Operator: Good morning everyone, and welcome to HealthSouth Second Quarter 2009 Earnings Conference Call. At this time, I would like to inform all participants that your lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. In order to accommodate all callers, please limit yourself to one question and one follow-up question.

Today's conference call is being recorded. Your participation implies consent to our recording this call. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Ms. Mary Ann Arico, HealthSouth's Senior Vice President of Investor Relations and Corporate Communications. Please go ahead.

Mary Ann Arico, Senior Vice President, Investor Relations and Corporate Communications

Thank you, and good morning everyone. Thank you for joining us today for the HealthSouth Second Quarter 2009 Earnings Call. With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; John Workman, Chief Financial Officer; Mark Tarr, Executive Vice President of Operations; John Whittington, our General Counsel; Andy Price, Senior Vice President of Accounting; and Ed Fay, Senior Vice President and Treasurer.

Before we begin, if you do not already have a copy, the press release, financial statements and the related 8-K filings with the SEC are available on our website. In addition to the required information, we have also provided a set of slides, which are available on our website. The first 15 slides will be referred to during the call. The remaining 17 slides include supplemental information, including GAAP reconciliation.

Moving to Slide 1, the Safe Harbor slide. 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 projections, forecasts, estimates and expectations are discussed in the Company's Form 10-K for 2008 and in its quarterly filings with the SEC, including the Form 10-Q for the second quarter 2009 scheduled to be filed today. 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 current estimates of future events, and speak only as of today. The Company does not undertake a duty to update or correct these forward-looking statements.

Our slide presentation and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of this slide presentation or at the end of the related press release, both of which are available on our website and as part of the Form 8-K filed last night with the SEC.

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

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Mary Ann, and good morning, everyone. Obviously the second quarter was another excellent quarter for HealthSouth, as we continued to execute our business plan and achieve solid results across all key operating metrics. We are especially pleased to have generated these results through a combination of volume growth and expense management, as we did in the first quarter.

Discharges from our hospitals increased 5.6% on an aggregate basis and 4.7% on a same-store basis. In terms of our service mix, we continued to see favorable trends in the number of stroke and neurological patients discharged from our hospitals, while knee and hip replacement discharges remained less than 10% of our total patients, reflecting our emphasis on our higher acuity cases.

Although our Medicare unit pricing was essentially flat quarter-over-quarter because of the rollback that went into effect April 1 of last year, our stronger volumes coupled with higher acuity patients and reasonable increases to our managed care pricing contributed to a 7% increase in our inpatient net operating revenues. Total net operating revenues increased 5.9%.

The second quarter also yielded positive results with respect to operating expenses. And we were especially pleased with the ability of our hospitals to manage their labor costs. Salaries, wages and benefits increased 2.1% in aggregate and were 49.4% of net operating revenues, an improvement of 190 basis points over last year.

Solid top line growth and effective expense management brought adjusted consolidated EBTIDA for the quarter to $94 million, an increase of 9.4% over the second quarter of 2008. And this included a one-time non-cash income tax adjustment of $4.9 million at one of our non-consolidated joint venture hospitals.

Another important operating metric for us is free cash flow. Adjusted free cash flow for the quarter was $29.8 million. This compares favorably to free cash flow of 7.5 million in the second quarter of 2008. And finally, adjusted income from continuing operations came in at $0.39 per diluted share, an increase of $0.22 per share over last year.

With that overview of the quarter's highlights, I'm going to ask John Workman to do a more thorough walkthrough of our results.

John L. Workman, Executive Vice President and Chief Financial Officer

Thank you, Jay. I will be referencing the slides we filed on Form 8-K in my comments today. As Jay mentioned, we are very pleased with the results for the quarter.

First looking at income statement revenues, which can be found on slide 5, in our inpatient hospitals our inpatient revenues increased by 7% over last year's quarter to $439 million. The current quarter includes revenues from our Vineland acquisition and our Arlington and Midland consolidations that were completed in the second half of 2008. As Jay mentioned, discharges on a same-store basis increased 4.7%.

Pricing, as expressed on a per-discharge basis, increased 1.3% from a year ago primarily as a result of treating higher acuity patients. Our length of stay was three-tenths a day shorter than the same quarter a year ago, which can be found on slide 23. Despite the shorter length of stay, our occupancy improved to 68.8% from 66.9% a year ago. Again, you can find that on slide 23.

In looking forward, we do want to remind you of a couple of items that may impact our second half of 2009 inpatient revenues. First, TeamWorks was installed progressively through 2008 in our hospitals. This will make our volume comparables more challenging for the second half of 2009. Second, CMS released its fiscal year 2010 final rule for the IRS last week, which included a 2.5% market basket update as well as new coverage requirements. However, the various healthcare bills being discussed in Congress include reductions to market basket updates for providers as a means of helping to pay for healthcare reform. Accordingly, it is possible this recommended market basket update eventually could be reduced by Congress.

In our outpatient facilities, staying with the revenue line, our outpatient and other revenue declined 3.2% from the same quarter a year ago. There were 15 fewer outpatient satellites this quarter than there were in the same quarter a year ago. This element of our business is more discretionary in nature than our inpatient hospitals. With this in mind, and with some potential additional closures, you should expect outpatient revenues to continue to decline in 2009, though I will remind you that outpatient is not a large portion of our revenue base.

Next, turning to operating expenses, which can be found on slide 6, salaries and benefits as a percent of revenue were flat sequentially from the first quarter of 2009, but improved 190 basis points from a year ago, demonstrating we are continuing to provide high-quality patient care, but on a cost-effective basis. There was a slight dollar increase of 2.1% year-over-year, which is generally attributable to the higher number of patients treated and a 3% average merit increase to all employees, except senior management, effective October 1, 2008.

We continue to see improvement in labor productivity expressed as employee per occupied bed, which was a 3.6% improvement. As we mentioned to you in 2008, we have made some changes regarding benefits, including paid time-off, which we believe also contributed to the improvement.

In looking to the second half of 2009, we expect salaries and benefits as a percent of revenue to grow for the following reasons. One, we are cycling through some favorable benefit changes made late in 2008. Secondly, the summer months usually include a more non-productive time due to vacation, which increases our salary costs. Third, we will be providing a merit increase to our employees, expect for senior management, effective October 1, 2009. And lastly, our new Mesa hospital will have startup costs, including salary costs and operating expenses during the second half of 2009 with very little patient revenues.

Next, in looking at hospital-related expenses, which are other operating costs, supplies, occupancy, and bad debts; as a percent of revenues, these increased by 40 basis points to a year ago, and 30 basis points sequentially from the first quarter of 2009. The second quarter of 2008 was favorably affected by a reduction of self-insurance cost resulting from a revised actuarial estimate in the second quarter of 2008, as we discussed last year.

Regarding the provision for doubtful accounts, it increased to 2% as a percent of revenues, which is a 30 basis point increase from the first quarter of 2009. We expect our provision for doubtful accounts to remain at 2% for the balance of the year. The principal cause is a provision towards pending Medicare claims that are being reviewed by one of our fiscal intermediaries.

