PARTICIPANTS

Corporate Participants

Mary Ann Arico – Chief Investor Relations Officer, HealthSouth Corp.
Jay Grinney – President, Chief Executive Officer & Director, HealthSouth Corp.
Douglas E. Coltharp – Chief Financial Officer & Executive Vice President, HealthSouth Corp.

Other Participants

Whit Mayo – Analyst, Robert W. Baird & Co. Equity Capital Markets
Ann K. Hynes – Analyst, Mizuho Securities USA, Inc.
Frank G. Morgan – Analyst, RBC Capital Markets LLC
John W. Ransom – Analyst, Raymond James & Associates, Inc.
Dana Nentin – Analyst, Deutsche Bank Securities, Inc.
Rob M. Mains – Analyst, Stifel, Nicolaus & Co., Inc.
A.J. Rice – Analyst, UBS Securities LLC
Gary Lieberman – Analyst, Wells Fargo Securities LLC
Kevin Mark Fischbeck – Analyst, Bank of America

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to HealthSouth Fourth Quarter 2013 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] You will be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Mary Ann Arico, Chief Investor Relations Officer.

Mary Ann Arico, Chief Investor Relations Officer

Thank you operator and good morning, everyone. Thank you for joining us today for the HealthSouth fourth quarter 2013 earnings call. With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer; Mark Tarr, Executive Vice President and Chief Operating Officer; John Whittington, Executive Vice President, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President, Financial Operations.

Before we begin, if you do not already have a copy, the press release, financial statements, the related 8-K filings with the SEC and the supplemental slides are available on our website at www.healthsouth.com.

Moving to slide two, the Safe Harbor, which is also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risks and uncertainties, many of which are beyond our control. Certain risks, uncertainties and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates and expectations are discussed in the company's SEC filings, including the Form 10-K for 2013 when filed and previous filings with the SEC. 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 the presentation are based on our 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 the 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 strictly adhere to the one question and one follow-up question rule to allow everyone to submit a question. If you have additional questions, please feel free to put yourself back in the queue.

And with that, I will turn the call over to Jay.

Jay Grinney, President, Chief Executive Officer & Director

Great. Thank you Mary Ann, and good morning to everyone joining today's call. This morning, we are very pleased to report the results of another strong quarter and year for HealthSouth. As we announced in January, the number of patients treated in our hospitals increased 3.8% quarter-over-quarter, bringing discharge growth for the year to 5%. Our functional outcomes as measured by FIM gain and length of stay efficiency remain significantly better than other inpatient rehabilitation providers, and at year end, 96 of our hospitals had disease-specific certifications from The Joint Commission. We believe these achievements underscore the quality of care provided by our dedicated employees, differentiate us from our competitors, and allow us to continue to gain market share in the communities we serve.

Importantly, our hospitals provided this care cost effectively as both labor and hospital-related costs as a percent of revenue improved quarter-over-quarter. Solid discharge growth and disciplined expense management allowed us to generate $142.3 million of adjusted EBITDA in the quarter.

As noted in the press release, we had several year-end reserve adjustments that affected this number. We established an $8 million reserve related to RAC audits and simultaneously reversed approximately $4 million in bad debt reserve related to these audits. These actions had the effect of negatively impacting adjusted EBITDA by approximately $4 million in the fourth quarter of 2013.

We also lowered the statistical confidence level used to determine our self-insurance reserves as a result of the enhancements in the way we manage our risks, the accumulation of additional historical data, and continued favorable trends. This one-time change benefited adjusted EBITDA by $6.7 million in the fourth quarter of 2013. Excluding these reserve adjustments, adjusted EBITDA grew 8.6% in the quarter.

We also celebrated several development milestones during the fourth quarter. We relocated into our new replacement hospital in Ludlow, Massachusetts, and broke ground on de novos in Delaware, Georgia, and Florida, all three of which are expected to be operational in the fourth quarter of this year.

Before turning the agenda over to Doug, I want to comment on our 2014 guidance and related considerations, which can be found on pages 17 and 18 of the supplemental slides.

Although we strive to meet the needs of all patients who require inpatient rehabilitative care, in keeping with past practice, we are using discharge growth of between 2.5% and 3.5% for purposes of establishing full-year guidance. From an expense standpoint, our hospitals will continue to manage their costs in a disciplined manner, but we plan on investing an incremental $4 million in 2014 for a patient experience TeamWorks initiative and the continued implementation of our clinical information system.

