MANAGEMENT DISCUSSION SECTION

Operator: Good morning everyone, and welcome to HealthSouth's Second Quarter 2010 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

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

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Paula. Good morning, everyone. Thank you for joining us today for the HealthSouth second quarter 2010 earnings call. With me on the call in Birmingham today are: Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer; Mark Tarr, Executive Vice President of Operations; Andy Price, Senior Vice President and Chief Accounting Officer; Ed Fay, Senior Vice President and Treasurer; and Julie Duck, Vice President of Financial Operations.

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

Moving to slide 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 second quarter 2010, which will be filed later this week, and its previously filed Form 10-Q for first quarter 2010, the Form 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 this presentation are based on current estimates of future events and speak only as of today. The company does not undertake a duty to update or correct those forward-looking statements.

Our slide presentation and discussion on the call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of the slide presentation or at the end of the related press release, both of which are available on our website and as part of the Form 8-K filed this morning 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. Good morning, everyone. Second quarter represented another solid quarter for HealthSouth. Discharges increased 3.6% sequentially and were up 2.2% compared to the second quarter of 2009. We were pleased with this growth despite the weakness in acute care volumes in most of our markets, and believe it demonstrates the relative resiliency in demand for inpatient rehabilitative services.

These discharges coupled with good pricing resulted in a 4.3% increase in our inpatient revenues. Outpatient and other revenues were down $3.7 million in the quarter, as outpatient visits continued to

decline due to closures of non-performing outpatient clinics and general market conditions. With the economy rate remaining weak, we anticipate continued softness in outpatient visits for the foreseeable future. Fortunately, as we have stated previously, this is a relatively low margin business for us. On a consolidated basis, net operating revenues increased $15.3 million or 3.2%.

We were very pleased with the performance of our hospitals as they continued to manage their costs in a disciplined manner. Both productivity and labor expenses measured as a percent of net operating revenues showed quarter-over-quarter improvement.

At the corporate level, G&A expenses remained flat. The increase in hospital related expenses was primarily due to an adverse, and we believe aberrant, jury verdict relating to a malpractice claim in South Carolina. We took a $4.6 million charge in the quarter as a result of this verdict, and we will be aggressively appealing it.

The continued leveraging of our cost structure allowed us to generate $103.7 million of adjusted consolidated EBITDA in the second quarter, compared to $94 million in the second quarter of last year, for an increase of 10.3%. Adjusted EPS increased 12.8% and grew from $0.39 per diluted share in the second quarter of 2009 to $0.44 per diluted share in the second quarter of 2010.

Finally, and I believe most importantly, the company generated $59.6 million of adjusted free cash flow in the second quarter, bringing year-to-date free cash flow to $108.6 million, compared to 62.2 million for the same period last year.

In addition to these solid operational results, we also executed on our growth agenda. On June 1, we completed the acquisition of Desert Canyon Rehabilitation Hospital, a 50-bed all private room hospital in Las Vegas, Nevada. And on June 14, we began accepting patients at our Rehabilitation Hospital of Northern Virginia, a 40-bed all private room hospital in Aldie, Virginia, just outside of Washington, D.C.

And last week, we announced two projects in the Houston market, the signing of the definitive agreement to purchase the Rehabilitation Hospital of Sugar Land, a 50-bed all private room hospital in the southwest quadrant of that market, and the purchase of approximately 6 acres in the Cypress area of Houston on which we will build a new 40-bed all private room hospital. We anticipate closing on the Sugar Land acquisition in late Q3 and opening the Cypress hospital in the fourth quarter of 2011.

As a reminder, we have developed a proprietary tool that we use to analyze markets for both de novos and acquisitions. We assess underlying demographic trends, focusing on growth in the Medicare population, analyze the competitive landscape, to evaluate the demand for inpatient the ability to services and dissect existing referral patterns of patients requiring inpatient rehabilitative care.

This analytical tool has allowed us to successfully open eight de novo hospitals and acquire four competitors since 2005. Both the Sugar Land and the Cypress areas of the Houston market ranked extremely high using this assessment. And we're excited about the opportunity to extend high-quality inpatient rehabilitative services to these segments of the Houston market.

With that overview, I'm going to turn the agenda over to Doug who will provide a more thorough review of our quarterly results.

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

Thank you, Jay, and good morning, everyone. I've had the pleasure of meeting or speaking with many of you since joining HealthSouth on the heels of our first-quarter earnings call and I look forward to working with all of you in the days ahead.

I'll focus my comments on some further detail on our operating performance for the quarter. I'll also speak to our cash flow and liquidity and attempt to provide some insight into our priorities on the

capital structure. During my comments, I'll be making frequent reference to the supplemental slides that Mary Ann directed you to at the outset of this call.

As Jay stated, we had another very solid quarter. Our consolidated net revenue grew by 3.2% to $496.9 million, driven by both pricing and volume increases. Our inpatient revenue was up 4.3%, comprised of a 2.2% increase in discharges and a 2.1% rise in net patient revenue per discharge. As a reminder, inpatient pricing benefited from a year-over-year increase in Medicare reimbursement rates including the 2.5% market basket update initiated in October 2009, subsequently offset by a 25 basis point reduction beginning on April 1, 2010, as mandated by the healthcare reform act.

A higher net revenue from our inpatient business was partially offset by an 8.3% decline in outpatient and other revenues, largely attributable to the operation of six fewer satellite clinics in the second quarter of 2010 versus the second quarter of 2009. As we have previously stated, the outpatient clinics are not a core business for HealthSouth. This business will become even more challenging beginning in Q4 of this year, when reductions to our reimbursement under the physician fee schedule for multiple therapy services kick in, unless further extended by Congress.

Based on the current composition of our business, we anticipate this new rule could impact our outpatient revenues by approximately $1 million per quarter beginning in 2011. We will continue to closely monitor the performance of each of our outpatient clinics and, where appropriate, move to close additional units.

We continued to exhibit disciplined expense management during the quarter. As compared to Q2 last year, our largest expense category -- salary and benefit costs -- increased 1.6% and declined by 80 basis points to 48.6% of revenue.

For the first six months of 2010, we achieved 50 basis points of expense leverage in this category versus the same period last year. And as further evidence of our labor efficiency, employees per occupied bed for the second quarter of 2010 improved to 3.48 from 3.51 in the second quarter of 2009.

