Operator: Good morning everyone, and welcome to HealthSouth First Quarter 2010 Earnings Conference Call. *[Operator Instructions]*

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

**Mary Ann Arico, Chief Investor Relations Officer**

Thank you, Juliane, and good morning, everyone. Thank you for joining us today for the HealthSouth first quarter 2010 earnings call.

With me on the call in Birmingham today are: Jay Grinney, President and Chief Executive Officer; Mark Tarr, Executive Vice President of Operations; John Whittington, Executive Vice President, General Counsel, and Secretary; Andy Price, Senior Vice President and Chief Accounting Officer; Ed Fay, Senior Vice President and Treasurer; Julie Duck, Vice President of Financial Operations.

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

Moving to slide one, the Safe Harbor. During the call, we will make forward-looking statements which are subject to risks and uncertainties, many of which are beyond our control. Certain risks, uncertainties, and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates, and expectations are discussed in the company's Form 10-Q for the first quarter 2010, which will be filed today, and it's previously filed 10-K – along with the previously filed 10-K for 2009 and other SEC filings. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented. Statements made throughout 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 those forward-looking statements.

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

Before I turn it over to Jay, I would like to remind you that we will adhere to the one question and one follow-up question rule to allow everyone to submit a question.

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.

The first quarter was another solid quarter for HealthSouth. Despite a steep ramp-up in January resulting from a large number of late December discharges, followed by weather-related disruptions to admissions in many of our Midwest, Mid-Atlantic and Northeast markets, we saw strong quarter-over-quarter growth in all of our key financial metrics.

Consolidated net operating revenues were up almost 4%, driven by better pricing, increased discharges, and an increase in the percentage of Medicare patients treated. Adjusted consolidated EBITDA increased 8%, thanks to disciplined expense management by our hospitals. Adjusted EPS

grew 23% from both solid operations and lower interest expense, and perhaps most importantly, adjusted free cash flow was up approximately $13 million or 35%.

In addition to these financial results, we were very pleased with our continued quality outcomes as measured by FIM Gain and length of stay efficiency, both of which are shown on page 5 of our supplemental slides.

As we've discussed previously, inpatient rehabilitation hospitals are one of the few providers required to assess a patient both at admission and upon discharge. This assessment is performed using the Functional Independence Measurement, or FIM, instrument. The FIM patient assessment tool evaluates a patient's ability to perform 18 physical and cognitive tasks such as self-care, mobility, and communication. FIM gain, which is the difference between the admitting and discharge scores, assesses the patient's improvement in performing these functional tasks. The greater the difference between the admitting and discharge FIM score, the more the patient has progressed during his or her stay.

The length of stay efficiency, or LOS efficiency, measures the rate of FIM improvement per day. In both instances, our hospitals continue to outperform other rehab providers participating in the UDS database. We are very proud of the quality of care our hospitals provide and believe these indicators are important measures of our value proposition to patients, physicians, and family members.

In addition to our core operations, we're also pleased with the progress we're making on the development front. As we have previously indicated, our strategy over the next two years is to build upon our inpatient rehabilitation platform through disciplined acquisitions and de novos. The recent definitive agreement for Desert Canyon Rehabilitation Hospital, a 50-bed, all private room hospital located in the southwest part of Las Vegas, represents the first of these, with other announcements coming in the weeks and months ahead. We expect to close on Desert Canyon in the second quarter.

It's important to note, however, we will remain very disciplined with respect to this growth agenda. We will not do a deal just to do a deal. We've established a thorough analytical framework for evaluating projects and have required return thresholds that must be met before we move forward with any given project. While we will continue to pursue new markets, we will do so in a prudent manner that will bring long-term value to our shareholders.

Overall, I believe we are off to a very good start for the year. I'm especially pleased with the resiliency of our business model. Although discharges were hampered by the steep ramp-up in January and bad weather in February, pricing was good, our hospitals did an excellent job of flexing expenses, and we were able to grow adjusted consolidated EBITDA and adjusted EPS, all of which demonstrates our business model is not solely dependent on volume growth.

With that, I'm going to turn the agenda over to Andy Price and Ed Fay. Andy will review the statement of operations and adjusted consolidated EBITDA schedule, and Ed will highlight our adjusted free cash flow, capital structure, and liquidity. Following their comments, John Whittington will touch on the E&Y arbitration and clarify recent settlement reports concerning E&Y, UBS, and the securities plaintiffs. And finally, I will address guidance.

**Andy Price, Senior Vice President, Chief Accounting Officer**

Thank you, Jay. I will be referencing the slides we filed with our Form 8-K in my comments today.

Beginning with revenues for the first quarter, which can be found on slide six our inpatient revenues increased by 4.8% over prior year, to 451.8 million. As Jay mentioned, this was driven by an increase in revenue per discharge as well as a 1.1% growth in discharges quarter-over-quarter.

Same-store discharges grew by 0.4%. Revenue per discharge increased by 3.6% quarter-over-quarter due to Medicare pricing increases effective October 1 of 2009, as well as rate increases from our managed care and other third-party payors. Medicare pricing increases were primarily driven by the 2.5% Medicare market basket update on October 1 of 2009. Recall that we will give back 25 basis points of the market basket increase effective April 1, 2010.

Also favorably impacting our revenue per discharge quarter-over-quarter was a proportional increase in the number of Medicare patients we treated, and a decline in the number of Medicaid, managed Medicare, and other third-party payor patients. Overall, traditional Medicare represented 70.4% of our total revenues in Q1 of 2010, an increase of 260 basis points over prior year as reflected on our Payment Sources slide on page 22.

Our quarter-over-quarter growth in traditional Medicare inpatient revenue is roughly 50% attributable to pricing increases, with the remainder resulting from volume gains. We also experienced a slight increase in the overall acuity of the patients we treated.

Our occupancy percentage was 69.2% in the first quarter of 2010, as compared to 69.9% in Q1 of 2009. Average length of stay quarter-over-quarter was unchanged, at 14.6 days. On a sequential basis, occupancy increased 270 basis points from 66.5% in the fourth quarter of 2009, reflecting the seasonal increase in census and length of stay we typically see in the first quarter, and utilization of additional capacity added in the latter half of 2009 via our Mesa de novo facility and capacity expansion projects. Trending of our licensed beds and occupancy statistics can be found on slide 24.

