainly saw that in some of our markets, particularly out West and in certain markets in Texas.

So in that respect, it kind of seems a little like or feels a little like 2010. And I don't know how much of that upstream volume softness is economy-driven and people concerned about deductibles and co-pays or being out and being at risk from an employment situation. But we do have a fair degree of confidence in that 2.5%, 3.5%. We're off to a nice start in July. So we feel pretty good about the ability to step up and raise our guidance for the full year.

And by the way, thank you for the investment grade comment. It is interesting to remember that five years or six years ago, we were I think two steps above the lowest junk rating, and here we are with our bank facility at investment grade. Not that I think we get much credit for it, but I do think it's – we certainly see that as a real achievement internal to the company.

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

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

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

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: I actually want to focus on your CON strategy. It seems heavily focused Florida. Can you just quantify what you think the actual opportunity is in Florida to expand? And do you think it would be more CON-focused versus acquisition-focused?

<A – Jay Grinney – HealthSouth Corp.>: I think it'll be more CON-focused. We do see other opportunities within the state, and it's really a function of going where the retired population is. We clearly have a level of service that is addressing the needs of the elderly, and so there's a big opportunity we think still in Florida and we're excited about all of the hospitals that we have there today. They're all doing exceedingly well and we're confident we'll be able to bring these new hospitals online. Some of them are going to be in partnerships; the hospital that we have in Stuart, Florida is a partnership with Martin Health. That's a great system. They have a very strong position in that market. And then, of course, other hospitals we may explore doing on a standalone basis.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: All right. Great. And just my second question has to do with sequestration. I know in the past you've stated you're comfortable with $16 million of offsets for the reduction. Just for modeling purposes, where do you think most of those offsets would come?

<A – Jay Grinney – HealthSouth Corp.>: Well, first of all, the offsets we have stated would be available if we wanted to freeze salaries for the rank and file. And obviously, we would be freezing it for all executives as well. But I think it's important to remember that back in 2008 and in 2009, we were in a very similar situation. I think we were one of the few companies that has actually – or few segments I should say – that's actually had to do deal with a pricing freeze, and we did that within the context of having to pay for the re-set of the 75% rule down to 60%. And so if you recall from April 1 of 2008 through the third quarter of 2009, so for 18 months, we had our pricing reduced back to a level that was equal to what we were paid in 2007.So it wasn't a rate freeze; it was rate reduction. And in that time period, we grew EBITDA, we grew cash flow, we grew EPS and we did that by focusing on the quality of care, allowing that quality of care to drive additional patients into our hospitals.

We were able to bring those patients on on a very profitable basis. We were very disciplined with our cost structure. And we are able to grow our EBITDA. So I don't want to say today that we're going to offset it by only $16 million. And so you can – you need to model just a $16 million net impact. Our approach is that we can continue to take market share. We're going to have new hospitals coming on next year. Those have always been brought on at a very profitable basis.

So we look at the sequestration, we look at next year and we still go back to our business model, which we've outlined and summarized in this supplemental slides, and we still say we can grow EBITDA 5% to 8%. And we'll get that through volume growth. We'll get that through disciplined expense management. And we feel pretty good about our prospects for next year.

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

<Q – A. J. Rice – UBS Securities LLC>: Thanks. Hello, everyone.

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

<Q – A. J. Rice – UBS Securities LLC>: I thought I might just actually jump off from that last conversation and get a broader update on your thoughts on Washington. We got the payment rule update. We got – last year, at this time, there was all the discussion that seemed to indicate people maybe didn't really appreciate or understand the rehab hospital business as – in context on a continuum. And I know you guys have had ongoing discussions trying to educate in Washington as we think about budget actions and so forth, and then finally on health reform. So those three sort of Washington topics, what are you doing, if anything that's different to get ready for health reform? How do you react to the provider – the IRF update and then the educational successes you've had or challenges?

<A – Jay Grinney – HealthSouth Corp.>: Well, I think, first of all, let's put the first comment into perspective. And I think that the Street way, way, way overreacted to the provisions that the President put in, the deficit reduction plan and his budget. And so the notion that all of Washington doesn't appreciate the value proposition of rehabilitation providers I think is a wrong assumption. There were some in the administration – I still believe that a lot of that was politically-driven – who put those provisions in, but they never saw the light of day.

