Operator: Good morning everyone, and welcome to HealthSouth's Third Quarter 2011 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. [Operator Instructions]. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Mary Ann Arico, Chief Investor Relations Officer. Please go ahead.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Jackie, and good morning, everyone. Thank you for joining us today for the HealthSouth third 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; John Whittington, our Executive Vice President and General Counsel and Secretary; 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.

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 risk 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 third quarter 2011, which will be filed next week, and its previously filed 10-Q for second and first quarter 2011 Form 10-K for year-end 2010 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, as part of the Form 8-K filed last night with the SEC.

Before turning 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 it over to Jay.

Jay Grinney, President & Chief Executive Officer

Great, thank you, Mary Ann, and good morning, everyone. We're pleased to report the results of another excellent quarter for HealthSouth that again highlights the strength of our business model. Total discharge were up 5.1% while same-store discharges grew 4% as demand for our services increased. Discharge growth occurred across all regions and was characterized by the continued shift to more neurological and stroke patients with fewer lower extremity joint replacement patients.

Our care management initiative yielded positive results as the discharge status of our patients improved through the utilization of standardized protocols for assessing and admitting patients, enhancing the care coordination of these patients and involving family members with the discharge process. By reducing the number of patients transferred back to acute care hospitals, we improved our Medicare payments which in turn contributed to a 3.3% increase in our net patient revenue per discharge.

We also continued to leverage our cost structure by treating more patients and achieving improved patient outcomes on a highly efficient basis. Of the $36.9 million of incremental net operating revenues generated in the quarter compared to last year $14.6 million or approximately 40% flow to adjusted EBITDA resulting in third quarter adjusted EBITDA of $110.5 million a 15.2% increase over the third quarter of 2010.

Finally we realized an important milestone in the quarter with the retirement of our 10.75 senior notes which brought our trailing 12 month leverage ratio to 2.9 times. Before Doug reviews the quarter in more detail I'd like to discuss our share repurchase authorization. HealthSouth generates a significant amount of cash and despite the near term uncertainty surrounding potential Medicare cuts. We believe the highest and best long term use of this cash is to reinvest it into growing the company.

This is predicated on our condition that the long-term outlook for HealthSouth remains positive for reasons we have previously articulated, including we are in a growing segment of healthcare the demand for in patient rehabilitated care is expected to increased by an average of 2.5% per year.

HealthSouth is a market leader in this segment, and we have a strong balance sheet that provides flexibility and the ability to adapt to changes affecting our business. While we still believe investing in growth is a correct long-term strategy, we are modifying our near-term strategy until we have better line of site into the changes coming from Washington.

First, we're going to move forward only with those de novo projects for which we have certificates of need. Those in Ocala, Florida, Martin County, Florida and Middletown, Delaware. Second, we will slow walk the other projects in the pipeline. Acquiring land if we have to in order to preserve our long-term flexibility, but not beginning any new construction on these projects until we have regulatory clarity.

Third, we have added another alternative for deploying our cash, by adopting a share repurchase plan in the event we experienced the kind of stock price volatility we had in the third quarter. This authorization along with the ability to prepay debt and strategically invest in our business gives us the full range of cash flow investment alternatives to choose from during this period of uncertainty.

With that, I'll turn it over to Doug who'll provide more detail on the quarter.

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

Thank you Jay, and good morning everyone. As a reminder, we completed the sale of five of LTCHs and closed the six during the third quarter. The results of the LTCHs were reclassified as discontinued operations for all of 2011 and prior periods beginning in the second quarter. As Jay summarized, we had another excellent quarter. Our consolidated net operating revenues grew by 8% over the third quarter of last year driven by an 8.6% increase in inpatient revenue. Discharges grew by 5.1% continued strong same-store growth of 4% and the balance coming from our hospitals opened or acquired subsequent to June 30, 2010.

For the first three quarters of 2011 discharges increased by 6.3% over the last year. As we look forward to Q4, please recall that we will be facing a tougher comparison as discharge growth in Q4 2010 was 5.9%. Revenue per discharge rose 3.3% in Q3 primarily attributable to a Medicare price increase of 2.25% which was effective October 1, 2010, higher managed care pricing, the impact of the initial Medicare enrollment period for newly opened and acquired hospitals on Q3 2010 reimbursement and improved patient outcomes.

We expect our Medicare reimbursement rates for Q4 of this year to increase by approximately 1.6% over Q4 2010. Please recall that this is just one of the components of our net revenue per discharge. Outpatient and other revenue rose 1.8% for the quarter as a $1.7 million benefit from state provider taxes was partially offset by the decline in revenue associated with satellite clinic closings. I remind you that the vast majority of our outpatient revenue is generated from our hospitals and not the satellite clinics. With that said, at the end of Q3 2011, we operated 28 satellite clinics versus 35 such units at the end of Q3 2010. We expect to close at least two additional satellite clinics in Q4.

Our continued focus on disciplined expense management combined with the solid increase in discharge volume resulted in operating leverage across all major categories of expenses. SWB for Q3 was 49.2% of net operating revenues an improvement of a 110 basis points over the prior year period.