Although not a large portion of our business, outpatient and other revenue declined 2.4 million or 5.8% from the same quarter a year ago, resulting from the closure of 10 outpatient satellites since March of ‘09 and a decline in same-store visits due to the severe weather in the Northeast and Mid-Atlantic states.

Next I want to provide some details of our operating expenses for the quarter which can be found on slide 7. Our salary and benefit costs increased 3.7% over the prior year, to 241.9 million, due to wage rate increases associated with our annual merit adjustment provided to employees on October 1 of ‘09 and an increase in the mix of licensed clinical staff in our hospitals. Ongoing standardization of our labor practices across our hospitals and the implementation of the new coverage requirements that became effective January 1, 2010, have decreased the use of non-licensed clinicians. This increased our average cost per full-time equivalent in the first quarter compared to a year ago.

Our productivity remained strong during the quarter, as employees per occupied bed, or EPOB, improved from 3.47 in Q1 in 2009 to 3.41 in 2010. Note that EPOB is typically at its lowest point during the first quarter of the year and we would expect to see this metric in the 3.5 to 3.55 range during the remainder of the year.

Our trended labor metrics are presented on slide 24. Improvements in productivity during the quarter along with our top-line growth allowed us to hold our salary and benefit cost as a percentage of revenue flat quarter-over-quarter at 49.3%.

Turning to other hospital-related expenses, which include other operating costs, supplies, occupancy, and bad debts, declined as a percentage of revenue by 90 basis points to 23.2% in Q1 2010, as compared to 24.1% in the prior year. Bad debt expense decreased 20 basis points quarter-over-quarter, resulting from the suspension of Medicare medical necessity claim reviews by our largest intermediary in 2009, and subsequent recovery of denied claims, as well as improvements in the recovery and capture of Medicare-related bad debts. The claim review process commenced again in April of 2010, and our bad debts as a percentage of revenue may trend to 1.5 to 2% in the latter half of the year, which is consistent with our prior experience.

Furthermore, our hospitals continued to focus on managing expenses during the first quarter in a lower-growth environment. These cost-containment measures, coupled with a reduction in bad debt expense and top-line growth, allowed us to reduce other hospital expenses as a percentage of revenue quarter-over-quarter.

As indicated previously, we anticipate incurring additional costs during the remainder of the year related to our TeamWorks initiative targeting case management functions which will begin in Q2, as well as the clinical information system pilot at our Loudoun County, Virginia, de novo hospital for which we are already incurring cost. This positive trend in salaries and benefits and other hospital-related expenses reflect our continued focus on providing high quality patient care but on a cost-effective basis.

Slide 8 presents our adjusted consolidated EBITDA in a top-down format with additional explanation of items we exclude from this calculation. A reconciliation of adjusted consolidated EBITDA to reported net income for the quarter is presented on slides 29 and 30.

Adjusted consolidated EBITDA was 106.4 million for the first quarter of 2010, compared to 98.4 million in 2009, an increase of 8.1%. This increase is attributable to Medicare pricing improvements and discharge growth; sustained efficiencies in labor productivity, allowing us to deliver a high-quality patient care on a cost-effective basis; and continued management of our expenses, including G&A.

Our adjusted income from continuing operations for the first quarter is presented on slide 9, with a reconciliation to reported net income on slides 29 and 30. In calculating adjusted income from continuing operations, we excluded the following items impacting both Q1 2010 and Q1 2009: professional fees, primarily associated with the continued pursuit of derivative litigation claims; mark-to-market adjustments on our interest rate swap agreements which are not accounted for as hedged instruments; and normalization of our tax provision.

In addition, Q1 of 2009 adjusted income from continuing operations excludes approximately 15 million in mark-to-market adjustments on our securities litigation settlement accrual which was settled in 2006 with shares of HealthSouth stock plus warrants. In September of 2009, we issued approximately 5 million shares of HealthSouth stock and 8 million warrants to the security litigation plaintiffs in full satisfaction of this obligation.

Adjusted income from continuing operations per diluted share was $0.48 for the quarter, an increase of $0.09, or 23.1%, over first quarter of 2009. This increase was primarily attributable to higher adjusted consolidated EBITDA and lower interest expense, offset by a 7 million increase in weighted average diluted shares.

Interest expense decreased 3.9 million quarter-over-quarter, primarily attributable to a decline in LIBOR as well as lower average borrowings resulting from debt reductions throughout 2009. The decline in LIBOR rates represents approximately 2.7 million, or $0.03 per share, of the year-over-year increase in adjusted earnings per share for the quarter.

The increase in diluted shares resulted primarily from the final settlement of our securities litigation in September of 2009, as discussed earlier. The additional 5 million shares we issued in connection with that settlement represents a $0.02 decrease in our adjusted earnings per share in Q1 of 2010.

Lastly, we have indicated that our stock compensation costs are expected to increase by $5 million over 2009 levels, to 18 million in 2010. We now anticipate stock compensation costs for the year to be approximately 16 million, and will be relatively consistent over the remaining quarters of 2010. The decline is due principally to forfeiture costs recorded in the first quarter of 2010 associated with recent attrition.

With that, I will turn the presentation over to Ed.

**Edmund Fay, Senior Vice President, Treasurer**

Thanks, Andy. I'm going to review our free cash flow for the quarter, and I'll cover matters pertaining to our balance sheet and liquidity.

On slide 10, we begin with our adjusted consolidated EBITDA and move through the adjustments necessary to arrive at cash provided by operating activities. Last year's first quarter cash from operating activities included the receipt of $100 million from our settlement with UBS, offset by legal expenses as well as $49 million of state and federal tax refunds. In the first quarter of this year, cash flow from operating activities had fewer non-recurrent items impacting it.

From our adjusted free cash flow on slide 11 you can see we generated $49 million of free cash flow this quarter, which is a $13 million improvement over prior year. The majority of that increase is due to our quarter-over-quarter adjusted consolidated EBITDA growth.

