MANAGEMENT DISCUSSION SECTION

Operator: Good morning everyone and welcome to HealthSouth's Fourth Quarter and Full Year 2009 Earnings Conference Call. At this time, I would like to inform all participants that your lines will be on listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions].

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

I would now like to turn the call over to Ms. Mary Arico, HealthSouth's Chief Investor Relations Officer. Please go ahead.

Mary Ann Arico, Chief Investor Relations Officer

Thank you, Christy, and good morning, everyone. Thank you for joining us today for the HealthSouth's fourth quarter 2009 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, General Counsel; 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 statements, 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-K for 2009, which will be filed later today, and previously filed quarterly 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 are made throughout the presentation are based on current estimates of future events and speak only as of today. The company does not undertake a duty to update or correct these forward-looking statements.

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

Before I turn it over to Jay, I would like to remind you that we will 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. Our solid fourth quarter results complete another excellent year for HealthSouth, a year characterized by continued volume growth,

disciplined expense management, strong cash flows, significant debt repayment and the addition of several new hospitals with more hospitals in the development pipeline.

Discharges in the quarter were up 4.6%, compared to the fourth quarter of last year, with growth across the entire portfolio. Full-year UDS data shows discharges from non-HealthSouth hospitals decreased four tenths of a percent in the year, while discharges from HealthSouth hospitals increased 4.8%. This data reinforces that we continue to gain market share and reflects the strength of our value proposition of providing high quality, cost-effective rehabilitative care.

From an expense standpoint, our hospital management teams continued to do an excellent job, especially in light of the large number of discharges during the holidays. We were especially pleased with our labor costs and productivity metrics, which were in line with expectations and showed solid improvement over prior year. These efforts resulted in fourth quarter adjusted consolidated EBITDA of $94.7 million, an increase of 8.2% over last year's fourth quarter.

As we've been able to do all year, we leveraged these strong operational results with continued debt repayment to drive adjusted earnings per share growth. Adjusted income from continuing operations, or adjusted EPS, was $0.22 for the quarter. However, as we previously reported, we took a one-time charge of $15.6 million, or $0.14 per diluted share, related to the early extinguishment of our floating rate notes which we replaced with fixed rate securities maturing in 2020. Without this one-time charge, our adjusted EPS would have been $0.36 per share compared to $0.24 per share last year, a 50% increase.

With that, I'm now going to turn the agenda over to Andy Price and to Ed Fay. Andy will do a thorough walk through of the statement of operations, while Ed will review the balance sheet, summarize the enhancement we made to our capital structure and discuss the use of our free cash flow in 2010. Following their comments, I'll ask our general counsel, John Whittington, to comment on the status of the E&Y arbitration. I'll then come back to discuss healthcare reform, 2010 guidance and the status of our CFO search.

Andy Price, Senior Vice President, Operations Accounting

Thank you, Jay. I will be referencing the slides we filed on Form 8-K in my comments today. Beginning with revenues for the quarter, which can be found on slide six, our inpatient revenues increased by 7% over prior year to 445.7 million. As Jay mentioned, this was driven by strong discharge growth of 4.6% during the quarter or 4.2% on a same-store basis as well as pricing improvements resulting from a 2.5% Medicare market basket update we received on October 1. Recall that this was the first Medicare pricing increase we have received since the rollback took effect on April 1 of 2008.

Our occupancy percentage was 66.5% for the fourth quarter of 2009. While volume grew 4.6%, occupancy only increased 40 basis points compared to the fourth quarter of 2008, reflective of additional bed capacity and a slightly lower length of stay during the quarter. Occupancy declined sequentially from 67% in the third quarter due to the completion of several of our capacity expansion projects, which added 65 new licensed beds during the quarter.

Trending of our licensed beds and occupancy stats can be found on slide 27 in the presentation. Although not a large portion of our business, outpatient and other revenue declined 8.6% from the same quarter a year ago, resulting primarily from the closure of 10 outpatient clinics since December of 2008.

Next, I want to provide some details on our operating expense for the quarter, which can be found on slide seven. Stated as a percentage of revenue, salaries and benefits were 50.1% for the fourth quarter of 2009, a decline of 30 basis points from the same period a year ago. The year-over-year improvement was partially due to previously discussed changes made to our comprehensive

benefits package, including standardization of certain aspects of our PTO program, which all took effect January 1, 2009.

Productivity, as measured by employees per occupied bed, or EPOB, improved from 3.64 in Q4 2008, to 3.55 in 2009. This is consistent with gains made throughout the year in productivity, as EPOB has averaged 3.53 for 2009 year to date versus 3.63 in 2008.

In addition, we also realized a 45% decline in contract labor FTEs during the quarter, resulting from our recruiting and retention efforts. This is reflected in the trending of internal FTEs and contract labor on slide 27. On a sequential basis, salaries and benefits as a percentage of revenue increased 40 basis points over Q3 2009, due to the lower census in the fourth quarter and a 2.3% merit increase provided to employees, excluding senior management, effective October 1 of 2009.

Turning to other hospital-related expenses, which include other operating costs, supplies, occupancy and bad debts, as a percentage of revenue increased 20 basis points to 24.5% in Q4 of 2009, as compared to 24.3% in the prior year. As we have mentioned on previous calls, prior year other operating costs include certain non-comparable benefits to insurance reserves and non-income related taxes during the fourth quarter which are contributing to this year-over-year increase.

For the year, hospital-related expenses as a percentage of revenue improved by 20 basis points as benefits from initiatives to standardize our formulary and dietary offerings as well as volume-driven efficiencies. These positive trends 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.

Turning to interest expense, interest expense increased 2.4 million quarter-over-quarter, primarily resulting from a $9.4 million benefit associated with the UBS Settlement in the fourth quarter of 2008.

Excluding this settlement, interest expense for the quarter declined by approximately $7 million of which 2.4 million resulted from lower LIBOR rates, and the remainder was attributable to the decline in average borrowings year-over-year.

The decline in LIBOR resulted in increased cash payments under our 5.22% fixed payment swap agreement, which covers approximately 956 million of notional amounts. As this instrument is not accounted for as a hedge, these cash payments are not reflected in our GAAP or adjusted EPS, but are reflected in cash flows from investing activities and in our presentation of free cash flow.

During the fourth quarter, the company amended its term loan agreement, redeemed its 2014 variable rate notes and completed an offering of 8 1/8% fixed rates notes due 2020. As a result of these transactions, as Jay mentioned, we recorded a $15.6 million loss on early extinguishment of debt during the fourth quarter, principally associated with a redemption premium and an unamortized debt issuance cost on the 2014 notes. Ed will provide a more detailed discussion of the company's recent debt restructuring and impact of the swap agreements later in the presentation.

Turning to adjusted consolidated EBITDA, which was 94.7 million for the fourth quarter compared to 87.5 million in 2008, an 8.2 increase. This was attributable to continued year-over-year discharge growth and Medicare pricing improvements, improvements in labor productivity, allowing us to deliver high quality patient care on a cost-effective basis and continued management of expenses, including general, administrative and overhead cost. This brings total adjusted consolidated EBITDA for the full year to $383 million, as compared to 341.2 million in 2008, an increase of 42 million or 12%.

