U S PHYSICAL THERAPY INC /NV
Form 10-K
March 10, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE TRANSITION PERIOD FROM TO

COMMISSION FILE NUMBER 1-11151

U.S. PHYSICAL THERAPY, INC.
(EXACT NAME OF REGISTRANT AS SPECIFIED IN ITS CHARTER)

NEVADA	**76-0364866**
(STATE OR OTHER JURISDICTION OF INCORPORATION OR ORGANIZATION)	*(I.R.S. EMPLOYER IDENTIFICATION NO.)*
1300 WEST SAM HOUSTON PARKWAY SOUTH, SUITE 300, HOUSTON, TEXAS	**77042**
(ADDRESS OF PRINCIPAL EXECUTIVE OFFICES)	*(ZIP CODE)*

REGISTRANT S TELEPHONE NUMBER, INCLUDING AREA CODE:
(713) 297-7000

SECURITIES REGISTERED PURSUANT TO SECTION 12(b) OF THE EXCHANGE ACT:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $.01 par value	**The Nasdaq Stock Market LLC**

SECURITIES REGISTERED PURSUANT TO SECTION 12(g) OF THE EXCHANGE ACT: none

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes o No þ

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. þ

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o	Accelerated filer þ	Non-accelerated filer o	Smaller reporting company o

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No þ

The aggregate market value of the shares of the registrant s common stock held by non-affiliates of the registrant at June 30, 2010 was $149,121,600 based on the closing sale price reported on the Nasdaq Global Select Market for the registrant s common stock on June 30, 2010, the last business day of the registrant s most recently completed second fiscal quarter. For purposes of this computation, all executive officers, directors and 5% or greater beneficial owners of the registrant were deemed to be affiliates. Such determination should not be deemed an admission that such executive officers, directors and beneficial owners are, in fact, affiliates of the registrant.

As of March 9, 2011, the number of shares outstanding of the registrant s common stock, par value $.01 per share, was: 11,788,846.

DOCUMENTS INCORPORATED BY REFERENCE

DOCUMENT	PART OF FORM 10-K
Portions of Definitive Proxy Statement for the 2011 Annual Meeting of Shareholders	PART III

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FORWARD LOOKING STATEMENTS

We make statements in this report that are considered to be forward-looking statements within the meaning under Section 21E of the Securities Exchange Act of 1934. These statements contain forward-looking information relating to the financial condition, results of operations, plans, objectives, future performance and business of our Company. These statements (often using words such as believes , expects , intends , plans , appear , should and similar wor involve risks and uncertainties that could cause actual results to differ materially from those we project. Included among such statements are those relating to opening new clinics, availability of personnel and the reimbursement environment. The forward-looking statements are based on our current views and assumptions and actual results could differ materially from those anticipated in such forward-looking statements as a result of certain risks, uncertainties, and factors, which include, but are not limited to:

- changes in Medicare guidelines and reimbursement or failure of our clinics to maintain their Medicare certification status;
- revenue and earnings expectations;
- general economic conditions;
- business and regulatory conditions including federal and state regulations;
- changes as the result of government enacted national healthcare reform;
- availability and cost of qualified physical therapists;
- personnel productivity;
- competitive, economic or reimbursement conditions in our markets which may require us to reorganize or close certain clinics and thereby incur losses and/or closure costs including the possible write-down or write-off of goodwill and other intangible assets;
- changes in reimbursement rates or payment methods from third party payors including government agencies and deductibles and co-pays owed by patients;
- maintaining adequate internal controls;
- availability, terms, and use of capital;
- acquisitions and the successful integration of the operations of the acquired businesses; and
- weather and other seasonal factors.

Many factors are beyond our control. Given these uncertainties, you should not place undue reliance on our forward-looking statements. Please see the other sections of this report and our other periodic reports filed with the Securities and Exchange Commission (the SEC) for more information on these factors. Our forward-looking statements represent our estimates and assumptions only as of the date of this report. Except as required by law, we are under no obligation to update any forward-looking statement, regardless of the reason the statement is no longer accurate.