As a reminder, SWB in the third quarter of 2010 was burdened by the ramp up of newly opened or acquired hospitals. Also as we again look forward to Q4 recall that SWB in Q4 of 2010 benefited from a $3.3 million favorable adjustment related to workers compensation.

Hospital related expenses for Q3 were 22.6% of net operating revenues an improvement of 10 basis points from Q3 of last year. The operating leverage achieved within this category was partially offset by an increase in bad debt expense. Bad debt expense for Q3 of 2011 was 1% of net operating revenues, better than we had anticipated, but still a 20 basis point increase over the prior year period.

Looking to Q4, we expect bad debt to be in a range of 1.2% to 1.3% of net operating revenues against 0.3% last year. With the year-over-year change primarily attributable to the increase in medical necessity claims reviews and a decline in prior period recoveries. G&A which excludes stock-based compensation expense for Q3 was 4.3% of net operating revenues, a 40 basis point improvement over the prior year period.

Our strong top-line growth and disciplined expense management led to another double-digit percentage increase in adjusted EBITDA. Adjusted EBITDA for Q3 was 110.5 million, an increase of 15.2% over Q3 of 2010.

For the first nine months of 2011, adjusted EBITDA of 343.3 million reflects 15.4% year-over-year growth. Our updated guidance for 2011, calls for adjusted EBITDA in a range of 450 to 455 million representing a 9.9% to 11.1% increase over 2010. Among other factors, this rate of increase would reflect the aforementioned tougher comparison for Q4 discharge volume growth, as well as the benefits of the low bad debt expense and favorable workers compensation adjustment experienced in Q4 of 2010.

Interest expense for Q3 was 26.3 million as compared to 30.8 million in Q3 of last year. As Jay mentioned, we completed the retirement of our 10.75% senior notes on September 1, and as a result continue to expect Q4 interest expense of approximately $24 million.

As anticipated Q3 EPS was impacted by an $18.5 million or $0.20 per share increase in income tax expense, primarily attributable to the release of the valuation allowance in Q4 2010. And by the $12.7 million or $0.14 per share loss on early extinguishment of debt related to the retirement of the 10.75% notes.

Please recall that Q3 2010 included a $9 million or $0.10 per share loss on interest rate swaps, which have since expired or been terminated. We are not anticipating any further loss on early extinguishment of debt in Q4 and expect the effective tax rate to be in a range of 38% to 40% for the quarter.

Adjusted free cash flow for Q3 was $32.4 million as compared to $53.8 million in Q3 of last year. The third quarter of this year was negatively impacted by the timing of approximately $16 million in interest payments, which effectively shifted out of Q4 and into Q3.

We also experienced a $17 million increase in accounts receivable of which approximately $8 million is another timing difference with the balance relating primarily to our revenue growth. The approximately $8

million timing difference in AR extends from the deferral of Medicare reimbursement at two hospitals, which were subject to legal entity re-organizations during the quarter.

Specifically, we changed the legal entity structure for our Harmarville, Pennsylvania and Miami, Florida hospitals as part of an ongoing effort to creating more simplified and efficient corporate structure. Although these reorganizations were completely internal in the case of these two hospitals we were required to undergo a Medicare change of ownership, which resulted in the temporary suspension of Medicare reimbursement. We have since received all requisite approvals and expect the deferred reimbursement to be wholly reversed in Q4.

We anticipate strong fourth quarter adjusted free cash flow aided by the normalization of these timing issues and resulting in full year 2011 adjusted free cash flow of at least $210 million, an increase of at least 16% over 2010.

Maintenance CapEx for the first nine months in 2011 was approximately $35 million versus approximately $25 million in the comparable period last year. We expect maintenance CapEx for full year 2011 to be approximately 50 million increasing to approximately 75 million in 2012. As a reminder, we include the capital cost associated with the rollout of our clinical information system in maintenance CapEx.

Turning now to the balance sheet, the closing of the sale of five of our LTCHs facilitated the completion of the retirement of our 10.75 for senior notes on September 1. This was the final step in the implementation of the capital structure strategy we first outlined for you in Q2 of last year and began initiating in Q3 of last year. We now have in place a debt capital structure characterized by manageable wealth based maturities with no significant maturities prior to 2016. Sufficient unfunded availability under our revolving credit facility limited principle amortization requirements numerous debt repayment options and flexible covenants.

Additionally through the first nine months of 2011 we have reduced our funded debt by approximately $184 million and as Jay referenced in his comments our leverage ratio for the end of Q3 stood at 2.9 times versus 3.7 times at the end of 2010. The elimination of the expensive 10.75% notes and a reduction of the leverage ratio to less than three times have been long standing objectives of our company and both were achieved well ahead of schedule.

The restructuring of our debt capital and the reduction in funded debt have a favorable impact on our future free cash flows and enhance our ability to invest in the array of strategic initiatives we've discussed on many previous occasions including de novos, acquisitions, direct expansions voluntary debt repayments and share repurchases. Our cash flow allocation decision between the investment alternatives will continue to be influenced by factors such as the relative risk return analyses prevailing macroeconomic and regulatory environments and the price and availability of assets within each category.

