MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to HealthSouth's First Quarter 2011 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 Mary Ann Arico, Chief Investor Relations Officer. Please go ahead.

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

Thank you Brandy and good morning everyone. Thank you for joining us today for the HealthSouth first quarter 2011 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 and Chief Operating Officer; John Whittington, our Executive Vice President, General Counsel and Secretary; 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 of 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 risk and uncertainties, many of which are beyond our control. Certain risk, 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 first quarter of 2011, which will be filed next week, and it's previously filed Form 10-K for the year ending 2010 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 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 the call 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. By any measure HealthSouth's first quarter was exceptionally strong and provides an excellent start to the year. Top line growth of 9.6% was driven by a 4.5% increase in same-store discharges while another 260 basis points of growth was added from hospitals acquired or built in the past year. All of our new hospitals are

performing well, and as we'll discuss in a moment, their success has reinforced our commitment to our de novo strategy. From an expense standpoint, our hospitals continued to provide high quality care on a disciplined, cost effective basis as evidenced by the 16% increase in our adjusted EBITDA compared to the first quarter of 2010.

Productivity and as a percentage net operating revenues labor, hospital related and general and administrative costs all showed solid quarter-over-quarter improvement. We also took a significant step toward retaining a portion of our most expensive debt by raising $122 million through the reopening of our 2018 and 2022 senior notes. As Doug will explain later, we plan calling and repaying $285 million of these notes at the initial call date of June 15, with additional repayments expected later in the year.

Finally, as previously stated we are reporting earnings per share from continuing operations attributable to HealthSouth on a GAAP basis beginning this quarter and are no longer reporting adjusted earnings per share. On this GAAP basis, first quarter EPS was $0.60 per diluted share compared to GAAP EPS of $0.40 per diluted share for Q1 of 2010. With that summary on the quarter's highlights I'm going to ask Doug to provide a more thorough review of the numbers.

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

Thanks Jay, and good morning everyone. I'll provide some additional color on our operating performance for the first quarter and also discuss our immediate plans for repaying the 10.75% senior notes. As Jay summarized, we had a very solid first quarter. Our consolidated net revenues for the quarter grew by 9.6%. Inpatient revenue was up 9.2% driven by 7.1% increase in discharges, and 1.9% rise in revenue per discharge. Our volume increase included 4.5% same-store growth as well as positive contribution from hospitals opened or acquired over the last 12 months.

Now please note that our Q1 results included $1.1 million net benefit to income from continuing operations related to state provider taxes. And, although this net amount is not material its components impacted number of line items and so I'd like to take just a moment to explain this more fully.

A number of states in which we operate hospitals assess a provider tax to certain healthcare providers. Those tax revenues at the state level are frequently matched by federal funds as part of the Medicaid program. In order to induce healthcare providers to serve low income patients many states redistribute a substantial portion of these funds back to the various providers. These distributions are frequently based on different metrics than those used to assess the tax and are thus in different amounts and proportions in the initial tax assessment. As a result some providers receive a net benefit while other experience net expense.

These provider taxes are a regular component of our financial results. However, during Q1 new provider tax was legislated in Pennsylvania a State in which we operate nine inpatient rehabilitation hospitals. The Pennsylvania provider tax program contributed $5.1 million to outpatient and other revenue in Q1 of 2011, but was offset by $800,000 decrease inpatient revenue from a similar program in Missouri in which we operate two inpatient rehabilitation hospitals resulting in a $4.3 million benefit to our Q1 net operating revenue. This revenue increase was partially offset by a corresponding expense of $3.2 million included in our Q1 hospital related expenses leaving us with the aforementioned $1.1 million net benefit.

And with that said, we once again exhibited disciplined expense control during the quarter. SWB for Q1 was 48.2% of net revenues a 110 basis points improvement over the first quarter of last year. Approximately 30 basis points of this decrease was attributable to the inclusion of the

provider tax revenue. The residual 80 basis points of improvement was driven by higher volumes, pricing adjustments and enhanced productivity.

As evidence of this latter employees per occupied bed which we refer to as EPOB improved to 3.40 from 3.41 last year. Hospital related expenses for the quarter were 23.1% a 10 basis points improvement over Q1 of 2010 even after absorbing a 40 basis point negative impact from the provider tax issue.

Bad debt expense for the quarter improved by 40 basis points to 1% of net revenues based on strong collections and recoveries of prior period write-offs. During Q1, we did experience the anticipated resumption of medical necessity claims reviews. If these claims move through the review and adjudication process it will age out resulting in an expected increase in bad debt expense over the balance of this year.

Our G&A expenses excluding stock based compensation for the quarter declined by 40 basis points 4.2% of net revenues as we achieved operating leverage against the revenue increase. As anticipated our first quarter interest expense increased by $4.6 million over the same period last year. This was attributable to the refinancing activity we completed in the fall of 2010 and the add-on to our 2008 gain in 2022 senior notes in March of this year which Jay alluded to earlier.