You go and talk to people on the Hill, there is no momentum; there is no traction around going after inpatient rehabilitation providers. And in fact, CMS last year in the final rule for skilled nursing came out and made some very strong comments about the value of inpatient rehabilitation relative to skilled nursing, that skilled nursing providers don't necessarily – when they're providing rehabilitative care – don't provide it at high – at the same quality level and don't save the program money. So there wasn't a lot of education that had to go on because people on the Hill, we felt people in the administration, even in the committees of jurisdiction understood the value of inpatient rehabilitation. And whether or not we could negate or somehow convince political agendas, I think that that's a much harder task. So there's nothing that we're seeing in Washington that would imply that inpatient rehabilitation is the focus of anything other than perhaps individuals in the White House. And again, you've heard me comment on what I think the motivation there might be.

So in terms of overall what's going on in Washington, it's just like everybody on this call knows, they're looking at next year, the fiscal cliff and what does all that mean. I think that, again, the market is overreacting to the potential risk. And I say that because the pricing environment for providers is as lean as it's ever been in the last 30 years. I mean you think about market basket updates and then all that take-backs as a result of the Affordable Care Act, you then layer on sequestration on top of that, I mean for most providers, next year, there's not going to be a lot of the Medicare dollars. So when we think about longer-term Medicare fixes, I think we're going to start talking about things that are closer to what you see in Simpson-Bowles that are longer-term in nature; they're structural in nature; they're tough political decisions that have to be made, but inevitably, they're going to have to be made.

We're going to have to look at eligibility age. We're going to have to look at means testing. We're going to have to look at putting co-payments behind or on certain services where they don't exist today. We're going to have to look at IME and GME. I mean we're going to have to look at a wide range of issues that are truly structural in nature and not necessarily payment-specific.

And as I said, they're just – there's nothing more to cut with the reductions of the Affordable Care Act, and then on top of that, with sequestration. And the only other comment I would make, A. J., and I realize I'm kind of going on and on here, but it's I think a very important topic. The other thing that I think the Street is missing, or maybe not the Street, but certain traders in healthcare stock, not necessarily investors, but traders in healthcare stock, miss is the demand is not going away. I mean there are a lot of providers in this space.

And just like back in 1997 when BBA was passed, everybody was saying the world was going to come to an end. There were winners and there were losers. There was some who went out of business, but then

there were those who had prepared themselves from a balance sheet standpoint and from a business model standpoint, and guess what? They did great and they're still around. And so I think we lose sight of that and the market is so over-reactive that they just lose sight of the fact that healthcare services is a service that – and a demand that is not going to go away. Someone is going to have to provide this service. And those who have prepared themselves for this kind of environment I think are going to do really well, and frankly, I put us in that camp.

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

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

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

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

<Q – Colleen Lang – Lazard Capital Markets LLC>: Just with the three de novos coming online next year in the middle of the year, can you just remind us of your general expectation for when you expect new facilities to generate positive sustainable EBITDA? And just any margin impact we should think about, particularly in the first couple quarters in which they're opening up?

<A – Doug Coltharp – HealthSouth Corp.>: Hey, Colleen. It's Doug Coltharp. And there's a chart that we include in our investor reference book that shows the historical progression of our de novos, but typically in about nine months, we see our facilities, our de novo facilities, reaching a point of sustainable positive EBITDA contribution. And then within another nine months, they typically have reached kind of a corporate average EBITDA margin. In terms of their impact on margins for next year, it's a slight drag, but we kind of look at it within the totality of everything else that's going on in the business, and we wouldn't use that factor alone as an excuse to say that EBITDA margin next year should be under pressure.

<A – Jay Grinney – HealthSouth Corp.>: The other thing, Colleen, just as a reminder, while we have three new coming on next year, we do have Ocala coming on at the end of this year. So that say comes online in December. As a reminder to everyone, we have to treat 30 patients before we can go back to Medicare and get the final certification to be able to provide the care and be paid. So the first 30 patients, we provide that care for free, and then we start ramping up. So there is going to be a nice lift next year or should be a nice lift next year to Ocala and then we have the two new de novos that we started this year. We had Cyprus. We've got Drake. They will be maturing next year and moving into same-store. And as we've seen in the past, those new facilities tend to continue to contribute maybe a little bit disproportionately as they go on.

<A – Doug Coltharp – HealthSouth Corp.>: And for those of you who might be interested in the slide that I referenced, it is Slide 67 in the current version of our investor reference book, which is available via our website.

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

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

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Thanks. Good morning, everybody.