As Jay mentioned in his opening remarks the recent volatility in our share price, which we believe has been largely related to investor uncertainty over the potential outcome of the deficit reduction debate together with the strengthening of our balance sheet lead to our $125 million share repurchase authorization.

This authorization is not meant to signal a reprioritization of our investment allocation decisions. Rather it is intended to enhance our flexibility to invest cash across the above reference spectrum of opportunities as and when we deem it appropriate based on current market conditions and our assessment of emerging opportunities and challenges.

Please note that the share repurchase authorization does not have an expiration date, it is subject to certain terms and conditions and maybe revoked at any time at the discretion of our Board of Directors.

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

Jay Grinney – President & Chief Executive Officer

Thanks Doug. Before taking questions, I'd like to comment on the E&Y arbitration and review our revised 2011 guidance. With respect to E&Y, hearings have occurred since our last call and additional hearing dates are scheduled through April of next year. While we hope these will be sufficient to conclude the formal proceedings as we stated in the past, we can't guarantee that they will be.

As a reminder, once the formal proceedings are finished the panel will begin their deliberations and we can't predict how long it will take them to render a final decision. Meanwhile we continue to believe our claims are valid and are pursuing them aggressively.

Now turning to guidance. On the strength of our year-to-date performance and as noted in the press release we are raising full year guidance for both adjusted EBITDA and earnings per share. The new range for adjusted EBITDA is $450 million to $455 million, which represents growth of between 9.9% and 11.1% compared to full year 2010. Full year earnings per share guidance has been raised to between $1.18 per share and $1.23 per share on a GAAP basis.

As a reminder, last year we reported full year adjusted earnings per share of $1.59 on a non-GAAP basis. As we've done in the past, we've included a schedule on page 18 of the supplemental slides that shows the differences between these two EPS measures.

Some of the key assumptions of our revised guidance are as follows. We expect fourth quarter discharged growth of between 1% and 2% which would yield very strong full year discharged growth of between 4.9% and 5.2%.

Fourth quarter volumes are difficult to predict, because of fluctuations in discharges around the holidays, and as Doug noted, we're up against tough comps from last year's fourth quarter when discharges grew 5.9%.

From a pricing perspective we anticipate sequential net revenue per discharged growth of between 1.3% and 1.8% compared to the third quarter. This growth incorporates the Medicare pricing increase that went into effect on October 1.

Finally, we expect labor as a percent of net operating revenues to be between 49% and 50%. Last year's fourth quarter SWB as a percent of net operating revenues was 48.4%. But as Doug pointed out, this number benefited from the $3.3 million or 60 basis point adjustment related to workers compensation. Additionally, the fourth quarter of 2011 will include an average 2% merit increase for all non-executive employees which was effective October 1.

With that operator, we'll open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions]. Your first question comes from the line of Darren Lehrich with Deutsche Bank.

<Q – Darren Lehrich>: Thanks. Good morning everybody.

<A – Jay Grinney>: Good morning Darren.

<Q – Darren Lehrich>: Hi Jay. So, I wanted to just ask about pricing it was just a little stronger than we expected this quarter. And I'm just wondering if you can comment on your managed care pricing trends and if you've got any commentary and how your updates from the Medicare advantage side of things as also trended, and if there is any mix in influencing the numbers there?

<A – Jay Grinney>: So the managed care pricing has been pretty consistent in that 3% to 4% range, most of the contracts that we have renew on January 1, certainly not all of them, but the majority of them do. And so we really didn't see much of that on a sequential basis. I think the strength in the pricing can really be seen in two ways, first last year we had several new hospitals that were in that first start-up period for receiving Medicare payments where we treat 30 patients and we don't get any reimbursement. So that negatively impacted our pricing last year. And then this year as I noted in my comments the care management initiative which we've talked a lot about and have said throughout the previous calls was designed to improve outcomes and specifically to discharge patients more patients directly home and fewer patients back into acute care hospitals.

So, when that occurs and we see better patient outcomes we get more of our payments on the full CMG basis rather than on a per diem basis. So managed care still in that 3% to 4% range and then the balance coming in because last year was benefited from the fact that we had those new hospitals in that startup period and then the effect of the Care Management TeamWorks initiative.

<Q – Darren Lehrich>: Okay that's very helpful. Nice trial and thank you.

Operator: Your next question comes from the line of Matthew Gillmor with Robert W. Baird.

<Q – Matthew Gillmor>: Hi everybody.

<A – Jay Grinney>: Good morning.

<Q – Matthew Gillmor>: Just on the volume comments, you provided about the strength in neuro, can you just sort of talk about some of the drivers there and also help might that affect your compliance threshold?

<A – Mark J. Tarr>: Yeah this is Mark Tarr. As you may have heard us talk in past quarters, we put a big program focused on our hospitals to better enable us to care for neurological patients that includes training for the staff. equipment, medical leadership within our hospitals, overall program marketing for those neurological cases. Did that for two-fold, one is that majority of these neurological cases pass the medical necessity guidelines that that we're under, and a big proportion of those neurological cases are in fact compliant cases. So, we have put a big focus on them for the past couple of years and we're seeing that in the growth that we have in the other neurological as well as our stroke cases.