Our income from continuing operations attributable to HealthSouth for the first quarter increased to 65.4 million versus 43.8 million in the same period last year and earnings per diluted share increase to $0.60 as compared to $0.40 the prior year. The increase in EPS was attributable to the improved operating performance for the quarter and $0.27 per share tax benefit. The tax benefit related to a settlement with the IRF for tax years 2007 and 2008 as well as a reduction in unrecognized tax benefits due to the last of the statute limitations for certain federal and state claims essentially a reversal of some prior Fin 48 reserves.

Our cash taxes for Q1 were $2.6 million as compared to $1.6 million as compared to $1.6 million in Q1 of 2010. For the full year 2011 we anticipate cash taxes in a range of $7 million to $10 million. As Jay noted earlier, please be reminded that we now report GAAP EPS only and no longer provide adjusted EPS. A reconciliation between these two measures is included on page 12, of the supplemental slides.

Turning to the first quarter we generated adjusted EBITDA of 123.4 million a 16% increase over last year driven by our strong operating performance. Adjusted free cash flow increased by 4.9% to $51.4 million. As we had anticipated free cash flow growth was somewhat tempered by increases in working capital, interest expense and maintenance CapEx.

Looking to the balance of the year, adjusted free cash flow will benefit by approximately $33 million from the cessation of the interest rates swap settlements, with this benefit offset by the anticipated year-over-year increases in maintenance CapEx and working capital. Based on our intended exercise of the call option on a portion of our 10.75% notes that I will discuss momentarily, interest expense for the final three quarters of 2011 should be roughly comparable to the same period last year.

Total CapEx for Q1 was 15.3 million versus 14 million last year and maintenance CapEx for the period was 9.4 million versus 5.6 million last year. The increase in maintenance CapEx is primarily related to hospital refurbishment projects.

Turning to the balance sheet, based on very favorable debt capital market conditions in March we raised $122 million via a $60 million add-on to each of our 2018 and 2022 senior notes. The incremental notes were issued at a premium of 103.25% and 103.5% respectively resulting in a blended yield of approximately 7%. Proceeds from this offering were used to pay down $45 million of borrowings under our revolving credit facility replenishing availability and the residual $77 million

is held as cash pending the initial call of the 10.75% notes. Those 10.75% senior notes have an initial call date of June 15, 2011 at a price of 105.375%. It is our intent to exercise the call option on $285 million of those notes.

With the premium this will require a cash outlay of approximately $300 million which we expect to be funded with the $77 million remaining cash proceeds from the March debt issuance and the balance will be funded under our credit facility. These actions will generate interest savings of approximately $12 million in the second half of this year and will also trigger a non-cash loss on the early extinguishment of debt of approximately $23 million. We are very pleased to be in a position to make such a substantial initial call on this expensive component of our debt capital and anticipate further repayment of these notes during the course of the year as we continue to generate free cash flow.

I'll now turn it back over to Jay.

Jay Grinney, President and Chief Executive Officer

Thank you Doug. Before taking questions I'd like to discuss the status of the E&Y arbitration, preview our accelerated de novo growth strategy and comment on 2011 guidance.

The E&Y update is more of the same, strong conviction in the merits of our claims coupled with concern that the process is moving so slowly. As we have previously stated, the rules of the American Arbitration Association requires us to keep the arbitration strictly confidential. Additionally, in accordance with E&Y's engagement letters the arbitration process which will resolve our allegation that E&Y negligibly and recklessly missed a seven-year multibillion dollar fraud is confidential.

Therefore, as we have said on prior occasions there are limited comments we can make. While we had hoped the arbitration process would be completed in the second half of 2011 significant scheduling conflicts will limit the number of hearings in the third and fourth quarters and will push the proceedings into next year. Since the beginning of the arbitration back in July of 2010 there have been approximately 10 weeks of hearings generally in four-day blocks of time.

Going forward the arbitrators have scheduled an additional 15 weeks through April 2012. Despite scheduling issues and the fact that the arbitration is taking longer than expected we remain confident in our claims and are committed to aggressively and diligently pursuing them to conclusion however long it may take.

The good news is we are not dependent on receiving any E&Y proceeds to execute our business plan. Over the past several years our primary objectives have been repaying our most expensive debt, creating a manageable maturity profile for the remaining debt and positioning our balance sheet for growth. Now that our leverage objective is within reach we believe the highest and best use of our cash is to invest it in our core inpatient rehabilitation business.

Since 2006 we've built and opened six new hospitals, some to complement our presence in existing markets, some to provide high quality inpatient rehabilitative care in new markets. The success of these hospitals has been undeniable. They achieved sustained positive EBITDA between three and nine months of opening in company average occupancy levels within a year. This strategy also is relatively low risk since it doesn't require assuming integration or new business risks and can be funded through cash on hand and if necessary through our revolver.

Furthermore, in case of non-CON markets we can control the number and timing of new hospitals while hospitals in CON markets like the one we recently announced in Ocala, Florida can be added as the CONs are granted. The success of our de novo strategy motivated us to expand our search

for new markets. While our business plan calls for opening two to three de novos each year we now are confident we can increase that number over the next several years. While we have not finalized these plans we are targeting to at least double the number of de novos added to our portfolio each year.