Maintenance CapEx is nearly $2 million below last year's number, and it's lower than we anticipate seeing on that line for the remainder of this year. Last quarter, we indicated maintenance CapEx would likely be in the $50 million range for the year, and we are still expecting something close to that.

Our swap payment is included in our free cash flow calculation. This swap does not qualify for hedge accounting so its payments don't run through interest expense, but we pick it up here as an item reducing our free cash flow. The $11.9 million payment we made in the first quarter is roughly consistent with the size payment we have made in recent quarters and anticipate making on this swap over the coming four quarters, assuming a stable LIBOR environment.

Let me refer you to slide 26 in the Appendix. That slide depicts each of the quarterly payments anticipated on this swap until it matures in March of next year. We will then begin to make payments on our two $100 million notional swaps which qualify for hedge accounting and whose cash flows will flow through interest expense. As the slide demonstrates, our cash obligation on swaps will diminish significantly as of the second quarter of next year, and this should offer further upside to our free cash flow momentum.

We did receive further state income tax refunds from 2004 and years prior during the first quarter. As has been our practice, we removed these receipts from our adjusted free cash flow as well as adjust to exclude professional fees being paid for legacy items such as our ongoing arbitration with Ernst & Young.

We used some of the cash we generated this quarter for modest debt repayment and continued investments in capacity expansions at existing hospitals, as well as the two hospitals we will be opening in Virginia later this year.

Turning to slide 12. We've continued to make steady progress on deleveraging, finishing the quarter at 4.2 times on a trailing four-quarters basis. This quarter's reduction is predominantly attributable to adjusted consolidated EBITDA growth. As we indicated on our last call, debt repayment opportunities are likely to remain limited over 2010 since our pre-payable debt, the 2013 tranche of the term loan, has a very low interest rate, around 2.5% in the current market environment, and the next call date on our bonds is in June 2011. We remain on track to achieve our targeted leverage ratio of 3.5 times to 4 times by the end of 2011.

From our liquidity schedule on this slide, you can see we finished the quarter with available cash of $117 million. Based on our available cash and undrawn revolver, we had $517 million of available liquidity at the end of the first quarter. This was an improvement of $36 million over our year-end

2009 position. Our current cash position offers us the ability to finance our announced acquisition and development projects from our balance sheet without anticipated dependence on our revolver.

With that, I'll turn the call over to John Whittington.

**John P. Whittington, Executive Vice President, General Counsel, and Secretary**

Thank you, Ed. Before I comment on our arbitration proceeding against Ernst & Young, I would like first to review and clarify the public disclosures issued last week regarding Ernst & Young and UBS settlements with HealthSouth shareholders and bondholders.

Some media sources reported the settlements as HealthSouth settlements, but in reality, HealthSouth was not and never has been a party to the UBS, Ernst & Young settlements announced last week. Those settlements were between former shareholders and bondholders of HealthSouth and Ernst & Young and UBS, respectively. Those claims were based on alleged violations of federal securities laws and were pending in the United States District Court in Birmingham. On the other hand, our claims against Ernst & Young are state law claims sounding in both tort and contract, and although our claims originated in state court, they were referred to arbitration by the state court judge. Since our claims are very different and involve different parties, we do not believe those settlements will have any material impact on our pending arbitration.

Now with respect to the arbitration, I would like to remind you that – again, that arbitration is a confidential process by its very nature, and we are limited in what we can report to you at this time. However, we are pleased to report that the arbitration process is proceeding according to schedule. We are also pleased to tell that you we continue to feel strongly about our claims and we are pursuing them aggressively. Finally, based on what we know today, we continue to believe and expect that the final resolution of the arbitration will be a second-half event.

With that, I will turn the presentation back to Mr. Grinney.

**Jay Grinney, President and Chief Executive Officer**

Great. Thank you, John.

As we've mentioned, we are very pleased with our first quarter results, and while we don't believe it's prudent to change guidance after just one quarter, we do feel comfortable guiding to the top of our adjusted consolidated EBITDA and adjusted EPS ranges based on this solid start. As illustrated on slides 13 and 14, doing so puts us comfortably in the growth ranges of our business model.

There are several factors that will influence whether or not we'll raise guidance after the second quarter. First, we need to be comfortable we can continue to manage our expenses to our volumes, which have rebounded in March and April. Second, we need to open our two new hospitals and complete our bed expansions on time and on budget, which will contribute to our volume growth. Third, some fiscal intermediaries renewed medical necessity reviews on April 1, so we'll need to gain some visibility on the impact these may have on our bad debts, if any. And finally, CMS is scheduled to issue their proposed rules for rehabilitation providers any day now, and while we don't anticipate any major issues, we will need to evaluate these proposed rules to determine if they will have any impact on our operations.

Before opening up the lines for questions, I want to thank and recognize Andy Price and Ed Fay for their leadership and outstanding contributions to the company during our search for a new CFO. By working directly with each of them over these past six months, I have grown to appreciate both their extensive technical expertise and their leadership capabilities. They are key members of

HealthSouth's senior management team, and I know they'll do a great job of onboarding our new CFO, Doug Coltharp, as he assumes his new responsibilities.

Doug's first day on the job will be tomorrow. A native of New Jersey with an undergraduate degree in economics and finance from Lehigh University and an MBA from Wharton, Doug brings a wealth of experience to HealthSouth, and we are very pleased to have him as part of our team. Doug spent nine years as a commercial banker before joining Saks Incorporated, where he served as its Chief Financial Officer for 11 years. Doug also serves on the boards of directors at three public companies and chairs the audit committees at two of them. I'm confident you will enjoy getting to know Doug and will appreciate the value he brings to HealthSouth.

With that, operator, we'll take questions.

## QUESTION AND ANSWER SECTION

Operator: Thank you. *[Operator instructions]* Your first question is from the line of David MacDonald with SunTrust.

**<Q – David MacDonald>:** Good morning, guys. Hey Jay, can you just spend a quick second on volumes? Obviously the first quarter number is skewed, but you guys had talked about volumes in the neighborhood of 4% in terms of discharge growth. Is that kind of what you saw in March, and is that a number that you're comfortable in terms of what you're seeing in April and what you still expect kind of as we move throughout the year?

