PARTICIPANTS

Corporate Participants

Michael A. Newshel - Vice President - Healthcare Equity Research, JPMorgan Securities LLC
Jay Grinney – President & Chief Executive Officer, HealthSouth Corp.
Mark Tarr - Executive Vice President and Chief Operating Officer, HealthSouth Corp.
Doug Coltharp - Executive Vice President and Chief Financial Officer, HealthSouth Corp.
Mary Ann Arico - Chief Investor Relations Officer, HealthSouth Corp.

MANAGEMENT DISCUSSION SECTION

Michael A. Newshel, Vice President – Healthcare Equity Research, JPMorgan Securities LLC

Good morning. My name is Michael Newshel, a member of the team covering healthcare facilities and managed care here at JPMorgan. Next up on the agenda, we have HealthSouth. Following the presentation, we'll have a Q&A session in the Yorkshire Room.

And with that, it's my pleasure to introduce Jay Grinney, the President and CEO of HealthSouth.

Jay Grinney, President, Chief Executive Officer & Director

Thank you and good morning, everyone. With me from HealthSouth today are Mark Tarr,our Executive Vice President, Chief Operating Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer; and someone somewhere roaming around, Mary Ann Arico, who's our Chief Investor Relations Officer.

So for those of you who may not know a lot about HealthSouth, we are the largest provider of inpatient rehabilitative services in the United States. We have about 9% of all of the IRFs in the country. There are about 1,134 total inpatient rehabilitation facilities. We own and operate 9% of those. The hospitals that we operate tend to be larger. And so from a bed standpoint, we have a larger market share. And then because of the focus that we have exclusively on providing inpatient rehabilitative care, we see more patients in our hospitals, on average, than other rehab providers nationwide. And so if you look at the number of patients served in our IRFs compared to the rest of the country, we have about 21% total market share.

Another way of looking at that, thinking about that, is one out of every five patients being admitted into an inpatient rehabilitation facility in the United States gets that care at a HealthSouth hospital. You can see the distribution of our hospitals goes from the Northeast down through Florida across to Southeast Texas into Arizona and New Mexico. We have two hospitals currently in California, but we're looking to expand in that state on a go-forward basis.

So that 21%, I think, is pretty significant considering we don't have any presence in the state of New York, never will. There are laws in that state that preclude for-profit operators from being in the state unless all shareholders are residents of the State of New York. And I'm not moving to New York nor are any of the other shareholders in Birmingham, I don't think. And we don't have a significant presence in Chicago. But besides that, we've got a really nice footprint nationwide, and we're looking to expand, as you can see, on the left hand side of this slide, looking to expand across the country, wherever we have identified a need for inpatient rehabilitative services.

Most of the patients we treat are Medicare. That's not because we target Medicare patients, it's just by the nature of the business. The care that we provide is for patients who have been discharged from an

acute care hospital, typically following an acute care episode of a neurological nature. They may have had a stroke; they may be suffering from a chronic neurological condition that renders them incapable of living independently.

They come to our hospitals; they spend an average of two weeks in our hospitals. They go through three hours of intensive therapy per day, per patient; that therapy would be physical therapy, occupational therapy, speech therapy. They're under the care of a physician. They're under the care of nurses trained specifically in rehabilitative care 24/7. And the goal is to get those patients to a point where they can be discharged back into their homes to resume their lives with their loved ones, and get back into their communities.

2013 was a great year for HealthSouth. We executed across all four dimensions of our business plan. We continued to focus on operational excellence; we looked at growing the portfolio. We continued to keep our eye on our balance sheet, looking for opportunities to strengthen the balance sheet wherever we could. And then a new element in 2013 was to introduce a shareholder distribution component of the strategy, where we were able to then bring back to our shareholders some of that excess free cash flow that we generated.

If you look at the operational performance, the thing that we're very proud of is the fact that we were able to grow the number of patients we were able to serve, 5% total in 2013. If you look at it from a same-store, that's about 2.5% out of same-store and 2.5% out of the new hospitals that we brought on during the year.