These reviews have increased in number, and while we continue to have a very high success rate with these pending claims, they are taking longer to adjudicate. As a reminder, we make provisions on these claims as they age since we are not assured of collections. Claims can take 15 to 18 months to work through the system, so we believe this is the right approach and somewhat conservative. We had a similar situation a year ago, and we were able to work through the process and return to a normalized provision rate of 1.5% to 1.8% of net revenues. We anticipate this will result in a similar outcome that should be normalized by 2010.

As we mentioned in our Year-End 2008 Earnings Call, the fourth quarter of 2008 included approximately $6 million of non-comparable benefits. These non-comparable items related to reduction in self-insurance cost and the elimination of expenses due to state law changes. As you consider a comparison to the second half of 2008 regarding EBITDA, you should remember these non-comparable items.

Next, turning to general and administrative expenses, excluding 123(R) cost, our G&A as a percent of revenue was 4.5%, reflecting a 40 basis point improvement to last year. As we have previously stated, our goal is to be at 4.75% of net operating revenues, excluding 123(R) cost.

Next, we've generally not talked about the line, equity and non-consolidated affiliates. But, this quarter has had a $4.9 million adjustment that is an out-of-period expense. We discovered an error in the quarter related to an understatement of prior period income tax provisions of a joint venture dating back to 2004 that gave rise to the out-of-period expense. This joint venture has independent accounting outside of HealthSouth and is a separate tax payer. It is accounted for on the equity basis, as we do not meet the control criteria that would allow us to consolidate the joint venture in our financial statement.

Some notes, this adjustment does not impact our cash balance. We will be exploring alternatives with our partner to structure the joint venture differently to make it more tax efficient. This is one of three joint ventures accounted for under the equity method. The other two are on our systems and are structured as partnerships. So, we have a different back pattern in those.

Next, turning to depreciation and amortization, we were generally flat to last year for the quarter. But, as you think about the second half, our new Mesa hospital and capital additions including bed expansions and refresh programs, are likely to result in higher depreciation in the second half of 2009.

Turning to the line, government class action-related settlements, this includes our mark-to-market non-cash impact of $48.6 million for the 5 million shares and 8.2 million warrants with a 41.40 strike price that we agreed to contribute as part of the Securities' litigation settlement.

It is an unusually large charge this quarter due to an increase of over 50% in our stock price since the end of the first quarter of 2009. I should point out, we anticipate now these shares will be distributed in the third quarter of 2009.

Next, turning to professional fees. This line generally relates to amounts being spent in pursuit of the derivative claims against Ernst & Young and Richard Scrushy. A credit or income exists in the second quarter, as we were able to reduce the liability for indemnification claims that could have been asserted by Mr. Scrushy, as a result of the judgment against him.

Next, I'd like to talk to items below operating expenses. Interest expense was $12.3 million below last year, due to our lower LIBOR rates and debt levels. I am going to speak more about debt later. With LIBOR approximately 35 basis points compared to 280 basis points a year ago, we are seeing favorable interest expense due to lower rate. Because our swap is at 5.22%, we are making cash payments which are not part of adjusted EPS because they are considered financing activity, but these are reflected on the cash flow statement and our cash flow analysis. The mark-to-market change – charge on the interest rate swap of 3.8 million was because LIBOR was lower in the second quarter than it was at the end of the first quarter.

As a reminder, our swap has stepped down slightly, but still covers 956 million of notional amounts, and is at a 5.22% fixed rate. The notional amount declines by 72 million next year, and goes to zero in March 2011. In June 2009, we entered into a received fixed rate swap at 5.22%, as a mirror offset for $100 million and paid $6.4 million in this transaction. We've also added 200 million of forward swaps that are effective in March 2011 through September or December 2012, at a 2.6 to 2.9% fixed rate.

Turning to the income tax line, we have a $300,000 benefit on the income tax line this quarter. The majority of this benefit relates to state income tax refunds expected from amended returns being filed for 2004, offset by other provisions.

Next, on slide 7, turning to adjusted consolidated EBITDA. As Jay stated, adjusted consolidated EBITDA was $94 million for the second quarter compared to 85.9 million in the second quarter of 2008. We attribute the improvement in 2009 over 2008 to strong volume growth, improved labor

productivity, allowing us to continue to deliver high quality patient care on a cost-effective basis and lower G&A expenses.

Next, turning to slide 9, net income, earnings per share. In discussing net income and adjusted earnings per share in the quarter, we believe there are some adjustments that should be considered, items either non-cash or non-recurring when considering income from continuing operations. The adjustments to EPS are similar in nature to adjusted consolidated EBITDA, but not identical. The adjustments to EPS generally relate to the professional fees line, mark-to-market or fair value adjustments to liabilities, and the gain on early extinguishment of debt. We have also adjusted to a normalized income tax expense to reflect a run rate for this element.

Considering these items, adjusted income from continuing operations is $39.8 million in the quarter, representing a $23.7 million improvement in income. And, adjusted EPS is $0.39 per diluted share, representing a $0.22 per share improvement in EPS over the second quarter of 2008. A portion of this improvement was the result of a lower LIBOR rate. If LIBOR was at the same level as the second quarter of 2008, adjusted EPS would have improved by $0.15 per share, representing a 88% improvement.

Next, turning to the balance sheet, available cash was 49.8 million at June 30, 2009. Cash was reduced by approximately $40 million in the first quarter in mid-June with the payment of our bond interest which is payable, to remind you, semi-annually on June 15 and December 15.

Next, in looking at long-term debt which can be found on slide 12, long-term debt was 1.702 billion at the end of the second quarter of 2009. Debt has been reduced $111 million since year-end 2008. Our leverage ratio declined 0.6 of a turn from year-end, and we are now at 4.7 times based on our trailing four quarters of adjusted consolidated EBITDA. Being at 4.7 at the end of the second quarter, we believe our longer term goal of 3.5 times to 4.0 times by the end of 2012 is progressively more achievable.

Just as importantly, our funded senior secured debt ratio is moving very close to 2.0 times at the end of the second quarter. This gives us more confidence that we should be able to refinance our bank lines when they come due in 2012 and 2013.

As you know, our credit agreement contains covenants, namely a leverage covenant and an interest coverage ratio. We are in compliance with these ratios as of the end of the second quarter of 2009. We have also included a liquidity schedule which can be found on slide 13. Based on our available cash and undrawn revolver, we had 449.8 million of liquidity at the end of the second quarter. This was an improvement of $110 million over our position at year end.

Our improving credit position we believe was recognized by the rating agencies in the second quarter. Moody's upgraded our corporate credit rating allowing the spread on our term loan to be reduced by 25 basis points, and Standard & Poor has moved our outlook to positive from stable.

Lastly, turning to cash flow, which can be found on slide 11, free cash flow adjusted for interest rate swap payments and dividends on preferred stock and excluding non-recurring items is $29.8 million for the second quarter of 2009, and is 72.9 million through the first six months of 2009. The quarterly results are significantly better than the 7.5 million in the second quarter of 2008, and are the result of increased earnings and working capital improvements. Total capital expenditures were 17.6 million for the quarter.

The following is a breakdown of the components. Capital expenditures not of a maintenance nature, were 10.1 million. These primarily represent payments towards already announced de novos, cost for bed expansions and some corporate expenditures. Maintenance capital expenditures of 7.5 million included money spent on our refresh programs in our hospitals.