We will complete this analysis during the next 90 days and we'll share the results with you on our next call. This emphasis on de novos will not affect our intent to acquire other inpatient rehabilitation hospitals and we still believe two to three acquisitions per year as achievable. A corallary to this accelerated de novo strategy is a more cautious approach toward diversifying into other post-acute services. When healthcare reform was passed last year accountable care organizations received a tremendous amount of attention. Many held at them as the new healthcare delivery model. As we contemplated this new world order, we reasoned it made sense to consider adding other post acute services to complement our facility based rehabilitation services.

While ACOs certainly are an intriguing long term model, the recently issued ACO proposed rules suggest the healthcare delivery system isn't going to be transformed overnight. These proposed rules are well intentioned, but in our opinion create outsides risks while providing little by way of a framework for assessing the potential returns from assuming these risks. In many ways ACOs echo the capitated model of the 80s and 90s though with the federal government setting the rules instead of the insurance companies doing so.

Given the inherent complexities of transforming a highly fragmented industry into one, consisting a cohesive, economically integrated providers its obvious ACOs are going to take years of pilots and evaluations before the merits of this concept are validated. Accordingly, we will focus on near term development efforts on expanding our IRF portfolio while participating in select ACO pilots when and where it makes sense to do so.

Focusing on an accelerated de novo strategy versus acquiring new businesses is further supported by our belief that provider reimbursement will come under increasing pressure over the next several years as federal and state governments attempt to reduce budget deficits. Couple this scenario with the prospect of rising interest rates and we believe the appropriate way to manage the company over the near term is by capitalizing on our position as the leading provider of in-patient rehabilitation in keeping our balance sheet delevered and strong. The consistency of our operating results and strong cash flows reinforced this approach.

As we look to the remainder of the year, we anticipate we'll continue to gain market share although weakness in acute care admissions is something we will continue to monitor. Pricing should remain stable and the proposed IRF-PPS net increase of 1.5% is consistent with the Medicare pricing adjustments we'd assumed for the fourth quarter. Although we had an excellent start to the year consistent with our past practice we are not going to increase our guidance at this time, with the exception of adding the tax benefit to our EPS range.

We will revisit guidance when we report second quarter results and retire the portion of our 10.75% senior notes. While we are not raising guidance at this time we do expect our full year performance will be at the high end of or greater than the current $440 million to $450 million of EBITDA and $1.28 to $1.33 per share EPS ranges.

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

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions]. The first question comes from the line of Darren Lehrich with Deutsche Bank.

<A>: Good morning Darren.

<Q – Darren Lehrich>: Good morning thanks good morning everybody. So nice quarter here, I think the obvious question is really about the de novo strategy its pretty notable in terms of how much additional growth you are getting from a lot of these development activities, you know when we were in Virginia I guess visiting that facility we got a pretty full update on your targeting. And I guess, I just wanted to understand is what you're seeing now in the marketplace an expansion of what you've defined is as your target markets, I'm just trying to understand what's really driving the decision to increase the de novos, I think they are coming they're ramping faster so that that may be part of it but is there something different about the marketplace that you are seeing to in order to make this decision?

<A>: Darren, it's not so much a difference in the market as it is two factors. Number one, the success that we've had with the de novos as we turn the corner at the end of 2007 and went into 2008 we had a strategy of de novos and acquisitions. The market collapsed at the end of '08 sort of put that on hold for well over a year. So we didn't have in that time period as we were de-levering the balance sheet and focusing on our debt we really didn't have, a lot of track record to go on. But we had enough that now we believe we have the know how to be able to ramp up an open additional hospitals and additional markets. The new markets have really been a function of us going back and looking at markets from a more discipline perspective. And looking not only where the population and our projected demand for services was greater but also looking at existing competitors in those markets to determine whether or not we could go in and believe that we would be able to be successful in continuing to take market share. So there were couple of factors one the success that we had and the confidence of that has given us that we can indeed identify open and make successful new hospitals. And then second is the, the fact that we've taken a more expansive approach in looking at markets for de novos.

<Q – Darren Lehrich>: That's great. I guess my follow up on this topic would just be for Mark you have a great margin structure to work with to do with what Jay is talking about. I guess just from your perspective operations should we expect to see, with an increase of de novos any real disruption in margins or do you think you can sustain what we're seeing here?

<A>: Yeah Darren I think we can absorb it within our existing structure. We done a good job of building bench strength the past couple of years so that we would position ourselves for growth once we got to that point so but there would be no reason to expect significant disruption at all.

<A>: And Darren at the corporate level we've already modeled out the additional resources that we think we may need over the next several years as we, as we launch a more aggressive approach to de novos. And, are very confident that that's a very de minimis investment and think about it from risk standpoint pretty low risk way of investing our free cash flow and getting some very nice growth over the next several years.

<Q – Darren Lehrich>: Okay, thanks a lot.

<A>: Yep.