<Q – Matthew Gillmor>: Okay, thanks. And then, if I can just kind of an open ended question about the discussions in DC and the Joint Committee process, I'm just wondering if there is any sort of updated thoughts around that and what that kind of current discussions are happening with policy markers?

<A – Jay Grinney>: I don't know that there is really an update that I can provide. I think we've all seen in the press over the last several days. Both sides of the aisle have publicized their respective plans. And, as we would expect I guess or some of us would expect, the other side of the aisle in each case dismissed those as being inadequate for whatever reason.

I've spend a lot of time up in DC over the last six to eight weeks. I have to tell you that there is not a lot of optimism that I'd been able to pick up that the Joint Select Committee is going to come to a resolution. I think that certainly that's very disappointing for the country, but specific to HealthSouth, I think that it tips the balance a little bit more into that sequestration situation that not. But, I think it's going to be very difficult to predict with any accuracy. I think it's going to be very fluid, obviously the 2012 elections and posturing and positioning for those elections, unfortunately in my opinion we'll influence the proceedings in Washington. I think that we just have to wait-and-see. I think the takeaway on this call however, ought to be, certainly the way we'd looked at it and that is that the demand for healthcare services is not going away.

And specific to HealthSouth, people who – there is a huge cohort, the baby boom cohort that is getting older and it's inevitable that that people who are going to get sick with the kinds of the ailments that we treat. So

somebody is going to have to be there, ultimately to take care of those patients and to contribute to the communitism which we serve.

We believe what we've done over the last several years has been exactly the right thing to position us to be that provider. And so, Matt I think its legitimate question and certainly we're very involved with the process. But in the final analysis, nobody knows. But, what we do know is that someone at the other end of this is going to be their providing care. And if the environment is really tough, there going to be fewer providers. And those who have strong balance sheets, have flexible strategies are going to prevail and in fact, we believe we'll be able to take advantage of market dislocations as they occur.

That's been proven throughout the last 40 years. Every time something big comes up there going to be the winners and there going to be losers. And you guys have to write notes and make predictions on who those are going to be, we think we're going to be the winner.

<Q – Matthew Gillmor>: Okay, great. Thanks very much.

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

<Q – Sheryl Skolnick>: Hi, thanks very much. And I apologize in advance to the back ground noise that I'm in an airport.

<A – Jay Grinney>: Good morning Sheryl.

<Q – Sheryl Skolnick>: Jay about your discussion of – hi, good. Your discussion of Washington is very helpful and I realize that nobody really knows what's going to happen. But as a senior and I would argue very capable management team in an industry that constantly whacked by Washington the Senate or Congress. And you've got to have some experience in the kind of crisis now it's the strategic planning that you need to do. But can you talk to us a little bit about what your contingency plans are in terms of, we're going to get something on November 23, whether it's we give up or it's the bill. And then we're all going to gag on our turkey on November 24, when we try to digest that. But I guess what I would say is, do you have contingency plans in place so that you can start implementing them in the events that they do a) propose something along the lights of the Obama budget or anything else you've might have heard. And b) should that proposal actually passed a month later be able to move forward very quickly with whatever you need to do to implement it?

<A – Jay Grinney>: Yeah we certainly do and I think that's the preparation is really occurred over the last several years. As we all know you can't clean up the balance sheet overnight, you can't create a maturity profile that is out six, seven, eight, ten years with manageable frontiers and so on. So that obviously in our opinion is step number one, make sure that the financial foundation is very strong. Number two, we have deliberately pulled back on the accelerated de novo strategy that we announced on the last call in order to preserve cash and then to strategically deploy that cash as we see the opportunity to present themselves across a pretty broad spectrum.

We could continue to prepay debt as you know, the 18s and the 22s have prepayment options on it. If the bonds traded down like they had in the third quarter, we could conceivably go out into the open market and purchase the bonds there. We now have the opportunity to go in and to buyback shares. And more importantly, we have the opportunity to pursue acquisitions...

<Q – Sheryl Skolnick>: Yeah.

<A>: Of competitors should the market reaction be such that there is an opportunity to do so. So, really there are a broad range of contingencies and I think that the way to characterize where we are today is, that we are in a bit of a wait-and-see mode and we're moving forward with the de novos where we have a certificate of need. Those are hard to come by we fought hard to get them, there is a demand.

<Q – Sheryl Skolnick>: Okay.

<A>: And frankly, there is a little – there is less risk when you could build a de novo. So, I think all of those together really position us pretty nicely to be in a bit of a wait-and-see mode not get out there extensively with any kind of strategy that would compromise our ability to be flexible and adapt in 2012.

<A – Doug Coltharp>: Okay, I would just add to that. The position that we've taken on our real estate is another strength that factors into contingency planning. Recall that we own roughly two-thirds of our hospitals that means we have great flexibility in terms of how we manage those assets also means that we're not subject to the automatic escalators that are found in so many leases...

<Q – Sheryl Skolnick>: It's correct.