Hospital related expenses increased by 4.6% over the same period last year, due to an increase in our professional and general liability insurance reserves and the launch of our TeamWorks Phase II initiative focused on care management. The increase in professional liability reserves is comprised of $4.6 million related to the jury verdict, which Jay discussed earlier, and a $2.9 million increase related to the semiannual update to our actuarial estimates. As a reminder, it is our practice to update these estimates in June and December every year.

Our Q2 expense related to the TeamWorks initiative was $700,000, and we anticipate approximately $1 million in expenses related to this initiative in the second half of 2010. These increases were partially offset by a decrease in our bad debt expense, which fell to 1.2% of net revenue versus 2% in the same period of last year, an improvement of $3.8 million. This improvement resulted from the suspension of Medicare medical necessity claim reviews by our largest fiscal intermediary in 2009, and the subsequent recovery of denied claims, as well as a favorable trend in the recovery and capture of Medicare-related bad debts. I will note that the medical necessity claim reviews were reinstated in the second quarter of 2010, and, as a result, we expect bad debt expense in the second half of the year to trend in the 1.5 to 1.8% of net revenue range.

For the first six months of this year, we achieved 30 basis points of leverage in hospital related expenses against the same period in 2009. As Jay mentioned, our G&A expenses for the quarter, which excludes stock-based compensation, stayed constant at 4.6% of revenues.

The growth in consolidated net revenues combined with our continued leveraging of the cost structure resulted in adjusted consolidated EBITDA of $103.7 million in Q2 and $210.1 million for the first six months of 2010. A top-down view of our adjusted consolidated EBITDA is depicted on page eight of the supplemental slides. Adjusted consolidated EBITDA increased 10.3% over the second quarter of 2009.

Interest expense for the second quarter declined by $1 million versus the same period last year, driven by a $57 million reduction in average debt outstanding with borrowing rates essentially flat year-over-year.

Adjusted income per diluted share is shown on page nine of the supplemental slides. Second quarter adjusted income per diluted share of $0.44 represents a 12.8% increase from last year, even with the addition of 6.7 million shares to the diluted count, the vast majority of which were issued in September of 2009 as part of our securities litigation settlement.

As Jay highlighted in his opening comments, our adjusted free cash flow, which is depicted on page 11 of the supplemental slides, of $59.6 million for the second quarter and $108.6 million for the first six months of 2010 was very strong. As we look to the second half of the year, we expect free cash flow to moderate based on a number of factors, most notably an increase in our net working capital primarily attributable to growth in our accounts receivable balance and some catch-up in our maintenance CapEx for the year based on project pacing.

The expected increase in our accounts receivable relates to the Medicare billings ramp-up associated with our new hospitals and the aforementioned resumption of the Medicare medical necessity claim reviews. The suspension of these reviews in the third quarter of 2009 resulted in a substantial influx of payments and a corresponding reduction in accounts receivable in the second half of 2009. The resumption of these reviews will reverse the trend and result in an increased AR balance in the second half of 2010.

Maintenance capital expenditures for the first of 2010 were approximately $14 million. Based on the pacing of certain renovation projects, we expect maintenance CapEx to increase approximately to 30 to $35 million in the second half of 2010, versus approximately $19 million in the second half of 2009.

Turning to the balance sheet, I refer you to our debt profile on page 25 of the supplemental slides. Our liquidity at the end of the second quarter was very strong with an excess of $170 million of cash on hand, an increase from approximately $117 million at the end of the first quarter. And we had no borrowings under our revolving credit facility.

Cash on hand continued to benefit from a reduction in restricted cash based on negotiated agreements with our partnership hospitals. The improvement in our operating performance and free cash flow generation, combined with the scheduled amortization of our debt, resulted in a further decline in our leverage ratio of 4.1 times. Offsetting the cash on hand against the funded debt at the end of the second quarter would result in a net debt leverage ratio of 3.7 times.

Although, we have substantially improved our capital structure over the past two to three years through both debt reduction and opportunistic refinancings, we believe there is room for further improvement. We recognize the potential interest savings to be gained by paying down or refinancing the 10.75% senior notes. That said, the maturity dates and other terms of our revolver and term loans render these instruments our highest priority at this time.

Specifically, we believe the terms of our credit facilities are somewhat cumbersome and overly restrictive for a company with the size, operating performance metrics and market position we exhibit. As one example, the terms of our credit facilities currently place restrictions on our ability to prepay debt. We also believe that it's prudent to revisit our maturity profile with an eye towards reducing the amount of refinancing activity required in any one-year period.

Depending on market conditions, we anticipate that some time during the next several quarters, we will be refinancing our credit facilities. We would expect this to included at a minimum an extension of the maturity date our $400 million revolving credit facility, which currently matures in March of 2012, and the repayment, either via cash on hand, refinancing or a combination thereof, of our term loan maturing in 2013.

If market conditions are favorable, the breadth of this refinancing may increase to include the repayment and/or refinancing in whole or in part of the term loan maturing in 2015 and the 10.75% senior notes for 2016, which have an initial call date in June 2011 at 105.375.

We are ahead of our original targets for reductions in our leverage ratio and now believe we will be below 4 times at the end of 2010. Our longer-term run rate target for leverage is 3 to 3.5 times. Obviously, should we receive any proceeds from the E&Y arbitration, this may accelerate our progression towards the long-term target.

And now, I'll turn it back over to Jay.

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Doug. Before we take questions, I'd like to do three things. First, give you an update on the status of the E&Y arbitration; second, provide some classification on a recent regulatory announcement that may have caused some confusion; and then, finally, address our revised guidance.

With respect to E&Y, please remember these proceedings are confidential and we are limited in what we can say about them. What we can say is that the trial phase has begun and we continue to believe the final resolution will be a second half event.

However, it should be noted that while the actual trial is expected to take six to nine weeks, this is not a typical trial conducted over consecutive days until it is resolved. Rather, the trial schedule is determined by the arbitration panel based on their availability as well as the availability of the parties and witnesses participating in the arbitration.