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

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: So I just wanted to ask a question here about debt expansions, and I guess just given the strength of volumes, I'm curious as to know how many of your hospitals are on the so-called watch list where they sort of approach that occupancy level where you start paying more attention to the potential need for more beds? And just want to get a sense from you sort of where we are, how that might influence CapEx – maintenance CapEx maybe not over the next six months, but into the next year or two?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. At any given time, that list of hospitals that are at or near capacity or approaching the capacity constraints of that individual hospital, and we do look at it on a hospital-by-hospital basis, is somewhere in the 15-hospital range, plus or minus. There are a couple of hospitals there that, frankly, we know they're at capacity. There's one in particular where we've made the decision that that's a hospital where we're not going to be adding any additional capacity.

We have – and that's – frankly, that's the hospital in Puerto Rico. It's at or full capacity, and it's really more reimbursement issue down there. If we could get into get into some additional contracts, we might reconsider that. And we're certainly working on that and hopefully we'll make some progress and be able to add beds down there.

So somewhere in the 15 to 20 range of hospitals is pretty much the list. And as we project out, and we got out several years, we still think that that number that we've been using historically, somewhere in that 80-bed to 100-bed range, and that's shown on Page 19 of the supplemental slides that we just issued, that's a good number. And so the corresponding CapEx is also a pretty good number, that $20 million to $25 million.

So as you think about the next couple years, we don't see the number of hospitals needing new beds to significantly increase from what we've seen historically. We don't see that bed addition number being significantly outside of that of 80- to 100-range. And we don't envision the CapEx required to bring that on to be significantly outside that $20 million to $25 million.

<Q – Darren Lehrich – Deutsche Bank Securities, Inc.>: Okay. Now, that's helpful. And then if I could, I just wanted to clarify something that Doug covered in prepared remarks, and it just goes back to the workers' comp topic. Obviously, we're seeing a little bit of upward pressure there, and I don't know, I guess I'd be curious to know what do you think some of the drivers are. What do you think you can do operationally to maybe manage that a little differently in the future and just help us frame what the trajectory is?

<A – Doug Coltharp – HealthSouth Corp.>: Sure. I think that the trend that we were seeing in the first half of the year is consistent with the expectations that we outlined at the beginning of this year, which is a year-over-year increase that would probably be in the $5 million to $6 million range. And some of it simply relates to not anniversarying some of the favorable adjustments in the accrual that we were able to get last year. We're not seeing any real change in terms of the number of incidents or the claims other than that which rises naturally with the increase in the scope of our business. We're not seeing anything alarming in those numbers.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I think that's a great point. The one that Doug just mentioned that it's really more a function of last year having some favorable adjustments to our worker comp accrual. And obviously, that's reflective of better management of the workers' comp claims. So we're not seeing anything from an operational standpoint that is a red flag. I mean we're obviously always very focused on the safety of our patients, the safety of our employees. We have pretty aggressive programs to help with back strains, to make sure that we have the services that we need to provide once they are injured. And frankly, one of the reasons we made the capital investment in these new beds is to provide the ability to weigh patients in the bed. We don't have a lot of additional lifting. We think longer-term, that's going to be a benefit and will help protect our employees. So there is nothing out there, Darren, that would suggest that this is a problem. In fact, just the opposite; I think we're doing a pretty good job. We feel that we're doing a pretty good job with this.

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

<Q – Frank Morgan – RBC Capital Markets Equity Research>: Was hoping you could provide a little bit of color on the geography perhaps of the volume growth that you've been seeing, and with that strong volume increase, you've obviously been great for productivity. So I guess it's kind of a two-part question; is the volume growth really what's driving the productivity? Or is there some structural change to the basic labor model that you're looking at? Thank you.

<A – Jay Grinney – HealthSouth Corp.>: It's primarily the leverage we get off that new volume. I mean we're always looking at ways to improve the productivity. As you know, we have a very sophisticated internally-created management reporting system. We refer to it as our Beacon system. It's something that gives all of our hospitals, all of our regional teams, and those of who us in corporate detailed visibility on a real-time basis down into the department level of every single one of our hospitals. We can then use that data to identify best practices, to then promulgate those best practices across the entire company with the idea that we are looking always to reduce the variability in our performance and then move the overall performance to best-of-class.

So from a volume growth standpoint, the weaknesses that we saw where there were really sort of challenging upstream was in the West and the Southwest. Primarily, it was Houston and Las Vegas markets were pretty tough in the quarter. But overall, we saw some nice growth in other markets in the West, in the Southwest, which is primarily Texas, Louisiana, Arkansas. And then, of course, in the balance of our markets, we saw some very nice growth. And I think that it's important to keep that growth in perspective to what was happening in the acute care world. I mean, we really did see some upstream softness in many of our markets, but despite that, we were able to grow 3%.