**<A – Jay Grinney>:** Sure. As we said, 2010 is really a transition year for the company. 2008, 2009, we didn't have pricing, and we had implemented the TeamWorks, we saw great results, and we built up volumes significantly in both of those years. We recognize that in 2010 and beyond, our volume growth was going to continue to come from same-store market share gains, but was also going to require capacity expansions and de novos to maintain that pace.

So, yeah, we're still looking at that 4%. The March/April timeframe was definitely in that zone. And so we feel pretty good about the projections for the balance of the year on volume, but as I said, we just want to get a couple months under our belt. By the time we report Q2, we'll have May completed, June, and we'll have July under our belts as well, so we've – we'll have seven months by the time we report the second quarter, and that will give us, I think, more than enough visibility.

I do want to, though, emphasize that the thing that I'm the most pleased with is that we're in this mode now where our business model allows us to pull many different levers. I mean, volume is always going to be important, it doesn't matter if it's HealthSouth or an acute care hospital or any business, volume always matters. But fortunately, we have an expense structure that allows us to manage to the bottom line and importantly, we've got a nice development pipeline that will continue to fuel that growth on a go-forward basis.

**<Q – David MacDonald>:** And then just I guess my second question, Jay, would be, we've seen on some of the growth CapEx, or some of the acquisitions and relationships that you've developed, being in-market. Can you talk about some of the benefits of doing acquisitions or deals in markets where you already have a presence and maybe some of the cost structure that you'd be able to leverage by building out an in-market presence?

**<A – Jay Grinney>:** Yeah, and clearly, each market will be different. If we were to go into a megamarket like Houston or Dallas, those dynamics may be a little different just because of the sheer size of the geography.

**<Q – David MacDonald>:** Sure.

**<A – Jay Grinney>:** But we do believe that there is value in rounding out markets where we have a nice footprint, and Las Vegas is a great example. To put it into perspective, we have two other hospitals there, two other rehabilitation hospitals, we have an LTCH. We did not have a hospital in the southwest part of the city. We were looking at that as a growth opportunity for us. We weren't getting a lot of patients from that quadrant. And frankly, this acquisition at Desert Canyon is a perfect fit for us, because it's brand new. While it has struggled, I will acknowledge that, that we're going to have to get in there and turn that around, it gives us an immediate presence in that market. So we do think that having a footprint across our geographic markets makes sense, but I will tell you that we're also looking at hospitals in new markets. So it's really going to be a balance.

In terms of the leverage that we bring, it's primarily in the sales and marketing and the coordination of care, in making the rehabilitative services that we offer be available as close to home for our patients and their families as we can get. In a big market, that makes a lot of difference, because you know, most of our patients are elderly. And because of that, they are not necessarily going to

want to travel 15, 20 miles to go back to their acute care hospital. They may do that for the acute episode, because it's a relatively short period of time, but when they are in our hospitals and they're there for a couple weeks and family members are attending and coming to visit and be with them, having a hospital in a geographic location that's close to where they live makes a lot of sense.

And so we have the ability to – from a sales and marketing perspective, to cast a wider net, if you will, to get patients who are maybe living in the southwest part of Las Vegas. They might not have otherwise wanted to come to our hospitals, now we'll have a presence there. And obviously, there'll be some synergies on labor as well. We can flex around and bring employees from one facility to another if needed, although that's not really a huge leverage for us, but it is something that we have access to.

Does that help?

Operator: Your next question is from the line of Whit Mayo with Robert Baird.

**<Q – Whit Mayo>:** Hey, thanks. Good morning.

**<A – Jay Grinney>:** Morning, Whit.

**<Q – Whit Mayo>:** Morning. I just wanted to go back and explore the volumes a little bit further, just with regards to the mix. Medicare was the highest we've seen I think ever, and can you kind of talk about the strength there in Medicare? And maybe couple that with the softness in managed care, is that – it's pretty consistent with what the acute care providers have said, but when you also say that the volumes have rebounded in March, are you saying that's for all payors? Just like a little bit more clarity around that.

**<A – Jay Grinney>:** Yeah, I think that the strength on the Medicare is really more reflective of the weakness in the managed care. And to your point with that, that is consistent with what we have heard from the acute care providers and what we're seeing in the markets.

In terms of the rebound, it really is pretty consistent. I mean it's not just Medicare that's coming back. We are seeing our managed care portfolio rebounding as well.

And the other comment I might make on the volumes is, interestingly we really didn't see a huge shift in the service mix. We did treat a few more lower extremity patients in the first quarter, but there wasn't a big mix change, wasn't anything substantial, and the rebound is – kind of brought us back to levels that we had seen historically.

**<Q – Whit Mayo>:** Great, that's helpful. And Ed, can you go back and elaborate on your comment that you made about – I think you said that you experienced some better payroll in the quarter as a result of the coverage criteria changes. Just like to understand that dynamic a little bit more. You may have talked about it before but I'm just not sure I follow you.

**<A – Jay Grinney>:** Well, I think what it was, was the – and this is Jay, I'll answer it. And it was actually Andy's comments, where he said that if you look at the average salary wages and benefits per FTE, that was up in an order of magnitude greater than what you would expect if you'd just looked at the merit increase. So it's up something like 3.5%, 3.7%. So – and we gave merit increases that were obviously less than that, and what we're seeing is, as we – and it's two things.

One, as we continue to use the new labor productivity tool that we rolled out last year, we're starting to get our hospitals and our supervisors and our directors of therapy and our chief nursing officers familiar with the tool, using the tool, and then our regional folks are starting to benchmark best practices and start to get some standardization. That is helping us with that mix, or contributing to the mix, where we're seeing more of the licensed professionals and fewer of the aides and the techs.

The second is the new coverage requirements, and the demand there that is part of the coverage requirements in terms of the three-hour rule and additional aspects that are part of that, and I can ask Mark to clarify or amplify on that a little bit.