Consequently, even though the trial phase has begun, you should not conclude it will be over in six to nine weeks. Although we can't predict when the trial phase will be over, we are very pleased it has begun. We continue to feel strongly that our claims are valid and we'll continue to pursue them aggressively.

Next I'd like to address a recent OIG audit report that may have created some confusion for some shareholders. On July 7, the OIG released a previously announced audit reporting on coding errors for patients transferred from the nation's inpatient rehabilitation hospitals in fiscal years 2004 through 2007.

Based on this audit, the OIG estimated that, nationally, inpatient rehabilitation hospitals may have been overpaid by approximately $34 million during this four-year period, and recommended that efforts be undertaken to recoup any actual overpayments. We've gone back to see if we have any exposure, and at this point have concluded we do not.

To put this into perspective, approximately one-tenth of 1% of our Medicare patients were discharged under this code during this timeframe. Based on the small number of patients and our focus on coding accuracy, if mistakes were made, we don't believe they will result in any material overpayment exposure for HealthSouth.

Now on to guidance. Our solid performance in the first half of the year coupled with better visibility into the second, allows us to raise our adjusted consolidated EBITDA range to 402 to $410 million and our adjusted EPS range to $1.66 to $1.74 per diluted share. Some of the key underlying assumptions we used in updating our guidance are as follows.

First, we're going to still remain fairly conservative. We think this makes sense in light of the continued weakness in acute care admissions and general uncertainty surrounding the economy. Given the anticipated continued softness in acute care volumes, which we'll be able to address by continued

market share gains, we are forecasting overall discharge growth in the 2.5 to 3.5% range during the second half of 2010. This will include discharges from newly acquired hospitals.

Pricing should remain at current levels through the third quarter, and then effective October 1 we'll see an increase of approximately 2.1% in our inpatient Medicare reimbursement. As previously stated, we anticipate our low margin outpatient business will remain soft. However, our inpatient pricing and discharge growth should be sufficient to generate second half top line growth of between 3 and 4%.

Also keep in mind, the third and fourth quarters historically are less productive quarters for us. First, volumes tend to be weaker in the summer months and rebound slightly in Q4. Second, our non-productive labor expenses go up as employees take vacations during the summer and at year-end, both of which causes our labor cost as a percent of net operating revenues to rise in the second half of each year. As we do each year, we also will provide a merit increase on October 1 for all non-senior management employees. This increase in labor cost will be partially offset by our Medicare increase.

Finally, although our year-to-date bad debt expense has been lower than historic levels, the recent renewals of ADRs that Doug mentioned, most likely will result in bad debt expense ticking up to approximately 1.5 to 1.8% of net operating revenues in the second half of the year.

In summary, we're very pleased with our performance thus far and believe we'll be able to continue this momentum into the second half of the year. Our business model continues to produce solid adjusted consolidated EBITDA, adjusted EPS and free cash flow gains and our development efforts are laying the foundation for this growth to continue into the future.

With that operator, we're ready to take questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question comes from Paxton Scott of Jefferies & Company.

<Q – Paxton Scott>: Hey, good morning.

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

<Q – Paxton Scott>: A question, Jay, and thank you for all that color on the volumes and kind of what you're seeing there and the acute care weakness is quite understandable. But you mentioned economic conditions, and so I'm just curious given the nature of your patient population, can you elaborate a little bit on kind of how you see the economy playing into your business at this point? Thanks.

<A – Jay Grinney>: It primarily affects the outpatient segment and we've mentioned that. But I think that all of us in the healthcare space are trying to grapple with exactly what kind of impact this is having. There was a recent article in the Wall Street Journal about how in May, for example, physician office visits were down like 7.5% year-over-year. So I think that in many respects, we're in sort of unchartered territory.

And I think that the general economy weakness really plays into our non-core outpatient, but it does, I think, have an impact upstream on the acute care. So it wasn't meant to be in addition to the acute care, it was meant to elaborate and explain -- sort of further reinforce that we think that there is just some uncertainty in the markets. The good news is that despite that, we really do believe that the fact that we were able to grow in the quarter, that we are able to increase our volumes sequentially, does speak to the fact that we are very nicely positioned in the healthcare continuum. That the demand generally is pretty inelastic. And we've seen that.

So I guess it's just a caveat, Paxton, and sort of a recognition that these are pretty unchartered territories. And we really don't know with precision what impact it has on acute care volumes, but certainly if they're going to be soft, it will have some impact on us. But we feel that we'll be able to continue to focus on talking about our value proposition, the quality of our care. We'll be able to continue to take market share. And I think that all of that combined will give us a 2.5 to 3.5% growth for the second half, which we would feel pretty good about.

<Q – Paxton Scott>: Okay. No, that's great. And my last question is on the guidance, I mean is it safe for us to assume that given that you had to take this $4.5 million reserve in the quarter, that that basically came straight out of your guidance as well?

<A – Jay Grinney>: It's safe to assume that we certainly had to incorporate that into the guidance.

<Q – Paxton Scott>: Okay, thank you.

Operator: Your next question comes from Darren Lehrich of Deutsch Bank.

<A – Jay Grinney>: Hey, Darren.

<Q – Darren Lehrich>: Hey, good morning, everybody. So I wanted just to ask a question about payor mix and we can see that you continue to have further growth in your Medicare fee for service volumes on a mix basis. But this quarter we saw a little less lift in revenue per in discharge then we did in Q1. So I'd just be curious to get a little bit of commentary from you about the interplay of pricing and rate and mix here in the stats?

<A – Jay Grinney>: Yeah, there are two things. Number one, as everyone knows, whenever we are able to close a cost report there's a true-up. We then make an adjustment based on the true-up with the Medicare program. And the delta year-over-year in terms of the true-ups last year, the true-ups this year, which is -- it's an ongoing recurring phenomenon -- was about, I think about $2 million. And so if you normalize for that, the rate increase, the change in discharge would have been closer to 2.6%. So that's just kind of one reference point.

The other thing that – as we've dissected, to the extent that we can, where the movements in managed care up to Medicare have occurred, most of that managed Medicare was in the traditional managed care or fee-for-service bucket. And, as you know, that's where we get paid essentially Medicare rates.

So a shift from managed Medicare in the fee for service bucket into traditional Medicare is not – if it's patient per patient, isn't going to give much of a lift. But there was a little bit of that sort of cost adjustment truing up that did play into the year-over-year growth on a per discharge basis.