Three new hospitals were integrated into the portfolio, I'll talk about those in just a minute, one was an acquisition in Augusta, Georgia; and then two de novos that we brought on, one in Colorado, one in Florida. Our focus has always been on ensuring that the quality of care that we provide our patients is superior to the quality that they might receive elsewhere. And in our industry, we have a measure, called the FIM measure, that all inpatient rehabilitation hospitals utilize to assess the level of independence of patients upon admission and then upon discharge.

So it's an 18 point scale, there are cognitive elements, there are physical elements, there's swallowing, there's ability to ambulate unassisted, 18 points that every single – excuse me, 18 measures that every single patient is evaluated against upon admission, throughout the stay and then upon discharge.

The difference between that FIM score upon admission and upon discharge is the FIM gain. The bigger the gain, the more progress that patient has made during their stay with us. And we are very proud of the fact that our FIM gain scores are consistently significantly above the rest of the inpatient rehabilitation industry.

And we believe that that's a function of the fact that this is all we do. We are completely focused on inpatient rehabilitation care. And as the nation's largest, we're able to train our therapists, provide training for our nurses to put the technology that our clinicians need in their hands, and to do that on the real-time basis. So we are very pleased with the fact that our FIM gain scores continue to outpace the rest of the industry.

Another initiative that we started a couple years ago was the installation of a new clinical information system in all of our hospitals. Some of you may not know this, but rehabilitation hospitals are not eligible for any additional payments from the government in putting in an electronic medical record. But despite that, we took the plunge a couple years ago, realized that the industry was moving towards an integrated and an electronically-driven industry. And so we made the commitment, signed up with Cerner, work with Cerner to help them further refine their inpatient rehabilitation platform. And at the end of 2013, we had the EMR in 36 of our hospitals, and we'll continue to add about 20 hospitals per year until all of our hospitals are on the same platform.

We also have hospitals throughout the portfolio that are a little bit aged, and we have the ability through our free cash flow generation to upgrade those that are in need of substantial renovations. We completed

two in 2013. Sunrise is just about finished. Chattanooga is completed. And then as we always look to strive and have demonstrated evidence of our superior quality of care, 96 of our hospitals have now received a disease-specific certification from the Joint Commission on accreditation of hospitals.

In terms of growth, I talked about the Walton acquisition, which was a very good acquisition for us in the first quarter. That hospital had established a very solid reputation in that market, but they were struggling, in part, with the challenges in this reimbursement environment that we're in, but also recognized that they didn't have the wherewithal to position the hospital for continued success going forward.

A big component of that was they didn't have the capital to put in electronic medical record system. So we, along with several other providers, went in, submitted a bid. We ended up being the successful bidder, and the results of that acquisition have actually exceeded our expectations. We got a great group of people over there, put in a new management team, brought in our systems, and the success has been, as I said, much greater than we had expected.

We also opened two hospitals, one in Littleton, Colorado, the other in Stuart, Florida, one, 40 beds; the other, 34 beds. The only reason we didn't open a 40-bed hospital down in Stuart was we were limited by a Certificate of Need regulations in that state. But we fully expect, based on the tremendous success that we've had in that hospital, to be able to go back very soon to get additional beds to meet the needs in that community. We also abandoned a leased hospital, built a brand new, all private room hospital in Ludlow, Massachusetts, 53 beds. We completed that in December, transferred the patients to that new hospital, and are very pleased with what we've accomplished there.

And then, as I mentioned earlier, we are looking to expand our footprint in our portfolio. We have three new hospitals, all under way; One in Altamonte Springs, Florida, a suburb of Orlando; Newnan, Georgia, which is a suburb of Atlanta; and then in Middletown, Delaware.

The last several years has been really focused on making sure that our emphasis on a strong balance sheet maintains a top priority for those of us at the company. And in 2013, we took some additional steps to ensure that our balance sheet remained very strong. We amended and extended our revolver, pushing that facility out to 2018. So the first maturity that we have is 2018. We've got some notes that are due then. We have the revolver due then. And then the balance of our debt profile is about $270 million of notes every two years out into 2022.

