Operator: Good morning, everyone, and welcome to the HealthSouth Second 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, Chief Investor Relations Officer

Thank you, Melissa, and good morning, everyone. Thank you for joining us today for the HealthSouth second 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 and General Counsel and Secretary, Andy Price, Senior Vice President and Chief Accounting Officer and Ed Fay, Senior Vice President and Treasurer and last Julie Duck, Vice President of Financial Operations.

Before we begin, if you do not already have a copy the press release, financial statement, and 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 risks, uncertainties and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates and expectations are discussed in the company's Form 10-Q for the second quarter of 2011, which will be filed next week, and its previously filed Form 10-Q for first year Form 10-K for the year end 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.

Most of you know that the operating sales for our LTCHs has been moved to discontinued operations. In an effort to assist you in recapturing your model we provided a number of slides in appendix of the supplemental slides we had quarterly reclassified numbers for 2010. In addition we will be providing you 2009 quarterly reclassified numbers we filed and release the second quarter 2011 investor reference book in mid August.

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. We are pleased to report the results of another excellent quarter and believe the value of our business model was again evident as net operating revenues increased 8.1% driven by solid discharge growth of 6.1% and an increase in net revenue per discharge of

2.6%, while adjusted EBITDA from 14.8% compared to the second quarter of 2010. Discharge trends were good across all regions and our quality and outcome measures remain strong.

Not only did our hospitals treat more patients and enhance outcomes they did so in a highly cost effective manner. As salaries, wages and benefits as a percent of net operating revenues declined 60 basis points over the second quarter of last year, while hospital related expenses as a percent of net operating revenues decline by 40 basis points. Importantly the company continued to generate strong cash flow. Our adjusted free cash flow for the quarter was $63.5 million and this compares favorably to adjusted free cash flow of $52.6 million during the second quarter of last year.

Finally, recognizing there was a total of $0.33 per share of non-recurring and tax related items that negatively impacted our results compared to last year our earnings per share was $0.14 for the quarter compared to $0.40 per share last year.

We also strengthened our balance sheet in the quarter by calling $335 million of our ten and three quarter percent senior notes leaving an outstanding principle balance of $164 million which we intend to call in the third quarter using a combination of the proceeds from the sale of the five LTCHs, cash on hand and some revolver capacity.

The final repayment of these bonds will achieve our goal of eliminating this high cost debt, a strategy that was initiated a little over a year ago by Doug Coltharp and if they and should bring our leverage ratio to three times by the end of the year significantly ahead of schedule.

In addition to these strong operational and financial results, we also announced two development projects in the quarter. First was the announcement that we received final approval for a new 40-bed hospital Ocala, Florida. This project began in 2008 but had been mired in the CON review and appeals process for the past two years. We will begin construction in the fourth quarter and are targeting a Q4 2012 opening.

The second was the announcement of our intent to purchase substantially all of Drake centers inpatient rehabilitation assets in Cincinnati, Ohio. This 38-bed hospital will be our first hospital in Ohio, and once some necessary renovations are completed we expect to admit patients in the fourth quarter of this year.

With that summary of the quarter's highlights we are going to ask Doug to provide a more thorough review of the quarter's results.

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

Thank you, Jay and good morning everyone. I will provide some additional color on our operating performance for the second quarter and also discuss our continuing enhancements to the capital structure.

I'll remind everyone that during the quarter we entered into an agreement to sell our LTCHs to LifeCare. Although this transaction will close in the third quarter for financial reporting purposes, the LTCHs moved to discontinued operations in the second quarter. And this change in retroactive for 2011 and prior periods.

As such the results I'll discuss on the call exclude the LTCHs for all periods. As Jay summarized, we had another very solid quarter. Our consolidated net operating revenues grew by 8.1% over the second quarter of 2010, driven by an 8.8% increase in inpatient revenue. The growth in the inpatient revenue resulted from volume and pricing improvements.

Discharges grew by 6.1% with 3.5% in same-store growth and the balance contributed from our hospitals opened to required subsequent to June 30, 2010. Revenue per discharge for the quarter was up 2.6% primarily attributable to an approximately 2.1% increase to our Medicare reimbursement rates which became effective October 1, 2010. And an approximately 3.5% increase in our managed care pricing.

Outpatient and other revenue for the quarter was flat on a dollar basis, compared to Q2 2010. Within this line item, outpatient revenue declined due to the operation of fewer units, we operate in 29 outpatient satellite clinics at the end of the second quarter of 2011 versus 38 at the end of the second quarter 2010. As well as the impact of the 25% rate reduction for reimbursement of therapy expenses for multiple therapy services, which we had previously estimated as a $1.4 million annual reduction to outpatient revenue. Decline in outpatient revenue for the quarter was offset by the inclusion of $1.9 million of state provider tax revenue. The rate of decline of our outpatient business continues to slow as we have successfully closed our most unproductive units. We continue to demonstrate appropriate expense discipline and realize operating leverage in each of our significant categories for the quarter.

SWB for Q2 was 47.8% of net operating revenues, a 60 basis point improvement over the same period in the prior year. We continue to rollout our TeamWorks Care Management initiative and at the end of the second quarter at completed implementation in 86 of or hospitals.

This initiative is designed to further enhance the quality of our patient's clinical outcomes as well as there satisfaction with our services and the initial results are encouraging. An important component of this initiative was to design the staffing model for case management that results in an increase in employees in the hospital case management department.

We are also utilizing more registered nurses and certify rehabilitation registered nurses in the prior years. We have encouraged our nursing and therapy associates to heighten their skill sets by seeking additional accreditation. Our company absorbs the cost of this educational programs and rewards the recipients of these accreditation with higher compensation.