Our adjusted income per diluted share for the fourth quarter of 2009 is presented on slide nine. In arriving at adjusted income from continuing operations, we exclude the following items which are

detailed on slide 34: gain and interest income on the UBS settlement, professional fees, government class action related settlements, loss on interest rate swaps and prior period income tax benefits. Considering these items, adjusted income from continuing operations for the fourth quarter of 2009 was 24.1 million, compared to 24.3 million in the prior period.

Adjusted income from continuing operations per share, or adjusted EPS, was $0.22 per share versus $0.24 in 2008. Note that adjusted EPS for the fourth quarter of 2009 includes the loss on early extinguishment of debt of approximately $0.14 per share. Also note that weighted average shares outstanding increased during the fourth quarter. This is a result of approximately 5 million common shares distributed in September 2009, related to our securities litigation settlement.

As presented on slide 10, adjusted EPS for the full year 2009, was $1.45 compared to $0.76 in 2008, an increase of $0.69 or 90.8%. This year-over-year increase was attributable to adjusted consolidated EBITDA growth, debt reduction and a decrease in LIBOR rates, those positive items offset by the loss on debt extinguishment and the increased share count that I referenced previously.

The decline in LIBOR rates represents approximately 25 million or $0.26 per share of the year-over-year increase in adjusted EPS. Excluding the LIBOR rate impact, the increase in adjusted EPS for the full-year 2009 would have been $0.43 per share or an increase of 57%. With that, I will turn the presentation over to Ed.

Edmund Fay, Senior Vice President, Treasurer

Thanks, Andy. I'm going to discuss our free cash flow for the fourth quarter and for calendar year 2009. Then I'll talk about the new debt issuance and the tender for our 2014 notes we completed in December. And I'll cover matters pertaining to our balance sheet and liquidity.

From our adjusted free cash flow found on slide 12, you can see we generated $10 million of free cash in the fourth quarter. At the end of the third quarter, we mentioned that our strong cash flow of $98.6 million reflected certain seasonal benefits that would be offset by payments in the fourth quarter. We made $38 million of interest payments on our unsecured notes in the fourth quarter. Trends in accounts receivable and other working capital items were also not as favorable as those in Q3. For the year, we finished with adjusted free cash flow of $173.6 million.

Year-over-year adjusted EBITDA growth reduced interest expense, and improvements in several working capital lines contributed to the strong cash flow performance in 2009. As we look forward to 2010, we foresee another year of strong cash flow performance. Further adjusted EBITDA growth will fuel cash flow generation this year. But certain items that contributed to growth in 2009 will not provide the same momentum going into 2010.

Free cash flow benefited from an accounts receivables reduction in 2009. In 2010, it will be negatively impacted by growth in accounts receivables as the business grows, and in particular, as we bear the initial working capital impact of bringing new hospitals online. Maintenance CapEx of $34.1 million in 2009 will increase in 2010. Including the refresh program, we would expect to spend approximately $50 million on maintenance CapEx this year.

Another item of note on our free cash flow report is our interest rate swap position. Our current swap position fully protects our cash flow profile from negative impacts due to interest rate increases. As Andy mentioned in his comments, decreases in LIBOR have played a role in the decline of interest expense, but remember that the payments on the swap are not flowing through interest expense.

We point this out to make you aware of the cash flow as opposed to earnings implications of interest rate changes. The net payment obligations on our interest rate swap reflect the difference

between the fixed rate we pay and the three-month LIBOR rate we receive. Three-month LIBOR declined significantly the past two years leading to increases in our net payment obligations in 2008 and again in 2009. Unless LIBOR were to rise from its current levels, we would expect the payments in 2010 to be similar in size to those we made in 2009. We will make our last payment on this swap when it matures in March 2011.

In 2009, we used free cash flow to pay down $151 million of debt. Turmoil in the credit market created opportunities to re-purchase notes in the open market at discounted prices. The rebound in the credit markets over the latter half of last year has reduced the attractiveness of re-purchase opportunities heading into 2010.

Our note maturing in 2016 continued to trade at prices well above its 2011 call price. This and our low term loan yields in the current interest rate environment both limit the attractiveness of re-payment opportunities in the near term.

That being the case and given the CapEx and development opportunities we foresee this year, we will be putting a priority on capacity expansion, development and de-leveraging through continued adjusted EBITDA growth. This is not to say debt repayment will not continue to be a priority for us, but in the current environment we prefer to be patient in allowing those occasions to develop.

Turning now to the balance sheet, in December we completed a tender offer for our 2014 floating rate note and issued a new fixed rate note maturing in 2020. These transactions contributed to our $34 million of debt reduction on the quarter. And we pushed a significant maturity in our capital structure back 5.5 years. I would refer you to slide 29 in our Appendix for a snapshot of our new maturity profile.

By replacing a floating rate with a fixed coupon we have reduced the LIBOR exposure on our interest expense line. This transaction and the term loan modification completed in October has contributed qualitatively to an improved capital structure for the company.

Looking at slide 13, you can see the progress we have made on debt re-payment and de-leveraging over the past four years. In 2009, we again accomplished a one-time reduction in our leverage ratio, and we finished the year at 4.3 times. This is the second consecutive year we have accomplished a one-time reduction in leverage. In 2009, adjusted EBITDA growth was as important a contributor as debt re-payment to the de-leveraging initiative. In 2010, we anticipate modest debt reduction, coupled with the adjusted EBITDA improvement that Jay is going to talk about to contribute to further reductions in leverage.

We remain on track to achieve our targeted leverage ratio of 3.5 times to four times by the end of 2011. We finished the year with available cash of $80.9 million. The reduction in cash from the third quarter is attributable to our debt reduction. For the year, our available cash increased $49 million.

Finally, there is a liquidity schedule on slide 13. Based on our available cash and undrawn revolver, we had $481 million of available liquidity at the end of the fourth quarter. This was an improvement of $142 million over our position at year-end 2008. We have continued to hold cash sufficient to limit our revolver dependence, and we have not made use of the revolver for cash or letters of credit since February of last year.

With that, let me turn it back over to Jay.

Jay Grinney, President and Chief Executive Officer

Thank you, Andy. And thank you, Ed. Before I begin my comments, I'm going to ask John Whittington to provide an update on the E&Y arbitration.

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

Thank you, Jay. As I have mentioned previously, the very nature of an arbitration proceeding is that it's confidential. And because of this confidential nature, we are limited in what we can disclose to you. However, I can say the following.

Number one, we continue to believe strongly and firmly in our claims, and we are pursuing them aggressively. Number two, the arbitration proceeding is on schedule, both the schedule we set for ourselves, and the schedule set by the three-person arbitration panel. And finally, based on the proceedings so far, we continue to believe that the final resolution will be a second half event.

And at this time, I think, because of the confidentiality that's all that I can comfortably say about the arbitration proceeding.

Jay Grinney, President and Chief Executive Officer

Okay. Thank you, John. It's hard to believe that exactly one year ago today on February 23, 2009, President Obama presented his healthcare reform agenda to Congress. And here we are today, one year later with a new proposal from the administration. Healthcare reform has moved from a discussion of when to a discussion of if. While nobody knows for certain what will happen, most agree it will follow one of two scenarios.