We also initiated an exchange of the most – probably the most expensive piece of our capital structure, the preferred stock, exchanged that for convertible subordinated notes. And that was a very successful transaction, reducing our dividend expense on the preferred by about $20 million a year.

We also think it's very important to own and control as many of the assets as we can. We have about 34 hospitals that are under some kind of lease arrangement. We've been able to get about 17 of those on a list where we can go in and, at the expiration of lease, buy that lease out, control the assets. We did four in 2013. We're going to do two in 2014, and then about one a year for the next 10 years.

We also have the opportunity to redeem a portion of our senior notes in 2018 and 2022. We initiated that, took advantage of that, in the fourth quarter. And then earlier this year, we resolved all of our outstanding issues with the IRS and entered into an agreement with them that actually increased our net operating losses by about $290 million.

The thing that we were very pleased to be able to do in 2013 was to return capital to our shareholders. Previously, the focus had been on making sure we had a very strong foundation from a balance sheet standpoint, from an operating standpoint. In 2013, we were finally at a position where we would be able to look at buybacks and dividends. We did both in the first quarter. Second quarter, we bought back about 9.5% of our outstanding shares through a tender, total cost about $234 million. And then, as you can see here, we paid the first dividend on October 15 and announced that we will be paying an additional dividend on January 15 of this year.

So with those results, we were able to increase our guidance for full year 2013. Previously, we had an EBITDA range of $533 million to $538 million. Now we've been able to tighten that up to $542 million to $545 million. And we've got very good visibility on the volume in the fourth quarter. Total volumes went up 3.8%. 2.5% was on new store, 1.3% came from new store, but that was slightly impacted negatively by the fact that, in the prior year, we had a 40 SNF beds that we closed. So if you normalize for that, same-store is about 1.8%, 1.9%.

We also had to climb over sequestration, but we were able to do that in the fourth quarter and had a very good quarter. Now the – we haven't finalized the numbers, so we're still looking at insurance reserves and other things that you would typically look at before you close the books, but we feel very good about that range for EBITDA and for EPS. The $2.50 to $2.52 includes about $1.31 of benefit from the settlement with the IRS. And so you need to kind of normalize that. And as you see here, pages 19 and 20, give you some additional information on the full year estimates.

So the real story, we believe, for HealthSouth is the fact that we are generating an enormous amount of free cash flow. And we've done that by strengthening the balance sheet, taken our leverage from over 5.5x down to just under 3x in a very short period of time. We've been able to reduce our interest expense by about $60 million. And that, coupled with strong operational performance, has resulted in a very, very significant increase, and the amount of free cash flow that the company is generating.

Every time I look at this slide, and I think back to 2008, and the fact that we were only generating $9 million of free cash flow and on a trailing 12 month basis at the end of the third quarter, it was $346 million. I take a lot of pride in what our management team has been able to accomplish.

So as we look at how to invest that free cash flow, we're very fortunate to have a lot of opportunities. First and foremost would be to continue to focus on growing the core business. And as we think about that, there are several different avenues for us. One is to add beds in our existing hospitals where the demand continues to outpace the supply. Last year, we added 68 beds to existing hospitals; we expect that number to be between 80 beds to 100 beds and even some years perhaps, greater than 100 beds, as we continue to meet that demand. That's a fabulous way of investing our free cash flow. We know the facilities, we know the markets, we know the demand, and we're able to bring these new beds on and to fill them very, very quickly.

We're also targeting between four and six new IRFs each year. That's a combination of de novos, where we've identified a market, where there is a need for inpatient rehabilitative services, but the demand is not sufficient to meet that need. We're also looking at opportunities in existing markets to either joint venture or acquire competitor IRFs, and then consolidate that business into our existing IRFs, shutting the competitor down, having the competitor enter into a non-compete, and then enhancing the overall position in that market. And then, of course, we're looking for acquisitions. There are not a lot of acquisitions out there, but those that are coming up, we're certainly at the table and being very disciplined with respect to acquiring additional IRFs.