Additionally, as I know you are aware, sequestration anniversaries on April 1, which will create a $7 million adjusted EBITDA headwind in the first quarter. Finally, full-year 2014 guidance should be viewed

within the context of the one-time benefit of the $6.7 million self-insurance reserve we just took in the fourth quarter.

With these considerations in mind, we are establishing the following guidance ranges for 2014: initial adjusted EBITDA of $555 million to $565 million, which as a reminder is after minority interest, and initial EPS of $1.86 to $1.91 per diluted share.

Doug will now provide a more detailed review of our results, and after Doug's comments, we'll open the lines for Q&A.

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

Thank you, Jay, and good morning, everyone. As Jay mentioned, Q4 was a solid finish to a strong 2013. There were two items in Q4 that Jay mentioned that merit additional explanation; the establishment of reserves related to RAC audits that begin in Q3 2013, and the reduction in our self-insurance reserves stemming from the lowering of the statistical confidence level. I'll provide explanations of both items as we move through the P&L for the quarter. I'll also discuss our guidance for 2014. During my remarks, I'll be making frequent reference to the supplemental slides accompanying our earnings release, so you may find it helpful to have those available.

Revenue in Q4 increased by 3.5% driven by inpatient revenue growth of 3.7% offset by a decrease in outpatient and other revenue. Discharge growth for Q4 was 3.8%, with 1.3% coming from same-store growth and 2.5% in new store growth. Revenue for the quarter was negatively impacted by approximately $9 million for sequestration and approximately $8 million to establish reserves related to RAC audits.

Those of you who follow the acute care providers know that RAC audits are a common and constant occurrence for that industry segment. We have providers have been fortunate to have had very little experience in this regard until recently. As we disclosed in Q3, in connection with CMS approved and announced audits related to IRFs, during 2013 we received requests to review certain patient files for discharges occurring from 2010 through 2013.

These RAC audits are post-payment reviews and focused on medical necessity criteria and admission. To date, the Medicare payments that are subject to these RAC audit request represent less than 1% of our Medicare patient discharges during those years, and not all of these patient files request have resulted in payment denials and terminations. RAC audit payment denials and terminations are subject to the same adjudication process as the prepayment MAC reviews we have discussed on a number of prior occasions, ultimately culminating in an administrative law judge or ALJ hearing. We have confidence in the medical judgment of both referring and admitting physicians, and as such, we intend to appeal substantially all RAC denials arising from these audits.

We have discussed with you before the substantial backlog and related delays in the ALJ hearings. The addition of these RAC audits will only serve to exacerbate that situation. As a result, it is difficult for us to forecast the timeframe for resolution of the denied claims appeal process, and based on direction from CMS, it may extend to an excess of three years.

The approximate $8 million revenue reduction in Q4 resulted from reserves against the claims reviews initiated by RACs in 2013. Approximately $4 million of this amount is a reclassification of bad debt reserves recorded in 2013 related to the RAC audits. Primarily as a result of this reclassification, our bad debt expense for Q4 declined by 70 basis points to 0.6% of revenue.

Continuing with our discussion of the Q4 P&L, we experienced significant operating expense leverage in the quarter helped by reductions in self-insurance reserves, including the one-time $6.7 million benefit attributable to the lowering of our statistical confidence level. As we have discussed previously, we utilize semi-annual reviews by a third-party actuary to assist in determining the appropriate reserve levels for our self-insurance programs.

The actuarial reviews assess both current and prior year trend lines and incorporate data for the broader industry. We believe our efforts to improve patient safety and overall quality of care as well as our efforts to reduce workplace injuries have helped contain our ultimate claims costs.

Based on these enhancements, favorable claims trends and the accumulation of additional historical data, we lowered the statistical confidence level used to establish our self-insurance reserves, resulting in the one-time benefit of $6.7 million.

In order to assist in your analysis, we have added slide 33 to the supplemental slides accompanying our earnings release. You will also find an expanded discussion of our self-insurance reserves in our Form 10-K.

For Q4, SWB as a percentage of revenue decreased 120 basis points from Q4 2012. SWB for the quarter was positively impacted by favorable trends in workers' comp expenses as well as the difference between a regular merit increase in Q4 2013 and the one-time bonus in lieu of merit paid in Q4 2012. Hospital-related expenses in Q4 declined by 10 basis points from the prior year, benefiting from the aforementioned favorable trend in our GPL expense.