**<A – Mark Tarr>:** Yeah, hi, Whit. One of the things we did as well is relative to the staff that goes out and evaluates patients, we now have a higher premium, where they're all licensed staff. So many of our hospitals had some non-licensed staff helping in that capacity, but we made a switch out toward the end of last year, all RNs or licensed therapists or respiratory therapists are now evaluating our patients. So that increase in skills mix added a little bit to our total SWB per FTE.

**<A – Jay Grinney>:** So basically, we're trading out higher paid individuals for lower paid, and that is contributing. That was really the comment that Andy made, was that if you looked at the cost per employee, it's up a little bit more than what we've seen in the past, and was a function of merit increases and then the changes we just talked about.

**<Q – Whit Mayo>:** Got it. Thanks a lot.

**<A – Jay Grinney>:** Yep.

Operator: Your next question is from the line of A.J. Rice with Susquehanna.

**<A – Jay Grinney>:** Morning, A.J.

**<Q – A.J. Rice>:** Thanks. Hello everybody. I know, Jay, over time, you've talked about the company might look outside of the traditional IRF focus into other areas, LTCH and home health in particular. Can you just update us on your thinking there? Is Doug coming on board make that move up as a priority, to look at those areas? And I noticed you had added, at least in your slide 20, a couple other post-acute areas, inpatient, psych, and hospice. I don't know whether they're just there for reference, or are those potentially areas of interest as well?

**<A – Jay Grinney>:** Yeah, let me take the first question – or the second question first. No, on slide 20, that was just lifted from a MedPAC report and is intended to demonstrate that inpatient rehabilitation hospitals have a significantly lower re-hospitalization rate compared to SNFs, to LTCH, home health, and that was really put in there as a reminder that, when we get down the road and we start talking about bundling and we start talking about acute care hospitals being paid for quality as measured by readmission rates, that our hospitals are very nicely positioned to be that quality provider and that post-acute provider. So we are not interested in inpatient psychiatric.

Now we have said that hospice remains an interesting service. We're not prepared to look at that aggressively today, but clearly that's something that I think is a needed service. It is a service that not too far afield from what we do, but it's not really in the sweet spot like LTCHs and home health are.

If you go to page 21, that really shows why we're in a wait-and-see mode on LTCH and home health. And to answer your first question, with Doug's arrival, I don't see us and I don't envision us moving into SNF and home health today. LTCHs, we own and operate six. There's always a possibility that we may look at an LTCH here or there, but clearly there's a lot of uncertainty over those services that have to be resolved, and we believe will be resolved, over the next couple years.

And as that resolution occurs, we will be able to A) build out and strengthen our inpatient rehabilitation base; and B) strengthen our balance sheet so that we're in a position, once the regulatory uncertainty has been obtained, to move into and to explore acquisitions in those new service lines.

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

**<A – Jay Grinney>:** Okay.

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

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

**<A – Jay Grinney>:** Morning, Gary.

**<Q – Gary Lieberman>:** Just with respect to the arbitration, I guess the comment was made that everything was progressing on schedule. Is there any way to get at least a little bit more detail in terms of what the schedule was, or what you expected the schedule to be?

**<A – Jay Grinney>:** While I'm tempted to answer that question, I'm going to ask Mr. Whittington to do so.

**<A – John Whittington>:** Thank you, Jay, that's very generous. When the panel was seated, consisting of three panel members, they convened all the parties and established a schedule for the depositions of expert witnesses, procedural motions, memoranda, briefing schedules, and what I have reported is that, at this time, all is proceeding according to that schedule on a timely basis. And that there's nothing that unexpected in the schedule or no alterations in the schedule. It's performing according to schedule.

**<Q – Gary Lieberman>:** Okay. That's helpful. And then one quick follow-up. Jay, you made a comment that you saw a little bit of a shift towards lower extremity cases in the quarter. Does that – that seems maybe a little bit counterintuitive. If weather impacted some of potentially elective procedures, I would think of lower extremity procedures falling into that category before maybe some of the neurological stuff that you do. Could you comment on that?

**<A – Jay Grinney>:** Yeah, I wish I could give you a real knowledgeable answer. It's very hard to know what that was attributable to. And it wasn't a huge increase. It's not like we've gone up to over 10%. We're still in that 9, 9.5% range of of lower extremity as a percent of total volume. So it's not a huge shift. It was just a slight increase that we saw, and frankly, Gary, I'm not sure that we know exactly why. I think one of the things about being in this business is the demand for health care services is often very, very difficult to pinpoint, and we think we know sometimes, but there's really never any way of knowing with 100% certainty. But it wasn't a big shift and we are seeing, in the March-April timeframe, volumes rebounding and the mix settling out to pretty much what we've seen in the past.

**<Q – Gary Lieberman>:** Okay. Thanks a lot.

**<A – Jay Grinney>:** You bet.

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

**<Q – Paxton Scott>:** Good morning, and congratulations on the great quarter.

**<A – Jay Grinney>:** Hey, Paxton.

**<Q – Paxton Scott>:** My first question is, Jay, can you just remind us, kind of from a historical basis, where managed care pricing has trended and kind of how that compares to what you're seeing today and what your outlook is for the near future? Thanks.

**<A – Jay Grinney>:** Well, managed care pricing is a little different methodology, first of all. It's on a per-day basis, and we get reimbursed based on very tightly managed lengths of stay. That per-day

rate on the commercial side is anywhere from 10-15% less than what we might get on the Medicare front. And in terms of rate increases, we've seen over the last couple years a pretty consistent 3 to 4, maybe 5% increase on our expected pay from managed care.

**<Q – Paxton Scott>:** Okay, perfect. And then secondly, just I was wondering if you could isolate some of the trends you saw in your LTCH business, both on the volume and pricing front? And then if you have any commentary about the proposed rule that just came out and kind of how that came out in terms of what you were expecting? Thanks.