As I said before, prior to 2013 up through 2012, focus was really on our balance sheet. We have substantially completed all of the debt repayment that we feel we need to. We think any kind of leverage below 3x is very strong, and we don't see a compelling need to continue to delever. But we are going to take advantage of opportunities, should they arise, in terms of calling the 2018s and the 2022s. We can call the 2018s in 2014 after October 1; so we may look at that. But clearly, as we look at where we're going to spend the cash, we think the balance sheet is in very, very good shape.

As I mentioned, we do have some opportunities to acquire facilities that are leased and bring them into an ownership. We'll look at doing that. This year, we spent I think $70 million, $80 million in lease acquisitions. Next year, it's going to be much less, and then after that, it's maybe $15 million, $17 million a year. And then, of course, we'll continue to focus on ways to return capital to shareholders, either through continued dividend payments or through additional share repurchase.

So as you think about the investment considerations for the bed expansions and de novos and the acquisitions and unit consolidations, I think it's a pretty strong and compelling story. We target all projects to have a minimum IRR of 15% on a pre-tax basis. As I mentioned, bed expansions are a great way to bring value to our company because we know the markets, et cetera.

Unit consolidation is very much the same. We're taking excess capacity out of that market. As we look at de novos, typically, they run between $18 million and $20 million, cash payback is five years to seven years. There is a ramp-up period. We have to treat the first 30 patients in those hospitals for free, basically, before we can get Medicare in there and get completely certified and licensed to continue to provide that care and to get reimbursed. But even with that, it's a very successful model for us, and all of the new hospitals that we've brought online over the last several years have actually exceeded our expectations.

And then, of course, we have the opportunity to add new hospitals through acquisitions. We think we have a lot to bring to the table, when we either joint venture or acquire a competitor rehabilitation provider with our clinical protocols, with the technology that we have, with the electronic medical record system that we're installing, with the technology that we're bringing in to all of our hospitals, with the clinical focus on exclusively inpatient rehabilitative care.

So in summary, as we look to the future, we think we have a lot of continued growth opportunities. Not only can we continue to expand in our existing markets, and we will certainly continue to do that, we also have the opportunity to expand in new markets through the de novos and through acquisitions.

I will say one of the things that we are looking at doing more of is joint ventures. We see that there are a lot of rehabilitation needs that are being provided today by acute care hospitals and systems. Many of those are very concerned about some of the other challenges that they're facing, particularly on the reimbursement side. And so they're looking for partners to come in and help them take what they have already created and to bring it to the next level. And that certainly is an important part of our strategy going forward.

And then longer term, we will consider moving into other complementary services in the post-acute space. We don't see any compelling need to do that right now. Frankly, there is also a lot of regulatory headwinds facing many of those other segments. We don't think that it is prudent to buy into those headwinds. We think that it makes a lot more sense to let the dust settle, see what our friends in Washington are going to do or not going to do, depending on their approach. And then we've got enough flexibility with the balance sheet that we'll be able to opportunistically pursue those opportunities as they present themselves.

We're also positioning ourselves for that shift in the delivery system. And we don't know exactly what that's going to look like. I don't think anybody does. We certainly don't know what the timing is going to be, but we do believe it's going to be more evolutionary than revolutionary. And so rather than betting big in a movement that may or may not happen, what we're doing is we're trying to position the company to be responsive, no matter what happens, no matter what those delivery system changes might be.

As I mentioned, we're pursing joint ventures today in many of our growth initiatives. We have 31 joint ventures already. Those create an immediate linkage with an acute care system that positions us with them to be responsive to changes in the delivery system as [ph] it (23:17) moves to a more coordinated care model. And we're putting in the clinical information system. So we'll have the opportunity to communicate with referrals, sources and other providers in the continuum.

We own and operate most of our hospitals. We have a lot of flexibility in terms of what we do with the assets. We have a very strong balance sheet; we're generating a lot of cash, which gives us a tremendous amount of flexibility. We haven't used that and we want to be very disciplined when we do have the opportunity to make sure that we protect the value that we have created in this company over the last 10 years.