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PART I

ITEM 1. *BUSINESS.*

GENERAL

Our company, U.S. Physical Therapy, Inc. (the Company), through its subsidiaries, operates outpatient physical therapy clinics that provide pre- and post-operative care and treatment for orthopedic-related disorders, sports-related injuries, preventative care, rehabilitation of injured workers and neurological-related injuries. We also provide physician services to third parties and operate two clinics which specialize in the outpatient, non-surgical treatment of osteo arthritis degenerative joint disease and other musculoskeletal conditions. We primarily operate through subsidiary clinic partnerships in which we generally own a 1% general partnership interest and a 64% limited partnership interest and the managing therapist(s) of the clinics owns the remaining limited partnership interest in the majority of the clinics (hereinafter referred to as Clinic Partnerships). To a lesser extent, we operate some clinics through wholly-owned subsidiaries under profit sharing arrangements with therapists (hereinafter referred to as Wholly-Owned Facilities). Unless the context otherwise requires, references in this Annual Report on Form 10-K to we , our or us includes the Company and all of its subsidiaries.

Our strategy is to develop and acquire outpatient clinics on a national basis. At December 31, 2010, we operated 392 outpatient physical therapy clinics in 42 states. The average age of the 392 clinics in operation at December 31, 2010 was 7.5 years. There were 292 clinics operated under Clinic Partnerships and 100 were operated as Wholly-Owned Facilities. Of the 392 clinics, we developed 287 and acquired 105. During 2010, we opened 19 clinics, acquired 25, closed 15 and sold 5. Our highest concentration of clinics are in the following states Tennessee, Texas, Michigan, Georgia, Maryland, New Jersey, Wisconsin, Oklahoma, Virginia, Florida, and Indiana. In addition to our 392 clinics, at December 31, 2010, we also managed 15 physical therapy practices for third parties, including physicians.

During 2010, we acquired a majority interest in 25 clinics in three separate transactions. On February 26, 2010, we acquired a 70% interest in five clinics in the northeast (Northeast Acquisition). On December 21, 2010, we acquired a 70% interest in a six clinic physical therapy group in the mid-Atlantic region (Mid-Atlantic Acquisition). On December 31, 2010, we acquired a 65% interest in a 14 clinic physical therapy group located in the southeast (Southeast Acquisition).

We continue to seek to attract physical therapists who have established relationships with physicians and other referral sources by offering therapists a competitive salary and a share of the profits or an ownership interest in the clinic operated by that therapist. In addition, we have developed satellite clinic facilities of existing clinics, with the result that many clinic groups operate more than one clinic location. Of the 19 clinics opened in 2010, seven were with new partners and 12 were satellites of existing partnerships. In 2011, we intend to continue to focus on developing new clinics and on opening satellite clinics where appropriate along with increasing our patient volume through marketing and new programs. In addition, we will evaluate acquisition opportunities.

Therapists at our clinics initially perform a comprehensive evaluation of each patient, which is then followed by a treatment plan specific to the injury as prescribed by the patient s physician. The treatment plan may include a number of procedures, including therapeutic exercise, manual therapy techniques, ultrasound, electrical stimulation, hot packs, iontophoresis, education on management of daily life skills and home exercise programs. A clinic s business primarily comes from referrals by local physicians. The principal sources of payment for the clinics services are managed care programs, commercial health insurance, Medicare and workers compensation insurance.

Our Company was re-incorporated in April 1992 under the laws of the State of Nevada and has operating subsidiaries organized in various states in the form of limited partnerships and wholly-owned corporations. This description of our business should be read in conjunction with our financial statements and the related notes contained elsewhere in this Annual Report on Form 10-K. Our principal executive offices are located at 1300 West Sam Houston Parkway South, Suite 300, Houston, Texas 77042. Our telephone number is (713) 297-7000. Our website is www.usph.com.

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OUR CLINICS

Most of our clinics are Clinic Partnerships in which we own the general partnership interest and a majority of the limited partnership interests. The managing therapists of the clinics own a portion of the limited partnership interests. Historically, the therapist partners had no interest in the net losses of Clinic Partnerships, except to the extent of their capital accounts. Since we also develop satellite clinic facilities of existing clinics, Clinic Partnerships may consist of more than one clinic location. As of December 31, 2010, through wholly-owned subsidiaries, we owned a 1% general partnership interest in all the Clinic Partnerships, except for one partnership in which we own a 6% general partnership interest. Our limited partnership interests range from 64% to 99% in the Clinic Partnerships, but with respect to the majority of our Clinic Partnerships, we own a limited partnership interest of 64%. For the great majority of the Clinic Partnerships, the managing therapist of each clinic owns the remaining limited partnership interest in the Clinic Partnerships.