<Q – Frank Morgan – RBC Capital Markets Equity Research>: Okay. Thank you.

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

.**<Q – John Ransom – Raymond James & Associates>:** Well, thought about you guys when I saw Scrushy was released. I thought that was a kind of poetic. A couple things; when you look at the MedPAC data and you see a majority of the industry is 23 bed units that lose money, you have to think that longer-term there's a big opportunity for you guys to go market to these not-for-profits and work on projects that maybe take that capacity out of the hospital, build something freestanding where you guys manage it. Am I just building a castle of air here? I know you do something in Stuart, but is there – do you guys have much of a development effort oriented around trying to help not-for-profits out of this business line?

<A – Jay Grinney – HealthSouth Corp.>: Sure. Yeah, we absolutely do, and I think Stuart is an example. The acquisition, frankly, of the 34-bed unit in San Antonio was responsive to the needs of CHRISTUS, which is a terrific system that has a huge footprint throughout the Southwest. So the approach I think that you've outlined is certainly one that we have been following and one that we pursue. We've said for a while that we think that there are opportunities longer-term to continue to consolidate in the industry, and I believe that that will be the case, especially in an environment where rates are being under a lot of pressure, both from the government side, as well as the managed care side.

<Q – John Ransom – Raymond James & Associates>: Okay. And just secondly, a different topic, if we look at your capital spending this year and thinking about your IT build-out and your de novos, without getting into multi-year guidance, but is this a good level to think about going forward? Or what happens when your IT spending tapers off? And do you expect this to continue because it was a little bit higher this year than we thought and we just wondered if we should, for conservatism, say keep at this level in the future years?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I think a couple of things, John. First of all, if you go to Page 18 in the supplemental slides, you can see that we've highlighted certain cash items, and one of them is the maintenance CapEx. And we did say that last year – I mean this year, we'd be in the $75 million to $85 million range. Some of that was a function of the clinical IT rollout. We do believe that that will be part of that maintenance CapEx for the next four to five years. That's approximately $20 million a year, give or take. And the uptick though in the first half, and as Doug mentioned, really was more a function of the accelerated investment in the bed replacement and some refresh. We're still going to come in that $75 million to $85 million range, and that's a good number. That's a good range I think to use over the next several years. And then as the IT program is fully adopted, clearly that number then will step back.

<A – Doug Coltharp – HealthSouth Corp.>: Recognize we're growing the hospital base and we have hospitals at an array of ages, and we think it's very important to continue to invest in our physical plant. We've done the bad replacement. We've got a program replacing the wheelchairs in all of our facilities. As

we mentioned a couple of times previously, you're going to see us probably undertaking two, maybe more than that, significant hospital physical plant refresh programs in any particular year. So as Jay mentioned, I think that that $75 million to $85 million maintenance CapEx number is a good proxy for the foreseeable future.

<Q – John Ransom – Raymond James & Associates>: Okay, thanks.

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

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

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

<Q – Gary Lieberman – Wells Fargo Advisors LLC>: Good morning. Nobody asked it, so I guess it's going fall on me. Can you give us an update on the E&Y arbitration?

<A – Jay Grinney – HealthSouth Corp.>: Somebody has to ask it. I want to John Whittington, our General Counsel, to answer because every time I answer, we get a crappy letter from their attorney and I want to avoid that. So John?

<A – John Whittington – HealthSouth Corp.>: Yeah. Thank you, Jay. No really much to report on. I will just give you a quick summary. Since we began the trial phase of the arbitration in July of 2010, we have held a series of hearings totaling over 100 days. Generally, these hearings are in four-day blocks of times. We are proceeding with additional hearings through the end of the year and into the spring of next year. We can provide no assurance as to the timing or the conclusion, but we remain confident and we are committed to aggressively and diligently pursuing these claims to a conclusion. As an example of how it's taking so long, our last hearing was in early July; our next hearing is in late October. That is simply a matter of scheduling, and everyone is doing the best they can to accommodate, but we will not have another hearing until late October, then we'll have one in November and one in December and on into the spring. But it's difficult to predict the conclusion time, but we are pursuing it aggressively and diligently and will continue to do so.

<Q – Gary Lieberman – Wells Fargo Advisors LLC>: Great, thanks for that update. You mentioned acuity, and I guess specifically the increase in neurological admissions. Is that something that you're going after specifically? Or did that just come your way? What's the plan there?

<A – Mark Tarr – HealthSouth Corp.>: Hey, Gary. This is Mark. Yeah, we are targeting neurological cases. We have programmatically stepped up in our hospital with equipment, with training, with medical leadership specifically to handle a higher acuity case. So the past three or four years, we have been targeting those neuro cases and we'll continue to do so.