We believe the staffing and skill mix changes are both a necessary and worthwhile investment as they further differentiate our service offering. However this initiative will impact our ability to achieve SWB leverage in the second half of 2011. Hospital related expenses for the quarter declined by 40 basis points over the comparable period in 2010 to 23.5% of net operating revenues.

Within this category, bad debt expense for the quarter was 1%, of net revenue versus 1.1% in the second quarter of last year.

Collection activity has been strong and we continue to benefit from the collection of prior period Medicare denials, although the number of claims that have completed the review process continues to decline. Based primarily on the resumption of medical necessity claims reviews we witnessed in the first quarter. We continue to believe it is appropriate to anticipate bad debt expense at approximately 1.5% of revenue in the second half of 2011. Finally, we also experienced operating leverage in our G&A expenses, which excludes stock-based compensation.

G&A for the quarter was 4.4% of net revenues and improvement of 50 basis points over the second quarter of 2010. Our strong operating performance generated adjusted EBITDA of $115.5 million for the second quarter, a 14.8% increase over the prior year period. For the first six months of 2011, adjusted EBITDA was $232.8 million, an increase of 15.5% over the first six months of 2010.

As anticipated, interest expense for the quarter increased by $4.8 million from the second quarter of 2010, to $34.9 million. Interest expense for the first half of 2011 was $70 million, as compared to $60.6 million in the first half of 2010. As I will discuss in a few moments, we now expect to complete the payoff of the 10.75% senior notes during Q3. And as a result, we expect second half interest expense to approximate $52 million and the interest expense in Q4 which will fully reflect the complete payoff of the 10.75% notes to approximate $24 million.

EPS remains a bit of a uncomplicated story. Please recall the beginning of this year the release that was substantial portion of the valuation allowance against our deferred tax assets and its corresponding impact on

the reported tax provision expense led us to discontinue our use of an adjusted EPS measure and to focus on GAAP EPS.

During the second quarter our income from continuing operations attributable to HealthSouth per share included a number of non-recurring and tax related items that in aggregate decreased our earnings by $0.33 per share as compared to the second quarter in 2010. These specific items are detailed in our press release as well as in the supplemental slides and they include a $26.1 million or $0.28 per share pre-tax loss on early extinguishment of debt related to our call of $335 million of the 10.75% senior notes in June.

A $12.5 million or $0.13 per share increase in income tax expense in the second quarter of 2011 compared to the same period of 2010 resulting from the Q4 2010 valuation allowance reversal I mentioned just a moment ago. A $10.6 million or $0.11 per share pre-tax gain related to a recovery from a former disloyal employee and a $2.7 million or $0.03 per share pre-tax increase and professional fees due primarily to our obligation to pay 35% of the aforementioned recovery to attorneys for the derivative shareholder plaintiffs.

After giving effect to these items, income from continuing operations attributable to HealthSouth per share for Q2 2011 was $0.14 per share as compared to $0.40 per share in the same period of 2010. Our basic and diluted earnings per share were the same for both periods.

EPS will be impacted in the second half of 2011 by the estimated $13 million pre-tax loss on extinguishment of debt we will incur with the anticipated call of the remaining 10.75% senior notes. As Jay mentioned we continue to generate significant adjusted free cash flow. As a reminder in our definition of adjusted free cash flow we add back the cash premium paid on the early retirement of debt.

For the six months ended June 30, 2011 we generated $111.7 million in adjusted free cash flow as compared to $98.3 million in the same period last year. Adjusted free cash flow in 2011 has benefited from increases in adjusted EBITDA and the expiration of interest rate swaps in March of this year. These improvements have been partially offset by anticipated increases in maintenance CapEx and interest expense. Maintenance CapEx for the first six months of 2011 $22.3 million, an increase of $9.5 million largely attributable to two significant hospital refurbishment projects. As we had previously suggested based primarily on the impact of these projects we expect maintenance CapEx for all of 2011 to approximate $60 million. During the second quarter we also entered into a contract with Cerner for the system wide implementation of a new clinical information system. This decision follows the successful piloting of the system in our Northern Virginia hospital. We have worked closely with Cerner to design a system that will digitize patient care and improve efficiency within our hospitals.

The rollout of this system across our hospitals will begin in 2012 and extend over approximately five years. The installation will be a component of our maintenance CapEx. The installation cost will vary some by hospital depending on items such as the size and physical plan and are expected to be in a range of $1 million to $1.5 million for hospital with approximately 75% of the initial spend being CapEx and the balance being expense. Accordingly we anticipate maintenance CapEx of approximately $75 million in 2012.

Turning to the balance sheet as Jay mentioned we are nearing the completion of the capital structure enhancement strategy we first discussed with you in the second quarter of last year and which we being implementing last fall. As we approach the closing of our LTCHs sale we expect to proceed with the call on the remaining 10.75% senior notes. Once completed we anticipate an annual cash interest expense run rate that will be approximately $22.4 million lower than the annualized run rate that existed in the first half of 2010 which was before we began the implementation of this strategy.

Combining this with the after mentioned expiration of the interest rate swaps we will create an annual adjusted free cash flow run rate that will be nearly $70 million higher than the annualized run rate that existed in the first half of 2010.

As a result of these actions, we anticipate that we will achieve our target leverage ratio of three times during 2011, and will haven't placed a debt capital structure characterized by manageable well spaced debt

maturities with no significant maturities until 2016, significant unfunded availability under our revolving credit facility, limited exposure to rising interest rates, limited principal amortization requirements, numerous debt repayment options and flexible covenants. We believe this capital structure will service well, as we continue to navigate in uncertain regulatory and economic environment.