In the majority of the Clinic Partnership agreements, the therapist partner begins with a 20% interest in their Clinic Partnership earnings which increases by 3% at the end of each year thereafter up to a maximum interest of 35%.

Typically each therapist partner or director enters into an employment agreement for a term of up to three years with their Clinic Partnership. Each agreement typically provides for a covenant not to compete during the period of his or her employment and for up to two years thereafter. Under each employment agreement, the therapist partner receives a base salary and may receive a bonus based on the net revenues or profits generated by his or her Clinic Partnership. In the case of Clinic Partnerships, the therapist partner receives earnings distributions based upon his or her ownership interest. Upon termination of employment, the Company typically has the right, but is not obligated, to purchase the therapist s partnership interest in Clinic Partnerships. In connection with several of our acquired clinics, in the event that a limited minority partner s employment ceases at any time after three years from the acquisition date, we have agreed to repurchase that individual s noncontrolling interest at a predetermined multiple of earnings before interest and taxes.

Each Clinic Partnership maintains an independent local identity, while at the same time enjoying the benefits of national purchasing, negotiated third-party payor contracts, centralized support services and management practices. Under a management agreement, one of our subsidiaries provides a variety of support services to each clinic, including supervision of site selection, construction, clinic design and equipment selection, establishment of accounting systems and billing procedures and training of office support personnel, processing of accounts payable, operational direction, auditing of regulatory compliance, payroll, benefits administration, accounting services, quality assurance and marketing support.

Our typical clinic occupies approximately 1,500 to 3,000 square feet of leased space in an office building or shopping center. We attempt to lease ground level space for patient ease of access to our clinics. We also attempt to make the decor in our clinics less institutional and more aesthetically pleasing than traditional hospital clinics. Typical minimum staff at a clinic consists of a licensed physical therapist and an office manager, as well as, if appropriate, a medical advisor. As patient visits grow, staffing may also include additional physical therapists, occupational therapists, therapy assistants, aides, exercise physiologists, athletic trainers and office personnel. Therapy services are performed under the supervision of a licensed therapist.

We provide services at our clinics on an outpatient basis. Patients are usually treated for approximately one hour per day, two to three times a week, typically for two to six weeks. We generally charge for treatment on a per procedure basis. Medicare patients are charged based on prescribed time increments and Medicare billing standards. In addition, our clinics will develop, when appropriate, individual maintenance and self-management exercise programs to be continued after treatment. We continually assess the potential for developing new services and expanding the methods of providing our existing services in the most efficient manner while providing high quality patient care.

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FACTORS INFLUENCING DEMAND FOR THERAPY SERVICES

We believe that the following factors, among others, influence the growth of outpatient physical therapy services:

Economic Benefits of Therapy Services. Purchasers and providers of healthcare services, such as insurance companies, health maintenance organizations, businesses and industries, continuously seek cost savings for traditional healthcare services. We believe that our therapy services provide a cost-effective way to prevent short-term disabilities from becoming chronic conditions and to speed recovery from surgery and musculoskeletal injuries.

Earlier Hospital Discharge. Changes in health insurance reimbursement, both public and private, have encouraged the earlier discharge of patients to reduce costs. We believe that early hospital discharge practices foster greater demand for outpatient physical therapy services.

Aging Population. In general, the elderly population has a greater incidence of disability compared to the population as a whole. As this segment of the population grows, we believe that demand for rehabilitation services will expand.

MARKETING

We focus our marketing efforts primarily on physicians, including orthopedic surgeons, neurosurgeons, physiatrists, internal medicine physicians, podiatrists, occupational medicine physicians and general practitioners. In marketing to the physician community, we emphasize our commitment to quality patient care and regular communication with physicians regarding patient progress. We employ personnel to assist clinic directors in developing and implementing marketing plans for the physician community and to assist in establishing relationships with health maintenance organizations, preferred provider organizations, industry and case managers and insurance companies.