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

Jay Grinney, President and Chief Executive Officer

Great. Thank you, John. Before we take questions, I'd like to provide our initial observations on the final IRF PPS rule that was issued last Friday, and discuss our revised guidance for 2009.

The final rule can be analyzed in two buckets. While the first bucket, payment updates, has several components to it, overall, we believe the payment updates are positive for the Company and for inpatient rehabilitation providers in general. The 2.5% market basket update clearly is a positive, especially since inpatient rehabilitation providers haven't received an increase since April 1 of last year.

As we will review in a moment, since HealthSouth is not dependent on high cost outlier payments, the increased outlier threshold component of the rule is essentially a non-issue for us.

Finally, although the other payment elements such as the updating of the CMS relative weighting and the various facility level adjustments will require additional analysis, our preliminary assessment of these indicate they will be neutral to slightly positive for the Company.

The second bucket is the revised coverage requirements for IRF providers. HealthSouth was very pleased to have had the opportunity to provide our comments to the proposed rules and we applaud CMS for their willingness to receive and consider this input.

As mentioned in the fact sheet that accompanied the release of the final rule, these new coverage requirements such as comprehensive pre-admission screenings, post-admission evaluations conducted by a physician, the development of individualized care plans within 72 hours of admission, and a minimum of three face-to-face physician visits per week, to name a few, all represent current best practices and will not fundamentally change our existing clinical or business models. Any potential modifications to existing documentation or additional training we may need, should be easily accommodated by the January 1 implementation date.

In summary, our preliminary analysis suggests that the final rule is a net positive for HealthSouth. Based on our solid year-to-date results and our positive outlook for the second half, we are raising our full-year adjusted consolidated EBITDA and adjusted EPS guidance as follows. Adjusted consolidated EBITDA is now expected to be in the range of 354 million to $362 million versus our original guidance of 342 to $352 million.

To put this revised adjusted consolidated EBITDA guidance into perspective, it's important to recall adjusted consolidated EBITDA was $167 million in the second half of 2008. And this included approximately $6 million of non-comparable benefits that John discussed earlier. With 161 million as our starting point, our revised adjusted consolidated EBITDA guidance takes into consideration the following: first, volume comparisons; second, typical second half labor cost trends; third, the temporary increase in our provision for doubtful accounts; and fourth, our expected market basket update.

As we've previously stated, second half volume comparisons are going to be challenging. As a reminder, our discharges grew 9.3% and 10.6% in the third and fourth quarters of last year respectively. While we don't anticipate matching these results, we are comfortable maintaining our 4%+ discharge projection for the second half.

As John indicated in his comments, there are several factors that historically contribute to higher labor costs as a percent of net revenue in the second half of the year: The first is our annual merit increase. As you may recall, merit increases for all non-senior management employees occur on

October 1 of each year. Market surveys indicate competitor salary increases have been in the range of 2 to 3% thus far in 2009. While we haven't finalized the target for this year's increase, we certainly expect to be within this range.

Furthermore, we will be coming up on the anniversary of some of the benefit changes we put in place in the second half of last year, and also we'll have one-time startup costs related to our new hospital in Mesa, Arizona, all of which will contribute to higher labor cost as a percent of net revenue in the second half of the year.

As John mentioned, our provision for doubtful accounts will remain slightly elevated in the second half due to the focus reviews being conducted by one of our fiscal intermediaries. As we stated previously, we would expect this to return to historic levels as a percent of net operating revenues next year assuming we maintain our success rate with these reviews. Historically, this success rate has been approximately 75 to 80%.

Finally, although the final rule included a 2.5% market basket update, we've chosen to take a more conservative approach in forecasting Q4 Medicare pricing, since all of the healthcare reform legislation being considered include some kind of market basket reductions. Accordingly, at the low end of our guidance, we're assuming no increase to our market basket update and a modest increase at the high end.

Based on this revised adjusted consolidated EBITDA guidance, we are also raising our full year adjusted EPS guidance to a range of $1.15 to $1.25 per share, up from the previous range up 0.80 to $0.90 per share. Improved adjusted consolidated EBITDA, lower interest expense, and projected additional debt repayments in the second half drive this adjusted EPS forecast.

We are very, very pleased with the performance of our hospitals and expect the second half of 2009 to yield solid results as well. Our dedicated employees continue to provide high quality care that attracts more and more patients to our hospitals. Page 17 of the supplemental slides for our earnings release illustrates a primary reason we are successful in attracting more patients.

The graph on the left indicates that HealthSouth therapists and nurses are able to help patients improve their ability to function independently to a greater degree than the UDS National Average, and we are able to achieve these results over a shorter length of stay as measured by the length of stay efficiency graph on that same page. This means we not only have better outcomes than the national average, but we achieved these results over a shorter period of time. Equally important is being able to provide this higher level of care on a cost-effective basis.

Page 18 of the supplemental slides shows that CMS projected our costs will be approximately 16% lower than the average estimated cost per discharge for all IRF providers for fiscal year 2010. This data was taken directly from the rate setting file that was issued by CMS when the proposed IRF rule changes were sent out for comments earlier this year. And because we are a cost effective provider, this data also indicates we provide an additional benefit to the Medicare program by not over utilizing outlier payments to supplement our revenues. Taken together with the previous slide, we believe this data confirms that high quality care can be provided on a cost-effective basis. It also points out that HealthSouth above average margins are directly related to our ability to manage our expenses in a disciplined manner without compromising the high quality care we provide.

In discussing healthcare reform, it's obvious everyone involved; government, patients, employers, insurance companies; are all seeking high quality care with measurable outcomes provided in a cost effective manner. What we've just reviewed demonstrate that HealthSouth is delivering on that goal. And we're doing it right now on a real time basis, in the communities we serve.

With that we will now open the lines up for questions.

QUESTION AND ANSWER SECTION

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

<Q – Gary Lieberman>: Thanks, good morning.

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

<Q – Gary Lieberman>: Maybe you can talk a little bit about the continued strong growth on the discharge front and maybe you'd just give a little bit color of where you're taking the market share from and have you seen any reaction from any of your competitors because of your share that you're taking?

<A – Jay Grinney>: The volume growth is really occurring pretty consistently in this quarter as we saw in previous quarters and it's being taken from other IRF providers. And frankly we're also attracting patients who might otherwise have gone to another setting other than an IRF. We did just the other day get some recent UDS data. We've reported on that in the past – it's on a quarter lag, but this is for the first quarter of 2009. And again, this is for all of the UDS reporting hospitals – rehabilitation hospitals, and it accounts for about maybe 65, 70% of all IRF providers. And in the first quarter, overall volumes for all non-HealthSouth UDS sites were down 2% and of course ours was up about 4.5%. So, we're clearly taking market share from other IRF providers, but we're also taking volumes from other settings. And we believe it's because of the quality of care and the fact that our patients when they come in, get well faster and we're able to return them home to their communities and to their normal lives.

<Q – Gary Lieberman>: Okay. And if I could just ask some quick follow-up on the fiscal intermediary review, is there anything to read into that in terms of why they might be reviewing additional cases? Is this only one fiscal intermediary or is this spread across a number of them?