**<A – Jay Grinney>:** Right, I'm going to ask Mark to give some color commentary on that.

**<A – Mark Tarr>:** Overall, I would say we continue to make progress in the operations of our LTCH hospitals. As you know, we have six long-term acute cares. Relative to the types of patients, the patient mix that we see, we continue to see a more acute patient in those. Our case mix index is increasing consistently in the majority of those hospitals. We purposely are going out and trying to increase the pulmonary, particularly those patients that might need chronic vent care, as well as those that have severe wounds. So overall, I would say we continue to see a nice shift for the majority of our LTCH into those types of patients that have a higher acuity level.

**<Q – Paxton Scott>:** Okay, great. And then just any commentary on the proposed rule and how that looks relative to your expectation – your previous expectations?

**<A – Mark Tarr>:** Certainly having the two-year extension on the MMSE will help continue to give a little relief on the 25% rule aspect. The majority of our hospitals were well within that range anyway, so we weren't going to be pressured real strong on that, but I think overall, it does give the industry a little breathing room.

**<Q – Paxton Scott>:** But on the CMS proposed rule for fiscal year '11, I guess for the payment update?

**<A – Jay Grinney>:** Oh. Yeah, that came in pretty consistent with what we anticipated. Fortunately, the LTCHs are a pretty small part of our overall revenues and so the impact will be fairly insignificant. I think that the bigger question for us and what we're really watching is, the outlier payment adjustments that will occur when the MMSE expires, and obviously the upcoding adjustments, we don't think that that's going to be a big factor for us. So is it material? No. And it's pretty consistent with what we had expected.

**<Q – Paxton Scott>:** Okay. Great. Thank you.

**<A – Jay Grinney>:** Yep.

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

**<Q – Bryan Sekino>:** Hi, good morning, This is Bryan Sekino on behalf of Adam Feinstein here.

**<A – Jay Grinney>:** Good morning.

**<Q – Bryan Sekino>:** Just wanted to ask a question on the cost side, with some of the – with the discharge pressure, the volume pressure in the quarter. Other than the labor line, really what were some of the – I guess variable costs that you were able to reduce as a result of the short-term fluctuations in volume?

**<A – Jay Grinney>:** It was pretty much across the board. There wasn't any single factor that contributed as much obviously as being able to control labor. But we continue to focus on all discretionary spending. We saw some improvement in our ability to contract for services, ancillary services that some of our patients may need, such as imaging and laboratory work.

We are also looking at supply costs very diligently. We continue to try to standardize our supply chain spend, so there – I guess fortunately, there wasn't any one single line item that kind of really moved the needle. It was just a combination of factors, but all of it is really managed at the hospital level.

I think the only thing that we really did at the corporate level that was a conscious decision was we pulled back on rolling out and starting this whole TeamWorks initiative. We said well wait a minute, if the volumes are a little bit soft and we got this bad weather, and we may not be where we want to be on the volume side, and we're asking our hospitals to manage their expenses, we better make sure we're doing the same thing up here.

So that really was the one item that we were able to control here at the corporate office. But besides that, it was really just a all-out focus, and that's one of the great things about this company, is Mark and the regional presidents and the hospital management teams, they do know how to manage very effectively, and there isn't any one thing that we can point to. It's just – it's in everybody's DNA and we do it really well.

**<Q – Bryan Sekino>:** Great, and just on the TeamWorks rollout, on the standardization of the process with case managers, is that – I guess should we see an expected, I don't know, ramp-up in costs on any specific line as a result of that rollout for the rest of the year? Some things kind of got kind of pushed in the last three quarters?

**<A – Andy Price>:** Those – this is Andy. Those costs will appear in other hospital-related expenses on our other operating expense line. And as I mentioned, those – that project is set to kick off in Q2.

**<Q – Bryan Sekino>:** Great. Thanks for the questions.

Operator: Your next question is from the line of Ann Hynes with Caris & Company.

**<Q – Ann Hynes>:** Hello.

**<A – Jay Grinney>:** Hello, Ann, how are you?

**<Q – Ann Hynes>:** I'm good, thanks. So when we look at your EBITDA guidance, 3 to 6%, and you grew adjusted EBITDA 8% in the quarter, I know you gave a few reasons why you're being – maybe I'll use the word conservative, but I guess when you look at those reasons, what is the greatest impact on why you don't think you can replicate Q1 8% growth?

**<A – Jay Grinney>:** Well in -

**<Q – Ann Hynes>:** Is it the de novos?

**<A – Jay Grinney>:** Yeah, let's separate the question. It's not as though we're not saying – it's not as though we're saying we can't replicate, or the rest of the year is going to be iffy. It's really more a function of, we only have one quarter. It was a good quarter. I mean, we feel very good about it. Obviously this is a transition year where we're – we have some pricing, we've got the ability to manage our expenses, we're not as dependent on the volume. And so we just want to – we want to make sure that we have a good sense of what that run-rate is.

I think that there's – if you were to look at one factor that was probably the most important, it would be hard. I think it's really a combination of volume and corresponding expenses. Can we continue to manage to the bottom line? And we feel pretty good about where things look in March, we feel pretty good about April, but we just don't want to get out ahead of ourselves and we think – we don't provide quarterly guidance, and so we think waiting another couple months, getting some

additional months under our belt, it just makes more sense to us, I guess, Ann, than trying to jump out and be too aggressive.

**<Q – Ann Hynes>:** Okay. And on your maintenance CapEx, I know you have a lot of projects going on at your existing hospitals. Can you describe some of the projects, maybe how many hospitals are being worked on, and your – what you think the return's going to be in 2010?

**<A – Jay Grinney>:** Well I'll start, answer the last part. The returns on the maintenance CapEx are really pretty de minimus, or non-existing. I mean a lot of that is putting new roofs on, upgrading the finishes in hospitals. And I'll let Mark talk about some of the bigger projects, but -

**<Q – Ann Hynes>:** Yeah, I guess that's what I meant, like the redo of the waiting room and stuff like that.

**<A – Mark Tarr>:** Yeah, hi, Ann. We've taken approximately six, seven hospitals now that we have included in what we have defined as our quote-unquote refresh project, where we look at our hospitals, many of them are 15 years old, it's been awhile since they've had a major updating and refurbishing. We've done everything from look at the flooring in the major corridors, all the patient rooms are being renovated with regards to their bath and shower. All of the – typically the beds are being replaced. The finishes in the patient rooms, much of the equipment in the gyms that, either are outdated or rusted, so on and so forth, we are replacing. As you mentioned, all of the public areas, particularly in the lobbies and the waiting room areas, we have updated and changed out the finishes and furniture there. So it's pretty much what you would consider to be an overall remodel of the hospital, helps us stay competitive in marketplaces where we're competing against either new rehab hospitals, or in some cases, nursing homes that are newer and perhaps in a little better shape than some of our hospitals have gotten.