SOURCES OF REVENUE

Payor sources for clinic services are primarily managed care programs, commercial health insurance, Medicare/Medicaid and workers compensation insurance. Commercial health insurance, Medicare and managed care programs generally provide coverage to patients utilizing our clinics after payment by the patients of normal deductibles and co-insurance payments. Workers compensation laws generally require employers to provide, directly or indirectly through insurance, costs of medical rehabilitation for their employees from work-related injuries and disabilities and, in some jurisdictions, mandatory vocational rehabilitation, usually without any deductibles, co-payments or cost sharing. Treatments for patients who are parties to personal injury cases are generally paid from the proceeds of settlements with insurance companies or from favorable judgments. If an unfavorable judgment is received, collection efforts are generally not pursued against the patient and the patient s account is written-off against established reserves. Bad debt reserves relating to all receivable types are regularly reviewed and adjusted as appropriate.

The following table shows our payor mix for the years ended:

	December 31, 2010		December 31, 2009		December 31, 2008	
Payor	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage
	(Net Patient Revenues in Thousands)					
Managed Care Program	63,993	31.4%	61,819	31.6%	61,775	33.8%

Commercial Health Insurance	50,243	24.6%	49,150	25.2%	45,866	25.1%
Medicare/Medicaid	46,165	22.6%	40,765	20.9%	35,203	19.2%
Workers Compensation Insurance	34,185	16.7%	34,458	17.6%	35,212	19.2%
Other	9,523	4.7%	9,130	4.7%	4,883	2.7%
Total	204,109	100.0%	195,322	100.0%	182,939	100.0%

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Our business depends to a significant extent on our relationships with commercial health insurers, health maintenance organizations, preferred provider organizations and workers compensation insurers. In some geographical areas, our clinics must be approved as providers by key health maintenance organizations and preferred provider plans to obtain payments. Failure to obtain or maintain these approvals would adversely affect financial results.

During the year ended December 31, 2010, approximately 24% of our visits and 21% of our net patient revenues were from patients with Medicare program coverage. To receive Medicare reimbursement, a facility (Medicare Certified Rehabilitation Agency) or the individual therapist (Physical/Occupational Therapist in Private Practice) must meet applicable participation conditions set by the Department of Health and Human Services (HHS) relating to the type of facility, equipment, record keeping, personnel and standards of medical care, and also must comply with all state and local laws. HHS, through Centers for Medicare & Medicaid Services (CMS) and designated agencies, periodically inspects or surveys clinics/providers for approval and/or compliance. We anticipate that newly developed clinics will generally become certified as Medicare providers. However, we cannot assure you that newly developed clinics will be successful in becoming certified as Medicare providers.

Since 1999, reimbursement for outpatient therapy services provided to Medicare beneficiaries has been made according to a Medicare Physician Fee Schedule (MPFS) published by the Department of Health and Human Services (HHS). Under the Balanced Budget Act of 1997, the total amount paid by Medicare in any one year for outpatient physical therapy or occupational therapy (including speech-language pathology) to any one patient is subjected to a stated dollar amount (the Medicare Cap or Limit), except for services provided in hospitals. Outpatient therapy services rendered to Medicare beneficiaries by the Company s therapists are subject to the Medicare Cap, except to the extent these services are rendered pursuant to certain management and professional services agreements with inpatient facilities. In 2006, Congress passed the Deficit Reduction Act (DRA), which allowed the Centers for Medicare & Medicaid Services (CMS) to grant exceptions to the Medicare Cap for services provided during the year, as long as those services met certain qualifications. The exception process initially allowed for automatic and manual exceptions to the Medicare Cap for medically necessary services. The Temporary Extension Act of 2010, enacted on March 2, 2010, extended the therapy cap exceptions process through March 31, 2010, retroactive to January 1, 2010. With respect to the MPFS, in April 2010, the Continuing Extension Act of 2010 was signed into law which extended the zero percent update through May 31, 2010. On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which extended the exceptions process for the outpatient therapy Medicare Cap. Outpatient therapy service providers may continue to submit claims when an exception is appropriate beyond the allotted Medicare Cap for services furnished on or after January 1, 2010 through December 31, 2010. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2010 was $1,860. On June 25, 2010, the President signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PACMBPRA). The legislation increased reimbursement to providers of outpatient physical therapy for Medicare patients by 2.2% effective June 1, 2010 through November 30, 2010.