<A – Jay Grinney>: It's primarily one. It is a fiscal intermediary that has a long track record of looking at and challenging admissions. We have established, internal to the Company, some pretty sophisticated capabilities and resources. We have been able to, as I've said a moment ago, win 75, 80% of these. We do frankly believe that these recent coverage requirements perhaps will help reduce some of the challenges and some of the reviews on a go-forward basis. We certainly hope so anyway. That's one of the reasons why we think that the final rule is a net positive for us. It does provide some additional clarification with respect to documentation and so on, and we're hoping that that's going to result in a more reasoned and a more balanced review by this one fiscal intermediary.

Just to complete that thought, as I think everybody on the call knows, the Medicare program is moving from a fiscal intermediary to a MAC system. The MAC is just another acronym for the contractor that administers the program. Today, we have about 70% of our hospitals with the one fiscal intermediary that we mentioned is conducting these reviews. And when we go to the MAC system, we have made the decision that we are going to have our hospitals be put under the jurisdiction of the MAC that governs that geographic region. So to put that into perspective, when the MAC process is completed, we will have only about 20% of our hospitals in this fiscal intermediary, who currently seems to be very aggressive in looking and challenging admissions.

<Q – Gary Lieberman>: And when will that be completed?

<A – Jay Grinney>: I can't remember offhand. I think it's maybe in 2011. We'll have to get back to you, Gary. I'm not sure that that's already underway right now. And we made the decision to diversify our fiscal intermediary risk, in large part because we saw that one fiscal intermediary and particularly one medical director can get a burr under their saddle, and then just it's a pain in the neck and it just costs them money, it costs us money, it's time consuming. We win 80% of these

things, but they keep doing it. So it's just a cost of doing business with that FI and we made the decision we want to minimize that on a go-forward basis.

<A – John Workman>: And Gary, they do refer to these widespread reviews to your earlier question. And secondly just to remind you, we make provisions for doubtful accounts just as these age. And as Jay said, because they take so long to adjudicate, up to 15 to 18 months, by the time you get up to 12 months, we basically have 100% reserved these. So we had a similar situation a couple years ago under widespread review and it cycled through and those came back to us as recoveries. But we do take I think a fairly consistent, and I would say conservative approach, in our provision for doubtful accounts.

<Q – Gary Lieberman>: Thanks a lot.

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

<Q>: Hi, very nice quarter. I wanted to touch a little bit on the labor expense. And I know John, you provided some good details there and thank you very much. But I just wanted to kind of dig into the success that you're having in managing these costs, which I assume is a direct result of your TeamWorks initiative to kind of roll that component out to the clinical side. And so I was wondering if you could provide any color on kind of where you are in terms of rolling that initiative out to your facilities. Thanks.

<A – Jay Grinney>: Actually Paxton, when we've talked about the labor component of TeamWorks, we've actually talked about that as being an 2010 and beyond event, to be very candid. What we're doing in '09 is establishing the information platform so we can better manage labor on a go-forward basis. Specifically, we're putting consistent time clocks in all of our hospitals. We're putting in some reporting capabilities as a part of that. Now that's not in place today, but we will have that in place by the end of the year, first part of 2010. And that's when we'll really be in a position to ramp up a TeamWorks' initiative for looking at best practices in our labor and how we're staffing in our hospitals.

I think that the results that we've seen thus far have really just been attributable to the focus of our hospital CEOs and our regional Presidents on understanding that we're in an environment where we need to make sure we're being very productive, that we're not spending any unnecessary costs on contract labor. I mean, it really is a function of putting the focus there, making sure that we have some rudimentary information technology in place and then build on that for 2010 and 2011.

<Q>: Okay, very good. And lastly, I was wondering if you had any update on the E&Y settlement and where that is in the arbitration process? Thanks.

<A – Jay Grinney>: Yeah, I'm going to ask John Whittington, who is our General Counsel, to answer that question.

<A – John Whittington>: Sure, thank you. As I reported on last quarter's call, we have initiated the selection process for an arbitration panel and we're going through that process under the rules of the American Arbitration Association. The process is continuing. And although it has taken longer than we originally expected, we are making progress. This panel, once it's finalized, will adjudicate all the claims in the arbitration. We currently have a list of 25 names, from which a three-person arbitration panel will be selected. If the current schedule is maintained without any further delays or extensions, we expect a panel will be in place by the beginning of October of this year. However, we do not have control over the process. It is a three-party process, that being the American Arbitration Association, Ernst & Young and HealthSouth. And because we don't have control, that date could be delayed, but we're hopeful that it will proceed timely.

I would like to remind you that all discovery, depositions, production of documents, etcetera have all been completed as part of the original litigation process that the derivatives filed. All has been completed except for the expert witness testimony, which will be the first thing that should be accomplished once the three-person panel is selected. Once that three-person panel is selected, we will move forward with pre-trial motions, the exchange of expert witness reports, and then the trial before the arbitration panel. We expect that trial to last between six and eight weeks once it commences.

<Q>: Okay, thank you. And lastly just any update on all the headlines related to the Scrushy settlement, anything you can provide us with there? Thanks.

<A – John Whittington>: Yes, there has been moderate success. We've collected a couple hundred thousand dollars. But the process is really just beginning. I would expect it to be a process that's going to take a long time. We are searching for assets all over the world and are being very careful and diligent. We don't have any information that can tell us right now how many assets and the dollar amount that he has. We do have good information going back to 2002 and 2003. So we're pursuing the leads that we have very diligently, but I do think it's going to be a process that could take a couple of years to flesh out all of those assets.

<A – Jay Grinney>: And those assets also would include any that have been transferred to other parties within the past six years, is it?

<A – John Whittington>: Well, that's right. And that's correct, Jay. And we have initiated fraudulent transfer complaints against Mr. Scrushy and various third parties that we know where assets have been transferred. The assets that have not been transferred, we are in the process of executing on those assets at this time, but that is a process that takes time.

<Q>: Okay, thanks. And again, very nice quarter.

<A – Jay Grinney>: Thank you.

<A>: Thank you.

Operator: Your next question comes from David MacDonald with SunTrust.

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

<Q – David MacDonald>: Good morning, guys. Hey, just one follow-up on that on the legal side. John, can you just – can you guys – I guess just how does it work in terms of things like properties etcetera? Can you force that to be sold? The dollars that have been transferred, it sounds like you can legally go after. Just a little bit more detail there on exactly how that works on the legal side?

<A – Jay Grinney>: David, are you trying to put a bid in on the lake house?

<Q – David MacDonald>: Saw a picture of it the other day.

<A – Jay Grinney>: Yes, impressive. John?

<A – John Whittington>: Yes. Assets that are in Mr. Scrushy's name are subject to levy and execution. And for instance, the lake house, it's a matter of public record. We have attached it legally and we've asked that it be sold for purposes of reducing the obligation that he owes the Company. Again, a public sale will be announced, it will be sold. And whatever is received from it will go to pay down the debt. There are a number of other properties that we are positioning to do the same thing with. The main thing we are trying to research are transfers of bank accounts and securities accounts, and that requires a lot of forensic accounting. Assets that have been

transferred from him to a third party can also be attached, but first you have to file a fraudulent transfer compliant under state laws and pursue the third party to bring them back into his name and we have done that and we are pursuing that. But again, that is a process that takes time. Once those assets are recovered, then we would go through the same process of executing and having those assets sold or monetized for the benefit of reduction of the debt.