Adjusted EBITDA for Q4 of $142.3 million increased 10.7% over Q4 2012. Adjusted EBITDA for the quarter was negatively impacted by approximately $8 million for sequestration and approximately $4 million for RAC audits. For the full year 2013, adjusted EBITDA was $551.6 million, an increase of 9% over 2012. As Jay mentioned, our adjusted EBITDA guidance, which again is net of minority interest, for 2014 is $555 million to $565 million.

The considerations related to this guidance are included on slide 17 of the supplemental slides, and specifically include an estimated $7 million negative impact in Q1 for sequestration – please recall that sequestration began on April 1 of 2013 – as well as the one-time benefit of $6.7 million in 2013 attributable to the lowering of the statistical confidence level used to establish our self-insurance reserves.

Turning back to the Q4 2013 P&L, interest expense was $26.5 million for the quarter as compared to $24.3 million in the prior year. The increase was primarily attributable to the exchange of new 2% convertible senior subordinated notes for shares of our 6.5% convertible perpetual preferred stock completed in Q4. Although the exchange results in an increase of reported interest expense, it reduced our preferred dividend creating an annual cash flow benefit of approximately $10 million.

As anticipated, D&A expense for Q4 increased to $25.2 million as compared to $21.7 million in the prior year. The increase was attributable to our continued capital investments in capacity additions, hospital refurbishments and the clinical information system.

The net loss per share of $0.31 for Q4 includes the $71.6 million premium on the convertible preferred stock exchange. EPS for the full year 2013 of $2.59 includes an approximately $115 million tax benefit related to our settlement with the IRS offset by the premium on the convertible preferred stock exchange. Our EPS guidance for 2014 is $1.86 to $1.91. The considerations related to our EPS guidance may be found on slide 18 of the supplemental slides.

The strength and consistency of our free cash flow generation was evidenced again in 2013. For the full-year 2013, adjusted free cash flow of $330.9 million increased 23.5% over 2012. This follows increases of 10.2% in 2012 and 34.1% in 2011. A bridge of adjusted free cash flow from 2012 to 2013 may be found on slide 16 of our supplemental slides.

I do want to point out that 2013 benefited by approximately $12 million due to the timing of a portion of our maintenance CapEx. More specifically, we made certain equipment purchases late in the year 2013 that were invoiced in 2013 but were due and paid in January 2014. As a result, our maintenance CapEx for 2013 of $75 million is approximately $12 million lower than we had anticipated, and as can be seen on

slide 20 of the supplemental slides, our expectation for maintenance CapEx in 2014 includes the previously assumed $80 million to $90 million run rate plus this carryover amount.

Our substantial free cash flow generation facilitated the funding of approximately $171 million in discretionary CapEx, the repurchase of approximately $234 million of common shares, and the initiation of a quarterly cash dividend on our common shares in 2013, with little to no impact on financial leverage and while maintaining more than sufficient liquidity.

In addition to ongoing investments in de novos and bed expansions, our discretionary CapEx for 2013 included the purchase of four hospitals previously subject to lease agreements and the acquisition of the Walton Rehabilitation Hospital in Augusta, Georgia.

Our balance sheet and liquidity remained strong at year end 2013. Our leverage ratio of 2.8 times was slightly higher than at the end of Q3, owing to the exchange of $320 million of new convertible senior subordinated notes due 2043 for 257,110 shares of our 6.5% convertible perpetual preferred stock. We had $45 million outstanding on our $600 million revolving credit facility at year end.

The exchange of the convertible preferred stock, the call of a portion of our 2018 and 2022 senior notes, which was also consummated in Q4, served to further enhance the flexibility of our balance sheet, improve cash flow, and decrease our cost of capital.

And now, I'll ask the operator to open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question comes from the line of Whit Mayo of Robert Baird.

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Hey, thanks. Just wanted to go back for a second to the – the RAC audits, and are there any specific types of cases that the auditors are looking at, and maybe can you talk a little bit about reserves going forward and your comfort level based off of the experience in the fourth quarter?

<A – Jay Grinney – HealthSouth Corp.>: I'll take the first part of that, Whit. They're just looking at a broad spectrum of cases. Now, as you know, we – we've already disclosed that it's a small number of the total cases, so it's – and it's not really zeroing in on any particular discharge. And that with – with respect to the reserves, I'll ask Doug to respond.