**<Q – Ann Hynes>:** All right. Thanks.

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

**<Q – Sheryl Skolnick>:** Thank you very much, and first, if you'll indulge me to say a huge thank you for slide eight, which I guess bears my initials. But it's immensely helpful to look at the company from the top down and to see the actual numbers that have been adjusted out or in, as the case may be, so thank you very very much for that, and for and -

**<A – Jay Grinney>:** Aim to please.

**<Q – Sheryl Skolnick>:** Yeah, it was great. And also for the cash payment schedule for the swap. Very, very helpful.

I don't think you actually answered the question on the coverage mandate, so if you could actually answer that prior question that would be helpful. And – but my real question is, as you look at the acquisition market, are you – now that reform is done, we know whether or not there is or is not bundling, we know a lot more things as you've shown in your slide about what the future looks like for rehabs. Yet at the same – I would think that perhaps acquisition pricing might either stabilize or rise, yet it sounds like your pipeline is getting more full.

So I'm curious about valuation on acquisitions, whether you're actually seeing any distressed situations? It sounds like the one in Las Vegas may not be distressed, but it's not doing particularly well. And whether or not you can still – and what you can tell us about acquisition multiples now, recognizing that you did not give us the terms of the transaction, but helping us to understand what you can buy assets for rather than build them, would be very helpful.

**<A – Jay Grinney>:** Sure. Yeah, and what was the comment on the coverage mandate? You said we didn't -

**<Q – Sheryl Skolnick>:** Yeah, you made comments about a coverage mandate. In addition to shifting from an unlicensed to a licensed staff for assessments, you also said something about increased labor cost due to a coverage mandate.

**<A – Jay Grinney>:** Oh, that's one and the same.

**<Q – Sheryl Skolnick>:** Okay. All right.

**<A – Jay Grinney>:** With the new coverage requirements comes – or one other new coverage requirements is to have licensed individuals doing the assessments. And so in the past, that was not a requirement, so -

**<Q – Sheryl Skolnick>:** A requirement of what? Your Medicare license?

**<A – Jay Grinney>:** Medicare, yeah. It's the new -

**<Q – Sheryl Skolnick>:** Yeah, okay, fine. That's the answer to the question I needed. Okay. Thanks.

**<A – Jay Grinney>:** Yeah, in terms of the acquisitions, the reason we don't provide information on pricing is because we don't want to be out there announcing to the next seller what we just bought the previous hospital from. So I think that logic is – makes a lot of sense to us, anyway.

We're not seeing any distressed properties. We are – the pricing we feel is still very – I would say it's similar to what we saw a couple of years ago, maybe a couple notches down, maybe instead of it being in the 7, 8, 9 times, it's maybe 6, 7, 8 times. But it's a pretty broad range. And obviously, whether or not the property is owned, whether or not it's leased, what the terms are of the lease, it does get to be a little bit complicated.

The pipeline is improving, it's definitely improving, and the dynamics are the same. The acute care hospitals that are looking to exit rehab are typically doing that not because they need the cash, although in some instances that's true, but it's typically because they're now seeing their volumes get up to the point where they need the space and they don't want to have to go out and add a wing. It's easier to sell rehab, reuse the space, get a little additional cash from purchased services.

So the pipeline is good. We're also looking, and part of the pipeline is, the de novos. And we said we would try to get at least two new hospitals started in 2010 and acquire at least two new hospitals. And as I indicated in my remarks, I think those are definitely going to be achievable and we're certainly on track for both of those.

**<Q – Sheryl Skolnick>:** Okay, and since one of these was actually a follow-up to get to you answer something. I'm curious about cash – free cash flow and cash flow from operations. Have you previously given any guidance on that, and sort of, if not, why not, and if you were to, what would it be?

**<A – Edmund Fay>:** We didn't give guidance on it last quarter, Sheryl, but what we did say is, if you recall, we had $174 million of adjusted free cash flow. And we called out some items that were particularly beneficial last year. So we indicated that although EBITDA growth will support it, that the declines in receivables we saw year-over-year last year was not likely to be repeated this year. So we did run into some headwinds. We didn't put a number out there, but we thought last year was a strong year. Might be hard to match that because of some of those comparables on the receivables side that would be hard to match.

**<Q – Sheryl Skolnick>:** Not to mention the UBS settlement and the tax refunds, et cetera, et cetera.

**<A – Edmund Fay>:** Well, those were backed out. We're not looking – so we're definitely not giving guidance on cash flow from operating activities because of a lot of those non-operating flows. But – so they would not have been in the adjusted number in any event.

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

**<Q – Frank Morgan>:** Thank you.

**<A – Jay Grinney>:** Hey Frank.

**<Q – Frank Morgan>:** You mentioned there was a resumption from the fiscal intermediaries looking at these, I'm curious, have you seen any activity on the RAC side?

**<A – Jay Grinney>:** No, we have not.

**<Q – Frank Morgan>:** Okay. A couple shopping list questions here. First, what was lease expense in the quarter? The startup losses on new developments in the quarter? And then any remaining outpatient clinics to be sold, how many would that be? Thanks.

**<A – Andy Price>:** This is Andy. Total occupancy cost during the quarter was $11.6 million.

**<Q – Frank Morgan>:** Okay. And then startup losses, on – and so that's – is that effectively a GAAP lease expense?

**<A – Andy Price>:** That includes straight-line lease expense as well as any other costs associated with those leases.

**<Q – Frank Morgan>:** Okay. Startup losses on some of your startups in the quarter? I think last quarter, it was a couple million bucks?