<Q – David MacDonald>: Okay. And then just a quick question on cash flow deployment. Once we get to the other side of the Ernst & Young settlement, Jay could – should we expect to see cash flow deployment maybe tip a little bit more towards growth, debt expansions, etcetera or should we expect continued focus heavily on debt pay down, what should we be thinking about there once those dollars come in the door?

<A – Jay Grinney>: I think that there are a couple things that have to occur. Number one, we would need to see improvement in the overall economy and a continuing opening up, if you will, of the credit markets because we do have – as you know, our bank facility comes due in 2013. We need to look at refinancing the bonds in '14 and '16. So we'll want to make sure that we have a sense of what the market is in terms of refinancing the balance sheet and what we would need to have going in that would give us the best terms, etcetera.

Having said that, clearly the E&Y settlement or recovery is going to be a catalyst. We think that the recent ruling by Judge Horn against Scrushy and putting that $2.8 billion out there, certainly bolsters our belief that there's a lot of money that should be coming back to the Company.

With that stronger balance sheet, yes, we will definitely want to be looking for acquisitions. We believe that if bundling becomes a pilot or a demonstration in whatever ultimate healthcare legislation that gets passed, we believe that that allows us to then use the next several years to expand our presence in inpatient rehabilitations, and where appropriate, to look for additional long-term acute hospitals and/or companies to potentially acquire. So the shorter term would be to deploy that cash for growth, provided we had the debt reduced, we had a balance sheet that we were comfortable could be easily refinanced, and that the credit market and economy were improving to the point where we felt comfortable moving forward with a more balanced growth and debt payment strategy rather than right now. Quite frankly, we're putting most of the focus on our balance sheet.

<Q – David MacDonald>: Okay. And then just last...

<A – Jay Grinney>: I would just say though, David, don't forget even though we may not be going out and building the five-plus de novos that we had talked about before the credit markets and the equity markets crashed last year, we are putting a fair amount of capital into bed expansion. And that is – that's been a very, very good return for us, that's been a smart place to put our money and so we're going to continue that. So I don't want anybody to be under the misunderstanding that somehow that's all we're doing, is paying down debt. I mean, we are growing and I think that the results sort of speak for themselves on our ability to do that.

<Q – David MacDonald>: Yeah. And then just last question, can you talk a little bit about the marketing on the stroke and neuro side and should we expect a continued mix shift, should we expect to see those two areas continue to outpace other things in terms of growth?

<A – Jay Grinney>: Yeah, I'm going to ask Mark Tarr to respond to that.

<A – Mark Tarr>: Yes, hi, good morning. Yes, you should expect to see us continuing to develop our neurological capabilities at our hospitals. We've put a lot of effort into it in the past couple of years. We continue to do it now. Everything from bringing on physicians that have specific training and interest in working with the neuro population, we have brought in certain types of equipment and technologies into our hospitals that allow us to treat patients with different modalities specific to

stroke and other types of neuro issues. We have provided specific training to our staff to credential them in a manner that they can have the skill set to further advance this neuro programming. So, yes, I think you should expect us to see continuing development specialties within the neuro population, and moving away from the orthopedic population.

<Q – David MacDonald>: Okay. Thanks, guys.

<A – Jay Grinney>: All right.

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

<Q – Adam Feinstein>: All right, thank you. Good morning, everyone.

<A>: Good morning, Adam.

<A>: Good morning, Adam.

<Q – Adam Feinstein>: Very strong numbers here. So, just – I guess a couple of just quick housekeeping things, and I'll take out a bigger question. So, before, when you were talking about the scrutiny from the large FI, I don't know whether you called out the impact from that, Jay. If you did and I missed it, I could follow-up offline. But just – when you were talking about that before, and I certainly understand the issue, but I was just was curious whether you had called out what the impact from that was.

<A – John Workman>: Yeah, this is John. I would say the best indicator is look at our percent of bad debts, how it went up from Q1 to Q2, a little impact in Q1. So, you're probably talking 30 to 40 basis points.

<Q – Adam Feinstein>: Okay.

<A – John Workman>: 1.5 to 1.8 is the right range. So, if we're at 2, you can kind of see how many basis points.

<Q – Adam Feinstein>: Great. Okay, and then just one additional housekeeping. And then before when you gave out the UDS data – I'm sorry, I just want to make sure I got the right number for the first quarter. Can you give us that number again for the initiative?

<A – Jay Grinney>: Yes. UDS data that just came out for the Non-HealthSouth sites, the total volumes were down 2%, compared to the first quarter of 2008. And if you look again at the UDS data, we were up 4.5% in that. So, apples-to-apples, overall, non-HealthSouth UDS down 2%, HealthSouth up 4.5%.

<Q – Adam Feinstein>: Okay, great. And then, obviously you guys have done a phenomenal job at growing volumes here and it's been an ongoing trend, which is great to see. Just wanted to talk about the competitive landscape, just clearly nursing homes have been investing a lot to ramp up their rehab. But, it seems like you guys are taking that share back. Just curious to get your thought as you think about the competitive landscape, and in that, kind of a separate question, but the same issue here, is just – I guess this – there's been the admission criteria stuff that was in the Medicare reg, and then in the nursing home final reg, there was some stuff in there about concurrent therapy and things of that nature. So, just curious whether you think that will lead to any changes in terms of people setting up rehab hospitals or even nursing homes, being involved in rehab hospitals? So, just a very broad question I know, but just curious to get your thoughts, Jay.

<A – Jay Grinney>: Yeah, I think that first of all, the proposed rules for the nursing homes, I think really are tightening up the ability of nursing homes to position themselves as rehabilitation

providers. I think it's going to be raising a higher standard and I think that that's going to frankly deter some nursing homes from trying to position themselves as providing rehabilitative services because frankly most of them do not, certainly not to the extent that you find in an inpatient rehabilitation hospital.

So, I think that the market share gains that were realized by the nursing homes were primarily in the lower acuity orthopedic cases like knee and hip replacements, simple knee, simple hip replacements. And, our belief is that that gain, if you will, has pretty much run its course. We're certainly seeing that in our hospitals. And, as I mentioned, we still see less than 10%, maybe 9, 9.5% of our patients, are lower extremity joint replacement patients. But, most of them, if not all them, have some kind of serious complication or co-morbidity that really requires them to be in our hospital.

So, I think that CMS is moving down the road both looking at rehab providers and looking at nursing homes. Anybody that says that they're going to provide rehabilitative services, they're raising the bar if you will, and asking and demanding that we all meet best practices. Those of us who are already at that best practice level, certainly, we applaud that. We think that's a good thing because it will start to really differentiate those who provide rehabilitative services and those who say they provide rehabilitative services.

<Q – Adam Feinstein>: Sure, and then just a follow-up question here. I just feel – what are your thoughts in terms of hospital based units, I mean is it the same thought process that they're raising the bar, so as a result, maybe some of the hospital-based units, maybe some of the hospitals close down some beds, or – and just curious whether you've seen anything like that?