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

Jay Grinney, President and Chief Executive Officer

Great, thanks Doug. Before we take questions, I would like to discuss two topics, our accelerated de novo strategy and our updated full year guidance. While I outlined the rationale for our de novo strategy on our last call, I'd like to reiterate several key underlying factors that helped to shape this approach.

The first is, we like the business we're in. We're the industry leader of an attractive segment of the healthcare continuum with a proven track record of providing high quality cost effective care. We believe the inherent demand for inpatient rehabilitation services will continue to grow due to the ageing of the population and the relatively non-discretionary nature of the underlying conditions we treat. Furthermore, we believe our scale will allow us to add new hospitals in a highly efficient manner.

The second is our belief healthcare will continue to face uncertain reimbursement and regulatory headwinds for the foreseeable future and that in this kind of environment successful healthcare companies will be those who have strong balance sheets that can accommodate additional pricing pressures, nimble gross strategies that can be funded without additional leverage and the track record of differentiated high quality cost effective care provided through a variety of market cycles and conditions.

The third factor is the absence of any near term structural industry catalyst that would motivate us to move into adjacent post-acute services. Beginning last year a tremendous amount of speculation circulated around accountable care organizations and how they were going to transform the $2.5 trillion highly fragmented healthcare industry into a series of risk taking economically integrated providers focused on chronic care and prevention.

Then came the proposed ACO rules and the realization that the industry's transformation will be evolutionary, not revolutionary, in nature. Finally by pursuing growth in our core inpatient rehabilitation business we can capitalize on our track record by achieving solid turns from investing in de novos and can avoid two significant risks associated with buying non-core businesses.

Risks that are amplified during times of uncertainty. First we avoid buying businesses that face known regulatory changes at prices that don't reflect those changes. And second we avoid assuming integration risks that are attended to non-core acquisitions.

These underlying assumptions in volume we concluded an accelerated de novos strategy with an effective way to create a return on the cash we're generating. Based on our analysis of growth opportunities and both existing and new markets we believe we can open three possibly four hospitals in 2012 and are targeting to open at least four new hospitals in 2013, '14, and '15. Opening the fourth hospital in 2012 is dependent of securing a final parcel of land in time to begin construction by the fourth quarter of this year.

The number of hospitals we can open in the out years will be dependent of securing final certificates of need for de novos in CON states. Finally to the extent possible we will attempt to balance our risk by opening some of these new hospitals and new markets and other in existing markets. Each de novo will be approximately 40 to 50 beds with all private rooms and will cost approximately $20 million to $25 million to build and equip inclusive of land, IT for our new clinical information system and working capital requirements.

In most institutes we will purchase enough land to support future expansions. Each de novo incurs between $350,000 to $500,000 of pre-opening cost most of which is expensed in the 90 days immediately preceding opening. Based on the success of our most recent de novos sustained positive facility EBITDA occurs within three to nine months.

While company average EBITDA margins are achieved by the end of the first full year of operations. The incremental G&A required to support this role is expected to be approximately $2.3 million in 2012 ramping up to approximately $3.6 in 2014. The additional cost will be for a new operating region the staff of which will be based in Birmingham and additional accounting, IT and human resources support.

We are targeting all de novos to achieve or exceed certain return thresholds including a minimum internal rate of return of 15%. It's important to note we will be able to finance this growth exclusively from expected free cash flow and if needed by occasionally tapping into our revolver capacity.

One of the principle advantages of this strategy is that we're not putting the company's balance sheet at risk. If the industry headwinds become too stiff we can shutdown the de novo pipeline complete those that are under construction and redirect our free cash flow to repaying our long-term debt. Alternatively if regulatory clarity is evident in compelling post-acute opportunities present themselves, we'll be in a position to pursue these opportunities with an unencumbered balance sheet.

As we said in May I think it's even more true today. This approach is a prudent way to manage the company during a time of reimbursement uncertainty while positioning it to take advantage of future growth opportunities once the industry risks are clarified or removed. With respect to guidance, we're increasing our adjusted EBITDA based on our strong year-to-date results and are revising our EPS guidance to reflect the planned repayment of our 10.75 senior notes.

Adjusted EBITDA is projected to be in the range of $447 million to $453 million and is based on the following second half assumptions. Discharge growth between 2.5% to 3.5% which would bring full year discharge growth to between 4.7% and 5.2%. As a reminder fourth quarter volumes are difficult to predict because of the year-end holiday season.

Furthermore volumes grew by 5.9% in the fourth quarter of last year aided by newly opened and acquired hospitals which creates some challenging second half comps. We expect pricing growth of approximately 3% on a per discharge basis. This assumes an increase of approximately 2% to our inpatient Medicare reimbursement effective October 1st, with no significant change to our managed care pricing before the new year.

On the expense side, we're projecting salaries, wages and benefits as a percent of net operating revenues to be in the range of 49% to 50% due to seasonality of second half volumes, the additional personnel to support our Care Management initiative that Doug mentioned and merit increases for all non-senior management employees between 2% and 2.25% effective October 1st. We expect bad debt expense as a percent of net operating revenues will be approximately 1.5%.

On a full year basis, $447 million reflects a solid 9.1 increase over last year's adjusted EBITDA, while $453 million translates into an impressive 10.6% growth over prior year. With the complete retirement of our 10.75 senior notes and the resulting charges for the early extinguishment of this debt, our new earnings per share guidance has been revised to $1.17 to the $1.22 per share.