The first and frankly in our view the most likely scenario envisions a less ambitious reform package being passed, something that can be supported on a bi-partisan basis. Under this scenario, a streamlined bill focusing on health insurance reform and concerns that have bi-partisan support, such as limiting an insurance company's ability to deny coverage or to rescind coverage would be passed later this year. This kind of bill would mean our Medicare pricing probably would not be reduced as was proposed in the Senate bill.

The second scenario contemplates the House passing the Senate version with additional modifications occurring through reconciliation at a later date. If this happens our Medicare pricing would be reduced by 25 basis points this year, resulting in a slight reduction of our net operating revenues.

For HealthSouth, the implications of healthcare reform remain unchanged. They center around bundling and pricing. In both scenarios, bundling will require pilots or demonstration projects, which obviously means it will have no near-term impact on the company. While pricing probably will be reduced at some point, although the timing and magnitude of these potential market basket reductions is unclear at this time. Assuming these potential reductions are in the zone of what was proposed in the Senate bill, we believe we'll be able to make the necessary adjustments to our operations without jeopardizing our ability to provide quality care.

I'd like to spend the balance of my time addressing our strategy and our guidance for 2010. To help put this discussion into perspective, I'd first like to draw your attention to slide 15 of the supplemental slides, which highlights the major components of our business outlook over the near-term, which we define as 2010 and 2011 and longer term 2012 and beyond.

Our strategy going into 2010 remains unchanged and can be summarized as follows: One, capitalize on our market-leading position of inpatient rehabilitation; two, reduce our leverage and strengthen our balance sheet; and three, prepare for potential expansion in the complementary post-acute segments once the regulatory landscape has been clarified.

We continue to believe a strong balance sheet is a strategic imperative. So we will remain committed to reducing our leverage to a range of 3.5 to four times by the end of 2011 at the latest.

As Ed noted in his remarks, if LIBOR remains at current historically low levels and our bonds continue to trade above their call price, there won't be major debt re-payment alternatives in 2010. So our de-leveraging focus next year will be on the denominator on growing adjusted consolidated EBITDA.

The foundation of our adjusted consolidated EBITDA growth over the near term will be continued market share gains, disciplined expense management and capacity expansion. We'll also generate adjusted consolidated EBITDA growth by adding new hospitals. In the second quarter of this year, we'll open a 40-bed hospital in Loudoun County, Virginia. And in the third quarter, we'll open a 25-bed satellite in Bristol, Virginia.

For the next several years, our goal will be to break ground and begin construction on two to three new rehabilitation hospitals each year, which means we'll have two to three new hospitals opening the following year, creating a nice stream of future revenues and earnings for the company.

Another source of adjusted consolidated EBITDA growth will be acquisitions of or joint ventures with other inpatient rehabilitation providers. These will be pursued to round out existing markets or to enter new markets. We'll target at least two such transactions each year, although these are harder to predict. And because they are less certain, we have not incorporated any adjusted consolidated EBITDA growth from acquisitions or new joint ventures into our guidance for 2010.

The good news is that all of this growth will be funded through our strong free cash flow. So while the focus in 2010 and 2011 will be on strengthening and expanding our core rehabilitation business, longer term we will pursue acquisitions of complementary post-acute services provided these acquisitions are accretive and don't burden our balance sheet with excessive debt.

Long-term acute care hospitals and home health are two adjacent services that are potential growth segments for us. We believe we can leverage our existing operating platform to realize synergies in the areas of sales and marketing, labor and to a lesser extent supplies and other hospital operating costs. We also believe there are potential longer-term efficiencies through consolidated billing and collection systems. But it's important to reiterate this is a longer-term strategy.

We do not plan on pursuing acquisitions of complementary post-acute services until we're comfortable with the following. First, we've realized the lower end of our leverage goal. Second, we've capitalized on the growth opportunities in our core rehabilitation segment. Third, we have greater visibility on pending LTAC and home health regulatory changes. And fourth, we've concluded the E&Y arbitration.

A strong balance sheet is extremely important to us. So it's essential to understand we will not pursue major acquisitions of other post-acute services until we have a capital structure that can absorb the additional risks that inevitably comes with any acquisition, let alone a major acquisition of a new business. Furthermore, we remain encouraged by the growth opportunities in the inpatient rehabilitation arena, and we want to exploit our scale and market position in this space to expand our platform.

Finally, as we indicate on slide 22 in the supplemental slides, there's enough regulatory overhang for LTACs and home health that for us warrant a wait-and-see approach. With this strategic overview in mind, let's talk about guidance for 2010.

We believe guidance should provide investors with a range of earnings based on management's assessment of our ability to execute our business plan within the context of a forecasted but uncertain business and industry environment. As such, our guidance is not reflective of what's possible if we hit on all cylinders. Rather, it presents a range of achievable outcomes based on the uncertainties we face as we begin the year.

As we look at 2010, we believe there will be continued opportunities to gain market share, although we acknowledge the comps will be more challenging. As a reminder, we grew our discharges over 7% in 2008 and 5.4% last year. This year, we're targeting discharge growth in the 4% range. This will be achieved through continued emphasis on our quality driven value proposition and will be supplemented by new beds coming online through capacity expansion projects and our two new hospitals.

Our pricing assumptions include, at the low end of the range, no Medicare increase in Q4. And at the high end of the range, a nominal market basket update. Pricing on our commercial book of business is expected to increase by approximately 3%. Labor costs and productivity will be influenced by several factors.

The first and frankly at this point the more difficult to quantify is the potential impact of Medicare's new coverage determinations and the impact it might have on our operations. As most of you know, Medicare implemented a set of new rules effective for patients discharged after January 1. While we spent considerable time in the second half of last year making sure our policies and procedures incorporated these new guidelines, there's going to be a period of adjustment to these new rules.

The second factor affecting our labor metrics will be the opening of our two new hospitals. As we've stated previously, there are one-time pre-opening and post-opening inefficiencies that negatively impact our labor metrics temporarily.

Overall, we believe we can accommodate these factors and are forecasting labor costs to be approximately 50% of net operating revenues with employees per occupied bed remaining in the 3.5 to 3.6 range. We'll also incur several one-time costs next year, including the startup costs at the Loudoun and Bristol hospitals as well as costs related to piloting an electronic clinical information system at the Loudoun hospital, and the investment we're making in our newest TeamWorks initiative, although this investment will be considerably less than our sales and marking initiative.

Finally, we anticipate G&A will remain flat as a percent of net operating revenue. With these factors in mind, our adjusted consolidated EBITDA guidance is a range of $397 to $407 million, which represents an increase of approximately four to 6%.

When evaluating adjusted EPS, the following need to be noted. First, we're assuming LIBOR stays pretty much unchanged, which means our interest expense for the year will be approximately $126 million. There will be a $5 million increase in our 123(R) costs, and most important, our diluted share count for the year will be approximately 108 million, which includes the shares distributed in the fourth quarter as part of the shareholder litigation which we have previously discussed.

Taking these factors into consideration, our adjusted earnings per share guidance is $1.60 to $1.70 per share, which represents an increase of between 10 and 17%. As a point of reference, this increase would be 15 to 22% if we use the same number of shares outstanding before the distribution of the shareholder litigation shares.