<Q – Darren Lehrich>: Okay, that's helpful. And then if I could just ask a follow-up. Maybe, Doug, you can help me out in this one. The professional liability expense that you've incurred and you did mention that you had the semiannual review for your actuarial study. I guess I'd be curious just to know if that single verdict played at all into the base reserves? In other words, it changed your experience such that you had to bring up the base and if you're going to be pursuing litigation here to recover that 4.6 million, would we be in a position to maybe lower the base in your next one? I'm just struggling with that.

<A – Douglas Coltharp>: They were actually disaggregated, Darren. The actuarial estimate was revised as of the end of June 30. It was actually done knowing that the claim that resulted in the verdict was outstanding, but not anticipating the kind of aberrant result that we exhibited. And the addition of the $4.6 million on top of the addition to the reserve that came from the actuarial estimate was in recognition of the fact that this was an outlier claim.

<Q – Darren Lehrich>: I see. Okay. And the timing for any recovery, to the extent you're pursuing that in the courts. Any thoughts on that?

<A – Douglas Coltharp>: The appeals process can be a lengthy one. It can sometimes take two to three years. But as I think we've suggested, we intend to pursue all avenues of appeal available to us, because we really do believe that this is an aberrant outcome.

<A – Jay Grinney>: This is an extreme outlier, if you look at our claims history, and this really is something that -- that we just fundamentally and vigorously disagree with the jury verdict. But, unfortunately, in healthcare from time to time claims do get put in front of 12 individuals who don't have any medical knowledge, no medical experience. What they hear is dictated by the trial judge and they make decisions that may or may not be based in fact. So, fortunately in the appeals process, as we all know and we've seen this ever since there's been malpractice litigation, that oftentimes these outrageous jury verdicts get overturned on appeal.

<Q – Darren Lehrich>: Okay. Thanks a lot.

Operator: Your next question comes from A.J. Rice of Susquehanna Financial.

<Q – A.J. Rice>: Thanks, hello everybody. Just real quick follow-up first of all with the last question. On the 4.6 million, is there any ongoing higher rate of accrual for professional and general liability that you're assuming on a quarterly run rate going forward, or is that all specifically contained to this quarter?

<A – Douglas Coltharp>: Again the actuarial estimates are updated in June and December of each year. As of June 30, having made an assessment of all open claim years, we feel like we're adequately reserved right now.

<Q – A.J. Rice>: I guess the point is sometimes when they do those actuarial assessments, they then ask you to raise your rate of accruals going forward, and I guess that's the question. Did they -- was your ongoing rate of accrual correct and therefore it doesn't need change going forward, or is this a signal that maybe you've got raise it a little bit?

<A – Douglas Coltharp>: Yeah, I'm sorry A.J., I hadn't initially understood your question. It has resulted in a slight tick-up in the accrual, but nothing that is material.

<Q – A.J. Rice>: Okay. I guess it sounds like to me -- and maybe, if I'm misreading what you're saying that's fine, point that out -- but it sounds like for the first time you guys are talking about possibility retiring the 10.75 notes earlier than the call date as part of your overall restructuring of your bank financing et cetera, et cetera. Maybe give us, I mean is the idea to position yourself with the restructuring of all of this as quickly as possible, to be able to take advantage of acquisition opportunities or is there some other dynamic that would be at work which would drive any kind of decision around those notes, because obviously you could refinance those at a much lower rate, I would assume, today?

<A – Jay Grinney>: Yeah, let me just preface it and then I'm going to ask Doug to respond to the specific question. Doug has brought a very fresh and strategic view to our capital structure and to our balance sheet. And I think he pointed out that it's a natural and very logical thing to look at the highest cost debt and see what can you do to reduce that.

What Doug has done, though, is he's brought in a broader view of the capital structure, looking at our liquidity, looking at maturities, looking at a whole range of different issues to help then develop a more comprehensive approach to how to strengthen this balance sheet over the long term to give us maximum flexibility. And to give us the ability to prepay a good portion of that debt. So with that, I'm going to turn it to – ask Doug to answer the question specifically. But it's not as if there was an event – other than the fact that Doug joined us -- that really caused us to step back and say, all right, let's put together a total comprehensive long-term plan that will improve the capital structure, give us the flexibility and allow us then to address and absorb any risks that might be coming down the pipe that we can't anticipate at this point.

<A – Douglas Coltharp>: And A.J., my intent had been to point out that we are very cognizant of the fact that the 10.75 represent a high coupon rate and there's significant interest expense associated with those notes running through our P&L. Having said that, I believe that there are priorities in front of the 10.75 with regard to the capital structure. And it starts with the fact that our $400 million revolving credit facility, although there are no borrowings outstanding and it really serves as a liquidity facility for us, has a maturity date of March of 2012. And in order to prevent that from becoming a current obligation, it needs to be extended in some way prior to March of 2011, before it gets with inside a year of that maturity date. Well that's going to be upon us in the not too distant future, so it was already time for us to be thinking about that.

As we start to think about moving that maturity date forward, we've got a $450 million maturity in the term loan B that matures in 2013 in front of that, and in order to extend the revolving credit facility and maturity date out by any kind of reasonable period of time, we're going to have to deal with that maturity. And that's why I placed the initial priority on dealing with the revolver and, in conjunction with that, that $450 million of debt that matures in 2013. Once we have solved that puzzle, if the market opportunity is available, we can look at a broader opportunity, but I think there too we would probably first be directing our attention to the $290 million or so of debt that's in 2015.

Although, the 10.75 represent somewhat of an eyesore from a coupon perspective, the fact of the matter is it's non-amortizing debt with very few covenants, that doesn't require any action until 2016. So we'd like to get to it when we can in order to pick up some of those interest savings, but it's about third or fourth on the priority list right now.

<Q – A.J. Rice>: Okay. All right, thanks a lot.

<A – Jay Grinney>: You bet. Thank you A.J.

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

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

<Q – Frank Morgan>: Good morning, two questions. First, obviously you've had this fluctuation in your bad debt expense, you've had the audits and they go away and you expect them to come back. Is there a normalized level that we should think about where bad debt expense should be over the long haul?