<A>: Properties that engaged in wholesale transactions.

<Q – Sheryl Skolnick>: Right. So and let me just follow-up with that first Doug, and congratulations on a year at the company I think this is your anniversary call. And it's that comment that you just made is speaks very much too how much exposure you had to the chance of the healthcare services delivery sector, over the last year. But let me follow up with this and I'm going to ask this with all kind intentions meant. Given that sometimes in often in Washington once an idea is floated it gets legs and it says it want to go away keep boomeranging back. My – in a perverse way might it not be better or if Washington thinking at a some point of time that might step up a 60% rule to 75% and it might gives us unified or uniform payment approach at some point in time, wouldn't it actually better for you to get it now rather than later. So that you take the hit you adjust the model you acquire you gain your market share your acquired a strategy asset in places is rather can't cope because the balance sheets and access to liquidity is not as strong and you move on as opposed to having this boomeranging and overhanging. Might that not actually be a better strategic outcome for you?

<A – Jay Grinney>: Well there is no question that the – the single biggest headwind and overhang frankly is the uncertainty.

<Q – Sheryl Skolnick>: Right.

<A – Jay Grinney>: I think that that's – that goes right to the heart of it. Anything that removes the uncertainty is a good thing. Why? Because of what you just implied, we would then be able to know what are the rules of engagements and we can then respond accordingly. So there is no question that getting clarity from Washington as you've heard throughout my comments today and previously, getting clarity is of utmost importantance. And not only for our ability to grow this company, but also for you and your colleagues and shareholders to have a better sense of what the playing field is going to be, and how we can respond. So, there is no question getting clarity is absolutely important. The goods news though is, I do believe we're going to have that. And I don't think we're going to be sitting here a year from now wondering what the rules of engagement are going to be. We're going to have some idea within the next 30 days to 60 days.

<Q – Sheryl Skolnick>: Yeah that's great. Thank you so much Jay.

<A – Jay Grinney>: Yup.

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

<A – Jay Grinney>: Good morning Adam.

<Q – Adam Feinstein>: Hi good morning it's actually Brian on the line for Adam.

<A – Jay Grinney>: Hi Brian.

<Q -- Brian>: Just wanted to ask you a question on the tougher comps you're facing in Q4, and I know you've had stronger discharged growth actually throughout 2011, so may be is it – is it that we're going to be facing these tougher growth numbers and, we can expect a little bit slower growth I guess in 2012 as well?

<A – Jay Grinney>: Well first of all with respect to 2012, we're – we're just now putting the budgets together and we haven't presented it to the Board. And so, we're going to be really commenting on '12. I will tell you that – that what we've seen thus far, we're pleased with. So, I think that the final forecast and so on guidance we'll wait until we report Q4. But I think we've always been fairly conservative as we go into a quarter on volume and just look at some of the acute care hospitals what they've reported on their same-store admits down 7%, down 2%. I mean where we operate in a pretty uncertain and somewhat volatile market still, so I think being reasonably cautious is not a bad way to go.

<Q -- Brian>: Okay, great. And just a follow up from here, you mentioned the Care Management rollout benefiting the pricing in this quarter, as it looks like you're completing with that stage of TeamWorks is this, you're going to able to boost your pricing or revenue per discharge, I guess for an ongoing impact into '12 as well?

<A – Jay Grinney>: Yeah we certainly believe that the program that we put in place with Care Management is sustainable and will continue to benefit first of all the patients, and then secondly, will help our reimbursement from Medicare.

<Q -- Brian>: Okay, great. Thanks a lot.

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

<A – Jay Grinney>: Good morning, Colleen.

<Q – Colleen Lang>: Hi good morning Jay. Just a quick question on the volumes, they've been better than expected all here. And can you just talk about what's driving the better than expected growth, is it more demand than you saw you initially see or are you taking more share?

<A – Jay Grinney>: I think its both I think it's a reflection of the underlying dynamic of our segment of healthcare. As we've said many times before a lot of that business is non-discretionary. It's not as subject and elastic to pricing issues as you find in some of the commercial businesses. So I think that's it, but we've also taken market share we believe. We've put a lot of focus on as Mark said, a variety of neurological programs focusing on strokes. We've really put an emphasis on extending our reach if you will in each of our markets going to new physicians and introducing them to our services. And then, obviously the new hospitals that we brought on last year as we saw in the first, second and now this third quarter have also contributed to the overall increase in our discharges.

<Q – Colleen Lang>: Okay, great. And then, last quarter you talked about encouraging your nurses and therapeutist associates to seek additional accreditation. About what percentage of your workforce is taking advantage of this and, how should we think about the impact on SWB going forward?

<A>: You know, I don't have that number right at my finger tips in terms of how many of the CRRNs, a Certified Rehabilitation Registered Nurses there are. But we certainly have seen that program be very successful. It does add to the cost, clearly we paid for and help and support the actual process of getting the training and then there is additional compensation component that is related to that.

I think the other thing that you have to keep in mind from SWB standpoint that we talked about in the past, is the fact that with this Care Management we've added probably a 100 employees across our portfolio, its about one in each hospital to help supplement that process and to get the kind of outcomes that we achieved.