As a reminder, and as Doug mentioned, our second half interest expense is expected to be $18 million less than our first half interest expense. So, I know we've taken a lot of time with our comments, but we wanted to be sterile as possible in discussing our results, de novo strategy and the basis for our updated guidance.

With that, we'll now take questions.

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] Your first question comes from Frank Morgan of RBC Capital Markets.

Your next question comes from Paxton Scott of Jefferies & Company.

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

<Q – Paxton Scott>: Hey, good morning Jay. How are you?

<A – Jay Grinney>: Good morning.

<Q – Paxton Scott>: Thanks for taking the questions. I understand your comments there towards the end on the 2.5% to 3.5% for the back year given the more difficult comps, but I'm just curious as we are thinking about this accelerated de novo strategy. And obviously with the elimination of the LTCHs that should, that's obviously going to boost your discharge growth as those were slight drag. As we think kind of 2012, 2013 I mean should we think about that 2.5%, 3.5% accelerating slightly?

<A – Jay Grinney>: Well I think it's too early to talk about the out years but clearly we will be revisiting our guidance with respect to volumes and so on when we talk about 2012. So I think that it's premature to talk about them today but I certainly would have you expect us to update and to talk about that as we reviewed 2012 with you in February.

<Q – Paxton Scott>: Okay very good. And then as a follow-up just obviously with everything that's going on in Washington there is a general concern over reimbursement particular on the medicare side and to my knowledge I haven't heard anything mentioned on inpatient rehab facilities but obviously you're a little bit more plugged in then we are what kind of color can you give us in terms of what you're hearing there? Thanks.

<A – Jay Grinney>: I think that everyone would agree that the situation in Washington is chaotic. Having said that, we are not hearing anything in the context of Medicare cuts that would severely impact us. We don't have any effect on reducing graduate medical education payments. We would be affected if the bad debt payments were reduced, but as we look at our portfolio and analyze that, exclusive of LTCH that's maybe a $3 million hit.

And all of the other changes really affect other segments of the industry. So, at this point I think – and certainly what we're avocating is listen, we gave at the office last year. I mean hospitals agreed when – I don't know agree is maybe not the right term, but we certainly received a haircut on future payments for the next 10 years. And I think what we're starting to see as the public company start to report and you start seeing the effect of the Medicare pricing reductions, if that's happening in the publicly traded high performance hospitals imagine what's happening in the 85% of the rest of the market that are not for profits and don't have the same cost structure.

So, I think that there is a realization out there that hospitals have already given at the office and already have sacrificed future payment cuts for 10 years. And I don't anticipate that there will be more, but there is always that risk. I mean, I think we're in uncharted territory. So, we have to be careful, we have to be prudent, we have to be managing this company. So that it can deal with what ever comes down the pipe.

And frankly, we're one of the few providers that's been able to demonstrate that even in an environment of loss and no increase, back in 2009 and 2010, we grew. So that's long winded answering but obviously we're spending a lot of time on it, and it's a major focus.

The other thing on the volume side pack and that Doug is going to mention is, we're not going to see any of the value of these de novos in '12. Because most of them, in fact all of them are going to be opening in the fourth quarter and its just a timing issue takes about a year to build them, we're in the process of securing land today. We've got to make sure that we got it permitted and etcetera. So, if we start in the third quarter of this year with these projects and we should be opening them then in the third or fourth quarter of next year.

So won't have an impact next year that's not to say we're not going to be looking at the kind of guidance that we give on volume, but it certainly is going to have a nice impact in '13 and beyond.

<Q – Paxton Scott>: Okay that's great. And then have you completed your analysis of your potential markets that you're going to be rolling these de novos or you still in preliminary phase of that?

<A -- Jay Grinney>: Two identified markets and we're buying land as we speak.

<Q – Paxton Scott>: Okay, perfect. Thank you very much.

Operator: Your next question comes from Colleen Lang of Lazard Capital.

<A -- Jay Grinney>: Hello Colleen.

<Q – Colleen Lang>: Hi, good morning Jay. Just a quick follow-up on the IRF de novo strategy, how many of the markets that your looking at right now are CON states versus non-CON states just given the timing differences and getting step up and running?

<A -- Jay Grinney>: It's about half and half.

<Q – Colleen Lang>: Okay.

<A -- Jay Grinney>: In several of those certificate of need states we've already filed a CON.

<Q – Colleen Lang>: Okay, great. And can you talk a little bit about the mix of volumes in the quarter and any areas where you saw stronger, weaker than expected growth?

<A -- Jay Grinney>: Certainly from a geographic standpoint, it was pretty evenly distributed. We saw a nice growth across all of the regions with respect to the program mix I'm going to ask Mark to give a little color commentary on that.

<A – Mark Tarr>: Yeah, the biggest shift we saw on our program mix was shifting out of orthopedic specifically the lower extremity joint replacement. We saw a drop of about 1% in that to an all-time low of 8.7% of our total patient mix and an increase in our neurological conditions and we saw an increase of that about 1%. So, what we lost out of the joint replacements were increased in the neurological conditions.

<Q – Colleen Lang>: Okay. And then just a quick one for Doug, do you expect to see a similar benefit on the outpatient side for provider taxes, some provider taxes in the second half of the year?

<A – Doug Coltharp>: No, we don't it's a little bit lumpy and it's getting harder to obtain as you can imagine because it is impacted by some of the battles and the squeezes that are happening in state budgets. So, it's hard to predict, but I would not assume that there is any contribution for provider tax in the second half.

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

<Q – Darren Lehrich>: Thanks.