By any measure, 2009 was an excellent year for HealthSouth, and we believe 2010 will be too. Our guidance provides a range of achievable results and incorporates the major elements of our business model: continued market share gains, de-leveraging, disciplined expense management and growth through de novos, acquisitions and joint ventures.

Before taking questions, I would like to comment briefly on the status of our CFO search. We have engaged the services of Russell Reynolds and are considering both internal and external candidates. The initial round of interviews will begin soon and I anticipate the process extending into early Q2.

Fortunately, we have outstanding leaders in Ed Fay and Andy Price, as evidenced by the fact that under their leadership, we were able to refinance a portion of our balance sheet last quarter, and

we closed out the year with a clean audit and no material weaknesses. So we aren't missing a beat.

This speaks volumes about the depth of our management team and the accounting, cash management, and internal control infrastructure that John Workman, Andy and Ed and their teams have created over the years.

With that, operator, we'll open the lines for questions.

QUESTION AND ANSWER SECTION

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

<Q – Whit Mayo>: Thanks, good morning, guys.

<A – Jay Grinney>: Hi, Whit.

<Q – Whit Mayo>: Good morning. I appreciate all of the comments, Jay, around the guidance. That's very helpful, given some of the confusion this morning. But was just hopefully – hoping that maybe you could clarify what your Medicare assumption is at the high end of the range? And maybe can you just sort of frame up, given some of your recent comments that you've had at investor presentations that have suggested that you felt like 15 to 20% earnings growth was do-able? Just hoping maybe you can help put those comments in perspective with your outlook.

<A – Jay Grinney>: Sure. And let me take the second one, first. We still think that the business model of five to 8% EBITDA growth, 15 to 20% EPS growth is achievable. That's still our model. We're not backing off on that at all. I think it really addresses the question of what is the right way to approach guidance. And what we have done over the years, and those of you who have known the company and have followed us. We don't put out there what we think we're going to be able to achieve if everything comes together, and we're able to really execute on all aspects of our business plan.

Nobody gets credit for just meeting expectations. I mean just look at the notes that are written. When a company meets expectations, there is sort of a sigh in the notes and they kind of, oh well, you just met the expectations. Well, we understand that. I mean that's part of the dialogue that goes on between shareholders and analysts and companies.

So we put out there at the low end what we're absolutely confident we can achieve. At the high end something that represents the kind of growth that we think is in the business model. We said five to 8% at the high end; it's six. We said 15 to 20% EPS at the high end; it's in that range. And frankly, if you take out the fact that we have five million more shares that we're going to have to create earnings for, that's 15 to 22%.

So we're definitely still hitting on the business plan. It's really how do you present guidance. And so we've always tried to present guidance that reflects what we are absolutely certain we can hit and achieve. And then as the year goes on and the uncertainty of the year becomes less uncertain, and we get a little more clarity, then we may be in a position to be able to raise guidance. But frankly we think that a more appropriate approach is the one that we've taken over the last couple years.

So with that, in terms of Medicare pricing assumptions at the high end, we do believe that we're going to have a haircut no matter what. It doesn't matter if there's reform that gets passed or the deficit starts getting attention in Congress, all providers are going to have to take some kind of haircut. So we are assuming a market basket. We are assuming a reduction to that market basket

in Q4 at the high end, and you know it's certainly in the range of what has been presented in the past as possible reductions in other healthcare reform packages.

<Q – Whit Mayo>: That's helpful. And maybe can you just comment, briefly, on the joint venture with St. Vincent's in Little Rock and maybe the strategic importance of that transaction and longer-term opportunities in that market?

<A – Jay Grinney>: Well, we have an existing partnership, and this was really designed to bring all of the partners' rehabilitation services into the partnership. So it's certainly a great move for us in that market. It's a very attractive market for us. We've got a very strong partner; we've got a great relationship with that partner. So it really signifies to me anyway that they've got confidence in us and want to be partners with us in all parts of the market.

I think more importantly, it represents that our development pipeline is starting to fill up. As I said in my comments, it's a little bit harder to predict with certainty when transactions can be completed. But we're pretty confident that we'll be able to get two to three additional acquisitions or joint ventures under our belt this year on top of the de novos that I mentioned as well.

And I think that that's really the key takeaway, is that last year, year of uncertainty, we used a lot of our free cash flow to repay debt. We used some of that free cash flow to take some of the near-term maturities and push those out, move it from floating to fixed. This year, we're going to be able to take our free cash flow and devote that to positioning the company for growth.

And then, as Ed mentioned, next year we'll be looking at some bonds that will be callable. Maybe we can take some of those out and use the free cash flow to continue the debt re-payment. But the big signal I think for Little Rock, and some of the others are the fact that we are focusing on growth. And those, as I mentioned, the acquisitions and new joint ventures are not incorporated into the guidance.

Operator: Your next question comes from the line of Paxton Scott with Jefferies & Co.

<Q – Paxton Scott>: Hey, good morning, guys. Very nice quarter, and thanks for taking the questions.

<A – Jay Grinney>: You bet, thank you.

<Q – Paxton Scott>: Jay, I was hoping – just going back to the healthcare reform issue, I was hoping you could touch on specifically on your LTAC portfolio and, given I guess we've got the payment rules coming up for expiration at the end of 2010, kind of where you see that business going in terms of, is it something that you want to expand if those payment rules were to come back into play? Or is that a business that you may consider getting out of? Thanks.

<A – Jay Grinney>: Yeah, great question. And clearly, there's in our opinion, there is still a lot of overhang on LTACs. And that overhang is not going to go away in our opinion any time soon. Now, as a provider of health services, we think that there is value in long-term acute care. We are proud of the fact that we own and operate six. We're very pleased with the outcomes and the patient satisfaction scores that we get from those. But it's a pretty small portion of our business. It represents maybe 3.5% of our total EBITDA. So it's not huge. But we certainly don't want to give up on that quite yet because we do think that there is value, again, as a provider. Our wait-and-see attitude is driven by the fact that unfortunately the sense that we get anyway is that the biggest regulator of our industry, Medicare, is still trying to think through and struggle with what is the role of LTACs.

And if you go to page 22 of the supplemental slides, what we've tried to do is just highlight and summarize some of the overhang on the various post-acute segments. And we've said over and over, over the last several years, every segment gets their time in the barrel, and we certainly had

ours with the 75% rule and some of the changes that were made. And unfortunately it's now time for LTACs primarily and I think SNFs [Skilled Nursing Facility] to a certain extent in home health to be in the barrel.

But we think that there's still a lot of regulation to come and instead of getting into that business to a greater extent now, we think it makes a lot more sense to take the free cash flow, take advantage of opportunities in the rehab environment, and then see what the – how the dust settles over LTACs and then make a decision. But certainly in the near term, we want to keep the LTACs that we own and operate, and we're very pleased with the results that we see from them.

<Q – Paxton Scott>: Okay. That's very helpful. And second, John, could you just remind us in regards to the E&Y settlement, assuming there is some judgment, what percent of the proceeds would go straight to the company? Any other – just terms that they are out there in the public domain that you can just remind us of?