<A – Mark J. Tarr>: Well another benefit that we've seen with the CRRN or that higher level accreditation for nurses and it's the reduced turnover. So that, once they commit themselves through achieving this additional

certification rehabilitation they're going to be around a while and they're going to want to practice in our hospitals.

<A – Doug Coltharp>: And well also by that the impact of the Care Management program is factored into the guidance that Jay gave you earlier in this call on SWB for the fourth quarter.

Operator: Your next question comes from the line of Doug Simpson with Morgan Stanley.

<Q – Doug R. Simpson>: Hey, I joined a little late but, I appreciate the commentary around volumes could – just be curious your perspective, we've heard from the payors, the providers and we've seen some utilization pressure in areas where one wouldn't necessarily expect any impact from the economy things like cardiac, IRF volumes have tracked much more steadily. Just curious beyond what you've said any read understanding the nature of the patients is different, but again we have seen some pressure in areas you wouldn't necessarily expect it. So just to be curious now with looking back over the last nine to 12 months if you pick up anything incremental that informs your view of that dynamic?

<A – Jay Grinney>: The answer is really no. I think that the demand is pretty steady, certainly we have seen the number of knee and hip replacement patients continue to go down and with our focus on neurological and stroke patients, we've actually seen an uptick. So there is nothing fundamental in the demand profile that would cause us to believe that going forward it's going to be radically different. I think part of what you see in the cardiac areas is frankly driven by technology and the ability to treat patients using enhanced technology and as we all know, stents are going up and cardiovascular surgeries are going down. So, and then you throw in all of the drug therapies, you don't quite have the same dynamic in the aging process.

I mean a lot of those conditions are environmental there related to diet and lifestyle and frankly most of the patients we treat the conditions are a function more of the aging process. And the fact that, the older we get, the more the systems that we have start to breakdown in the more chronic conditions that show up. So, I think it's really that in my mind is more of a driver than anything else.

<Q – Doug R. Simpson>: Its fair point, I think the aging process has been shown to accelerate during an earning season. But maybe you could just talk a little bit about, there has been a lot of discussion over the last couple of months, obviously about reimbursement you touched on it earlier. But maybe talk a little bit about your efforts to educate people down in the hill about the relative patients that is differential between what you all do versus a typical SNF rehab unit and how is that process going?

<A>: I think that the process is going very well, because all we're doing is presenting facts. First of all, when we go on the hill, we share the information that we've shared with our shareholders in the past on the total spending that Medicare spends on inpatient rehabilitation the fact that that's flat since 2004 as a percent of total Medicare spending it's actually gone down. And then, we share with members of Congress and staff numbers on Congressional Committees, some of the recent reports coming out of CMS, from with the final rules for skilled nursing where CMS came out and said, listen, the assertions by some that there is really no difference between skilled nursing and rehabilitative care that assertion is false. The assertion that skilled nursing saves the program money it's not substantiated.

So, it's really pretty easy to talk about our physician, the industry's value proposition if you will, for the program and for the beneficiaries by just presenting the facts. And those facts are very well received.

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

<Q – Joanna Gajuk>: Good morning it's actually....

<A – Jay Grinney>: Good morning, Kevin.

<Q – Joanna Gajuk>: Good morning, actually this is Joanna.Gajuk for Kevin today.

<A – Jay Grinney>: Hi Joanna.

<Q – Joanna.Gajuk>: First question. Hi, how are you? I actually had a question on bad debt, it seems like the numbers keep on coming better than expected, this quarter it was 1.0% and how the expectation for fourth quarter is 1.2% to 1.3% so that's below the prior guidance for 1.5% in second half of the year and the numbers imply 1.1% around for the full year. So the question I have is whether the full year number is a good run rate, or whether you expect actually the bad debt to increase going forward?

<A – Doug Coltharp>: Again, the primary reason for the fluctuation in bad debt has been the unpredictability of the medical necessity claims reviews. And there are a number of things that are unpredictable about that. One is the volume. Two is the speed with which the adjudication process proceeds. And, we think that on a go-forward basis it is probably prudent to continue to expect bad debt in that 1.4% to 1.5% range. We obviously don't undertake all efforts to bring that number in lower than that based on how we code things and our interactions with Medicare, but because it's so unpredictable we think of the better course of action is to plan conservatively.

<Q – Joanna Gajuk>: Okay, that's helpful. And also I want to follow-up to something not mentioned on this call but on prior call, in terms of when you quantify the impact of the change into 75% rule and you indicate that you want to hit the revenue by $42 million bad debt, EBITDA by $26 million, so that implies a margin -- incremental margin of some about 60% on the loss volumes. So the question I have is, is that the right way to think about it or there is some cost that we're missing here?