On November 2, 2010 CMS released a final ruling on the Multiple Procedure Payment Reduction (MPPR) that includes changes to the reimbursement for Medicare related therapy services that will become effective January 1, 2011. Under MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 25%. This reduction will result in an estimated 7% rate reduction for therapy services provided in calendar year 2011 for Medicare. In addition, CMS will make changes to the Relative Value Units (RVUs) and the Geographic Practice Costs Index (GPCI) to the Resource Based Relative Value System (RBRVS) that would potentially mitigate the 7% rate reduction, assuming that Congress acts with regard to the pending Sustainable Growth Rate (SGR) Physician Fee Schedule reduction.

On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA) which tabled for one year the scheduled Medicare rate reduction for physicians, physical therapists and various other healthcare service providers. Further, under the Physician Fee Schedule, during the week of December 27, 2010, CMS

released corrected payment amounts for 2011 that incorporates the changes included in the MMEA. Effective January 1, 2011 pursuant to CMS s ruling on the MPPR, the practice expense of

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second and subsequent therapy codes billed in a single day will be reduced by 20% to 25%. This reduction will result in an estimated 5% to 7% rate reduction for our reimbursement for therapy services provided in calendar year 2011 for Medicare patients. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2011 is $1,870

Since the Medicare Cap was implemented, patients who have been impacted by the cap and those who do not qualify for an exception may choose to pay for services in excess of the cap themselves; however, the Medicare Cap may have resulted in some lost revenues to the Company.

Medicare regulations require that a physician or non-physician practitioner certify the need for skilled therapy services for each patient and that these services be provided under an established plan of treatment, which is periodically revised.

Medicaid has not been a material payor for us, constituting less than 2% of historical revenue.

REGULATION AND HEALTHCARE REFORM

Numerous federal, state and local regulations regulate healthcare services and those who provide them. Some states into which we may expand have laws requiring facilities employing health professionals and providing health-related services to be licensed and, in some cases, to obtain a certificate of need (that is, demonstrating to a state regulatory authority the need for, and financial feasibility of, new facilities or the commencement of new healthcare services). Only one of the states in which we currently operate requires a certificate of need for the operation of our physical therapy business functions. Our therapists and/or clinics, however, are required to be licensed, as determined by the state in which they provide services. Failure to obtain or maintain any required certificates, approvals or licenses could have a material adverse effect on our business, financial condition and results of operations.

Regulations Controlling Fraud and Abuse. Various federal and state laws regulate financial relationships involving providers of healthcare services. These laws include Section 1128B(b) of the Social Security Act (42 U.S. C. § 1320a-7b[b]) (the Fraud and Abuse Law), under which civil and criminal penalties can be imposed upon persons who, among other things, offer, solicit, pay or receive remuneration in return for (i) the referral of patients for the rendering of any item or service for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid); or (ii) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, ordering any good, facility, service, or item for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid). We believe that our business procedures and business arrangements are in compliance with these provisions. However, the provisions are broadly written and the full extent of their specific application to specific facts and arrangements to which the Company is a party is uncertain and difficult to predict. In addition, several states have enacted state laws similar to the Fraud and Abuse Law, which may be more restrictive than the federal Fraud and Abuse Law.

In 1991, the Office of the Inspector General (OIG) of the HHS issued the first of its regulations describing compensation financial arrangements that fall within a Safe Harbor and, therefore, are not viewed as illegal remuneration under the Fraud and Abuse Law. Failure to fall within a Safe Harbor does not mean that the Fraud and Abuse Law has been violated; however, the OIG has indicated that failure to fall within a Safe Harbor may subject an arrangement to increased scrutiny under a facts and circumstances test.

Our business of managing physician-owned physical therapy facilities is regulated by the Fraud and Abuse Law. However, the manner in which we contract with such facilities often falls outside the complete scope of available Safe Harbors. We believe our arrangements comply with the Fraud and Abuse Law, even though federal courts provide limited guidance as to the application of the Fraud and Abuse Law to these arrangements. If our management

contracts are held to violate the Fraud and Abuse Law, it could have an adverse effect on our business, financial condition and results of operations.