<A – Doug Coltharp – HealthSouth Corp.>: Yes, Whit. Our guidance assumptions for 2014 include some continuing RAC activity, with the impact estimated to be somewhat less than that which was experienced in 2013.

<Q – Whit Mayo – Robert W. Baird & Co. Equity Capital Markets>: Okay. That's – that's helpful. And my second question is I guess for Jay. I was just curious how much time you may have spent looking at the new site-neutral changes and patient admission criteria changes for LTACs, and I know you divested your facilities, but just kind of curious as you think about how that could potentially play out for rehab because it does seem that, you know, policymakers are pointing LTACs towards more even than ICU patients, and today a lot of the LTACs are really rehab hospitals that are billing at LTAC. So just kind of curious from your perspective do you see more risk or opportunity for you with those potential changes?

<A – Jay Grinney – HealthSouth Corp.>: It's – I think it's hard to know right now with any precision. I think that there's probably a little more upside benefit to us than risk. Some of those patients, as you correctly pointed out, could conceivably be treated in an inpatient rehabilitation hospital. So I think it's going to narrow the focus of the efforts of the LTACs and what they can provide clinically, and it may then create some opportunities for us to treat more patients.

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

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

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

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: So, I have a focus on free cash flow. So when I look at slide 20 in your bridge from 2013 to 2014, it looks like free cash flow adjusted will be about, say like $350 million to $360 million in 2014, and in the following slide, you have earmarked about $180 million of uses. So that leaves about $175 million of free cash flow unused. So I guess when I look at 2013, you did deploy a lot of free cash flow to shareholders. At what point during the year do you make that decision to maybe, I don't know, do acquisitions, increase your dividend or do other things with your free cash flow?

<A – Jay Grinney – HealthSouth Corp.>: That's really a dynamic ongoing process, Ann. We're not waiting for any particular milestone. We're constantly evaluating what is the best deployment of that free cash flow. But I think you point out a very significant strength of this company, and that is the very strong free cash flow generating capacity that we have. And so as we did last year, we found ways and identified ways and then executed on those ways to return value, and we certainly expect to continue to do that in 2014 and beyond.

<Q – Ann Hynes – Mizuho Securities USA, Inc.>: Okay, and great. And just, can you give a little more detail on the $4 million investment in the patient experience, the TeamWork initiative?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, it's a combination of – that $4 million is a reflection of two items. One, we are initiating a new TeamWorks undertaking, and as you know in the past, we use the term TeamWorks as the moniker inside our company for any company-wide effort to identify and promulgate best practices. We started with sales and marketing back I think in 2008, 2007; we did case management several years ago. We've looked at some of our supply-chain initiatives, and now we're putting our big focus on patient satisfaction or the patient experience. So we'll engage an outside consultant to help us with that process. And then the other portion of that $4 million is just the incremental costs associated with the continued ramp-up of our ACE IT or our clinical information system.

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

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

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

<Q – Frank Morgan – RBC Capital Markets LLC>: Maybe just to start at a high level, I know in the past you all have had some ideas for Washington with regard to pay fors, and with another doc fix potentially coming, can you update us on your proposal I think looking at capping outlier payments, maybe where that is in the process in the scoring?

And then my second question would be more specific to the – maybe for Doug on just how do you go about reserving for MAC versus RAC, and how do you think about it when you come up with those numbers and those reserves? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: So in terms of the pay fors, what we're hearing, Frank, is probably the same thing that everybody on the call is hearing, and that is there is an interest in trying to resolve once and for all this annual problem of the SGR formula resulting in significant cuts to physicians who are treating Medicare beneficiaries. And I think that everyone in Washington realizes that for a host of different reasons, the scoring of that fix has come down pretty dramatically, and I think that the fact that the three committees of jurisdiction, on the House side, Energy and Commerce, Ways and Means, on the Senate side, Finance, all have come up with a single bill, albeit a five-year fix, it really sort of signals the fact that there is agreement in Washington that it ought to be resolved.

But as we all know, the problem is how are you going to pay for it? And what we're hearing is that there are really a lot of different opinions, which suggest that this may not get done this year on a full-year basis. And if you think about it, or as we think about it from then a practical standpoint, if it doesn't get done on a five-year basis and it's just kicked down the road, it'll probably be kicked down the road into 2015 and that will allow everybody to sort of say it's off the radar and now everyone's going to focus on the 2014 mid-term elections.