<A – Jay Grinney>: Hi, Darren.

<Q – Darren Lehrich>: Good morning everybody. I guess I just want to first say Doug I know you guys did a great job with the balance sheet, so it's just a great result. I wanted to ask just about big change in Q2 just from a regulatory perspective in the post-acute sector was this, face-to-face change for home health and I know you have a very small exposure in home health at this point, but I guess the question really is, Mark was there anything that you saw in terms of benefit? Did referral sources ditch the lower acuity home health setting in favor of your setting, because of the hassle of face-to-face and then specifically within your home health business, can you just talk to the trends there?

<A – Mark Tarr>: Darren I can't say that we saw a big impact from that. I will say that the fact that the vast majority of the patients that go into our home health are conversions from our inpatient rehab side of the business. The whole face-to-face physician requirement really did not impact us at all, because our patients would have recently seen a doctor as they were in our inpatient rehab hospitals. So, I don't want to say that we saw a big impact from a shift from outside referral sources is just the comment that I make on that just a whole face to face requirement really did not impact us at all.

<Q – Darren Lehrich>: Okay. And then Jay, a sort of related question, but usually we get an update on the arbitration. It's been sort of quiet there. Can you just provide us with anything in terms of the activity levels to the extent you can? Thanks.

<A – Jay Grinney>: Yeah, Darren that was an oversight on my part, in part because of just grinding on, but really no change from what we talked about last week or last call there have been sessions that have been held. The arbitration is grinding on and there is really no change in our forecast that this is going to be a first half 2012 event that gets resolved there unless E&Y is willing to come to the table to settle ahead of time and I don't expect that I think that E&Y is highly sensitivize to drag this out, drag this out, drag this out the arbitrators have to give both sides as much leave way and as much time to present their case. We're always available to meet that's not always the case on the other side. So I hate to say this but it's the same old same old.

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

<Q – Sheryl Skolnick>: Good morning everyone. Jay I want to complement you on the transparency that you've given us on so many points not just the capital structure plans put kudos again to Doug but also on the disclosure the timing disclosure of that OIG issued down in Houston and the handling of that, but also on your explanation for why you're expanding your de novo strategy which is where my question actually is. As you look at the timing and the pacing of this rollout of the strategy the first question is when should we as we model this when should we think about the cost beginning to ramp up I assume the answer of that's going to be third quarter but if you can help us think about when we see cost you've already helped us think about when we're going to see volumes and revenue but when we're going to see these costs that would be very helpful the other related issue is, if you could give us a sense of how many markets you're actually looking at, and characterize them by these would have been primary markets under the strategy before you've expanded it and maybe perhaps now to more secondary or markets where you've talked about last quarter considering going into markets that perhaps have either less dense population or smaller markets etcetera. If you could characterize that pipeline for us, I would appreciate it?

<A – Jay Grinney>: Sure, in terms of the expense, if you're looking at it from an income statement, the cost will – there will be a modest increase in the fourth quarter of this year as we assemble a new regional office. And we've got the space here, but we'll be recruiting regional leadership. And again that leadership is comprised of a Regional President, Regional Controller and a Regional Head of our Marketing, and then of our Human Resources.

So, it's not a huge staff, we're getting a lot of support then from the corporate folks and again we've got the office already identified it will be up here with the other Birmingham based folks. So there will be a modest increase there from a capital standpoint, the hospitals will begin construction in the fourth quarter and the spend that $15 million to $20 million spend there will be obviously some upfront as we buy the land and then the spend will sort of ramp up into 2012 and really start to accelerate in the second half as we bring these

hospitals to completion. In terms of the characteristics of the market, what we did is we went back and we essentially looked at four things and one was kind of a new way of looking at the market but they included population size and then the underlying growth of the over 65 segment of the population. And we're still pretty consistent on the size of the market.

I will say that based on our experience and the success with the TeamWorks sales and marketing the size of the market is actually increasing instead of looking at a tight cluster of zip codes we're looking at a broader range of zip codes from which we would be able to potentially attract patients.

Second thing that we look at is the number of possible admissions that might qualify or would qualify for an admission into a rehabilitation hospital and the conversion of those into existing rehabilitation facilities. Third thing that we look at is what is that base of existing rehabilitation providers, how much market share are they getting and to what extent are they matching the kind of conversion that we're seeing. And then the last thing that we look at is what kind of conversion rates in that population of potential rehabilitation admissions, how many of those are going to skilled nursing facilities.

So, those are the four key components I mean there are other things that we look at cost of land frankly we are not interested in jumping into a highly unionized environment but we are looking at all those things and I think that the difference today is not so much the size of the market as it is the market dynamics specifically how many patients are being currently converted into a rehabilitation admission and how many are going into a skilled nursing environment where clearly the level of services is much less the quality is not as good and we believe, just as we saw in Northern Virginia, an opportunity to bring a higher level of care presents itself and that's how we are looking at these markets.

<Q – Sheryl Skolnick>: It's very helpful and this is actually a question for Doug. I have to pick a nit here I'm having some difficulties following your calculations for adjusted free cash flow I mean I get the fact that you're going to subtract somethings and add somethings back, but I guess I'll ask the question this way since I can't spend and add back and I don't know too many people who can. On what point should we begin to see tradeoff cash flow from operations as presented on the GAAP financial statements. Year-over-year comparisons been positive?

<A – Doug Coltharp>: I think you're going to see if this is the answer to the question I think you're going to see virtually all the noise removed by the end of 2011.

<Q – Sheryl Skolnick>: Okay.