<A – Doug Coltharp>: I think that is the right way to think about it. That implies $16 million in mitigating cost reductions, you may recall that about $12 million or so almost 3/4 of that was our ability to fluctuate labor cost in conjunction with the decrease in volume. We predicted that as a result of the adoption to 75% with our net discharges declined by about 2,500 so $12 million net expense reduction related to adjusting our SWB in conjunction with that volume loss. And the other $4 million was predominant supply area, as again from lower volumes we'd had some variable expenses there. The reason that you don't see the same flow through rate on, if we down if you do on, on the way up, is that we do have some fixed expenses out there, most notably in the form of occupancy expenses and then there are certain components of our labor cost that are relatively fixed as well. Those being the administrative staff that each one of our hospitals as well as just core staffing level.

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

<Q – A. J. Rice>: Hi everyone.

<A – Jay Grinney>: Hi AJ.

<Q – A. J. Rice>: Two fairly technical things here, just to ask about, one, one of the things you guys have talked about using your cash for is buying in properties that are currently under operating leases. And with the pause or sort of staging out of the development program, I wondered if that I might become more of a priority and how much you might spend on that? And then I just wanted to ask about professional fees. That's been trending down for – well third quarter is lower than second and it looks like your guiding it down. A) I know that something you call out, can you just remind me what it is and then is that related to the, E&Y or something else. And do you think it's basically your winding that number down at this point largely go away next year?

<A – Doug Coltharp>: Yeah the first question regarding lease buyouts, we actually did consummate one of those in the third quarter. It was relatively small one for a facility that we have in Kentucky and the buyout was in about the $7 to $7.5 million range. We have one pending, which would be roughly $20 million payout whether that closes in the fourth quarter of this year, in the first quarter of next year, it's difficult to discern. Those are purely opportunistic for those to arise a couple of things have to happen. One is, we have to be – we have to have a purchase option embedded in the lease. We have to be coming to the end of the lease term, and then our negotiations with the existing landlord have to be such that we determine that it is economically preferable to engage in the buyout versus a renegotiation of the lease.

I think that these will happen sporadically over time, I don't think anything in the reimbursement environment necessarily suggests that we want to pursue those anymore aggressively than we had in the past.

The professional fees have run a little bit higher this year than we anticipated simply, because is as everyone on the call knows the proceedings with E&Y have gone on for more projected period than we had anticipated. We continue to believe that the most likely timeframe for a resolution is sometime in the first half of 2012, and obviously if we're looking at a partial year of expenditures in 2012 versus the full year in 2011 we'd see a reduction in those fees, and then hopefully as we move out to 2012 we'll see that category eliminated completely.

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

<Q – Frank Morgan>: Good morning.

<A -- Jay Grinney>: Good morning Frank.

<Q – Frank Morgan>: I though it's interesting that you called out one of the drivers, the rate growth related to your better discharge to home and I guess effectively not having a short-stay outlier payment. Can you tell us how your stats compared to the industry overall I don't know if that's something it's included in UDS data, but your discharge to home rates, how would that compare to the industry? And then, are there any other kind of potential drivers within the Medicare system that could perhaps help you continue to drive rate growth. So that's the Medicare question. And then, how are you doing on the managed care pricing side, anything you're seeing there growing the mix or how does the pricing look there? Thanks

<A – Jay Grinney>: Yep, first of all we don't have any short-stay outliers payments. What happened is the difference between a patient who gets discharged back to an acute care hospital versus staying in for the full length of stay that is expected is the difference between getting the full CMG payment versus getting a per diem.

So that that's a part of what's happening as clearly the more patients that we're able to treat first and foremost we feel that that they get better outcomes if we can treat them for the entire expected period of time and then discharge them home. In terms of comparing us to others, the only data source we have is the UDS data and what we do is, they look at it compared to what is expected based on the database that they have of similar patients being discharged from other providers. And we on a hospital-by-hospital basis, look at that pretty carefully.

So overall, we're right in the zone sometimes we're little bit better than the expected and so we feel pretty good about the effort and the fact that this has a lot of sustainability to it. Not only from a patient outcome standpoint, which is really the most important thing, but it does enhance our payments.

Now on the managed care side, as we said before, really not a big difference there we're still in that 3% to 4% range as we've said for I guess quite a while now that that's pretty much what we expect that's pretty much in line with what we're getting.

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

<Q – Robert Mains>: Thanks. Good morning.

<A – Jay Grinney>: Hi, Rob.

<Q – Robert Mains>: I know it's fairly small part of the business but I know that the outpatient business in this year was affected by the MPPR cuts assuming we get some sort of reasonable doc fix that you might correct assuming that the reimbursements at least in that business should be stable next year?

<A – Jay Grinney>: Yes.

<Q – Robert Mains>: Okay. But that should be layered on to likely decline in the number of clinics?

<A – Jay Grinney>: Yeah.

<Q – Robert Mains>: Okay.

<A – Jay Grinney>: Well the outpatient business that is not conducted in our hospitals it will continue to decline.

<Q – Robert Mains>: Fair enough. Okay that's all I have. Thank you.

<A – Jay Grinney>: All right. Thanks Rob.

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

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

<Q – Gain Lieberman>: Good morning this is Ryan on for Gary.

<A – Jay Grinney>: Okay.

<Q>: Just a question on the Healthcare IT spend I guess could you just refresh my memory. Are there incentive payments that you can expect to be receiving as you are spending this?