<A – John Whittington>: Yeah. We're under an obligation to pay 25% to the federal securities plaintiffs and then the derivative attorneys are entitled to some fees, and they have been capped at 11%. We get to deduct the expenses against those two claims. So probably something in the 70 to 75% range would be our recovery.

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

<Q – Frank Morgan>: Good morning.

<A – Jay Grinney>: Morning, Frank.

<Q – Frank Morgan>: Quick question here on pricing and the acuity mix in the quarter. I noticed where pricing was up about 2.3% and I know you had a market basket update of about 2.5%. And I notice you mentioned that commercial pricing was, I don't know if that was for the current, for the fourth quarter or maybe that was for 2010, but up about 3%. So I'm just wondering was acuity lower? Has there been any kind of a shift in the overall acuity of your mix of business? Thanks.

<A – Jay Grinney>: Well, first of all, for clarification, that 3% is what we're forecasting for 2010. And I'll ask Mark to address the program mix.

<A – Mark Tarr>: Yeah, hey, Frank, we've seen – it's pretty consistent with prior year. We continue to move out of orthopedic cases, particularly those lower extremity joint replacements and move into stroke and other neurological, so by sheer fact of moving the program mix out of orthopedic into a greater concentration of neurological cases, we continue to see some up tick in our case mix index. It's slightly over where it was prior year.

<Q – Frank Morgan>: But I guess my question is, wouldn't that result in pricings being higher than say just what the market basket would be? Or is it something happened on the commercial side, the other 30% of the business that's dragging the rate down a little bit? Thanks.

<A – Jay Grinney>: I don't know that there is anything significant that's dragging that – dragging it down. We didn't see a big change in our – in the mix overall. So I think that the 2.5%, that's probably what the market baskets were. There may be some small changes in there, but nothing that certainly is concerning to us.

<Q – Frank Morgan>: Okay. Thank you very much.

<A – Jay Grinney>: All right. Thank you.

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

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

<Q – Sheryl Skolnick>: Good morning. Thank you for taking the question. Okay. So if I'm confused by your guidance, and I think I understand credit agreement EBITDA, I can't imagine what the average investor is doing this morning. So, first of all, I don't know that I actually heard what the top line growth expectation was, summing up all the parts and pieces.

Second, I'm a little bit concerned about the different – the definitional differences between what the Street estimates may be based on for EBITDA and EPS, and what your guidance is based on. And I'm wondering whether or not, and this really isn't a question about the future of the company, as so much as it is the performance of the securities.

If you can't possibly work with us to make those things easier to predict than to predict on the same basis that you're going to guide us on because there's some numbers in here that we're – that come into EBITDA from tax adjustments and the like that there's just no way we can predict that. And to guide us to a number we can't predict seems unreasonable, so – and maybe perhaps not wise. So can you help us understand why you're doing it this way, and what we need to think about to be more accurate in our predictions? And also, a little detail on the top line.

<A – Jay Grinney>: Sure. Well, first of all, it's really not a departure from what we've done in the past. I'm not saying that that should.

<Q – Sheryl Skolnick>: Yeah, I've had an issue with that too, but go ahead.

<A – Jay Grinney>: I'm not saying that that necessarily justifies it, but you know clearly from a reporting standpoint, we do think that there is some value in the consistency. And we started, gosh, this was back probably in 2004 – 2005 timeframe of reporting it on an adjusted consolidated basis.

Clearly, as we move forward, we do want to work with you and other analysts and shareholders to try to bring some simplicity and some clarity to the numbers. We certainly do believe that we have provided transparency. Now it may be complicated, but it is we believe transparent in terms of reporting the numbers and showing what the cash flow is and so on.

In terms of the top line, we did not give guidance with respect to top line and we haven't in the past. So we're not going to be providing that today. But I think that if you take the volume and pricing assumptions, and you start from where we ended up the year, I think, that getting to your own range is not going to be that complicated.

In terms of the EPS and the EBITDA, I think, that part of the issue is clearly the fact that the swaps that we put in place early are not accounted for on a hedge accounting basis. That creates noise, and we understand that. The good news is that burns off next year. And so that will take one layer of complexity off. And you know once we get on the other side of the E&Y litigation, all those professional fees that are sort of normalized out, that burns off as well. But you know, we'll definitely work to see if we can provide as much clarity and simplicity as we possibly can.

<Q – Sheryl Skolnick>: Okay. And I would appreciate that. I think it would solve a lot of problems because the range is rather large. And I guess perhaps to a more fundamental and substantive question. With House reform being stuck, and we'll call it lingering in limbo, with the current structure of Medicare, managed care and premium increases being fairly steep there, I would guess that your mix is going to still stay mostly traditional Medicare and not shift over to the Medicare managed care mix. But in that environment, and given that there aren't that many other ways to diversify your business, where I'm going with this is, on the rehab industry itself is still experiencing overall declines, and that seems odd. You're able to gain market share. So your top-line growth as being constrained by pricing, it's up to you as you've articulated to grow the volume. You've mapped out a strategy. But I'm a little bit concerned that maybe over the longer term or

even over the medium term that the lack of industry growth in discharges might also affect you. What's it going to – why should I not be worried about that?

<A – Jay Grinney>: Well, a couple things. It depends on the timeframe that you're looking at. If you're looking at this over the next say 12 to 24 months, I think, that the fact that we have been able to take market share in the past, the fact that we're saying that we think we can grow volumes 4% in 2010. The fact that we have a track record of at least meeting expectations and often beating those, I think, that that may give you some – I don't – I mean that's a judgment call for you.

<Q – Sheryl Skolnick>: Right.

<A – Jay Grinney>: But I think that the other thing that is important is that we're seeing a pipeline of development opportunities that, at least for the next 24 months, we believe will provide the kind of additional IRF business that frankly makes us want to stay here, stay in this space. There is no question, Sheryl, longer term, we will be moving into other complementary services. And some may argue hey, you've got a balance sheet that you could do it today. You know frankly we're not that comfortable moving out with a 4.3 times leverage and moving into an acquisition, a very more aggressive acquisition mode where we're talking about brand new businesses.

We think that it is – it makes a lot more sense to get the balance sheet a little stronger, get on the other side of the E&Y arbitration, put some more cash on the balance sheet, de-lever through EBITDA growth, and then start to look for those opportunities that allow us to diversify. But that's why I tried to explain that we clearly are gearing up for a move into other complementary services, and gosh, we'd love to be able to do that right now, but I'm much more focused on strengthening the balance sheet before we do that. And you know that's just kind of a judgment call on do you manage a company a little more cautiously or a little more aggressively. And I think at least in today's environment, it's probably a better approach to be a little bit more prudent.

<Q – Sheryl Skolnick>: I don't disagree with that and I thank you, and you certainly have the cash flow to do it. Thanks so much.

<A – Jay Grinney>: Yep, thank you, Sheryl.

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

<Q – Darren Lehrich>: Thanks, hi, good morning, everybody. I had a question just related to the initiatives you indicated in your prepared remarks that may impact some of the cost assumptions embedded in your guidance. And I hear what you're saying about salary and benefit expense being flattish at 50%. I'm just wondering if you could discuss a little bit more the new TeamWorks initiative and the IT pilot, and maybe just frame for us or quantify for us even what some of those other cost impacts are that are embedded in your guidance?