<A – Doug Coltharp>: Kind of a lot of the stuff that certainly the very substantial loss on extinguishment that we've had we're about to recognize the last piece of that with the removal of the residual ten and three quarters. And I think some of the other things that have created noise, it created gap between those two measures will be eliminated by the time we exit this year.

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

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

<Q – John Ransom>: Good morning. I was going to ask, if Doug is going to be bored now and how does the capital structure stand, how is going to be this time. It looks like it, is it going to be – is your capital structure pretty stable from here or there any other changes you're thinking about?

<A – Doug Coltharp>: I think its going to be pretty stable.

<Q – John Ransom>: So what you're going to do with yourself?

<A – Doug Coltharp>: Jay & I talked yesterday about the fact that, I hope to start a disposable position.

<A – Jay Grinney>: Definitely not. One of the things John that was really an opportunity for us when John Workman left and went up to Omnicare great opportunity for him up there and obviously, everybody seen what he and John Figueroa has done. The opportunity for us to really focus on growing the business has been something that we look forward to, we now have a balance sheet that is in good shape and Doug's expertise and background really land itself perfectly to focusing on growth in the company.

I think that that he will be very busy and we're really pleased that he is on board, has brought a lot of value in a very short period of time to this company.

<Q – John Ransom>: I was kidding. Can you remind me, how much pro forma, how much capacity will you have on the year bank revolver, once all the moving part should on?

<A – Jay Grinney>: Say that one more time.

<Q – John Ransom>: How much capacity will you have on your bank revolver once all the pieces are put in place, what do you anticipate that look like when all of a sudden that?

<A – Jay Grinney>: To give -- Doug something to do, I'll ask him to respond to the question.

<Q – John Ransom>: Okay.

<A – Doug Coltharp>: About $300 million.

<Q – John Ransom>: Okay. And you like to keep about that amount available do you not for – isn't that your rules kind of...

<A – Doug Coltharp>: Our general rule of thumb is always to keep at least $250 million in unfunded capacity and actually I think I was probably even conservative with that $300 million, because I would actually expect that even after we fund the 10.75 that maybe close to $350 million, so we'll be well within those parameters.

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

<Q – Adam Feinstein>: Hey, hey. So, just maybe just a couple of things here, I guess Jay maybe you can comment on mix a little bit as well, did you guys see any sort of change of mix I'm just curious if we look at some of the main areas how your mix played off for the quarter?

<A – Jay Grinney>: I mean mix or the service mix?

<Q – Adam Feinstein>: The service mix.

<A – Mark Tarr>: Hey, Adam. The service mix as we've seen in past quarters here recently we continue to see the shift away from that orthopedic categories and to the neurologic categories. As I said earlier, this most recent quarter we saw a shift – the larger shift was away from the lower extremity joint replacements where we dropped down to 8.7% of our total cases and saw an increase of about what we lost in the joints, an increase in neurological cases and that continues to be the trend that we've seen really for the last several quarters now.

<Q – Adam Feinstein>: Okay. And then how would you define the competitive landscape these days just with the nursing homes and just continue blurring of the lines here, would you say that things are stable here or what would you say that you think it's more competitive and obviously you guys are showing pretty strong volume growth. So you're clearly taking market share but just curious as you think about just the competitive landscape?

<A – Jay Grinney>: I don't see that the landscape is changing that much. And frankly we don't see a blurring of the distinction between nursing homes and rehabilitation hospitals affect quite the contrary. I think that the

physicians who have to make the ultimate decision where does a patient get discharged once there's no longer an appropriate acute care admission. Our focusing as or the hospital case managers increasingly on what is the best setting for the patient and where is that patient going to get the best quality care.

And clearly there are patients that can go into nursing homes. If they need some sort of low level services and its more convalescent in nature, but if a patient is suffered a stroke they suffered to debilitating neurological condition. They are unable to care for themselves and there is a concern that that patient may not be able to make it up into an independent lifestyle. They are going to admit that patient to a rehabilitation hospital.

So we are actually seeing more physicians, more hospital case managers appreciate and understand the quality differentiation that we provide the better outcomes that we provide and as everybody knows at some point down the road there is going to be in 2013 there will be a focus on acute care readmission rates and some penalties associated with rates that go out of the expected range. So that the lines are actually becoming more distinct and we think that's frankly to our advantage.

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

<Q – Whit Mayo>: I wanted to follow-up on John's question for a second. I mean with the accelerated de novos strategy which you've clearly put a lot of thought into, to me its almost inconceivable how your net debt is not going to go below two times next year with the potential to be even lower, you're going to call bonds, you're selling the LTCHs you get the proceeds there. So I was just wondering as you look out at what leverage ratio do you think is the minimum before you would think about buybacks to augment your capital deployment strategy. Well still maintaining a lot of flexibility to be opportunistic with larger acquisitions if they should present themselves?

<A – Doug Coltharp>: I think your observation is correct that we would expect that based on the free cash flow generating levels of the company. Leverage should continue to go down as we move forward into 2012 in terms of what kind of level we ultimately achieve or feel comfortable with its really going to depend on how the regulatory environment continues to evolve and what kinds of external growth opportunities we are seeing as we stated once we get below three times we're comfortable with the level of leverage particularly given the composition of our debt capital. If we take it down further it could be viewed as temporary as we evaluate those growth opportunities in the emerging regulatory environment.

<Q – Whit Mayo>: Okay. So maybe...