**<A – Jay Grinney>:** No, no, no, no. That was what we anticipated the costs being for the ramp-up period.

**<Q – Frank Morgan>:** Okay.

**<A – Jay Grinney>:** And so for the quarter, I don't have that right in front of me, but maybe a couple hundred thousand?

**<Q – Frank Morgan>:** Okay.

**<A – Jay Grinney>:** So it's not a material level at this point. The hospitals are going to be opening up in these latter part of Q2 and into Q3, so the closer you get to the opening date obviously, the steeper the ramp-up.

And then in terms of the outpatient clinics, those satellite clinics, we just – we look at them on a quarter-by-quarter and even month-to-month basis, and at this juncture, we don't envision closing any more, but we're never going to take that off the table.

**<Q – Frank Morgan>:** Okay. Thank you. Oh, actually one more, if you're still there. I'm assuming, with all this new coverage requirements, are you continuing to use less and less contract labor? I mean I know in past quarters is there's been big drops there, but would this need for the coverage requests for having licensed professionals, would that in any way affect your contract labor expense?

**<A – Mark Tarr>:** Hey Frank, it's Mark. We don't think it's had a material effect on it. Our contract labor, where we did have it this past quarter, was in those markets where we had the highest percentage of growth, so we continued to have a big focus on contract labor. There might have been one or two slots where we had some open licensed therapy positions that we needed to use some temporary contract labor in it, but I would say overall, the coverage guidelines have not driven contract labor in a material amount.

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

**<Q – John Ransom>:** Good morning. The differential on your rates, Medicare, managed care, and Medicaid, has that widened in the last couple years as you've worked through the Medicare price freeze?

**<A – Jay Grinney>:** I wouldn't say that it has. I mean it – I don't have a schedule right in front of me, John, to answer that, but just kind of doing a quick scan, I – it really hasn't changed that much. And of course, we do get paid on a different methodology for managed care, it's on a per-day basis, and we get obviously a case rate on the Medicare.

**<Q – John Ransom>:** Okay, could you just help us think about the kind of rough differentials between those three payor classes, so we can think about sensitivities to payor mix shifts?

**<A – Jay Grinney>:** Yeah. I think what we might have to do is follow up with you on that, just because I don't have that immediately in front of me. But I will say that overall, the managed care and Medicare differential is in the 15% range, plus or minus. And -

**<Q – John Ransom>:** Okay.

**<A – Jay Grinney>:** – in terms of managed Medicare, that's going to be close to that managed commercial.

**<Q – John Ransom>:** Right. Thanks. And secondly, I mean you're sort of rapidly going from being leveraged to being not that leveraged. Is there any one or two things that's in your legacy credit agreement that you'd like it get rid of, but maybe it's too expensive, given the rates you have, or any significant impediments when you think about?

**<A – Edmund Fay>:** It's really not a terribly burdensome credit agreement for us right now. We like the interest rate on it. The covenants, we have ample room right now under our interest coverage and our leverage ratios, and we have covenants around acquisitions, we just – we upped that last year when we amended and extended our credit agreement. We have plenty of room under our CapEx covenants. So it's not a terribly burdensome agreement. There might be some improvements we'd want in a new one, but there's nothing really that right now is tying our hands in anyway.

**<Q – John Ransom>:** I mean, maybe this is a better answer for the new CFO, but at what debt to EBITDA would you even consider buying back a modest amount of shares?

**<A – Jay Grinney>:** Well actually, that won't be Doug's decision, that'll be the board's. And I will tell you right now, we feel that the growth opportunities are really a much better investment opportunity for us than buying back shares.

**<Q – John Ransom>:** You're saying your stock's too expensive, is that what you're saying?

**<A – Jay Grinney>:** No, not at all -

**<Q – John Ransom>:** I'm kidding, I'm kidding.

**<A – Jay Grinney>:** You got me on that one, John. But definitely don't think that it's too expensive. But we do feel that – we're managing this for the long term, and to be focused on the long term means that we need to make sure that we have new hospitals coming online in 2011, 2012, and beyond. And so, if those opportunities weren't there, it might be a different matter.

Furthermore, as we look out into 2011, we do see some significant debt repayment and recapitalization opportunities that will bring additional value to our shareholders. So going to a – I don't know, and this is just my bias, I'll tell you that right now. But going to a stock repurchase is – kind of says that you don't have any other place to put your money to grow, and we just frankly don't believe that that's the case.

**<Q – John Ransom>:** And just a couple other things. How – maybe this is a hard question to answer, but kind of following up on your little acquisition this quarter. How deep is the market, would you say, for high quality rehab hospitals?

**<A – Jay Grinney>:** It's not a huge market. It's not as if there are thousands of these. There's probably a hundred or so that are free-standing, besides us. There's probably a little bit more than that, maybe 120. So there's certainly enough to I think keep us busy for awhile, and we certainly think that there's enough for the foreseeable future to fuel the growth that we have articulated and the objectives that we said we're going to try to achieve. Obviously, as we get down into the 2014-2015 timeframe, we'll have a stronger balance sheet that will allow us to then look at not only continuing the IRF buildout, but also look to expand into new areas.

Operator: Your next question is from the line of Darren Lehrich with Deutsch Bank.

**<A – Jay Grinney>:** Morning, Darren.

Operator: Darren, your line is open. And there is no response from that line.

**<A – Jay Grinney>:** Darren I think must be on another call. Operator, do we have any other questions?

Operator: There are no further questions at this time.

**Jay Grinney, President and Chief Executive Officer**

All right. Great. Well thank you, everyone, and we really appreciate the attendance on the call today. I think Mary Ann has a final comment, and then we'll sign off.

**Mary Ann Arico, Chief Investor Relations Officer**

If you have further questions, please call me at (205) 969-6175.

As a reminder, we will be attending the JMP Securities Conference in San Francisco next week, the Robert W. Baird Growth Conference in Chicago the following week, and we still have spots for our June 9 Open House at our new Loudoun County, or Aldie, Virginia, hospital. Thank you.

**Jay Grinney, President and Chief Executive Officer**

Thanks, everyone.

Operator: Thank you all for participating in today's conference call. You may now disconnect.