<A – Jay Grinney>: I think that there is – that's probably a different phenomenon. Our take is that the hospitals, the acute care hospitals that have rehabilitation units, because of all the other challenges that the acute care hospital management teams face, really don't put that much of a focus on their rehab units. That's not to say that the quality isn't there, that's not to say that they're at a lower standard. It's just at the end of the day there's only so many dollars to go around, and most of the hospitals that we compete against are going to put the dollars in their operating rooms, expand their emergency room, enhance their high specialty services such as open heart, and so on. They're not going to put it into inpatient rehabilitation. So, I think in looking at the hospital units, the phenomenon isn't there's a lower quality, therefore we're going to benefit. I think it's more, we focus on this, we are specialized on this, the physicians know that, the physicians know that if they bring a patient to a HealthSouth hospital, the patient is going to be discharged sooner than they would, and at a higher functioning level, than if they went into the acute care units there at the hospital.

<A – Mark Tarr>: And, a reminder, Adam, we have about a third of our hospitals that are joint venture with acute care systems.

<Q – Adam Feinstein>: Okay, good. Excellent, thank you.

<A – Jay Grinney>: All right.

Operator: Your next question comes from A.J. Rice with Soleil Securities.

<Q – A.J. Rice>: Yes, hello, everybody.

<A – Jay Grinney>: Good morning.

<Q – A.J. Rice>: Just, first to follow-up on the line of questions about the E&Y. Obviously, getting started, I think it slipped a little bit from where we were thinking earlier in the year. What is the

biggest variable in just getting the whole process moving forward that creates some uncertainty as to timing?

<A – John Whittington>: Originally, when we met with E&Y to prepare for this arbitration, we engaged the American Arbitration Association. We agreed that the selection of the panel would be critically important to all the parties. So, we devised a plan where the AAA would provide us with 25 names of potential candidates for the panel. Those 25 names were originally submitted, but both sides determined that many of those people had conflicts. They had either done work for E&Y, or their family members had been in hospitals at HealthSouth. So, additional names were added and additional conflicts arose. So, after several months, we have finally agreed, as of about 15 days ago, on the 25 names. That is the one factor that has delayed the formulation of the panel, eliminating conflicts, and getting a group of 25 people who had no conflicts.

We now have arrived at that position. The process is now moving forward. The process of reducing the 25 to 3 is basically a 60-day process, and that's why I said we think the beginning of the October we should have a panel in place. However, if any disagreements arise, any disputes arise, if conflicts are uncovered that we didn't know about initially, there could be further delays. Hopefully, there won't be. But, we are very pleased that we now have the 25 person group in place, and we are moving forward with the process of eliminating certain names, and getting down to a 3-person panel that can begin the arbitration process.

<A – Jay Grinney>: If you think about it, A.J., there are – there have to be two parties in this, E&Y and us. And, clearly, it is in E&Y's best interests to delay, to delay, to delay, to delay. I have to believe that the Scrushy settlement, and the judgment by the court I should say, has got to – have gotten to their – gotten their attention, and we are going to push forward. I think that the delays have pretty much run its course. But, as John said, they could continue to try to drag this out. I know it's been a long time coming. We're all frustrated with the process. We would like to have that behind us. But, we're certainly a lot closer today than we have been, now that panel of 25 has been agreed upon. The clock really starts ticking now, and we think that things will be able to move forward a little more expeditiously.

<A – John Whittington>: I would just follow up with a remainder, that what normally takes a long time in any trial, whether it's an arbitration or not, is not the actual trial, it's the preparation for the trial. The deposition of witnesses, the exchange of documentation, all of that sometimes takes months, if not years. That has all been completed. It was completed as part of an agreement in the original derivative action. So, because discovery has been completed, all the depositions have been taken, I think once the panel is finalized, matters will move pretty quickly.

<Q – A.J. Rice>: Okay. Jay, you've mentioned a couple of times the Scrushy verdict, the 2.8 billion. Is there any reason, I mean obviously that's great that a judge looked at it and came up with that huge number. Is there any direct precedent that this sets, or evidence in some way that it forms, that would influence the outcome of the arbitration panel?

<A – John Whittington>: I guess I better answer that, since...

<A – Jay Grinney>: Well, let me ...

<A – John Whittington>: But that seems like kind of a legal-type question. The evidence of the findings of the trial judge will be admissible. In fact, as you obviously know, it's public record. The tribunal that works on the arbitration panel will not be required to follow or be bound by any of those findings. But, they will be aware of it. The damages that we seek against E&Y are substantially similar, although not exact, to the damages that we've recovered against Mr. Scrushy. I mean, the damages that the Company have sustained are pretty much the same. We had individual claims against Mr. Scrushy for selling stock that maybe he shouldn't have and related party transactions that perhaps he shouldn't have. But, other than that, the damage claims are essentially the same,

and we have proven those against an independent judge, and we think we'll present that same evidence in this arbitration panel. But, the panel is not obligated to be bound by that finding.

<Q – A.J. Rice>: Okay, that's great. Thanks a lot.

<A – Jay Grinney>: Okay.

Operator: Your next question comes from Ann Hynes with Ftn Equity.

<A – Jay Grinney>: Good morning, Ann.

<Q – Ann Hynes>: Good morning. How are you?

<A – Jay Grinney>: Great.

<Q – Ann Hynes>: So, just going back to the rehab PPS, can you define what you consider a modest increase in your guidance for Q4 in the high end of the range?

<A – Jay Grinney>: If you look at the market basket at say 2.5%....

<Q – Ann Hynes>: Yeah.

<A – Jay Grinney>: And you cut that basically in half, that's where we would put the bottom-end maybe of a modest range.

<Q – Ann Hynes>: Okay.

<A – Jay Grinney>: So, clearly we think, we need to get to 2.5%. We've been without an increase for 18 months. Our costs have continued to go up. So, we believe and are actually very encouraged to see that 2.5%, but we're also realists. And we know that there's a lot of debate in Congress, obviously, they're in recess right now. But, when they come back in the Fall, that's going to be topic number one. And everybody's going to be looking to providers to help pay for this reform package, however big it might be. So, we could have probably just put in the full 2.5%. We chose not to just, we – as you know ...

<Q – Ann Hynes>: Yeah.

<A – Jay Grinney>: Manage pretty conservatively and set expectations accordingly.

<Q – Ann Hynes>: Okay. So you have like 3 million on the high-end and if nothing happens, you could get 7 to 8 million?

<A – Jay Grinney>: We've said in the past that 7 to 8 is where we would get – where we would be if we had that 2.5.

<Q – Ann Hynes>: Okay.

<A – John Workman>: So, we should announce for our full market basket.

<A – Jay Grinney>: Full market basket, yeah.

<Q – Ann Hynes>: Yeah.

<A – John Workman>: At this point, honestly Ann, when we said that, it was probably a little higher than 2.5.

<A – Jay Grinney>: Yeah.

<Q – Ann Hynes>: Okay.

<A – John Workman>: But, that's not been the history, the history's been higher than 2.5.

<A – Jay Grinney>: That's right, yeah.