<A – Jay Grinney>: You know, what we've seen historically is that somewhere in that 1.5 to 1.8% of net revenues is about right if the current level of those additional data requests come in. So it's -- fortunately, again we're not positioned like many acute care providers, where they have 10, 12, 15% of net revenues are bad debt. Ours is pretty low exposure. But we do think that, that 1.5 to 1.8% is about the right range to think about assuming that the ADRs start picking back up it to their historic levels.

<Q – Frank Morgan>: Okay. And another question, maybe Doug can weigh in on this one too. Obviously, you're thinking a lot about refinancing right now, but in terms of just development opportunities, acquisition opportunities what is your preference with regard to future funding for those types of efforts?

<A – Jay Grinney>: In terms of -- this isn't Doug, but in terms of...

<Q – Frank Morgan>: Lease financing, debt financing...

<A – Jay Grinney>: I mean, we -- the great news is we're generating some very strong free cash flow, more than sufficient to meet our ongoing acquisition and de novo strategy. We -- as we look at the development pipeline and we've said two to three de novos opening each year, maybe two to three acquisition each year, we think that that's a very doable pace. The acquisitions obviously a little bit harder to predict because you've got to have a willing buyer, willing seller, agreed upon price and

terms. But we feel pretty good about the pipeline that we're working. So we definitely do not see that we're going to have to go out and do any debt financing to achieve the de novo and the tuck-in acquisition strategy that we've set out for ourselves.

<A – Douglas Coltharp>: And maybe just to elaborate on that, as we look on an acquisition by acquisition basis, at whether or not we should lease the facility of acquire and own it, it really boils down to three key factors, cost, control and flexibility. We'll obviously look at the cost that's embedded in the lease and compare that to our other financing sources, doing it on balance sheet through one of our – through our revolving credit facility or elsewhere. Control is probably paramount, which is we are adamant about the fact that we need to control the license and the CON for the facility and some of the other sources of real estate financing that are out there in the healthcare world, don't readily permit that.

And finally, there's flexibility, which is we want to be able to control the destiny and the fate of these hospitals on a go-forward basis, and to the extent there's anything embedded in the proposed lease arrangement that inhibits our ability to exercise complete discretion, we're probably going to steer more towards just complete ownership.

<Q – Frank Morgan>: Okay. One final and I'll hop off here. Jay, obviously a lot has happened over the last couple of months in a lot of sectors of post-acute care. I know you've talked about keeping your eye on a number of different segments and clearly with what's happened in home health over the last couple of months, any updated thoughts on your interest level, either more or less interest in any of these other sectors? And really I'm talking about long term, I'm not talking about over the next couple of quarters. But has your interest in any particular sector increased or decreased as a result of what you've seen happen over the last couple of months? Thanks.

<A – Jay Grinney>: Yeah, you're right. There's been a lot of regulatory changes. But frankly, there's really no change. We've been saying pretty consistently now that -- and we have a slide in the supplemental slide that summarizes some of the regulatory overhang that's out there. We've said all long that – it's on page 16 of the supplemental slides. There's a lot of uncertainty that home health is going to have to work through, SNFs, LTCHs. In many respects, our time in the barrel, if you will, has concluded.

I mean, think about it. A couple of years ago, LTCHs and home health and SNF were sort of minding their own business, and continuing head down and we were getting beat up. We had 75% rule, we had changes to the weightings in the CMG. We had these coverage requirements. Well, our time is now finished and now people are looking at home health and skilled nursing, looking at the rate of increase in overall Medicare expenditures, that's drawing a lot of fire. All the other coding issues that the home health providers are going through.

We do believe that the next couple of years are going to be years of a lot of changes in post-acute. We feel really good about the fact that our space, we believe, is going to be relatively untouched, not because we're good guys, but just mainly because we've already been touched. And so they are going to go focus on the other segment. Has it increased or decreased, no. Does this -- do the -- the recent scrutiny in the other post-acute providers surprise us, no. We've been anticipating this, we've been talking about this, most of what's out there isn't a secret. And so it's just a matter of time and allowing time to pass, and we see the impact.

Frankly, what we see are going to be some potentially nice opportunities down the road. And one of the reasons why we want to structure our balance sheet the way Doug outlined is to be flexible. So that we can take advantage of opportunities if they make sense. I think everybody knows us well enough, we're not going to go out and do deal just to do a deal. We get investment bankers coming in just about every other week and they got these booklets and what -- think about that and think about this. We just tell them, guys, you're not listening to us. You're just not listening to us. We're not going to do a deal, just to do a deal. We're going to be very disciplined. We're focusing on the capital structure; we're focusing on the balance sheet. And the plan that we've laid out for ourselves which really hasn't changed that much, which is on slide 14, really kind of describes it.

There are going to be a couple of more years that we're going to have to go through, get the uncertainty out of the market. And then A), our balance sheet will be a lot stronger. B), we believe the pricing for complementary services will be more realistic. And C), the regulatory environment will hopefully be such that some of these marginal lower quality providers get squeezed out and those of us who have scale will be able to step in and roll up some of these segments. Not that I have an opinion on that, Frank, but it's my soapbox.

Did I cut off all questions, operator?

Operator: Your next question comes from Ann Hynes of Caris & Company.

<Q – Ann Hynes>: Good morning.

<A – Jay Grinney>: Good morning, Ann.

<Q – Ann Hynes>: So I just want, if we could drill down on your comments about you being more conservative on volume because of the economy. Can you give us a little more detail on is it commercial versus Medicare? Or are you seeing some softness with Medicare? Or is it -- and maybe by specific discharge, are you see more weakness in ortho, which could be more economic sensitive, versus some of your other discharges?

<A – Jay Grinney>: No, it's really more the economy -- the weakness in the economy, we believe, is having some upstream effect on acute care volumes and 95, 96% of our patients come from acute care hospitals. So there's going to be some impact there. What we've seen, if you look at it on a quarter-over-quarter basis, where we've seen declines in the kinds of patients are cardiac patients, non-traumatic brain patients; the increases have been in neurological. We have seen a slight uptick in joint replacements, mainly those with the co-morbidities, and then in other orthopedic cases oftentimes involving spinal cord injuries.