<A – Jay Grinney>: Well, let me start by saying that the TeamWorks initiative, we have not formally launched, we're in the process of interviewing consultants that will help us to get this rolled out and to roll it out in a – on a high quality basis and as quickly as possible.

The specific topic is going to be on our case management. We have about 350 case managers in our hospitals. They're the individuals who essentially guide the patient through the rehabilitative stay. And then spend a lot of time focusing on where that patient is discharged. And as such they're pretty important – they play a very important role in the patient care experience in a rehabilitation hospital.

We think that there is an opportunity to go in, to really do a deep dive, identify best practices and then promulgate those best practices across the entire portfolio, just as we did with our sales and marketing. But this time, the focus would be on enhancing the patient experience, enhancing the outcomes and enhancing the overall perceptions of care that the family members, the physicians

and the patients have while they're in our hospital. And it's frankly taking what we think is one of our strengths, which is the outcomes and quality and ramping it up and saying we're not going to just accept that we're going to identify ways to take that to the next level. And we believe that this is going to be able to do that.

Unlike sales and marketing where we were going to invest X and we knew or anticipated that we'd get a return on that through new patients coming into our hospitals, this is really much more of an investment. It's a one-time investment. We haven't done a major TeamWorks project for two years now. We said we're going to be doing a new one. We looked at labor. We looked at case management. We looked at a lot of different areas. And we said it really makes sense to strengthen and enhance that component.

With respect to the electronic clinical information system, we've talked about that in the past. We don't have an electronic clinical information system today. We have partnered with a vendor to pilot that at our new hospital in northern Virginia. We thought that made the most sense. It will take a while to test that. That will certainly be at least a 12-month, possibly 24-month test before we then start looking at, does it make sense to make the investment of putting one of these systems in all of our hospitals. The magnitude clearly on the TeamWorks I think everybody knows in the first go-around we invested about $11 million. It's not going to be even half of that. So the investment is going to be much less. But it's going to be a couple million dollars or even several million dollars. And I think on the electronic information system, we're looking at about one to $2 million for that. So there are some one-time costs in 2010 that frankly are investments that we're making into the future.

<Q – Darren Lehrich>: That's really helpful. And then if I could just follow up on something Jay, the development pipeline, I think, you characterized it as starting to fill up. And I know your comments have been a little bit more upbeat about joint ventures and acquisitions overall. I guess I wanted to just hear from you what your thoughts are about how your integration teams are set up, and how we should be thinking about joint ventures and acquisitions from a – I guess a contribution standpoint? If they're not currently in your guidance, how will they sort of fall into play and just maybe generically if you could help us think about that?

<A – Jay Grinney>: Sure. Well, I think first of all we feel very confident in our ability to integrate new joint ventures or acquisitions. We've demonstrated over the last couple years, although it's has been a little bit more modest. But we have been able to do that pretty successfully. We did that in Vineland, New Jersey for example. We've been able to do that in other markets, Wichita Falls, several years ago. Of course, the new hospitals in Fredericksburg and Sarasota, the new hospital in Petersburg, Virginia, the new hospital in Mesa, Arizona. New hospitals, we feel really good about our ability to bring them on and to bring them up in a profitable way.

I think that the contributions, I mean, if you think about a typical 40-bed inpatient rehabilitation hospital, revenues are going to be in the 10 to $15 million range. You know what our EBITDA multiples are. So you can start to see what two to three new hospitals might mean if we're looking at acquisitions in that ballpark.

Clearly at least the acquisitions that we're looking at create opportunities for growth, or we wouldn't be pursuing them. So I don't know how to help you really quantify the contribution because each transaction is going to be unique. And clearly, joint ventures only contribute a portion of the total earnings capabilities, but hopefully that discussion right now answers at least some of the questions, or helps to frame it a little bit for you.

<Q – Darren Lehrich>: That's great. Okay. Thanks a lot.

<A – Jay Grinney>: Yep.

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

<Q – Bryan Sekino>: Hi, good morning.

<A – Jay Grinney>: Morning.

<Q – Bryan Sekino>: Just a quick question here on the volume growth. Clearly, you've beaten the UDS stats each quarter. And you mentioned the additional capacity is part of that 4% growth number despite the sluggish industry numbers. Can you also just give us an update in terms of, is there anything in your existing capacity that you're assuming for your guidance that allows you to grow these volumes above the industry average at that 4% level?

<A – Jay Grinney>: I think a big part of the growth that we are able to achieve and the above industry growth is reflective of where we are located. We are fortunately in many markets where the over 65 population is growing at a rate faster than the 1.9 to 2% national average. That gives us a slight advantage to those markets where the Medicare population is flat or maybe declining. We have a large concentration in Pennsylvania for example. Pennsylvania has either the second or the third largest concentration of Medicare enrollees in the entire country. So we try to place the hospitals, historically and certainly on a prospective basis in markets where we know that the growth opportunities exceed the national norms.

So that hopefully gives you a sense of where that – why we're positioning it, and why we're able to grow, and in some of our hospitals – great example, Sarasota, Florida we've had this brand-new hospital in 2005 or 2006, it's a great market. Growth down there has been phenomenal. We've had two bed additions.

We've got the hospital out in Mesa. We opened it up as a 40-bed hospital. We're already looking at potential expansion out there. Why? Because the market's growing. So a lot of it is strategically positioning these hospitals in markets where we know that the growth is at or above the overall industry levels. And frankly, we've looked at opportunities where the growth isn't as robust and we've said no, that's not where we want to put our capital.

<Q – Bryan Sekino>: Thanks. And just a quick follow-up here. You mentioned the 24-month pipeline. As you think longer term, I know, you've mentioned that 4%, that growth as well. Is it your expectation that we'll kind of see capacity – additional capacity become kind of a smaller portion of that growth longer term? And really, as you mentioned, the markets that you're growing at just a robust rate, get you that longer-term growth?

<A – Jay Grinney>: Well, there's no question that the larger the same-store base, the more our 4% is going to be predicated on capacity expansions and the addition of de novos into that mix. And then of course if we're able to get some acquisitions that's certainly going to be additive as well. But we still believe fundamentally that the core value proposition that we offer, when you think about the business, you got to bring it all the way down to the market level, you got to bring it down to the patient level.

At the patient level, we provide, we believe, superior care, better outcomes than our competitors, we're more responsive – we try to be – to the patients, to the family members and to the physicians. And that, I mean, if you really want to know why do we grow, why are we able to because that's all we do. And most of our competitors are units inside hospitals where it's not their primary focus.

And I'm not saying that their – the dedication of those employees is any less. It's just they don't have the resources, the expertise, the standardized clinical pathways, the technology that we have and I do believe that there is an element of that that allows for our above market growth.

<Q – Bryan Sekino>: Great. Thanks for taking my question.

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

Operator: Your next question comes from the line of David MacDonald, SunTrust.

<Q – David MacDonald>: Good morning, guys. Hey, Jay, just a quick question. You talked a little bit about a potential ramp-up in growth, CapEx. Is there any reason for us to expect a material change from kind of that 100 beds that you guys have talked about in terms of growth? And then when you look at acquisitions, joint ventures or bed expansions, any preference internally or is it just kind of going to be an opportunity-by-opportunity basis?