Clearly, our focus has to be on maintaining a very disciplined cost structure, ensuring that we are providing the highest quality of care. We do think that ultimately, that is what is going to differentiate us from other providers, and our focus on being the best of class remains our number one priority.

And then we are experimenting and putting our toe in the water with different delivery models. We're participating in some ACOs, looking at some bundling programs. Those are all very early stage as they are for most of us in the space, but we do think that by participating in those we'll be in a very good position to respond as the industry moves into its new stage.

So with that, I see our time is out. And so we will now take – move over to the Q&A. Thank you.

Mary Ann Arico, Chief Investor Relations Officer

It's in the Yorkshire Room.

Jay Grinney, President, Chief Executive Officer & Director

It's in the Yorkshire Room.

Corporate Participants

Jay Grinney – President, Chief Executive Officer & Director, HealthSouth Corp.

Other Participants

Mike A. Newshel – Analyst, JPMorgan Securities LLC

MANAGEMENT DISCUSSION SECTION

Mike A. Newshel, Analyst, JPMorgan Securities LLC

All right. So, as others are coming in, why don't we use the time to your advantage. We're here for Q&A.

Unverified Participant

Question for Jay.

Jay Grinney, President, Chief Executive Officer & Director

Sorry.

QUESTION AND ANSWER SECTION

<Q>: What's your biggest competitive threat?

<A – Jay Grinney – HealthSouth Corp.>: The government. The question was what's the biggest competitive threat? And frankly, I think the biggest competitive threat is the government. It's very hard to know today what legislators are going to have to do as they address some of the serious financial issues facing the country. And we're 80% Medicare dependent. And while that creates some challenges for us, the good news is that at least in the Medicare program as long as you're providing high-quality care, you're meeting the needs of the patients, you meet all the requisite qualifications for participation, you're able to continue to provide that care. And that population is growing 3% per year. So, the demand for inpatient rehabilitative services is expected to grow. The average age of our patient is 72. The average age of our Medicare patient is about 78. So you've got this huge bolus of individuals in the baby-boom generation that are now just hitting the 65 threshold. And as they age, that demand for rehabilitative services is going to continue to grow.

<A>: I think it's important to note as well, when you look at the universe of IRFs that are out there in the freestanding business that we exist in, and we have 103 hospitals right now, the next largest aggregation that we're aware of any single competitor is 12, and then the number drops off from there. So it'd be very difficult for any other party to replicate a network of freestanding hospitals such as we have, based on the fragmented nature of the rest of the industry, based on the tremendous capital that would be required to accomplish that aggregation. And then from the de novo perspective, they would face the same certificate of need requirements in about 50% of the states in the country that make it a challenge for us sometimes to expand.

<Q>: Plus the other IRFs are attached to acute care hospitals.

<A – Jay Grinney – HealthSouth Corp.>: Most of them are.

<A>: In terms of number. And when you look there too, yes, there are competitors like HCA that have a large number of acute care hospitals and have a fair number of IRFs within their units. They don't overlap with us in a lot of markets. But the acute care hospital industries are also very highly fragmented, and remember 85% of that industry is not for profit.

<A – Jay Grinney – HealthSouth Corp.>: We just also mention that we have an update on a quarterly basis, an Investor Reference Book. I hope that you – if you don't have a copy here, that you'll get one. But if you go to page 15 of that Investor Reference Book, it is a snapshot in time of performance of the company. And 18 months of that timeline was a period when our payments from Medicare were actually reduced. So, if you look at the first quarter of – excuse me; the second quarter of 2008, we started a program – the government started a program where our payments were reduced back to 2007 levels. And that was to help pay for a change in the then 75% Rule to a permanent 60% threshold. So, as a pay for that permanent fix at 60%, the IRF industry had their payments reduced for 18 months. And despite that rate pressure, we were able to grow volumes, take market share and to grow our EBITDA. So, while we certainly don't look forward to changes from a reimbursement standpoint that may come out of Washington, we do feel that we're positioned to be able to absorb those and to work through those and to continue to grow.