So it's very hard to know what that cause and effect is, but based on what we're seeing in the markets, there's really a lot of choppiness in the acute care volumes. And we've got to believe that somehow that's going to filter down into our volumes, but we still think, frankly, getting 2.5, 3.5% volume growth in the second half. I've been reading a lot of the reports from other health care providers, I think there wouldn't be a single one out there who wouldn't trade that.

<Q – Ann Hynes>: Yeah. And just a follow-up on your IT expenses. When sell-side analysts were in Virginia in June, you gave some details on your IT expenditure over the next few years. And I think since then, the meaningfully use final guidelines came out, and were probably a little less erroneous for acute care hospitals. Does that change your predictions over the next five years with that spend?

<Q – Jay Grinney>: No. As you may know, the inpatient rehabilitation hospitals are not in the list of hospitals available for stimulus funds and so the meaningful use criteria doesn't apply to us. You know, our view on this all along is not should we do it, it's just when and what platform and at what price. And right now, we are piloting the new clinical information system at our newest hospital up in Northern Virginia. And it's going really well. We had a board meeting up there last week, toured the hospital, had an extensive download for the board on the clinical information system. And they had a chance to see it firsthand. So it's really, and as the board concluded with us, putting in a clinical information system in today's environment, it's just a cost of doing business. I mean it's just like improving the HVAC system or putting in a new roof, you've got to have it.

The good news is we're not so far behind. In fact we kind of feel like we're in the middle of the pack. And we don't have to be way out on the bleeding edge. So we can take our time, we can do a thorough review; we can take and analyze where the benefits are. And as we said in the meeting with the sell-side, we're not factoring in huge windfall gains on the investment. This is going to be for quality and it's going to be reduced medication errors. But it's not going to be something that has a huge return on invested capital; it's just going to be an investment we're going to have to make.

Operator: Your next question comes from Whit Mayo of Robert W. Baird.

<Q – Whit Mayo>: Hey, thanks for squeezing me in.

<A – Jay Grinney>: Hey, Whit.

<Q – Whit Mayo>: Hey. First question I have just on SWB, you've made some really good progress on that line item for some time now. Can you, one, maybe talk about whether the 50% number is still the right number to think about for the second half of the year? I understand a lot of the seasonal factors there. And secondly, maybe can you elaborate on how you've managed the expense through the quarter. I see the EPOB down, but when I look at the dollars on that line item, they are flat year-to-year. So just looking for some additional commentary on any measurements you made within the quarter?

<A – Jay Grinney>: Yeah, I'll ask Mark in a moment to just talk about the management of our labor. I will say, I think that the system that he put in place throughout the hospitals last year, that labor management system, has allowed us to get more visibility and more real time management. To your question about the SWB as a percent of net, it does tick up in the second half of the year.

And you just go back historically and you can see that it does go up into that 50% range. And so, we expect that. In terms of managing it, we really try to flex down. So we'll cut out contract labor when we can, we'll cut off the part-time labor while we can. But I do think we've got a handle on that. I'll ask Mark to just provide a little more elaboration.

<A – Mark Tarr>: Yeah, Whit. The key to us is to flex up and down as volume goes up and down. And, as you heard us say last year, we consolidated and standardized all of our time clocks in our hospitals. And then in the last six months, we've rolled out some management tools through the reporting within our own IT group that allow our CEOs, our controllers in our hospitals, to have insight into their labor spend literally within a one-day lapse. Instead of having to look back on a two-week payroll basis, now they can see real-time where they are on EPOB, on total salary spend. So they can go in and make the adjustments as we see fluctuations in volume; the quicker they can do that, the better off we are and maintain our EPOB.

<Q – Whit Mayo>: Okay, that's helpful. Maybe my second question is just on the volume side. Doug, do you have a spot number for what the same store patient days were? Your length of stay was down about 2% and presumably your patient days been may be down more than the discharges. Just wanted to see if I'm reading that correctly?

<A – Douglas Coltharp>: Tell you what, why don't you give us a couple of minutes to see if can track that down and maybe we can move on to the questions and respond to that thereafter?

<Q – Whit Mayo>: That's fine. Thanks a lot.

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

<Q – Sheryl Skolnick>: Thank you very much. And if you can multitask while you're looking for the patient days, I have a financial question. It was delightful to get the fresh perspective on your capital structure and the debt maturities in particular, but I'm very curious as to which of the restrictions in your credit agreement -- and recognizing that it fundamentally dates back to 2006, which was a very different company then. Which of the restrictions are particularly restrictive for right now? I know you said, the debt prepayment, but is it the restricted payments basket or are there other limitations in the credit agreement that are chafing?

<A – Douglas Coltharp>: Yeah. Sheryl, I do want to see the primary motivation for opening up the credit facility is going to be driven by the maturity date and the amount of refinancing that it necessitates in any particular year, and how those are linked together. That said, I would say that as

we sit here today, there isn't any one provision in the credit agreement that's terribly restrictive against what we want to do.

But as we look forward down the road, there are some of those baskets and there are numerous baskets -- debt repayment for capital expenditures in any particular year for acquisitions, any of which could start to become somewhat more cumbersome. And this then relates into the fact that the credit facility is tied up and the same agreement covers both the revolving credit facility and the two term loan B tranches. And that makes it extremely difficult to get an even innocuous amendment when you need it.

When you're dealing with a more traditional bank types of arrangement, you have strong relationships with the credit providers in that facility. And because those participants are typically also then availing themselves of opportunities with the company to participate in investment banking services and operating services, it's frequently easier and less expensive to go to that group and say, I need an amendment for one of these items. When you're dealing with the type of structure we are, there becomes only one solution to getting even an innocuous amendment, how much are you going to pay me.

And when you combine that with, as you suggested, the underlying credit agreement was put in at a place when the company was in a very different position and was a different company. In spite of the best efforts of numerous attorneys and some hard-working bankers to reflect more of the company's current position in the various amendments, just to pick up the agreement and say, I'd like to know if we can do X within the confines of this agreement, takes about a week of drilling through series of amendments back to the original agreement, only to come up with an ambiguous answer.

<Q – Sheryl Skolnick>: Yeah, I know.