<Q – Gary Lieberman – Wells Fargo Advisors LLC>: Okay, great. Thanks a lot.

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

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

<Q – Joanna Gajuk – Merrill Lynch, Pierce, Fenner & Smith, Inc.>: Good morning. Actually, this is Joanna Gajuk for Kevin today again.

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

<Q – Joanna Gajuk – Merrill Lynch, Pierce, Fenner & Smith, Inc.>: Hi, how are you? Question for you for – I'm sorry, about one of the items for your long-term outlook I guess, business outlook. In the slides, it seems like you lowered the outlook for managed care pricing to 2% to 4% in 2013 and 2014 from previously 3% to 5%. So it's not a very dramatic change, but still I guess given there will be some pressure on

Medicare rates going forward, I just want to hear your thoughts for reasons why you think that managed care pricing will be lower than what you were thinking before?

<A – Jay Grinney – HealthSouth Corp.>: You know, you see what's happening in the managed care environment. Look what happened to WellPoint and the pressure that they're under. You think about the constraints that they're going to be under as a result of the Affordable Care Act, things that they were able to do historically to manage their underwriting risks, things like dropping, rescinding, having rate differentials, all those things are no longer going to be available. So the managed care companies still have to try to eke out a profit, I would argue that they more than eking out, but the only way to do that is to go after the provider payment.

So I think this is just a reflection of reality and I would venture to say that if you talk to most of the providers out there, they would be saying essentially the same thing, that they expect that pricing on the managed care side is also going to be under pressure going forward. And that, again, it goes back to the hospital companies and provider companies that are going to do well in that kind of environment are those companies who have a proven track record of being able to grow volumes, and that's where I think we differentiate ourselves from other providers who are seeing their volumes constrict and under pressure. So we're all going to face pricing pressure. The successful companies, the ones that are going to be able to grow are those that have the ability to take market share, which we've been able to demonstrate now for the last five years.

<Q – Joanna Gajuk – Merrill Lynch, Pierce, Fenner & Smith, Inc.>: Yeah. That makes sense. I really appreciate the color. And just a follow-up to this. So what do you think the incremental margin on new volumes would be because it seems like weighted average pricing, even the reduction in managed care outlook, is going to be less than the wage burden on the – below what you outlined here in terms of benefit growth expectations. So the question is how much volume do you actually need to offset that margin compression? Or is that some other cost item that you can leverage here?

<A – Doug Coltharp – HealthSouth Corp.>: So, Joanna, it's Doug Coltharp. I think what you can kind of look at in terms of some high-level math. So let's assume that we move into 2013, sequestration becomes the loss we're anticipating, and that would suggest that net-net you're looking at Medicare price change that is flattish. So essentially, no change in Medicare pricing. And were at that 3% level from a managed care perspective, which is the low end of the revised range. If you then couple with that what we have stated is a reasonable assumption for discharge growth of 2.5% to 3.5%, that would put you in a range of 3% to 4% of revenue growth before looking at any growth by acquisition or any other opportunities. We believe that in an environment of 3% to 4% revenue growth, we should be able to hold our EBITDA margin. There will be some things that we will have to overcome, like the cost related to the continuing rollout of our clinical information system and some other things that are moving in an upward direction. But our ability to continue to generate operating leverage in our hospitals at that kind of revenue growth level should allow us to essentially hold a flat EBITDA margin.

<Q – Joanna Gajuk – Merrill Lynch, Pierce, Fenner & Smith, Inc.>: Great. Thank you so much for the color.

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

Operator: You have a follow-up from the line of John Ransom with Raymond James.

<Q – John Ransom – Raymond James & Associates>: Just to go back to E&Y for a minute, and I decided I'd give a break for this quarter from asking that, but Gary helped me out. I think I remember last time, Jay, you were hopeful that the testimony phase will be finished by middle of 2012. So it sounds like the testimony phase will continue at least into first quarter of 2013. Is that a fair way to read the timings for this?

<A – Jay Grinney – HealthSouth Corp.>: Again, to save the opposing counsel's time in responding with a letter, I'm going to let John Whittington answer this.

<A – John Whittington – HealthSouth Corp.>: The short answer is yes.

<Q – John Ransom – Raymond James & Associates>: Okay. Thanks.

Mary Ann Arico, Chief Investor Relations Officer

Lynn, I think we can go ahead and conclude.

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

Jay Grinney, President, Chief Executive Officer & Director

Thank you, everyone.