<Q>: Can you offer us an assessment of what you are hearing out of Washington in terms of how they view the IRFs and [indiscernible] (4:32 – 4:48)?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. First of all, the question is how do they, in Washington, view the IRF industry? And I don't think that there is a singular view of IRFs, certainly in Congress, which is where we spend most of our time and our focus. We're in 28 states, so we have a pretty good footprint in Washington as we advocate for our patients. There is an acknowledgement of the value proposition that rehabilitation providers offer.

There is also an acknowledgement that over the last several years, there have been changes to IRF payments and criteria that have limited the number and kinds of patients that we can treat. We're not getting a sense that there is a big appetite in the legislative side of Washington to change that. One of the proposals that's been out there is to move this 60% Rule back up to 75%. Well, Congress permanently set it at 60% back in 2007. We get the sense that members appreciate the fact that if you raise that threshold to 75%, you're limiting access to needed services for Medicare beneficiaries and that the alternative would be for those patients to go to a nursing home, which I think there is an acknowledgement that the level of care in a nursing home is much less intensive than what you would find in an inpatient rehabilitation hospital. So, that's kind of Congress.

If you go over and you look at CMS, our assessment is that that same attitude is within CMS. They recognize the value of inpatient rehabilitative services. I think we all understand that when margins get too high, Medicare margins get too high, it will bring scrutiny. Right now the industry is between 10% and 11%, for the IRF industry, and that's pre-sequestration. So, once we see what the effects of sequestration are, that may then drop that margin back down below 10%. And so, we don't really know – we're certainly not anticipating any significant change coming from Washington. But we do believe that no matter what happens in Washington that providers who can provide high-quality care, do it on a very disciplined cost-effective basis are going to be survivors.

The demand for the services is not going away. As I mentioned a minute ago, that demand is growing at about a 3% per year clip. And even though that baby-boom generation may not today be needing inpatient rehabilitative services, you think down the road another five years, 10 years, certainly 15 years and that demand is going to be pretty significant.

<Q>: [ph] Jay, (7:56) is enough opportunity for growth just [indiscernible] (7:59) you may have 40% of freestanding facilities, and my guess would be 50% of freestanding license [indiscernible] (8:07). Do you think that this is enough growth for the next two years to five years just given how much share [indiscernible] (8:11)?

<A – Jay Grinney – HealthSouth Corp.>: Yes, we do. And it's in part driven by that demand profile that I just mentioned. But it's also enhanced through what I mentioned in the formal remarks, which is a recognition by many of the existing rehab acute care hospital providers that their ability to continue to offer high-quality rehab services is at risk in this new world order of reduced reimbursement. And those that are thinking down the road and saying, okay, if this moves to some kind of coordinated care model, can we as the acute care hospital be absolutely certain that all of the services that we are offering are going to be of the highest caliber. And many are recognizing that, when it comes to their core business, surgery, oncology programs, et cetera, cardiac programs, yes, that's where they can put their focus and that's where they can put their capital and that's where they can really excel. But there are a whole host of secondary services that frankly they just don't have the ability to excel. And so, we're being invited in or we're coming in and discussing, to an increasing degree, where those opportunities are for them.

So, I think that the growth profile is: one, the demand is going to continue to grow so we can meet that; two, we've got the opportunity to expand into new markets. Many of those I think are going to be joint ventures; and then, the third, as I mentioned in the remarks, in many of our markets, the over-65 population is growing at a rate substantially higher than the national average. And so, we're running out of beds in many of our markets and where we have to go back in and add additional beds.

<Q – Mike Newshel – JPMorgan Securities LLC>: Other questions? Yeah.

<Q>: [indiscernible] (10:13 – 10:20) for new hospitals. What limits you from going beyond that? Is that [indiscernible] (10:24)?

<A – Jay Grinney – HealthSouth Corp.>: That is certainly one of the limiting factors. And when we target that four to six new IRFs and about 80 new beds, the 80 beds is really just a function of what's the demand profile in our existing markets. And every other week we do – we have a meeting, senior management, the three of us, along with regional presidents and others from corporate, and we assess

what the needs are in our existing hospitals. We get a hospital in that's 75% occupancy, they're on the list. They get up to 80%, 85%, we start taking action to make sure that those hospitals have the new beds online at the time when they need those.