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

<Q – Adam Feinstein>: Hi there, thank you. Good morning everyone. I wanted to ask, I guess just back to the discharge growth obviously very strong number. You know your guidance that you

guys talked about at the Analyst Day at the end of the year last year was 2.5% to 3.5% growth. You know obviously you are tracking higher than that. I know, you know your comments about you think you'll come in at that high end of the guidance range in terms of the EBITDA, but how should we think about the discharges for the year? Is the 2.5% to 3.5% still the right way to look at it? Is it fair to assume you'll be at the high end of the guidance range for volumes as well?

<A>: Yes. We, I think that's a very appropriate way of looking at that.

<Q – Adam Feinstein>: Okay and then just I wanted to get some more color just in terms of mix and what areas are you seeing the nice growth in so just obviously I know stroke has been a big area of focus for you guys, but just curious in terms of the different categories?

<A – Mark J. Tarr>: Yeah hi and this is Mark. As we've seen in the past several quarters our neurological programs continue to grow matter of fact from a category standpoint that was the largest growth in discharges. We also had growth in major multi-trauma, amputee and pulmonary. The programs that we saw a reduction in, we continue to see a decline in our replacement of lower extremities or the knee replacements, osteoarthritis and rheumatoid arthritis. So as we have continued to beef up our program mix and competencies on our neurological we see the nice volume growth in those categories.

<Q – Adam Feinstein>: Okay, and then Jay, just I want to get your outlook on the reimbursement landscape, Reg came out last week looks fine with 1.8% increase, but just curious to get your thoughts just about, anything in the Regs and obviously doesn't in that you guys just monitored the nursing home Reg was pretty negative last night I just don't know what that signals in terms of future tone from CMS so just curious in terms of your thoughts on the reimbursement landscape?

<A>: Yeah, I mean I think that the, the reimbursement landscape as I mentioned in my comments I think is going to be, is going to be pretty tight over the next several years. I mean, it's obvious that we have a huge budget deficit it obvious that entitlement programs are going to have to be addressed. And one of the reasons why we try to manage our company as conservatively and as prudently as we have is because we are aware of that I mean we're not looking just today, we're looking down the road and saying, where do we think the, the industry is going to be and what are the pressures that are going to be facing us, two, three, five years from now.

As far as the landscape is concerned, the expenditure on inpatient rehabilitation have been declining over the last several years as a percent of total Medicare outlays. And so I think that the, the positive update that we received or the modest update I wouldn't say it is positive. But the modest update that we received I think is a reflection of the fact that this particular segment is not out of control it's not, going up at double-digit rates. The industry doesn't have the kind of margins that you find in other segments. And then looking at the regulatory challenges that are facing segments I mean, I must admit I was a little bit surprised at yesterday's proposed rulings for SNFs but only because of timing. It wasn't as if nobody expected that the windfall that was received over the past year was going to stay there. I mean, so I don't know, we've only been there supervising those timings I thought it would a year from now and but it happened sooner rather than later.

So I think that the landscape is going to be tough. I think that providers who have strong balance sheet will do just fine and that's how we try to position ourselves and that's why as we look at growth. We are not dependent on acquisitions. We don't have to go out and acquire anything. We can grow and grow significantly through the existing cash flow and focusing on our core business. And we think with the pressure now off of the Medicare program coming out with those very difficult ACO proposed rules we just we don't think that there is this near-term imperative that you got to jump on this ACO bandwagon. We'll test it. We'll participate but we are not going to bet the company on something that is untested.

<Q – Adam Feinstein>: All right, thank you very much.

Operator: Your next question comes from the line of Colleen Lang with Lazard Capital Markets.

<A>: Good morning Colleen.

<Q – Colleen Lang>: Hi, good morning. I guess we've seen this quarter the acute care hospitals have been reporting that all volumes are weak in their businesses in general the patients coming to the hospitals are much sicker, more acute. Do you think you guys your volume growth this quarter is all benefit from that phenomenon in both the LTACH side?

<A>: Certainly, there is going to be some benefit to that as we have indicated previously there's probably about 3% or 5% of patients who get discharge from acute care hospitals that are candidates for in-patient rehabilitative care. So we should not expect a one to one correlation between acute care volumes and in-patient rehabilitation volumes, but we do see a sicker patient. There is no question that the patient who we are seeing today are more medically complex than those that we've seen in years gone by and that's not just a reflection of the neurological shift but also a reflection of the fact that these patients come with comorbidities they are medical dependent often times on a close monitoring and that's one of the benefits of having those patients in an in-patient rehabilitation hospital versus say a nursing home when that level of surveillance and cover just don't exist.

<Q – Colleen Lang>: Okay great thanks for the color. In giving a commentary earlier ACO have the hospitals or physicians in your market had starting talking to you about ACO programs and what there in turns that as well. And well – I guess the decision just can be a market by market decision based on the doctors?

<A>: Yeah it definitely be a market by market but I have to tell you that what we are hearing and what I said a moment ago about ACO's is really being fed in a lot of different quarters and I think we have to step back and understand that to the best of our knowledge Medicare never said and/or CMS never said that ACOs were going to be the model for all providers and that's where the industry unexplicably was going to go. There's always been an acknowledgement that ACO was one of several different kinds of models that might help to rein in costs. I think that as we look at the Regs and as others did, you start thinking about the upfront costs associated with those regulations.