In February 2000, the OIG issued a special fraud alert regarding the rental of space in physician offices by persons or entities to which the physicians refer patients. The OIG s stated concern in these arrangements is that rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We rent

clinic space for a few of our clinics from referring physicians and have taken the steps that we believe are necessary to ensure that all leases comply to the extent possible and applicable with the space rental Safe Harbor to the Fraud and Abuse Law.

In April 2003, the OIG issued a special advisory bulletin addressing certain complex contractual arrangements for the provision of items and services that were previously identified as suspect in a 1989 special fraud alert. This special advisory bulletin identified several characteristics commonly exhibited by suspect arrangements, the existence of one or more of which could indicate a prohibited arrangement to the OIG. Generally, the indicia of a suspect contractual joint venture as identified by the special advisory bulletin and Opinion 04-17 include the following:

New Line of Business. A provider in one line of business (Owner) expands into a new line of business that can be provided to the Owner s existing patients, with another party who currently provides the same or similar item or service as the new business (Manager/Supplier).

Captive Referral Base. The arrangement predominantly or exclusively serves the Owner s existing patient base (or patients under the control or influence of the Owner).

Little or No Bona Fide Business Risk. The Owner s primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, delegating the entire operation to the Manager/Supplier, while retaining profits generated from its captive referral base.

Status of the Manager/Supplier. The Manager/Supplier is a would-be competitor of the Owner s new line of business and would normally compete for the captive referrals. It has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

Scope of Services Provided by the Manager/Supplier. The Manager/Supplier provides all, or many, of the new business key services.

Remuneration. The practical effect of the arrangement, viewed in its entirety, is to provide the Owner the opportunity to bill insurers and patients for business otherwise provided by the Manager/Supplier. The remuneration from the venture to the Owner (i.e., the profits of the venture) takes into account the value and volume of business the Owner generates.

Exclusivity. The arrangement bars the Owner from providing items or services to any patients other than those coming from Owner and/or bars the Manager/Supplier from providing services in its own right to the Owner s patients.

Due to the nature of our business operations, many of our management service arrangements exhibit one or more of these characteristics. However, the Company believes it has taken steps regarding the structure of such arrangements as necessary to sufficiently distinguish them from these suspect ventures, and to comply with the requirements of the Fraud and Abuse Law. However, if the OIG believes the Company has entered into a prohibited contractual joint venture, it could have an adverse effect on our business, financial condition and results of operations.

Stark Law. Provisions of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. § 1395nn) (the Stark Law) prohibit referrals by a physician of designated health services which are payable, in whole or in part, by Medicare or Medicaid, to an entity in which the physician or the physician s immediate family member has an investment interest or other financial relationship, subject to several exceptions. Unlike the Fraud and Abuse Law, the Stark Law is a strict liability statute. Proof of intent to violate the Stark Law is not required. Physical therapy services are among the designated health services . Further, the Stark Law has application to the Company s management contracts with

individual physicians and physician groups, as well as, any other financial relationship between us and referring physicians, including any financial transaction resulting from a clinic acquisition. The Stark Law also prohibits billing for services rendered pursuant to a prohibited referral. Several states have enacted laws similar to the Stark Law. These state laws may cover all (not just Medicare and Medicaid) patients. Many federal healthcare reform proposals in the past few years have attempted to expand the Stark Law to cover all patients as well. As with the Fraud and Abuse Law, we consider the Stark Law in planning our clinics, marketing and other activities, and believe that our operations

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are in compliance with the Stark Law. If we violate the Stark Law, our financial results and operations could be adversely affected. Penalties for violations include denial of payment for the services, significant civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