In terms of the new IRFs, however, certificate of need is going to be a big limitation. As we explore joint venture opportunities, frankly, the biggest limitation there is just the ability of the potential partner to move quickly and to meet the expectations that we have in terms of our timetables.

<Q>: [indiscernible] (11:35 – 11:38)?

<A – Jay Grinney – HealthSouth Corp.>: Yes. And we've talked about that in 2013. We see that as a growing trend. It's not an exponential change, but it certainly is a trend that we anticipated we would see and we started to see in 2013.

<Q – Mike Newshel – JPMorgan Securities LLC>: Yeah.

<Q>: Can you give us more color on the scope of the JV that [indiscernible] (12:03 – 12:13)?

<A – Jay Grinney – HealthSouth Corp.>: So, I'm not sure I understand the specific question, but the nature of those joint ventures is very similar to what we have with our – with 31 existing joint ventures. And so, envision a large acute care hospital or hospital system in a given market, they may have a 20, 30, 40 bed rehab unit underutilized. They recognize, we recognize that there are many more patients being discharged from local community hospitals as well as their hospital, who would benefit from rehab services, but aren't getting those rehab services or they are getting them in a sub-acute setting.

And so, it's really a recognition that it would be transformational for them, because it would take their rehab services to a much higher level, offering services to patients who are medically complex, that they are not able to take care of today. Plus, it's transformational for us, because we're entering new markets through that joint venture. And at least in a couple of those instances, we see that as being a door that's being opened to then other markets in states where we currently don't have a presence or a very, very limited presence.

<A>: Some of our partnerships date back to the 1990s. So, we know how to run partnered hospitals and how to be a good partner. So, what Jay is talking about in terms of the development pipeline, we're just starting to see more and more opportunities, partner-type opportunities. But we've been running partnership hospitals with acute cares for quite some time.

<A – Jay Grinney – HealthSouth Corp.>: And some of those are in big, with large academic medical centers like Vanderbilt in Nashville, Barnes-Jewish Christian in St. Louis, University of Virginia in Charlottesville; I mean, University of Massachusetts. We've got University of Missouri. And then we have partnerships with large non-academic medical centers like Martin Health down in Stuart, Florida. So, it's a wide range of partnership arrangements that we think links us up very nicely should the delivery system moved at a faster pace towards some kind of risk sharing, integrated care, whatever you want to call it, ACOs, bundling. As that moves forward by linking up with an acute care hospital, we're mitigating some of that, that delivery system change risk that might present – might be presented if we're out there all by ourselves.

<A>: And to be clear, when we talk about these JV opportunities, we're not taking over the management of an existing unit in an acute care facility. The partnership is – the unit is contributed by the acute care player, meaning that they exit that space and sign a non-compete in return for equity ownership in either one of the existing HealthSouth facilities or we use that as a catalyst to enter new market by building a de novo facility.

<A – Jay Grinney – HealthSouth Corp.>: And they get to reuse that space. So, as they look down the road and they're expecting an influx of patients as a result of the Affordable Care Act, they are seeing that they have a choice. They've got a 20-30 bed unit that is designated for inpatient rehabilitative services

today, maybe it's 40% occupied, maybe it's less. And they're anticipating an increase in medical surgical patients coming into their hospitals. Do they go out and add capacity and make a capital commitment to bring on that new capacity? Or do they say we're going to reuse that space? We'll joint venture this, so we'll continue to get the benefits. Certainly, they're expecting and we're expecting that that benefit will go up. They'll do better, make more money on that rehab unit as it is spun out and joint ventured with HealthSouth. And they get to then repurpose those 15, 20, 40 beds for med/surg purposes, which is really in their core business.

<Q – Mike Newshel – JPMorgan Securities LLC>: [ph] Alex (16:20)?

<Q>: [ph] In the future (16:22) how do you ensure [indiscernible] (16:24 – 16:33) and that margins you get today, how do you ensure the hospital then drive [indiscernible] (16:37)?