So it's very hard to know what's going to happen. We have been on the Hill. We had a fly-in with about 20 of our CEOs a couple weeks ago, we've got another one scheduled, meeting with members, particularly members who serve on those committees or represent states where we have a presence, and are lobbying and advocating for this outlier cap. I will tell you the receptivity has been very strong, and – at least among members and their staffs, and it's primarily because they see the merit in the argument. If you reset the 75% rule from 60% to 75%, it reduces the number of Medicare beneficiaries who can receive the inpatient rehabilitative care that their physician has determined they need to get.

On the other hand, if you simply cap the amount of outlier payments any single rehabilitation provider might get at say 10%, that puts the burden then on us as providers to become more efficient, because we've done a pretty thorough analysis on those outliers and we know that it is not a function of hospitals treating extraordinarily complex cases, rather, it is a function of rehab providers having costs that are way out of line and getting a disproportionate amount of their payments, their total rehab payments, from that outlier pool. I mean, there's some providers out there that are getting 30%, 40%, 50% of their total IRF payments are from the outlier. Well that's – and their case mix index is less than what we see in the industry.

So there's clearly a problem there. It's getting traction, it hasn't been scored, and I think it's just too difficult to know how all of this is going to play out.

In terms of the reserves, I'm going to ask Doug to respond to that.

<A – Doug Coltharp – HealthSouth Corp.>: Yeah, the similarity in the MAC and the RAC programs is primarily two-fold. First is that both are focused on medical necessity criteria and the second is that the ultimate appeals and adjudication process is essentially the same. The differences are that the RACs are post-payment reviews and the MACs are prepayment reviews, and that results in different geography in terms of where we establish the reserves. The RAC reserve appears as a contractual allowance, an offset to revenue, and the MACs is bad debt.

In addition, the form of medical necessity criteria review differs for the two. The MACs have been specific types of cases based predominantly on diagnosis codes. The RACs have focused their medical necessity criteria review on FIM scores at both admission and discharge. And in terms of establishing the reserves for the MACs, we have substantially more history on the ADR activity that we've had with the MACs, and we've had enough history to develop what we are confident in in terms of statistical models to establish the reserve level.

We are substantially more early on with regard to the RAC activity. We believe we've had enough activity to make a good estimate, which is reflected in the reserves that we established at the end of 2013, but certainly any additional audit activity from the RACs will serve to enhance our estimating procedures.

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

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

<Q – John Ransom – Raymond James & Associates, Inc.>: [indiscernible] (31:31). Just the [indiscernible] (31:34) gotten through some of the typical ones. Are you any closer to seeing the day where post-acute becomes more of a single category versus for [indiscernible] (31:48), and are you any [indiscernible] (31:50)?

<A – Jay Grinney – HealthSouth Corp.>: John, I am very sorry, but you broke up pretty consistently throughout that question. I'm not sure that I fully understood it.

<Q – John Ransom – Raymond James & Associates, Inc.>: Can you hear me now – better?

<A – Jay Grinney – HealthSouth Corp.>: You're still breaking up.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay. I'll move on then. I'm sorry.

<A – Jay Grinney – HealthSouth Corp.>: Okay. Sorry.

<Q – John Ransom – Raymond James & Associates, Inc.>: I'll go back in the queue.

<A – Jay Grinney – HealthSouth Corp.>: If you can find a land line or something or get into a place where you can get a little bit better reception, go back in queue and we'll answer your question.

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

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Hi. Good morning. This is Dana Nentin in for Darren. On just...

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

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: ...on just – good morning. On de novos, are you seeing anything new or different with respect to the ramp up of those facilities?

<A – Jay Grinney – HealthSouth Corp.>: No, nothing new. They continue to be a very successful growth model for us. The only thing that we have seen with respect to de novos, and we've talked about it on other calls, is as we go forward, we expect more of those will be joint ventures with acute care partners that have a rehab presence. And we think that that makes sense particularly as we enter new markets and we have an eye towards some kind of evolution to an integrated delivery system of some sort, be it ACOs or bundled payments. And so that's really the only thing that is a little different, but we've talked about that for the last I guess year or so. But in terms of ramp up, no, the hospitals that we have opened continue to meet or exceed our expectations.