<A – Jay Grinney>: Well, the good news is we have enough, we're generating enough free cash flow that we believe we can pursue all of the above. But clearly the preference, if we only had a dollar to spend, we would unquestionably spend that on a bed expansion or a capacity expansion project versus a de novo or an acquisition. There's no question about that. Why? Because it's, we're investing in a market we know, the volumes can be brought on very incrementally. You don't have the startup costs. You don't have the transition that you would in an acquisition or joint venture, moving from one platform to the next. So there's no question that capacity expansion clearly remains a top priority. In answer to your first part of your question, yes, I think that you can certainly look for us to continue to invest an amount that would bring an additional 100 beds on, but frankly I'm not going to say that it couldn't be more than that.

As we look at the opportunities and as we look at some of the success that some of our hospitals are having, it's not inconceivable at the end of the year that we might be reporting on more than just 100. But frankly, right now, I think that that's a very good metric. And I think that that's a good way of looking at the growth opportunities.

<Q – David MacDonald>: Okay. And then just one follow-up. And I don't know if you guys can even answer this, but I know with the Ernst & Young litigation, there was some pre-trial stuff that needed to be cleaned up before the hearing actually began. Has that stuff been cleaned up and is the hearing going on as we speak?

<A – Jay Grinney>: We will let our General Counsel respond.

<A – John Whittington>: The arbitration process is going on as we speak. And it is moving forward on a timely basis. There are still some preliminary issues, such as exchange of expert witness reports that is on going. But it is proceeding on, as I said earlier, both our own schedule and the schedule as set forth by the three-person arbitration panel.

<Q – David MacDonald>: Okay. Thank you.

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

<Q – Gary Lieberman>: Thanks. I guess maybe just a follow-up on that last question to try to get some more detail. It sounds like everything is on schedule with regards to the arbitration at this point. I guess looking back historically though it's been pushed off in terms of when you thought the resolution would come. So I guess your thoughts are that it's now sort of a second half of 2010 resolution, is there stuff out there that conceivably pushes that into 2011 or beyond that?

<A – John Whittington>: I guess anything's possible, but I think that would be very unlikely, based on what we know today.

<A – Jay Grinney>: And Gary let me just, as you look back, and I think that that's a fair statement. We certainly, this time last year, we were certainly more hopeful that the process would be moving along at a faster pace, but we are also very respectful of the fact that arbitration proceedings are not controlled and can't be controlled by us. And once the panel was assembled, those three

judges are the ones who are in control and we're going to be, we will remain very respectful of the instructions that we've received.

And I know that everybody would love to get that resolved sooner rather than later, heck we would, but a process is under way. It's not one that we can control at all. And we're going to be very respectful of that process and of the instructions that we've been given. So I know that waiting is never easy, but I guess if it's any consolation, we're a lot closer to this thing getting wrapped up today than we were a year ago or certainly four years ago.

<A – John Whittington>: Jay, I would only add to that the delay that I'm aware of was in the selection of the panel itself. That was a process controlled by the American Arbitration Association. And that process did take much longer than we anticipated. But since the panel has been seated and taken charge of the process, the process has moved very smoothly and on schedule. And right now, I know of no reason or have no reason to know that it would not proceed on the schedule that it's currently on.

<Q – Gary Lieberman>: Great. That's very helpful. One quick follow-up. In terms of I guess you had pretty good margin expansion from an EBITDA perspective in 2009 versus last year, you know, I guess in terms of what you baked into the guidance range, are you assuming that margins stay flat or that they expand or kind of what have your thoughts on that?

<A – Jay Grinney>: It would be modest expansion quite frankly, and the factors that we talked about, and again this is our forecast, as we begin the year, and you know we'd love to have a crystal ball that was perfect, but we don't. And so most – I think everybody on the call understands that we try to look at things realistically, but we're going to err on the side of caution, rather than exuberance. And there are certain things that we know, investments that we're going to make. We know we've got two hospitals coming online. That's going to have an impact.

We know that we're making the investment in this new case management TeamWorks initiative. While not at a 10 and $11 million range, there's going to be some costs associated with that, kind of one-time costs. And then we have the clinical information system, we've given you sort of a magnitude of what that's going to involve. And that's an investment, there's not necessarily a return on that today. But as we manage the enterprise, we think that those investments, both on the case management and on the clinical information system, are the right investments to make for the long-term value and benefit of the company, of patient care, and ultimately we believe for the shareholders because we think it will create a much stronger company longer term.

So – and we've said – remember we've said all along, HealthSouth is not going to be a margin expansion story. It's going to be an EBITDA growth story. It's going to be an EPS growth story. And one that is consistent. And we think still that the business model that we've put out there is one that's achievable. And maybe at the low end of the range of our guidance, we slip a little bit below that. But as we said, we try to put the range out there on a basis of what we know we can absolutely produce, and then we're always going to be looking to do better.

Operator: Your next question comes from the line of Erin Blum with Goldman Sachs.

<Q – Erin Blum>: Hi, good morning. Can you give us any comments on the trends you're seeing regarding general hospitals shutting down their inpatient rehab units?

<A – Jay Grinney>: We don't see a lot of that in our markets. We don't see in fact that at all. We do see more acute care hospitals exploring their alternatives. Many of those who have historically offered inpatient rehabilitation, I think, last year probably were in a wait-and-see mode when bundling was proposed, and that was sort of the buzzword, and everybody was thinking bundling was going to be put in place within two years or three years and didn't really understand that this would be a much bigger process and much more complicated.

So I think that today what we're seeing are more acute care hospitals looking at their rehab, seeing if there are opportunities to get a better return, lower their risk and take a little money off the table through a partnership opportunity. And some of those we're going to be at the table, some of them we're not, but we see the market really not changing too dramatically with respect to the view of the acute care hospitals.

<Q – Erin Blum>: Okay. Thank you.

<A – Jay Grinney>: Yep.

Operator: Your next question comes from the line of Brian Williams with Avondale Partners.

<Q – Brian Williams>: Good morning. On your strategy for your outpatient clinics, you've been closing these as your leases have come up. And can you talk a little bit about the tranche of your upcoming lease expirations for your current portfolio? And then also kind of how many clinics do you expect to see at the end of 2010 and into 2011?

<A – Jay Grinney>: Sorry, could you repeat the second part of the question?

<Q – Brian Williams>: Yes, just what's your lease – what the lease expirations are that are upcoming for your current portfolio?

<A – Jay Grinney>: Yes. First of all, I don't have – we don't have the – what that lease profile looks like. But I do want to correct one comment, and we may not have been clear about this in the past. But we close the outpatient clinic not simply because the lease is running up. I mean we close them when they're no longer profitable, and we don't believe that there's an opportunity to bring those into profitability. So it's a little more situational than it is related specifically to the lease. So we don't have the information right here on what that profile looks like. But even if we did, and we could give you the information that would not necessarily be reflective of the number of outpatient clinics that we would be closing.

Frankly, we continue to push our operators to make these profitable, but it's a tough business. And you think about the changes that are coming down the pike, with caps and physician re-imbursement, our outpatient volumes are tied to that. I mean it's still – I think that's going to be a pretty choppy segment for the foreseeable future. The good news is it's a pretty small aspect of our business from a revenue standpoint and even smaller from an earnings contributions standpoint.