<Q – Ann Hynes>: All right. And didn't the final rule also include a provision that allows you not to include Medicare Part C beneficiaries to the 60% rule, and if so, does that open the pool for you? How does that impact you, do you think?

<A – Jay Grinney>: Well, it does allow the inclusion of Part C in determining whether or not hospitals meet the Medicare 50% level in order to qualify for using the presumptive method for evaluating and determining compliance. So what does all that mean? That means that it's a good thing that we can count the Medicare Part C patients. It doesn't have a huge impact for us overall because we don't have a lot of markets where we see a lot of Part C patients ...

<Q – Ann Hynes>: Yeah, okay.

<A – Jay Grinney>: However, in some markets in the West, we do, and it will help us. Mark, where would you think we ...

<A – Mark Tarr>: Yeah. Ann, it should help – should at least give us some flexibility in meeting our compliance percentage. According to our records, about 71% of our Medicare Advantage discharges are compliant patients. So it should help give us a little flexibility. On those hospitals in those markets where perhaps that 6% threshold has come in a little bit tougher.

<Q – Ann Hynes>: Okay.

<A – Jay Grinney>: And that's – typically we've seen that in some of our Western markets.

<Q – Ann Hynes>: Okay. And on your occupancy, it's very high for hospital – acute care hospitals much lower. How much do you think it can rise more before you have to add more labor or add more beds? How much leverage do you think you have to that occupancy?

<A – Jay Grinney>: What we have determined internally for an average HealthSouth hospital, for our portfolio, where we have a mix of semi-private and private rooms, predominantly semi-private, that occupancy level starts to become a bit challenging at 75%. That's when we start looking at it and evaluating whether or not additional beds are going to be required. As you know and as I mentioned earlier, we've added beds this year. I think at the end of this year we'll have an additional 100 beds added throughout hospitals across the portfolio. We've got another 60 beds that we are already – that we've already sort of booked for next year and there may be additional beds on top of that. So every two weeks, we look at our hospitals look at those that are at or above 75%...

<Q – Ann Hynes>: Okay.

<A – Jay Grinney>: Then we determine are they in a Certificate of Need state or not. If they are in a Certificate of Need state, we then have to follow certain guidelines that are state-specific and state CON-specific to determine when we can add the additional beds. For example, in Florida we can add 10% or 10 beds, whichever is greater, once we have achieved 90% occupancy for 12 consecutive months. So that then allows us to sort of pre-plan when we need to add beds in the CON state.

Non-CON state is a whole different matter. And we've done this in Albuquerque, we've done this in other hospitals out West where there isn't any Certificate of Need and we can very easily just bring the beds on whenever we need them. So, we think that this 100 beds per year is going to allow us to keep out in front of, for the most part, the capacity requirements that we have. The only real limiting factor is the Certificate of Need states. You can't necessarily add when you want, often times it's a little bit delayed. But, usually you get the beds. It just takes a little bit longer than you would in a non-CON environment.

<A – Mark Tarr>: And one caution is, remember that the occupants we quote is an average.

<Q – Ann Hynes>: Okay.

<A – Mark Tarr>: So as Jay said, you have to look at it by hospital. We do have a fair amount of hospitals that are low occupancy because they were inherited hospitals that we acquired that had a lot of beds. They are not our 40-50 bed units, they're 100 bed units or more. And so those realistically aren't going to get up into the – they'll never probably get to the 75 or 80%.

<A – Jay Grinney>: And we've said in the past, we typically have between 10 and 15 hospitals that we're watching at any given time to determine the number of beds that we might need and so it's definitely a manageable number. We have a pretty well-organized process internally. As I mentioned, we monitor that – John and Mark and myself, others monitor that every other week. We're sitting down and looking at the bed needs whether – what are the trends indicating, when do we need to bring these on, what kind of planning do we need to start today? So, we feel pretty good about being able to stay in front of that.

<Q – Ann Hynes>: All right. And one last question. How much...

<A>: Hello...

<Q – Ann Hynes>: Yeah?

<A – Jay Grinney>: You went out.

<Q – Ann Hynes>: Oh, I'm sorry. How much does your guidance assume incremental free cash flow is used to pay down debt besides what we know already?

<A – John Workman>: Well, I wouldn't be assuming there's a – there's some contractual pay down.

<Q – Ann Hynes>: Yeah.

<A – John Workman>: We haven't been specific about how much debt, I mean, when we buy debt back in the open market, it is just that. It's a market decision based on where those debt levels are trading.

<Q – Ann Hynes>: Okay.

<A – John Workman>: As you probably know, our bonds are now trading above par, our term loans traded up as has our floater. So we are not going to pay too far up. So, it will be a market condition, so we – there is no specific number.

<Q – Ann Hynes>: Okay, great. Thank you.

<A – John Workman>: Okay.

Operator: Your next question comes from Sheryl Skolnick with CRT Capital Group.

<Q – Sheryl Skolnick>: Thank you so much and thank you for extending the call so that we could ask some additional questions.

<A – Jay Grinney>: Absolutely.

<Q – Sheryl Skolnick>: This was the first of I think several more difficult comparisons and you did a very good job. I actually have two questions and one is, dovetails right on your – just immediate last comments about the credit markets and where your bonds are trading. I'm curious given that some of the acute care hospitals have stopped permission and been granted permission to issue senior secured debt or almost senior secured debt in the case of HCA and in the case of Tenet. What HealthSouth's thoughts are about perhaps using that as a mechanism to stretch out some of the 2012, 2013 maturity of the term loan and perhaps even looking at doing some exchanges on the – either the floaters or the 10.75% notes?

<A – John Workman>: Sheryl, we are always looking at all the different alternatives and we are aware of those and, Ed Fay, our Treasurer and myself keep a pretty constant contact with the banks and the status and I mean, those are all good questions. I mean the interesting...

<Q – Sheryl Skolnick>: Markets haven't rarely been this tight in the last 12 months, yes.

<A – John Workman>: If you look at our term loan where it's traded up to, that would quote LIBOR plus 359 is its yield is on spreads LIBOR plus 225. You're probably aware, Select went out, did an amend and extend this just recently and I think they stepped up their spread 175 basis points. So, there's definitely something to be done. What the issue is, anything we do is going to be negative arbitrage on the interest rates right now. And so it's a question of positioning ourselves for the longer-term, giving up interest or having higher interest expense in the shorter-term. However, this Ernst & Young is the key pivotal issue for us.

<Q – Sheryl Skolnick>: Right.

<A – John Workman>: Is trying to get our arms around that because that kind of sets the stage. But to your point, we have a lot of options available to us this day. And the fact that Moody's upgraded us, S&P changed our outlook even though we think we're probably better than what they're even telling us, are all positive signs. So who we will monitor that. We're not going to wait to the last minute. We're going to do something clearly in advance, but we'd like to get a little bit more visibility on Ernst & Young because that's a big watershed event for us.

<Q – Sheryl Skolnick>: And what about reform?

<A – John Workman>: Well, I think reform is probably some of the uncertainty of being a huge negative has kind of died down.

<Q – Sheryl Skolnick>: Right.