<Q – Dana Nentin – Deutsche Bank Securities, Inc.>: Okay, great. And then just, I guess, on the back of that, can you update us on some of the discussions you've been having with those hospital relationships? Have you seen any developments there that might be helpful to growth?

<A – Jay Grinney – HealthSouth Corp.>: We don't comment on transactions or potential transactions until they're completed. But I do think it's fair to say that what we saw in 2013 is continuing into 2014, and that is many of the acute care hospitals who have a rehab service line recognized that there are opportunities to enhance the outcomes and the clinical efficacy of those programs and that there are also opportunities to provide that higher level of care to more patients who need that care and they're looking for partners to help them do that.

And so we're there in many of those markets having those conversations. They do tend to go a little bit slower. There's no question about that. If you look at the timeline that we might have for a wholly-owned de novo, we can do a market assessment, evaluate the benefits of going in, what we think we can do to help patients in that community get access to the care that they need, and pull the trigger pretty quickly.

When you're looking at a partnership arrangement, there are many more steps that have to be followed, valuations, third-party valuations that have to occur, terms that have to be negotiated, and so it's a slower process. The benefit however is that at the end of the day, if you can consummate that partnership, you're locked into a large acute care hospital that can be your partner as you seek to provide that care to as many patients as are required and as many patients who would benefit from that care.

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

<A – Jay Grinney – HealthSouth Corp.>: Hi, Rob

<Q – Rob Mains – Stifel, Nicolaus & Co., Inc.>: Yeah, thanks. Good morning. The two questions I have, first of all, a follow-up to Frank's question about Washington. If we don't get an SGR repeal, as you suggested, we still got to get some sort of fix for the rest of the year, and just your thoughts about the likelihood that IRFs would be fingered as a pay for just a temporary patch?

And then the second question, in the guidance for this year, for 2014, could you tell me whether there's any additional lease buyouts included and what the assumption is for Medicare rates for October? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: Okay. So in terms of IRFs potentially paying for a short term fix, I think all providers will be at risk. I don't think that we are disproportionately at risk in large part because inpatient rehabilitation is a relatively small and stable component of total Medicare spending. It's somewhere in that $7 billion to $8 billion range as an industry in terms of Medicare spend. And if you look at total IRF spending as a percent of total Medicare spending, it's remained fairly constant at 1.2% since 2008. So are – is there a possibility that we could be tapped for a short term fix? Yes. But I personally don't believe and certainly nothing that we've heard while we were in Washington or from our folks in Washington would suggest that rehabilitation providers are disproportionately at risk.

And in terms of the lease buyouts, I'm going to ask Doug to respond to that.

<A – Doug Coltharp – HealthSouth Corp.>: Yeah, Rob, I'll hit both the lease buyouts and then the assumption on Medicare pricing for October of this year. Lease buyouts, as we had suggested through the course of 2013, we're going to decrease from 2013 to 2014 and really in the years beyond. We moved from kind of a unique situation where based on the timing of the options that were available to us in 2013, we had a larger universe set and we were able to consummate on four of those transactions. Our anticipation is that we'll have one opportunity in 2014. That's reflected in our assumptions on slide 21 regarding the utilization of cash flow. The estimated cost there will be about $15 million to $20 million, and I would anticipate a somewhat similar level as you look to 2015 and the immediate years beyond.

With regard to Medicare pricing assumption, we last rolled forward our business outlook slide in the materials for the J.P. Morgan conference in January, and those assumptions have not changed. We're assuming a market basket update of 2.9% to be offset by the healthcare reform reduction of 20 basis points and then an assumed 100 basis points in the productivity adjustment.

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

<Q – A.J. Rice – UBS Securities LLC>: Hi, everybody. Two – I'll give my two questions upfront here. First, on the discharge growth assumption for next year, 2.5% to 3.5%, can you give us what the implicit same-store figure is there and whether you made any adjustments for weather in that in the first quarter? And then on therapists, just a update on some basic metrics of availability, productivity, turnover rates, that kind of thing?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, in terms of the discharge growth, we did not include any negative impact for weather, although I will tell you that clearly the weather has been disruptive in the first quarter. We're still pleased with the discharge volumes that we're seeing, but there's no question that it's been disruptive. I mean, there's been a lot of ice and snow in places that don't get that very frequently. And then in the Northeast, as you know, there's a lot of snow, certainly more than is normal. And that – we don't parse it out between same-store and new store in terms of that 2.5%, 3.5%, but if you look historically, it's typically that same-store, new-store is about a two-thirds, one-third break down, and we would expect that that would be continued into 2014. But we haven't really broken it down.