<A – Jay Grinney>: To your point Whit we are going to be evaluating where is the best – what is the best return for our cash and Doug has mentioned before and we've talked about this. We're going to look at a wide range of strategies. So, we don't want to rule out anything and we don't want to put anything on the table, because it will be a function of what's happening in Washington. I mean we're no different than so many other businesses that are waiting to see what kind of clarity is going to be, if any, is going to be created in Washington from a regulatory standpoint. So, we can get on with our business.

<Q – Whit Mayo>: That's helpful. And maybe just one quick last question, Jay in the past you commented you're looking at I think some new supply initiatives, is there anything new there I mean any opportunities on pharmacy that you're seeing?

<A – Jay Grinney>: Most of the initiatives that we have identified we're working, there is nothing that is going to be moving the needle significantly but the supply chain focus has been here for the last couple of years. We've got an outstanding individual running that. We've got an equally outstanding senior executive over that area. And they have been very good at finding savings throughout that entire supply chain and obviously focusing on standardizing our formularies from a drug standpoint and then using our buy to get additional savings.

So, we feel pretty good about that and whatever I may have said in the past should not have been implying that we were waiting and that sort of next in line. That's something that Dave Klementz has been working on for at least the last year and a half, two years.

<A – Doug Coltharp>: These are ongoing initiatives and you don't see pop-up on the radar screen but it doesn't mean that we are not out there looking for opportunities to improve the efficiency. And a great example of one that's been underway in 2011 that's producing some very nice results is on our overall food cost in our facilities.

<A – Jay Grinney>: And that's where you actually see it is in the other operating expense as a percent of net revenue. We continue to see that decline, we continue to get leverage out of that and so while that may not be a headline initiative it certainly something that we take very seriously and that the hospitals also take equally seriously.

Operator: Your next question comes from Kevin Fischbeck of Band of America, Merrill Lynch.

<Q – Kevin Fischbeck>: Good morning. Since you guys had some LTCHs previously I assume you recently up to date on the whole patient as a criteria initiative there now. Theoretically if that was to go into place that would cut LTCH volumes which could be a good thing for them based upon what they will get in return but that volume would have to go somewhere. Have you done any work around what type of volume might shake lose from the LTCHs and that would be meaningful to the, to your industry?

<A – Jay Grinney>: We have they primarily on our knowledge of the kinds of patients that we've been able to treat in our LTCHs and knowing that there are LTCHs out there that frankly trying to attract patients who may not technically qualify for in LTCHs. So do we think that there maybe some upside the answer is yes do we have we quantified what that is the answer is no because I think it's very hard to know with any certainty what the patients criteria is going to look like. So based on what we are seeing there is some drag of the patient criteria. In my opinion that really didn't meet what we believe the intent was I mean it really sort of just kind of codified existing parameters and regulations and they it wasn't if they came up and said all right, these are the kinds of patients as they did in the 75% rule.

These are the patients that you can admit you got to get ex percent and just where you got it. Every patient has to be linked the 25 average they're going to stay at 25 as suppose to all of the population. So the criteria that I saw was pretty mushy and the fact that it hasn't been scored yet, our knowledge suggest that it's going to be hard to get it through. So it needs to be clarify once we do that we'll obviously look and say hey well there are opportunities to bring some of those patients the appropriate for admission into rehabilitation hospitals.

<Q – Kevin Fischbeck>: Okay. And then just following up on one of the points you made earlier about the markets that you look at one of the criteria that you're looking at was conversion of the rehab patient into nursing home. Can you just talk a little bit more about what the opportunity is there would a high conversion rate imply more opportunity if you can take them for nursing home or less opportunity because it's just a lower acuity type rehab patient wasn't sure exactly what the, this is the case?

<A – Jay Grinney>: If the conversion rate is high we see that as a positive because if we believe that if we come into a market and the, and are able to offer a higher level of rehabilitative services that some of those patients who don't have – I mean it's really I believe is that they don't have the option. And so if the option isn't there, they default into a nursing home admission. So, our belief is and what we've seen in every market where we've entered is that the offering that higher level of care is a differentiated service and it's something that physicians, patients and families look for. So, we see that as a positive if the conversion rate is high. It's an opportunity.

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

<Q – A J Rice>: Hi Jay.

<A – Jay Grinney>: Hi.

<Q – A J Rice>: Two questions, I guess. First of all just understanding the IT initiatives with Cerner, if we think about 2012 and 2013, is that reallocating capital dollars towards this or are we going to see a bump up in your capital and trying to think about free cash flow deployment how much do you think that would represent possibly?

<A – Jay Grinney>: It would be a bump up.

<A – Doug Coltharp>: Yeah and as mentioned earlier that we would anticipate, we include that as component of our maintenance CapEx out of the total spend on a per hospital basis, which will vary between $1 million and $1.5 million per hospital for installation cost and the variance in that range really depends on the physical configuration and the size of the hospital.

About 75% of the installation cost will show up as CapEx. The balance is expensed in the period leading up to installation. And we're anticipating this roll out across our existing hospital base will be relatively evenly paced over five years, so you'll have about 20 of those hospitals being converted in a particular year and though we – the maintenance CapEx in 2012 that's about $75 million and we would expect based on the existing composition of our business that it will remain in the $75 million to $80 million level for the years that follow.

<Q – A J Rice>: Okay, that's great. And then just quickly on – I know the focus is on the de novo involved in those out but there is also occasionally an opportunistic outright acquisition. Can you comment? I don't think – I didn't hear you say what the state of play is there in the IRF space. Is there – are you seeing properties in light of all the different things that are going on in the capital markets, etcetera and what are the prospects for doing some deals there?