<A – Douglas Coltharp>: And the way that we have to operate is in an abundance of caution, we think it's a better practice to go back and get an amendment or a waiver to resolve the ambiguity. And then that takes you right back into the position where somebody's saying, okay how much are you are going to pay me for that.
<Q – Sheryl Skolnick>: That's right. You're constantly being held up. I couldn't agree with you more and I think it's, as I said, it's refreshing and delightful to hear your perspective on it. And I think very valuable, even though it may disappoint some folks who assumed that there was a near 100% likelihood that you'd actually act on the 10.75% notes when they become callable. Which you might still do. I'm not saying you won't, but this is a little bit different plan of attack.

And if I could move on to sort of my follow-up, a related question moving down the capital structure, as I look at HealthSouth's stock I, and those who actually put money to work buying stocks, are I think often if not perpetually perplexed by why it seems to not trade better, in the sense that you've got very strong fundamentals, you've got a dramatically improving balance sheet over the life cycle of the company, you've got significant improvements in free cash flow. And you're still moving forward. Even though EBITDA growth is not 20%, it's still quite respectable. So I guess I'm perplexed as to what's keeping the stock down here? And I'd appreciate management's outlook on that, even though I know it's typically something that management doesn't like to respond to. I wonder what the street is missing that you clearly see that maybe others don't? And then the second thing is, if this persists and you keep building up cash, at what point do you consider selling the company?

<A – Jay Grinney>: I can answer that last part. At no point that we can see, because we, frankly, see a lot of really exciting growth opportunities ahead of us. I think your point, though, on why are we trading where we are is a very good one. And I don't know what people are missing. I don't know if we're being caught up with other hospital companies and there's confusion about how we're different. We try to articulate those differences.

And we do think that providing the kind of results that we've been able to will help. I do believe that the improvement in our leverage will help get us on other screens that we may be precluded from or off today. But it's very hard to know precisely why. What we can control and what we try to control is,

number one, the forecasts and the projections, and then the execution against those forecasts and projections. And we do believe that there will come a time when the uniqueness of our performance and so on will be appreciated.

<Q – Sheryl Skolnick>: And the reliance perhaps on the E&Y verdict -- people waiting for that as opposed to perhaps focusing on the fundamentals?

<A – Jay Grinney>: Potentially. I think that's a very excellent point. The good news is, though, we're a lot closer today in getting that thing resolved one way or the other. And we still feel very strong about the validity of our claims. As I mentioned, the trial phase has began. The sequence and the schedule may not be known to us at this point, because of what I said, but it's begun. So we're -- things never move as fast as we would like but they are moving forward. And in very short order, we'll be on the other side of that.

Operator: Your next question comes from Gary Lieberman of Wells Fargo.

<A – Jay Grinney>: Hi, Gary.

<Q – Gary Lieberman>: Thank you for taking my question. It looks like from some of the --one of the slides in the appendix with the discharge growth, it looks like in the first quarter the industry growth was substantially weaker than your own and it sounds like that probably continued into the second quarter. Is there any evidence from that, that there are more acquisitions or potential acquisitions sort of coming to your attention or maybe even approaching you?

<A – Jay Grinney>: You know, it hasn't had a huge impact on the acquisition pipeline. It remains a situation where the host acute care hospital typically is not selling their rehabilitation unit out of desperation. I mean if they're in tough straits, they're going to be looking to one of the acute care hospitals maybe to buy the whole thing. On the other hand, there are occasions where we have hospitals, where we've got hospitals in markets, they're full. And -- or they have other plans for those beds. That definitely is a contributing factor.

On the freestanding side, yes, do see a fair number of those that become available or that we look at. I will tell you that that some of those, though, they've got some hair on them. Not all of these freestanding rehabilitation hospitals, are owned and operated by rehabilitation providers. And as you know, we're highly regulated. As we get in, there are going to be some that we might we want to pursue --we get in, and we realize that the owner has some real serious regulatory issues that they've got to get resolved before we can move forward.

<Q – Gary Lieberman>: And then just one follow-up, I'm not sure if you said, but was there any specific case type that was weaker than others for you in the quarter?

<A – Jay Grinney>: You mean in terms of the program mix?

<Q – Gary Lieberman>: On the inpatient side, yeah in terms of the mix of program mix, was there any specific patient that was weaker?

<A – Jay Grinney>: The weakness both sequentially and quarter-over-quarter was in the cardiac and pulmonary conditions. And we also in the quarter-over-quarter saw some non-traumatic brain injury decreases. And on a sequential basis, fewer lower extremity fractures in the second quarter.

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

<A – Douglas Coltharp>: Just wanted to take a moment to respond back to Whit's question previously. The inpatient days for the second quarter were up about 65 basis points versus the second quarter of last year, and the vast majority of that was attributable to same store growth.

Operator: Your next question comes from Bryan Sekino of Barclays Capital.

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

<Q – Bryan Sekino>: Good morning. Quick question here. I know you've provided a lot of the statistics on the Desert Canyon and how the volume has really ramped up there. I just wanted to see if you have a similar opportunity at Sugar Land and, as you think about the two to three, is that -- acquisitions you'd do each year? Is that really how you gauge what's on your radar in terms of an underperforming, under-occupied facility and something that you can improve right away?

<A – Jay Grinney>: Yeah. We do look at the quality of the asset we're buying. We're not troubled if it is having difficulties, as was the case in Desert Canyon. We felt that we were able to bring some value to that hospital and we saw a very nice increase in our volumes. I think that the Sugar Land is a similar, but they're actually performing at a fairly decent level right now. In the case of Sugar Land, we've always said we like that market. Historically, in fact, we were looking at this particular asset a couple of years ago. And we said we're not going to get into Texas and make an acquisition and then two weeks or two months later have some start-up, physician-owned syndicated hospital open up two or three blocks away.

And with the prohibition against physician-owned hospitals, Texas is now a pretty attractive market for us. And so, Sugar Land is an opportunity to acquire something in the far southwest quadrant. There aren't a lot of other competitors. A lot of those patients are having to go all the way down to the Texas Medical Center. And we've got the same thing up in the Cypress area. Again great underlying demographic growth, good Medicare population growth, a lot of inpatient rehabilitative need, and that need is being met either downtown or having to travel 20, 30, 45 minutes for care. So we think that both of those are going to be really nice opportunities for us.