The risks that you have to assume, the fact that the targets are set basically by CMS and so you've got to target to perform against and you want, you've got to get at least 5% improvement before you start sharing in those. And then does that mean that the new target for year two was going to be set at where you were in year one and does it mean you still have to get 5% off the parameters? There is a lot of complexity and uncertainty surrounding this. As you expect, I mean it's a brand new concept and I know people at CMS have been working very hard to get these out. But I just think that rather than providing more clarity we've really seen it provide more uncertainty and with that uncertainty a lot of the acute care hospitals in our markets have stepped back and said, wow we didn't realize it was going to involve that. We may not be that interested. And again this is the pilot, you know and then after the pilots you have to evaluate the results of those pilots and then you have to modify those results and modify the model. And so its, you know I just, our view is that business as I say intriguing potential, but not anything that we're going to build the strategy around any time now that these proposed rules are out.

Operator: Your next question comes from the line of Kevin Fischbeck with Bank of America Merrill Lynch.

<A>: Good morning.

<Q – Kevin Fischbeck>: Okay, great. Good morning. I wanted to talk a little bit more about the de novo development pipeline. How should we think about that from modeling perspective, you said that you are doing more of these going forward, does that mean that there is going to be more startup losses that will be flowing through the numbers, or is that just going to be offset by wrap up of recent deals? How do we think about modeling that and you said you are going through this process in the next couple months, when should we reasonably expect to see these new openings, is this kind of second half 2012 issue or could it happen even sooner than that?

<A>: No, it will be second half of '12 and then certainly in 2013 and '14. There will be – we've started progress on the hospitals in Ocala. We've got hospitals on construction in the Cypress area, the Cypress Fairbanks area at Houston, those will become, that will be coming on later in the fourth quarter of this year, obviously contributing significantly the next year. So the timing of this is going to be in '12 and beyond in terms of the impact of these hospitals opening up. In terms of the cost there are going to be some modest startup costs. We will see that but you know the growth and success of the existing portfolio should certainly be able to observe that. Will there be some temporary margin compression initially, but you know potentially, but I don't think it's, it's not going to be a 200 basis point or anything of that magnitude.

<A>: Yeah I think the two line items where you might see some and I think Jay is exactly right which is it's going to be, it's going to be a nominal impact. You will see as we have seen previously a little bit of pressure on SWB line and the period where these are ramping up. And then you'll also see a little bit in the depreciation line as a CapEx comes on board. But as the number of our portfolio continues to grow and the incremental adds are going to be less out the total base and for the impact on the margin are to be muted.

<A>: And Kevin as you probably know, we have a an investor reference book out online and in that there is a section on our de novos and timeframe for developing those estimated startup cost and so on. So you can take a look at that I think we provided enough information for you to go in and then you can make your assumptions to the number of new hospitals and then use that information to help model.

<Q – Kevin Fischbeck>: Okay. And then just to clarify what you said about kind of taking more extensive view on de novos, industry make a great use of capital, high return, low risk but whenever you start talking about doing more something like that, you get a little bit worried that the incremental return are not going to be as high as you would be getting if you were to do kind of just to select two or three it could be doubling that, how do you think about the incremental returns from accelerating the de novo pipeline is it going to be just as good as kind of what you've always seen or by definition is it a little bit less but still better than any other use of capital. If yes how much of this is a view on we don't see a very use of capital versus it is just a huge opportunity that you probably were taking advantage of should it be doing before?

<A>: Well I wouldn't say that we should have been doing it before. First of all, as I mentioned in 2008, '09 and into '10 we were using the cash flow that we were generating to strengthen the balance sheet and to ensure that we had a very solid platform for moving forward. So the return that we expect is really going to be just as good as what we've done thus far with those six hospitals. We, as Mark said we've been building up the operational bench strength. We've spent a lot of time identifying what the resources are going to be needed here in the corporate office. We are definitely not going to bite off more than we can chew, but we are very confident as we look at how seamlessly we've been able to bring these other hospitals on and I think again the results speak for themselves. You can look at the number of hospitals that we've opened up over the last couple of years; and you know we hadn't missed a beat. And so we're now very confident that this management team can easily accelerate that and get exactly the same time the returns on those new hospitals that we had with the existing ones.

<A>: One of the things that we look at is part of this analysis is we took the criteria that we've been utilizing to screen new markets for de novos and we apply that against our best performing legacy hospitals. And that led us to two conclusions, one is that markets with a lower population density and we were utilizing to screen de novo opportunities to support a very successful rehab hospital particularly our 40 to 50 bed prototype model. And the second thing is we were not giving as much weight into conversion rates in some of those markets as we think is appropriate as we evaluate new markets. And by conversion rates we mean the percentage of total CMS eligible 13 discharges in the market and ultimately windup in a rehab setting. So as we did that analysis it broadened the number of perspective markets for us. And we are confident that as move into those markets we're going to continue to generate returns that are comparable to what we've seen from our recent de novo activity.