In terms of therapists, we measure our – that metric a couple ways. One is how many openings do we have, and then second, what kind of turnover are we experiencing, and we haven't seen a dramatic uptick in the number of openings. Our hospitals have been pretty successful in recruiting and retaining high-quality therapists. I think the therapists that we bring on to our hospitals enjoy working in a 100% rehabilitation environment. And looking at the turnover, our turnover rates are 200 plus basis points below what you see on the national average.

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Thanks. Good morning.

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

<Q – Gary Lieberman – Wells Fargo Securities LLC>: When I look back at the original guidance for 2013, I think it was $506 million to $516 million of EBITDA. In hindsight, I would say it was pretty conservative. Can you talk about the approach you took to guidance for 2014 and if we should think that there's similar upside?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, and I – that's a good question, and there have been a lot of notes hitting last night and this morning about the conservative nature, and admittedly, it is conservative. I mean, we feel that we have a responsibility to our shareholders to provide guidance on what we are very confident we can achieve. I think it's very fair to say that we are all incentivized on this

side of the call to do a lot better than that, and that's something that we take very seriously. So there is a conservative element to that guidance, and we think that that's appropriate because so much of our profitability is going to be tied to the ability to continue to gain market share and to treat more patients who need inpatient rehabilitative services.

And frankly, we just don't take that for granted. I mean, we don't look back and say, oh, okay, we grew 5% last year, that's a lay down, we can easily grow 5% this year. Now, do we set goals internally that are more aggressive? Of course we do. But we feel that when we're providing guidance, our responsibility is to share with our shareholders what we have a lot of confidence we can deliver on, and then strive day-in and day-out, month-in, month-out, quarter-in, quarter-out to do better than that.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay. And then as a follow up, can I ask what were some of the specific assumptions in the decrease in the self-insurance reserves?

<A – Doug Coltharp – HealthSouth Corp.>: Again, the primary thing there was that we reduced the statistical confidence level that we used to form that estimate, and that's really looking back at the last several years of how actual losses developed with regard to our assumption about how they would develop, utilizing the input from a third-party actuary to also then put that in the context of what's happening in the broader industry spectrum. And when we made that assessment, we determined that we were against the universe of potential losses in each particular year. We were estimating too high a probability of those coming to fruition. So we've lowered that. That is not something that you would expect to see occurring on an annual basis. It is something that should occur very infrequently, and the end of 2013 was the appropriate time for us to make that adjustment based on the data that we had at our disposal.

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

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

<Q – Kevin Fischbeck – Bank of America>: Good morning. I wanted to follow-up on some of your comments about doing more joint ventures and see if that has anything to do with the commentary that 2014 may be a time period where you start to look at more ancillary acquisitions. Is – you kind of dovetail doing joint ventures as part of an ACO-type strategy. Are your joint venture partners at all asking you to expand services, or is that something that is separate? And if it is separate, where are you on that?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, it's very separate, and in fact, many of our joint venture partners have the same view as we do on ACOs. There's a little more receptivity to bundling, but we have not been asked by our joint venture partners to expand our services. And we'll continue to look and evaluate which services make sense. I think it's fair to say that we have said pretty consistently that we believe aggregating different services in existing markets would be certainly a first step in looking at potential expansion into another complementary area. So we do continue to believe that healthcare is a local market service and so there needs to be some degree of synergies in those markets. But to answer the first question, no, we're really not getting any kind of pressure whatsoever by our joint venture partners to expand.

<Q – Kevin Fischbeck – Bank of America>: Okay. And then just maybe just a clarification on the two things. I think you addressed them, but I just want to make sure. You had two one-time items, the RAC item and then the malpractice item. Just wanted to understand exactly what you think the ongoing impact is from those two items in your guidance. You mentioned RAC would be less than 2013. I wasn't sure if that was on a gross basis or on a net basis since you had a corresponding partial offset on bad debt. So what's that impact...

<A – Doug Coltharp – HealthSouth Corp.>: [indiscernible] (46:51).

<Q – Kevin Fischbeck – Bank of America>: [indiscernible] (46:53).

<A – Doug Coltharp – HealthSouth Corp.>: Go ahead. I'm sorry.