<A – Jay Grinney>: No.

<Q -- Ryan>: Okay.

<A – Jay Grinney>: We're not eligible for the hi-tech reimbursement.

<Q -- Ryan>: Okay. And then I guess as we think about you guys have done a good job on taking market share and you mentioned extending your reach as being a part of that should we be thinking about Healthcare IT as potentially extending your reaching further and maybe enabling more share to be taken or is it more about sort of just overall productivity enhancement, how should we be thinking about the potential upside from that?

<A – Jay Grinney>: Yeah the way we're looking at the IT spend is really from a quality of care. And, it will definitely benefit the patients to have the nurses and the therapists spending more time with them, and less time charting. So, the first and foremost we think that this is going to be a plus from a patient care standpoint.

Secondly, longer-term we need to make sure that we have the ability to connect with other providers, should the market evolve into a bundled environment or an accountable care organization I think that the sharing of information both clinical and financial across providers is going to be extremely important. And so, that really requires obviously that we have that on an electronic platform.

Operator: Your final question comes from the line of David Macdonald with SunTrust.

<Q – David Macdonald>: Yes.

<A – Jay Grinney>: Hey David.

<Q – David Macdonald>: Had a couple of questions. First, Jay I'm just wondering since some of these concerns about the potential resurfacing of the 75% rule, I'm curious, have you seen any uptick in terms of

income and phone calls whether it's a hospital kind of rethinking there wing potentially again or a freestanding guy in terms of just strategic acquisition opportunities?

<A – Jay Grinney>: Nothing that really would be in those categories. I think that what's happening is that everybody that we're certainly talking to is really in a wait-and-see kind of mode. I mean, I mentioned that earlier, the uncertainty that is out there is pretty significant. And I think that a lot of people, us included, we're waiting to get some clarification and then once we have that we'll be able to respond.

I do believe however that there are going to be certain circumstances where our competitors are simply not going to be able to maintain the same level of support, maintain their programs at the same level of quality as certainly as we have. When you think about the fact that 920 of the 1,150 inpatient rehabilitation facilities out there are departments or units of acute care hospitals.

And, if you believe that the reimbursement environment for acute care hospitals along with all other providers is going to become more intense rather than less, more challenging rather than less, those acute care hospitals are going to have fewer resources to spread across their organization, and they are going to have to make some tough calls about what are their core services and what are the services that they are going to have to outsource or some how rely on others to provide.

That I think will occur. When? I don't know, I think it liable it depend on what happens when they are watching. But I do think that that will create an opportunity for us and it's frankly one of the reasons why we're slow walking the de novos, we do think that uncertainty may create some acquisition opportunities, and we want to make sure we've got enough dry powder to execute those.

<Q – David Macdonald>: And then just a quick follow-up with you guys driving more neuro and stroke cases the vast majority of which I assume are compliant. Just a little color on the 26 million impact you had talked about was that kind of a snapshot in time when the budget was released?

<A – Jay Grinney>: Yeah.

<Q – David Macdonald>: So that could be a potentially noticeably lower number if you continue to see the strong growth that you're seeing in neuro and stroke is that a fair way to think about it?

<A – Jay Grinney>: Yeah I mean it could, I think a lot of that really also depends on what's going on in the competitive landscape. I mean if that, as we just said if that resulted in other units having to close that creates market share opportunities for us.

Operator: Your next question comes from the line of Paxton Scott with Jefferies & Company.

<A – Jay Grinney>: Good morning, Paxton.

<Q – Paxton Scott>: Hi good morning and thanks for squeezing me in here, I'll be brief. Just going back to the de novos, Jay, if we do get to the end of the year and it's the 2% sequestration. Does that give you enough visibility to where you reaccelerate back on the de novo strategy or do you kind of hangout and see what else could come up in the ensuing months that could provide greater opportunity for you? Thanks.

<A – Jay Grinney>: Well I mean if the sequestration goes into effect and if there is some resolution on the doc fix and let's say that that's done with a modest amount of additional custom providers. We could definitely see reintegrating that de novo. I think Paxton, what we really have to do is just say that it's – we're really in a wait-and-see mode. It really depends on what kind of environment we find ourselves in what has been or not been approved in Washington. I think the good news is and what I hope you take away from it is the fact that we're continuing to generate a lot of cash as Doug mentioned. We hope to get at least $210 million this year that's an additional what $60 million, $70 million in the quarter, if you just look at where we are thus far. So I mean, that that's a lot of additional cash we'll be waiting, looking to see how we deploy that, we've got a lot of flexibility on how we do so.

<Q – Paxton Scott>: Okay. Thank you very much.

Jay Grinney, President & Chief Executive Officer

Operator, are there any other questions?

Operator: That was our final question. I'll now turn the floor back over to you for closing remarks.

Jay Grinney, President & Chief Executive Officer

Okay.

Mary Ann Arico, Chief Investor Relations Officer

As a reminder, we will be attending the Lazard Healthcare Conference and the Citi North American Credit Conference, Citi in November. If you have additional questions we will be available later today. Please call me at 205-969-6175. Thank you.

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