Operator: Your next question comes from the line of Kemp Dolliver with Avondale Partners.

<A>: Good morning Kemp.

<Q – Kemp Dolliver>: Thanks and good morning. First question relates to the notes and your thoughts regarding permanent financing as you take out the notes over the course of the year?

<A>: Right, I think yeah, we feel like we got the financing in place. The actions that we began taking with regard to the capital structure in the fall of 2010 and then consummating the senior notes add-on in March really positioned us to make this very substantial move against the 10.75. With the revolver increased to $5 million and with the maturity date pushed out 2015 we're very comfortable funding that $200 million plus under the revolver. That also give us pre-payable floating rate debt and as we continue to be a strong free cash flow generator which is our expectation we'll be able to pull down that balance as appropriate. Even with that $200 million plus funded under the revolver still leaves us with a lot of access availability under that facility.

And then you know really the balance is already been taken care of with the layered senior notes maturities. So we will, this initial move is kind of taking care of and then as we move into the second half of the year we're going to continue to look at our free cash flow generation and assess incremental opportunities to pull down more of the 10.75. We fully anticipate that will it progress beyond $285 million in 2011 and our objective is to have those 10.75% notes completely out of our capital structure here and not to distant future.

<Q – Kemp Dolliver>: That's great thank you. And second question relates to the de novo discussion, one observation that has been made to me is that the, since the tightening up of the 75% or 60% rule the number of providers has declined I think probably more so in say the hospital units side than the free standing hospital side. Is it fair to assume that is also a driver and your thoughts regarding accelerating de novos?

<A>: You know, it's a consideration but I have to tell you it really wasn't a top criteria we really look at the markets from a demand standpoint. And as Doug said, looked at it within the context of existing de novos, the success that we've had there, other hospitals that we've had in smaller markets and we just concluded that we can enter markets and be very successful not have to be constrained as much as we have been in the past. And admittedly we are taking a little more conservative view I mean we are investing shareholders money. We wanted to make sure that that investment was going to pay off, it has.

So, I think that the decline in the number of IRFs is more a function of the quality of care. It's very hard to have a 20-bed unit with 10 patients or 8 patients in there and be able to maintain the quality in that unit. It's also a financial drag and as hospitals start to tighten their belts both the for profit and not pro provident and see their reimbursement squeezed I think they are going to have to make decisions and I don't think that there are many players out there that can be all things all people. So, was it a factor, yeah, it played a role but it wasn't, it was a pretty minor role.

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

<A>: Hey, Gary.

<Q – Gary Lieberman>: Thanks, thanks, good morning. May be just a follow up on that, on the last topic, your discharge growth continues to be really strong and your market share gains look like they have somehow not decelerated if anything they have accelerated. Can you give us any kind of perspective in terms of if there is an upper limit for the amount of market share that you feel like you can take and are you close to that and how should we think about that?

<A>: You know I don't believe that there is any upper limit that is on any kind of near-term horizon. And when I say near-term I mean as far as I can see and so I think that the opportunity is really to provide that higher level of rehabilitative care in markets where there isn't a rehabilitation provider and where that care is being provided in a suboptimal level. And we saw that in case of our hospital in Loudoun County Northern Virginia. Patients were going either to nursing homes, they were traveling for hours to get rehabilitative care we put a hospital and it's been I think a God sent for the patients in that community first and foremost. But it's also been very convenient for their families and very much appreciated by the physicians.

<Q – Gary Lieberman>: Okay. And may be if I could just follow-up I haven't heard you talk too much about the team works initiatives. Can you just give us an update are those, fully implemented everywhere and kind of what is that one of the key, continues to be one of the key strategies in terms of continuing to take market share?

<A – Mark J. Tarr>: Hi Jay this is Mark. Yes, team works from a sales and marketing standpoint has been fully implemented in all of our hospitals, all of our markets. As you may know this year our team work's initiative is focused on care management or those functions following up under the case management services of which we rolled out I believe 36 [ph] of our hospitals have now been in the process of having that implemented. And we would have that rollout to all of our hospitals in the next couple of months. So our effort to standardize best practices in those areas that we think we'll bring value and continue to increase the performance of our hospitals remains a very big focus for us.

<A>: And I think that the, the nature of inpatient rehabilitation lend itself more than any other service that I am familiar within healthcare to this best practice approach. I mean you think about acute care hospitals and the range of services that they may offer the capital that's required to provide those services, the personnel expertise that's required. In our case, as you've heard from Mark a minute ago, the service is pretty much the same yet shifting, but its shifting in virtually all of our markets. So this is one service that really can benefit from best practices and that's why we've made this a key operational priority.

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

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

<A>: Hey, A.J.

<Q – A.J. Rice>: Let me just really quick on the labor front, we hadn't talked that much about what you see in terms of therapist productivity, turnover rate, wage rate increases or trends in that, can you tell us sort of what you've seen and what you are anticipating as you think about the rest of the year?