<Q – Bryan Sekino>: Great, thanks. And then just one more question here if I may on the TeamWorks initiatives, I know you provided the impact in the quarter. Can you give us the timeline in terms of, I guess the completion of this stage of TeamWorks? And then, how you envision that manifesting itself on your costs, the impacts of the standardization of case management?

<A – Mark Tarr>: Yeah, hi Bryan, this is Mark, let me give you an update on that. As you know, we do call this TeamWorks effort Care Management, it is the process of looking to standardize the case management facets within our hospitals which has been a big focus of ours, leading up to this project where we review and examine all opportunities from the time of admission for a patient through the whole discharge planning process. We're about three months into this project. This project will go for the rest of this year; we would expect full implementation sometime in the mid 2011. You'd asked about how it's going to manifest in our hospitals, I think it will be a much more of qualitative manifestation with results from a qualitative standpoint than cost. We do look to have better coordination of our patients throughout the process, better communication with the patient and patient family. And ultimately we expect to see improvement on both outcomes and patient satisfaction.

Operator: Your next question comes from José Ransom of Raymond James.

<Q – John Ransom>: Hi. This is José's brother John. How are you?

<A – Jay Grinney>: I'm good.

<Q – John Ransom>: . I think my heritage is French, I'm not sure, if we have any José's. This is for Doug, let me just throw out a hypothesis and tell me whether this is reasonable in your mind or not reasonable? I guess, I'm thinking if you get some kind of settlement out of E&Y, you could then proceed from a point of even better strength to go back to your banks and why wouldn't you do a large facility which would leave you enough liquidity to do everything you needed to do, including take out those bonds next year if you chose to call those?

<A – Douglas Coltharp>: There are at least two key components to that hypothesis. One is the amount capacity that's available in the market in any particular window, and what we are seeing out

there along with everybody else is a period of extreme volatility that impacts both the public debt market and the bank market as well. And the windows are opening and closing much more quickly than they would in a more stabilized environment. We cannot sit around and wait for an eventual settlement from E&Y to come in, as we start to think about our refinancing activities. If an attractive window opens up in the market that allows us to meet a good number of our objectives, but not to completely revamp the entire balance sheet, then I think it's going to be our position to seize upon it.

If a broader window opens up and/or during this timeframe, we do receive a favorable settlement from E&Y, does that increase our capabilities to go at a broader restructuring and potentially capture some of 10.75s? The answer is absolutely, yes. But we wouldn't suggest that we're going to sit around and wait for the resolution of that matter before we start taking proactive steps to better position the capital structure.

<Q – John Ransom>: Okay. Second question, I'm sorry if I didn't pick up on this in your slides but what do you anticipate your swap payments to be this year? And what compared to last year?

<A – Douglas Coltharp>: Running about $11 million a quarter right now. We dipped slightly below the $11 million assuming LIBOR stays constant at roughly 0.54%. We'll run slightly below $11 million as we move into the final quarter of the swaps, which is the first quarter of 2011.

<A – Jay Grinney>: And John, that is on page 12 of the supplemental slides.

<Q – John Ransom>: And then those drop to zero, correct, after the 1Q of '11, just to clarify that?

<A – Douglas Coltharp>: That's right. Those swaps will terminate beginning in March of 2011.

<A – Jay Grinney>: But we do have the ...

<A – Douglas Coltharp>: We've got two forward starting swaps for $100 million each, one that rolls on in March of 2011 and one that rolls on in June of 2011, and both of those are at much more favorable rates.

<Q – John Ransom>: Okay. Thank you.

<A – Douglas Coltharp>: .. inside 50% of the fixed cost versus the current swaps.

<Q – John Ransom>: Okay, that's it from José. Thank you.

<A – Jay Grinney>: Thank you.

Operator: Today's final question comes from Miles Highsmith of RBC Capital Markets.

<Q – Miles Highsmith>: Hey, guys. Good morning.

<A – Jay Grinney>: Miles.

<Q – Miles Highsmith>: Hi, just had one technical follow-up actually. Doug, in terms of retiring the 2013 bank debt versus the 2015 tranche, can you just take out the '13 and not pay down the '15 or is there kind of a ratable requirement where if you're going take out one you'd have to do both at the same time?

<A – Douglas Coltharp>: We can deal with the 13s without the touching the 15s.

<Q – Miles Highsmith>: Okay, so no restrictions there?

<A – Douglas Coltharp>: Right.

<Q – Miles Highsmith>: Okay, great. And then just one unrelated follow-up. Doug, you also mentioned in terms of kind of keeping some control over certain facilities. And you talked about the lease versus buy and wanting to control the CON. Did I hear you right in that you were saying if you're leasing a facility in that example, that you wouldn't be able to control the CON, so you would want to buy a facility in that case? I guess I just wasn't clear as to whether you could come in and apply for and get the CON, but just actually lease the actual real estate or the machinery? Thanks.

<A – Douglas Coltharp>: There are certain situations available when either the CON or the license is held by the owner of the property and that we would essentially go in under our management agreement to operate the facility. And I guess what we're suggesting to you is that is not a priority for us, that's not a preferred structure.

<A – Jay Grinney>: We simply won't do that. The issue is – I mean, there are a couple of issues. Number one is, we're not going to look for acquisitions that we don't have control of the CON, if it's a CON state, or the license. I mean, that's a nonstarter for us. From that point on, really it's a matter of looking at the cost and the terms of the lease and if that's an acceptable lease arrangement and we've got the kind of protection that we need and it's long term with renewal options et cetera, we'll definitely look to lease. But the CON control and the license control are absolute must-haves. We won't go in just with the opportunity to occupy some space and run a rehab hospital.

<Q – Miles Highsmith>: Got it. Makes sense. Thanks a lot, guys
.
<A – Jay Grinney>: Okay. Well, thanks everyone we appreciate your time. Operator, are there any other questions?

Operator: There are no further questions. This concludes the question-and-answer session of today's call. Are there any closing remarks?

<A – Jay Grinney>: No.

Mary Ann Arico, Chief Investor Relations Officer

Well, if you have any additional questions, please call me today at 205 969-6175. Thank you.

Jay Grinney, President and Chief Executive Officer

Thank you.

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