<A – Jay Grinney>: I think that – on that Sheryl, I think that the bigger issue six months ago, three months ago was bundling going to a transformative element to some kind of healthcare reform package. And as you know, CBO was not able to score that as a big win. So it's now being put to a pilot or maybe a demonstration, which really kind of kicks it down the road and gives us and the whole industry, a chance to test it, evaluate it, see if there really are benefits.

The other issue is will we see a significant reduction to our annual market basket updates. That's something we're going to have to see. We know that in the package that was agreed among the

hospital associations, the Senate Finance Committee and the White House, there was $155 billion of savings that the hospital industry committed to. We're not privy to all of the details, but we believe that that package does include a reduction to annual market basket updates. So we'll just have to see how that unfolds.

The good news is that I think we've demonstrated at HealthSouth, because we have not generated earnings exclusively by taking out costs, we're managing the costs, but we're focusing on the volume growth. We've been able to achieve those volume – that volume growth. We've been able to grow top line even in fairly constrained pricing environments. So...

<Q – Sheryl Skolnick>: That's right. And that's what I was hoping that you would say, that it sounds like you would not necessarily let reform get in your way of a prudent restructuring of your balance sheet.

<A – Jay Grinney>: Absolutely not...

<Q – Sheryl Skolnick>: Okay...

<A – Jay Grinney>: Absolutely not.

<Q – Sheryl Skolnick>: Okay. And can I ask another question, dovetailing on – so while we're still on Medicare, since it dominates our lives these days, one of the side effects that I would be concerned about of the new criteria for admission would be the demand for specialized medical professionals, in particular the physicians and then the rehabilitation nurses and other members of the specialized team. Now, I would imagine that HealthSouth, given where HealthSouth is generating outcomes already, as you've said, you do this, this is your best practice. And I would imagine that these practices are generally routine with the exception of additional documentation that they're springing on you. But might there not be some advantage to hospital-based units who already have relationships with and who are already paying neurologists to cover their ER to have additional relationships with their acute care hospital-based units and might there not be a shortage of some of these trained physicians?

<A – Jay Grinney>: There's always the possibility of the – of a shortage of the trained physicians. But we believe, to your point, that these coverage requirements really are best practices, and for the most part we're already doing virtually all of it. As we said, we may have to shore up our documentation. I'm going to ask Mark to respond to his take on availability of physicians and impact that that might have on ...

<A – Mark Tarr>: Yeah, sure.

<Q – Sheryl Skolnick>: Okay, thanks.

<A – Mark Tarr>: I don't see that being a material change really to the industry and certainly not to us. And we're fortunate to have some wonderful physicians in – at our hospitals, physiatrists which are the specialty focus for physical medicine and rehabilitation, neurologists. I mean it goes down the full spectrum. Certainly there are some challenges in some marketplaces. There are always going to be geographic preferences among physicians in terms of location, and from time-to-time we might have a little bit more difficulty recruiting physicians in certain geographic areas than others. But I don't see any of the additional requirements or clarification of requirements that came out this week as being a major deterrent for our ability to be covered with physicians.

<Q – Sheryl Skolnick>: And may I just a follow up on one thing, are you allowed under the current Medicare rules to pay them fees for doing these assessments or no?

<A – Mark Tarr>: All our physicians are independent practitioners. They bill on their own, the professional side, we do have physicians that help provide us medico-administrative oversight of which we do have contracts for that. But in terms of this post-admission assessment, that would be part of their requirement for the attending of that patient.

<Q – Sheryl Skolnick>: Understood. Thanks very much.

<A – Jay Grinney>: Okay.

<A – Mark Tarr>: Thanks, Sheryl.

Operator: Your next question comes from Pito Chickering with Deutsche Bank.

<Q – Philip Chickering>: Good morning, guys.

<A – Jay Grinney>: Hi, Pito.

<Q – Philip Chickering>: I will keep it short, as it's the end of the call here. But I guess the question is looking at your productivity, I believe that local CEOs are determining staffing levels right now without the use of a lot of IT systems. And the question here is for Mark. I guess what do you sort of envision as the tools that you will be providing CEOs, how can that really help them to sort of improve the productivity and what is the timing of the rollout?

<A – Mark Tarr>: Yeah, hey Pito. We're – as you know, we're in the process of putting in standardized time clocks in all of our hospitals – all of our hospitals with the exception of few had some time clocks, but they weren't standardized. So we weren't able to do roll-up reports on either a facility-specific basis, on a regional basis or on a national basis. So we are in the middle of that roll-out now. I think you'll see the upside benefit of that standardized time clock process more in 2010 than 2009. Early indications are those where we have rolled it out, I know the management teams appreciate the real-time reports that they're able to get. They're able to respond faster. Before, we were almost dependent upon a 2.5 to 3 week look-back in terms of a two-week payroll cycle. So I think you'll see more and more of that benefiting our management teams into 2010 as we get full roll-out and full implementation of this initiative.

<Q – Philip Chickering>: Okay, great. And then a follow-up on the Medicare Advantage question again, I guess what is the percent of revenues you guys currently get from Medicare Advantage? And now that that will count towards your 60% compliance, will you mark it differently to sort of get more of those patients?

<A – Jay Grinney>: I think our total percent is about 5% for Medicare Advantage, so it's a pretty small amount. In terms of marketing, I don't know that it's really going to change. We look for the patients who need the care, patients who have the conditions that we think would benefit from intensive rehabilitative services. So it might make it a little easier in some of our Western markets, but frankly we're not going to be changing the overall approach that we take. It will be really just sort of continuing to identify patients that need the care.

<Q – Philip Chickering>: So as a quick sort of follow-up to that, I mean it seem like this – sitting back a little bit, if you have 5% of your revenues coming from Medicare Advantage and 70% of those are compliant, shouldn't it provide for some tailwinds on – and more non-compliant patients in 2010?

<A – Mark Tarr>: Yeah. As we mentioned earlier, I think it will provide some additional flexibility for some of our hospitals that run close to that 60% compliance where certain months or certain weeks, they may be in a position of turning down some non-compliant patients in order to maintain that 60% threshold. So if we're getting additional compliant patients from these Medicare

Advantage, yeah, that should help provide some more flexibility for those hospitals that are currently having to turn down some patients. It's tough to quantify that, but I would certainly think that it will help us as Jay said, particularly out West, and then we have some other pockets even in the Midwest like a St. Louis market where we do have a high number of Medicare Advantage patients.

<Q – Philip Chickering>: Great. Thanks a lot guys.

<A – Mark Tarr>: Welcome.

<A – Jay Grinney>: Thank you.

<A – Mary Ann Arico>: Thank you, Pito.

<A – Jay Grinney>: I think that's – we're told there's nobody else in the queue, is that right Operator?

Operator: Yes. There are no further questions. I would now like to turn the call back to Ms. Arico for any closing remarks.

Mary Ann Arico, Senior Vice President, Investor Relations and Corporate Communications

If you have additional questions, we will be available later today. Please call me at 205-969-6175. As a reminder, we will be attending the Stifel Conference in Baltimore in September. Thank you very much.

Jay Grinney, President and Chief Executive Officer

Thanks everyone.

Operator: This concludes today's HealthSouth Second Quarter 2009 Conference Call. You may now disconnect.