<A – Mark J. Tarr>: Hey, A.J., this is Mark. As you know, we make labor management a big focus on hospitals including having rolled out an IT platform for field based managers to use and making

adjustments as we see volume fluctuations. From a market standpoint we aren't really seeing a large increase or tightening on the labor stand front. The nursing seems to be available in most market places. There are certain markets where therapy availability is tighter than others, but overall it's been pretty good couple of years for us from a staffing and availability of staff standpoint.

<Q – A.J. Rice>: Okay. And than may be, I know we've talked around awhile about this discussion around the de novo strategy and you reiterated the desire that there will be two or three acquisitions, but you know as we progress to the end of this year and start looking out into the future assuming you pretty much addressed the majority of the 10.75 notes. When you think about the 250, 300 million or so free cash flow what, how do you start to see that allocating between these strategies than anything else?

<A>: So, recall that as we address the 10.75 one of the things we are going to be doing is pushing the substantial amount this $200 million plus are revolver. So overtime we want to see that come down as well. But I think on a go forward basis the prioritization of the cash flow is going to be to the de novos and the acquisitions and to a further reduction in debt on our balance sheet. When we have moved completely through that when the debt is stabilized at a level that we're completely comfortable with which is somewhere inside that three times and we're not all that far from there. We can begin beyond the amount of capital that is devoted to the expansion of our facilities we can look at some other alternatives including whether or not it make sense for us to look at some of the shares that we were issued as part of the shareholder settlement at the end of the third quarter of 2009 and get those back, we can look at number of different alternatives.

<A>: And the other thing, A.J. that we've mentioned in the past is the installation of an electronic network information system we're piloting, we piloted very successfully in Northern Virginia, we're going to piloting it in two other hospitals this year we're very pleased with the results. And so that's another use of that CapEx excuse me the cash flow to put into that IT CapEx. And that's going to be a five year rollout, but it will involve additional capital dollars.

Operator: Your next question comes from the line of Rob Mains with Morgan Keegan.

<Q – Robert Mains>: Yeah thanks, good morning.

<A>: Good morning, Rob.

<Q – Robert Mains>: I just have one question and that's sort of following up on one of Adams questions. This is probably fairly hypothetical, but when you look at where clinically you are moving in your hospitals, I'm summarizing that you've got a lot, a fair amount of room under the 60% rule, I'm just wondering if we see the this careful rule if it gets finalized that some of this might have less incentive to do orthopedic type patients that you used to see a while ago, whether you see there a possibility of getting more of those hips and knees or whether that's really not the clinical direction that you see the company going in?

<A – Mark J. Tarr>: Hi Rob, this is Mark. I mean there is a chance that we can see some of those orthopedic patients come back, once they are in way careful not only – and we have room under our compliance percentage we've run north of 6%, but the area of medical necessity comes into play when you take these orthopedic patients. So we'd have to be careful that that they do have those cormobidity, those medical complexities that would clear the hurdle from a medical necessity standpoint with our Medicare advice.

<Q – Robert Mains>: It's a great point. Thank you, that's all I had.

<A>: Thank you.

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

<A>: Hey, Frank.

<Q – Frank Morgan>: Good morning. I'm really intrigued with this continued expectation of gaining market share from all the providers out there, and I'm curious, is there any specific characterization you can give from where you're seeing the most market, who are you taking market share from the most? And within continuation of market share take away, is it in some way maybe perhaps delaying you're considering getting into other business lines and you're saying hey, the market opportunities are good here. We'll stick with continued growth, de novos and maybe the notion of our post-acute service lines maybe we push that back. Is it a fair way to think, is it the right way to think about?

<A>: Definitely the second part is the right way to think about it. And that is we are clearly signaling today that the interest level in pursuing other complementary post-acute services is in fact much less today than it has been over the last couple years. And, it's in large part because we were looking for signals from CMS as to whether or not these ACL model was going to be attractive enough to drive business into that model. And our conclusion is that while it's intriguing we don't see it as being transformational at least in the near term.

In terms of where the market share is coming from and I think we probably have to understand it's not as if there is a defined market share number that we can go out and point to and say, all right we know with 100% certainty that there are X number of patients to qualify for inpatient rehabilitative care. That is a little bit of a fluid number because this is really a function of not only the underlying medical conditions in the population, but also judgment and decision is made by physicians with respect to where the patient can get the care and then availability of those services. So, I think that the market share the actual market considerably continued to growth A as the population ages and that I think is one of the fundamental attributes this strategy is affected we are in segment that is growing you know as the population ages, there is going to be more patients who are going to be coming into that elderly group and they are going to need rehabilitative care service.

So I think the share gain is really coming from physicians who excuse me from patients who otherwise would have gone to skilled nursing, conceivably its from other inpatient rehabilitation providers, may be even to some extent long-term acute care hospitals. So I think that there – we have to think about the market A is growing and then B we are continuing to take advantage of that and then we are trying to bring patients to our hospital that might otherwise go to other sectors.

<Q – Frank Morgan>: Okay, thank you.

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

<A>: Good morning, John.