<A – Jay Grinney>: Really there is not a lot of change in what we said in the past. There are some properties. We just announced the acquisition of Drake, but clearly those are more challenging. They're harder to come by. I suspect that in the future if the Medicare reductions in increases for the acute care hospitals have the effect that I think it's going to have, I think that there are going to be many acute care hospitals looking for cash and certainly to the extent that there that they may be operating a rehab facility that's breaking even or maybe it's costing them some money, and we're in that market and we can acquire and then consolidate that into our existing hospital. We definitely will be pursuing those and are. But it's – there is really no change A J, but I think that it's something that may change based on the financial situation of the acute care hospitals.

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

<Q – Gary Lieberman>: Thanks for taking my question. Maybe you could loan Doug out to Jefferson County you can help them with some of their debt issues?

<A – Jay Grinney>: There is an idea!

<Q – Gary Lieberman>: I know you talked a little bit about the CONs but I guess for the 15 or 16 de novo facilities you have in the pipeline, how many of those require CONs?

<A – Jay Grinney>: About half and half. And as I said many of those CONs have already been filed.

<Q – Gary Lieberman>: Okay. And then I guess to the extent that you don't get all of those CONs for the other half. Is that 15 or 16 assume that there is some higher gross numbers, are you looking at potentially 20 year or plus potential de novos and you assume that 15 or 16 of them get done?

<A – Jay Grinney>: Yeah there is, we're certainly factoring into all the number that we gave some degree of slippage in the ability to get CON approved. So there is some additional markets, additional hospitals that

we're looking at. So, it's fair to say that there is a little bit of excess capacity beyond what we've already talked about.

<Q – Gary Lieberman>: Okay. So we can think about 15 to 16 a sort of a net de novo number?

<A – Jay Grinney>: Yes.

<Q – Gary Lieberman>: Okay. And then it seems like your ability to continue to take market share in the existing markets it almost seems endless. Can you just sort of give us an update there on your comfort with continuing to be able to drive the continued market share gains that you see in those markets?

<A – Jay Grinney>: Yeah, I was thinking about that because I figured somebody would ask that question I was going to ask Mary Ann to go back and see how many quarters we've got that question. And I think it's one that we've received a lot. The underlying demand has some momentum just by virtue of the demographic shift. The aging of the population as we've said in the past, there is maybe 1.5% underlying growth that's occurring simply because population is getting older. But as we look out we still feel comfortable that we are able to continue to take market share. We think that the services that we offer truly do differentiate us. We think that the shifting focus on quality and outcomes and readmission rates will play into our strong suit. So yeah we still think that our ability to grow organically can continue for the foreseeable future.

Operator: Your final question comes from John Ransom of Raymond James.

<Q – John Ransom>: Hi. Just a quick follow-up. Let's say that our brilliant politicians retroactively give you a rate for you in the effort to fund some money. Is there anything you could do to offset or that have to dealt with your next set of merit increases?

<A – Jay Grinney>: Yeah. There are clearly would have an impact on our merit increases. There is no question on that.

<Q – John Ransom>: But you've already given that, would you take it back or would you look at it for the next year?

<A – Jay Grinney>: We wouldn't take it back, I can't see doing that.

<Q – John Ransom>: Yeah.

<A – Jay Grinney>: I really think it happens. That would be very, very high. I think clearly the senior management levels would, we would be able to do a lot more flexible there but that's not going to move the needle.

<Q – John Ransom>: Yeah. So, we should think about that it probably rippled straight on your EBITDA than in the short term, if that would occur?

<A – Jay Grinney>: Yeah, possibly but if that would occur, I would suspect that the effect on some of our competitors would be even more pronounced.

<Q – John Ransom>: Right.

<A – Jay Grinney>: At least we've got some flexibility and I think in that kind of situation we would obviously drive for stronger volume growth.

<Q – John Ransom>: Okay. And then my other question is there a practical or structural limit to what E&Y can do to drag this thing out?

<A – Jay Grinney>: I don't there is anything structurally. I certainly don't think that this is going to be quite done indefinitely. We're further along that we were three months ago not by much, but we're further along and I think that the first half of '12 is still an appropriate range to be thinking about at least concluding the proceedings. Now, the arbitrators are going to have to take all this and review it and make an ultimate decision and how long that will take is not clear.

<Q – John Ransom>: All right. So let's just say the arbitrators, you conclude this the arbitrators come back in June of 2012, and say, okay, why don't you have $100, yeah, obviously $100 is a funny number, but what can they do then to say well, we need to meet in the fourth quarter of 2048 and figure it out and we get back to you sometime in the 28th century. I mean does the clock tick? Can they then pushed out of another year and hem & haul and appeal and anything like that or is there some where they have to come out with the money within a certain amount of time?

<A – Jay Grinney>: I let John Whittington to respond, because otherwise I might get in trouble.

<Q – John Ransom>: Okay. Thanks.

<A>: John, generally in an arbitration you forfeit your appellate rights. They are limited very, very limited appellate rights and arbitration.

<Q – John Ransom>: Okay.

<A – John Whittington>: And in general what will is that if there is a verdict it has to be compiled with in 30 days after the entry of the verdict.

<Q – John Ransom>: 30 days. Okay, great. That's perfect. Thank you.

Operator: At this time there are no further questions. I'll now turn the call back to Mary Ann Arico for closing remarks.

Mary Ann Arico, Chief Investor Relations Officer

Yes. As a reminder we will be attending two conferences in September the Baird and the Morgan Stanley Healthcare Conference in New York. If you have additional questions feel free to call me later at 205-969-6175. Thank you.

Jay Grinney, President and Chief Executive Officer

Thanks, everyone.

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