<Q – Brian Williams>: All right. Great. Thanks.

<A – Jay Grinney>: Okay.

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

<A – Jay Grinney>: Morning, Rob.

<Q – Robert Hawkins>: Hi. Good morning. Thanks for taking the call. I guess one item I keep seeing, or noticing, and I want to try to get behind is the commercial revenues, as a percentage of your total revenues. They seem to be kind of declining, maybe it's demographics, and maybe the Medicare business is better. But can you guys give us a little bit of color on that, and kind of, I know your pricing, you pointed to as being robust with commercial payers. But I guess what's happening as you change your case mix more to neurology? Are they getting it and sending you patients?

<A – Jay Grinney>: Yeah, I think, if you look on page 28 of our supplemental slides, if you look at the payment sources, there's actually been a slight up tick in managed care and other discount plans. And it's not a huge component. I will tell you that the managed care, the commercial business is a more challenging business for us because of the case management that's done by

the insurance companies. They're – it takes a lot to get the patient in once they're in. They're almost being micro-managed by the insurance company.

Now, the good news is, we have over the last several years worked with a lot of medical directors in a lot of these insurance companies to help them see and help them quantify the value of an inpatient rehabilitation admission in terms of outcomes, in terms of fewer returns to acute care hospitals, more discharges to the home, compared to other settings. And we've been pretty – feel pretty good about our ability to convince the medical directors of that value proposition, but it isn't a business that typically has the kinds of patients that we normally treat.

<A – Mark Tarr>: Hey, Rob. This is Mark. One of the other characteristics of the patients that we see, particularly on the Medicare Advantage or overall managed care portfolio as a whole, is that these patients are sicker. They have a higher acuity than our normal patients to begin with. So as Jay said, there's a lot of scrutiny before we even get approval to take these patients in. And therefore, we've had to work a lot with our medical directors and networking with their medical directors at the managed care products.

<Q – Robert Hawkins>: Okay. So Mark does that mean that these are more trauma-oriented, less young strokes. Because I mean if I separate out just the managed Medicare piece from that, the commercial piece is down 130 basis points. And then if I take kind of the comments you were saying earlier, isn't that really the future here is medical management and where you guys want to head with this and being able to kind of prove out that value? And wouldn't this be an audience that should start growing. Or is it just kind of like – it's just because the demographics are so rough relative to what the rehab acute setting is.

<A – Jay Grinney>: Yeah, really.

<Q – Robert Hawkins>: That it's not a good business?

<A – Jay Grinney>: No, that's a good question. Clearly, the demographics, just the aging of the population and the fact that that aging population does start to statistically access the system more frequently. I mean that really is the major market. Mark addressed the commercial book and the ability to grow that. We're certainly not giving up on that by any means, and we still think that there are a lot of patients out there, commercial patients, who would do a lot better in a rehabilitation hospital than say a nursing home, and we fight for them on a daily basis.

<A – Mark Tarr>: Yes, Rob. That is value – that is the foundation of our value proposition right there in terms of the outcomes that we get in a rehab hospital, versus a nursing home. And as you know I mean it takes a lot of justification and has for the past several years for any of the managed care companies to approve anything other than the lowest – least costly level of care. So that's what we do in our value proposition. We show the outcomes that we can get for the length of stay and the cost for that patient to be in our hospitals.

Operator: Your final question comes from the line of Chris Rigg with Susquehanna Financial.

<A – Jay Grinney>: Morning, Chris.

<Q – Chris Rigg>: Hey, Jay and Mary, just, hello everybody.

<A>: How are you?

<Q – Chris Rigg>: Good. I'm going to come back to the E&Y thing and see if you can comment on this. I know when the original process was building up, E&Y filed for a summary judgment ruling. Is that something that will get announced separately? Or are we not likely to hear anything until there's a complete resolution of everything outstanding?

And then second on that, I think Jay you mentioned that you – one of the criteria for looking at acquisitions was getting the E&Y settlement or not settlement but arbitration done. Is there – maybe give us a flavor, are there things that you plan to do, or things that you're thinking about but sort of are on hold because of the E&Y arbitration? And then you'll move ahead with once that's done, once you see how that turns out?

<A – Jay Grinney>: Let me answer the second part, and then I'll ask John to respond to the first part of the question. Just for clarification, the E&Y arbitration being resolved is one of four things that we believe need to occur before we make a big move into an adjacent service on a large scale basis. So there's nothing that we are foregoing today because of E&Y. We're pursuing the de novo strategies; we're pursuing the acquisitions strategy. We're looking to expand our inpatient platform. And there's nothing in that aspect of our growth in other words over the 2010-2011 timeframe that would – or is dependent on E&Y.

What we're thinking is that E&Y – well, again, John – you heard John say this, and you know, we've said it before. We feel very, very strongly about the logic and the foundation of our position. And we think that there's a lot that could be coming our way because the damages and the pain that we've suffered.

So what we need to do is we need to continue to de-lever. We're going to do that through EBITDA growth. Next year, there'll be some debt re-payment opportunities. That gets us to the point of then looking for that growth opportunity that is in an adjacent space that would be more than just a one-off but looking at transactions of a larger nature.

<Q – Chris Rigg>: Okay. And then in terms of re-financing the balance sheet, and I guess the call provisions are out there a little bit, I mean, that also awaits resolution on the E&Y or not necessarily?

<A – Jay Grinney>: No, not necessarily. If the 10.75 – they're callable at 105 3/8 in June of 2011.

<Q – Chris Rigg>: Right.

<A – Jay Grinney>: Right now, they're trading at, what, at 107.

<A>: 108, maybe.

<A – Jay Grinney>: 108. Frankly, we think that's a little rich...

<Q – Chris Rigg>: Right.

<A – Jay Grinney>: To go out there and to buy some of those. If anybody on the call wants to sell us those at 105, 104, that's a different ball game. But at this point, it's a little rich.

<Q – Chris Rigg>: Right.

<A – Jay Grinney>: And so once those become callable, as you saw us do this year, when the floaters became callable, although a little bit less call price. We're definitely going to be looking at all of the avenues that are available to us.

<Q – Chris Rigg>: Okay. And just the summary judgment question?

<A – John Whittington>: Yeah, A.J. I think that to answer your question would violate the confidentiality order. What I would say, though, is be mindful that this is an arbitration proceeding. It's not a trial based on the federal rules of evidence. So it is a different type proceeding. And that's all I'm comfortable saying with respect to your question.

<Q – Chris Rigg>: Okay. All right. Thanks a lot.

<A – Jay Grinney>: Okay. Operator, any other questions?

Operator: There are no further questions at this time.

Jay Grinney, President and Chief Executive Officer

Great. Well, thank you everyone. Appreciate all of you taking the time and participating on this call.

Mary Ann Arico, Chief Investor Relations Officer

Thank you. If you have additional questions, we'll be available later today. You can call me at 205-969-6175. As a reminder, we will be attending the RBC Capital Markets Healthcare Conference in New York next week, the Raymond James Conference in mid-March, and the Barclays Conference in later March. Thank you.

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

Jay Grinney, President and Chief Executive Officer

Thank you, operator.

Operator: Thank you, have a great day.