<Q – John Ransom>: Hey good morning. I'm just curious kind of your latest thoughts about the home health sector I know it's a sector you've taken a, you've got kind of long-term interest in, just given the reset in SNF today. As you looking at home health businesses do you, what kind of odds would you put on kind of same kind of one-time reset administratively and how would you price that and as look at deals?

<A>: Well, first of all we are not looking to any home care and as I said you know our interest level in that is significantly lessened and we have no intention of pursuing any home care acquisitions. We are really looking to reinvest in our core business. In terms of the probability I mean I think that the fact that line item continues to grow for Medicare. As we've seen over the last several years and the fact that the industry has some very high margins Medicare margins to me it is just that they are going to be looking at that. We know right off the back that they're going to be looking to

rebate that. So I don't know, I just, I think that we've said all along that we thought that those two segments had some risks associated with them not because they are bad people or they are bad providers, they are just, Medicare spending more money on them. And in today's environment that's going to draw some scrutiny.

<Q – John Ransom>: Okay, and just one another follow up for Doug, just mechanically let's just say we were modeling, something 50 to 60 million a quarter in free cash flow, would you, as you take out the rest of the 10.75 should we think about that as kind of a once like the quarter or how do you kind of take bites of that and how are going to go back mechanically?

<A>: It's just the specific mode by which we'll do that, the timing is undetermined at this point John. But I think there are a couple of things to keep in mind, one is I know everybody on the call knows this, but just as a reminder the call option is not something that exists just at one point of time. Once we get inside the call protection if you will on June 15th of this year that option is available to us for the duration that the bonds are outstanding with the premium required to call those decreasing on an annual basis every June 15th. So its out there all the time and with proper notice to the trustee we can call those in increments of any size essentially on a rolling basis. The second is there is the possibility that we might see attractive places and or perhaps even below the call price for various reasons in the open market and we have the ability to consummate open market purchases. We also can from time to time and obtain a reserve enquiry or somebody calls us and offers those bonds. So there are number of different methodologies that we can utilize to pull those in and we're going to continue to evaluate all those.

Operator: Your final question comes from the line of Sheryl Skolnick [ph] with CRT Capital.

<A>: Good morning, Sheryl.

<Q>: Good morning, it's actually Nick sitting in for Sheryl.

<A>: Good morning.

<Q>: Congratulations on some great results this morning. Just a question to, I don't mean to beat a dead horse here on the 10.75% notes, so we should not assume at all that any cash on hand will be used to repay to call those notes, it will only be free cash?

<A>: No, we're using $77 million of the cash that is on the balance sheet at the end of the first quarter.

<Q>: Correct. But going forward, are you seeing – what I'm getting at, are you – what's your target cash balance kind of the now that you are considering the accelerated de novo strategy?

<A>: Yeah, I got you there are couple of other things to keep in mind about the cash that existed at the end of the first quarter. One is that based on the restructuring of our capital structure a very substantial coupon payment was actually dropped in the first week of the second quarter versus the first quarter. So that consumed some of the cash that you saw at the end of the first quarter as well. And we also included in our press release that we had reached a settlement agreement with the State of Delaware regarding a dispute over unclaimed property and that required a cash payment to the State of Delaware that also dropped out of that cash in the first week of April. We now have excess cash that existed at the end of the first quarter was perhaps not as large as you might otherwise discern.

On a go forward basis we continue to believe that the amount of cash that's kind of tracking in the system at any point in time. Is probably $25 million to $30 million and then depending on what we're seeing down the road in terms of immediate other cash needs could be knowing that a bed expansion is coming online and – we have required payment there or if know that we're getting

close to the point where we need to make a halfway related to some of the de novos we might hold a little bit more. But I think I am balancing not of cash that we think would we require to retain on the balance sheet is somewhere between a low of 30 and high of 50.

<Q>: Okay, that's fair. And then one quick housekeeping question for you. Going forward modeling bad debt expense should we, is it safe to use that as a go forward run rate what we saw this year as a percentage of revenue?

<A>: No, we've actually included that in our guidance slide just as well at the outset of the year. We've suggested that based on two factors one is the pool of prior period recoveries available to us was diminishing and second that we were starting to see already early in the first quarter when we had our last call the resumption of medical necessity claims reviews we had anticipated that for 2011 we'd see bad debt that lies in 1.5% range. In the first quarter and although we did see the ramp-up in the reviews we saw more recoveries than we had anticipated and that put us down to 1%. Factoring that in we've now lowered our expectation for 2011 from 1.5 to 1.4%. It's a volatile number. It's kind of hard to predict. But that's what we're suggesting you should use as a modeling assumption.

<Q>: Excellent, thanks so much guys.

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

Operator, Brandy, that will be our last call. I have some concluding comments. As a reminder we will be attending the Bank of America Merrill Lynch Healthcare Conference in Las Vegas on May 10th and 11th. If you have additional questions we will be available to talk to later today. Please call me at 205-969-6175. Thank you.

Jay Grinney, President and Chief Executive Officer

Thanks, everyone.

Operator: This concludes today's HealthSouth's first quarter 2011 earnings conference call. You may now disconnect.