<Q – Kevin Fischbeck – Bank of America>: I'm sorry. So what's the impact on that, and is it revenue or bad debt? And then on the workers' comp and malpractice, I guess it sounds like the $6.7 million is not something you'd expect to recur, but is there an ongoing benefit of $1 million or something smaller?

<A – Doug Coltharp – HealthSouth Corp.>: Okay. So on the RAC side, the impact that we're referring to for 2013 was for the full year, not the fourth quarter, and that's the $8 million impact. With regard to the geography on where you'll see that, that's going to be in – tracks any incremental reserves that we take for RAC activity will be in the form of contractual allowances. These are post payment reviews, the appropriate accounting is as a contractual allowance, not as bad debt. So that's where the impact will be on a go-forward basis. And when I said that our 2014 guidance included some continuing RAC activity with the ultimate impact being less than 2013, the reference point was that $8 million number that I was utilizing.

And then the second question was on the statistical confidence level, yes, that $6.7 million should clearly be viewed as a one-time benefit. With regard to what we'll see in terms of expenses in our self-insurance programs for 2014, that is embedded in our 2014 guidance and it does assume the continuing benefit of some of the enhancements we've made in programs like enhancing workplace safety and patient care and so forth. So we continue to refine those programs. We think we continue to get better at it, and the run rate assumption is baked into our guidance.

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

<Q – John Ransom – Raymond James & Associates, Inc.>: Hey, [indiscernible] (48:47) about 20 minutes ago. Good.

<A – Mary Ann Arico – HealthSouth Corp.>: We can hear you.

<Q – John Ransom – Raymond James & Associates, Inc.>: Can you hear me?

<A – Jay Grinney – HealthSouth Corp.>: Yes. Yeah, we can hear you.

<Q – John Ransom – Raymond James & Associates, Inc.>: Okay, great. Just to go back to the bundling question, there seems to be some disagreements in D.C. about, number one, who would control the dollars, whether it's the hospital or some other third party, and number two, what the, I guess possible timing might look like, and I would just be interested in your updated take on both of those? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I think that bundling as well as just the ACO development is going to be an evolutionary process. If you look at the results that have come out on the ACOs, our take is that it is those results are very, very mixed. Not all ACOs in the first year generated savings, not all of those that generated savings were able to share in those savings. And those that did on average were getting somewhere in the $3 million to $4 million per ACO just – if you just do the simple math and try to average it out. And as a result, if you think about the start-up costs of being anywhere from $5 million to $10 million on an all-in basis, it's still not a compelling business model. Now, it may be over time, and year two may be different, and the results may show that this is where the industry is going, but it's not persuasive at this point anyway.

And in terms of bundling, I think it's a little easier to get your arms around bundling as a provider because you're selecting certain DRGs or certain diagnostic codes to bundle payments around. And I think that the control of that is going to be collaborative. I don't think that there's going to be a single entity that ultimately controls all of the dollars unless they have ownership of all of the services, and that is not the model that's out there. So I think it's going to be an evolutionary process, and I think it'll take several years for that to really kind of unfold and for a consistent model to emerge.

<Q – John Ransom – Raymond James & Associates, Inc.>: So not to put words in your mouth, but in other words, you would say it's unlikely for example that an acute care hospital would simply get an extra dollop of dollars which would be intended for them to subcontract out all the – whatever's needed on the post-acute side, that it would be different from that?

<A – Jay Grinney – HealthSouth Corp.>: Well, I think it would be different. I don't think that they would just get it and be told, okay, we're going to give you X number of incremental dollars and you figure out what you're going to do with the – your post-acute services. We certainly haven't heard anything that would suggest that is a model. I can see where the bundling pilots could continue and might take different forms, but in those kind of arrangements, all of the providers have come together ahead of time and said, all right, we'll take the bundled payment, and maybe it's the acute care hospital that is at the head of the table, but everybody around the table has a voice in how those payments are going to be split up.

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

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

Operator: At this time, there are no further questions. I will now return the call to Mary Ann Arico for any additional or closing remarks.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Laurie. As a reminder, we will be filing the updated Investor Reference Book by sometime next week and attending the RBC Healthcare Conference, and the following week, we'll be attending the Raymond James Healthcare Conference. If you have additional questions in the meantime, please feel free to call me at 205-969-6175. Thank you.

Operator: Thank you for participating in HealthSouth fourth quarter 2013 earnings conference call. You may now disconnect.