<A – Jay Grinney – HealthSouth Corp.>: I don't know that there is a way that we can be certain of anything in the future [ph] Alex (16:45). But I would tell you we do believe that; number one, by partnering with an acute care hospital, there's – our incentives, our financial incentives are aligned to ensure that we do get the right amount. We also believe that by ensuring that we put our focus on quality and that we're in a very – that we do that on a very cost-effective disciplined basis that we will be at the table and participating. How those ACOs are going to work out -- I mean it's anybody's guess. We're involved in a lot of negotiations right now. We see that as being sort of our toe in the water, if you will, to experiment with this. But I don't know – whenever question is how do you guarantee and it's something in the future, I don't know how to answer that. I honestly don't. I think what you have to do is just ensure that you are as prepared as possible and that you have the strongest business model possible and you have the strongest balance sheet possible. And those three together, along with a flexible approach to how we would provide that care, I think, guarantees that we'll have a run and that we'll be in the hunt, if you will.

<A>: We are by far the most cost-effective provider of those services in the country. So, if the ACO begins to price those services in a way that we can't make an adequate margin, that means that nobody else in the industry is going to be able to make an adequate margin, which means capacity will exit the industry and then you wonder how the patients gets appropriately treated.

<A – Jay Grinney – HealthSouth Corp.>: And the other thing that I think is important to keep in mind is that in that new world order, presumably – and maybe I am being presumptuous here -- but presumably the silos that have been created by Medicare for the sole purpose of defining how post-acute providers are going to be paid, in an integrated model, those silos go away. Those regulations go away. The need for them is obviated, because there is a single payment and there is a single payment going to the ACO. Well, in that kind of world order, I would envision us treating in our rehab hospitals many more patients than we're able to treat today, because we're limited today by those government regulations. We can't take knee and hip patients – replacement patients unless they meet a very, very narrow definition of what the government deems to be an appropriate admission to a rehab hospital.

Well, in that new world order, presumably, the government is sitting back saying we're going to get out of the business of regulating how providers are paid and we're going to be focusing on outcomes and quality and we're going to let you all determine what's in the best interest of the patient. We can't wait for that kind of environment, because we know that there are patients going to skilled nursing and other facilities that we can't treat that we would be able to treat and do so on a very high-quality basis.

<Q>: [indiscernible] (20:10 – 20:24)?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. All our hospitals are licensed as acute care hospitals. So, we treat patients who need 24 hours, seven day a week nursing care, and can participate in inpatient rehabilitative services, physical therapy, occupational therapy, speech therapy, at least three hours a day. The kinds of patients that we could treat going forward in that new world order would be back into many of those orthopedic cases. Knees and hips that we can't treat today, cardiac conditions that we can't treat today, there's a whole host of conditions that CMS through regulations has said, either you can't treat or you can treat a very, very small number because we've got this measure out there called the 60% Rule

that is going to always sort of regulate how many patients of different kinds you can treat. So, there's a wide range actually of patients that prior to 2004 we were treating, that after the rule went into effect we were no longer able to treat as many of those patients.

Any other questions?

<Q>: [indiscernible] (21:38 – 21:48)

<A – Jay Grinney – HealthSouth Corp.>: We put that number out there. We're sticking with that four to six because I think our focus has always been on, be it providing guidance in terms of EBITDA and EPS or putting metrics like that out there. We want to be able to provide to the investment community numbers that we are confident we can execute on. And so, we get no benefit in overpromising. We get a lot of benefit if we over-deliver. And so, I think that that four to six is a number that you guys are looking at how to factor that in and build that into your model. I think that's a good number to use. And then, we'll look to surprise you.

Anything else? [ph] Tom (22:40), you cannot ask a question. No, you cannot ask.

<Q>: [indiscernible] (22:44).

<A – Jay Grinney – HealthSouth Corp.>: We all did. But he's got a tan. He must have come off his island.

<Q>: [indiscernible] (22:50).

Jay Grinney, President, Chief Executive Officer & Director

Yeah. Any other questions? All right. Thank you very much.