HIPAA. In an effort to further combat healthcare fraud and protect patient confidentially, Congress included several anti-fraud measures in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created a source of funding for fraud control to coordinate federal, state and local healthcare law enforcement programs, conduct investigations, provide guidance to the healthcare industry concerning fraudulent healthcare practices, and establish a national data bank to receive and report final adverse actions. HIPAA also criminalized certain forms of health fraud against all public and private payors. Additionally, HIPAA mandates the adoption of standards regarding the exchange of healthcare information in an effort to ensure the privacy and electronic security of patient information and standards relating to the privacy of health information. Sanctions for failing to comply with HIPAA include criminal penalties and civil sanctions. In February of 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. Title XIII of ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH), provided for substantial Medicare and Medicaid incentives for providers to adopt electronic health records (EHRs) and grants for the development of health information exchange (HIE). Recognizing that HIE and EHR systems will not be implemented unless the public can be assured that the privacy and security of patient information in such systems is protected, HITECH also significantly expanded the scope of the privacy and security requirements under HIPAA. Most notable are the new mandatory breach notification requirements and a heightened enforcement scheme that includes increased penalties, and which now apply to business associates as well as to covered entities. In addition to HIPAA, a number of states have adopted laws and/or regulations applicable in the use and disclosure of individually identifiable health information that can be more stringent than comparable provisions under HIPAA.

We believe that our operations fully comply with applicable standards for privacy and security of protected healthcare information. We cannot predict what negative effect, if any, HIPAA/HITECH or any applicable state law or regulation will have on our business.

Other Regulatory Factors. Political, economic and regulatory influences are fundamentally changing the healthcare industry in the United States. Congress, state legislatures and the private sector continue to review and assess alternative healthcare delivery and payment systems. Potential alternative approaches could include mandated basic healthcare benefits, controls on healthcare spending through limitations on the growth of private health insurance premiums and Medicare and Medicaid spending, the creation of large insurance purchasing groups, and price controls. Legislative debate is expected to continue in the future and market forces are expected to demand only modest increases or reduced costs. For instance, managed care entities are demanding lower reimbursement rates from healthcare providers and, in some cases, are requiring or encouraging providers to accept capitated payments that may not allow providers to cover their full costs or realize traditional levels of profitability. We cannot reasonably predict what impact the adoption of any federal or state healthcare reform measures or future private sector reform may have on our business.

COMPETITION

The healthcare industry, including the physical therapy business, is highly competitive. The physical therapy business is highly fragmented with no company having as much as six percent of the market share nationally. We believe that our Company ranks third nationally in outpatient rehabilitation providers.

Competitive factors affecting our business include quality of care, cost, treatment outcomes, convenience of location, and relationships with, and ability to meet the needs of, referral and payor sources. Our clinics compete, directly or indirectly, with the physical therapy departments of hospitals, private therapy clinics, physician-owned therapy clinics,

and chiropractors. We may face more intense competition as consolidation of the therapy industry continues.

We believe that our strategy of providing key therapists in a community with an opportunity to participate in ownership or clinic profitability provides us with a competitive advantage by helping to ensure the commitment of local management to the success of the clinic.

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We also believe that our competitive position is enhanced by our strategy of locating our clinics, when possible, on the ground floor of buildings and shopping centers with nearby parking, thereby making the clinics more easily accessible to patients. We offer convenient hours. We also attempt to make the decor in our clinics less institutional and more aesthetically pleasing than traditional hospital clinics.

ENFORCEMENT ENVIRONMENT

In recent years, federal and state governments have launched several initiatives aimed at uncovering behavior that violates the federal civil and criminal laws regarding false claims and fraudulent billing and coding practices. Such laws require providers to adhere to complex reimbursement requirements regarding proper billing and coding in order to be compensated for their services by government payors. Our compliance program requires adherence to applicable law and promotes reimbursement education and training; however, a determination that our clinics billing and coding practices are false or fraudulent could have a material adverse effect on us.

We and our clinics are subject to federal and state laws prohibiting entities and individuals from knowingly and willfully making claims to Medicare, Medicaid and other governmental programs and third party payors that contain false or fraudulent information. The federal False Claims Act encourages private individuals to file suits on behalf of the government against healthcare providers such as us. As such suits are generally filed under seal with a court to allow the government adequate time to investigate and determine whether it will intervene in the action, the implicated healthcare providers often are unaware of the suit until the government has made its determination and the seal is lifted. Violations or alleged violations of such laws, and any related lawsuits, could result in (i) exclusion from participation in Medicare, Medicaid and other federal healthcare programs, or (ii) significant financial or criminal sanctions, resulting in the possibility of substantial financial penalties for small billing errors that are replicated in a large number of claims, as each individual claim could be deemed a separate violation. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA) simplified and expanded the principal liability provisions of the False Claims Act and appropriated over $500 million for federal law enforcement authorities to combat financial fraud in 2010 and 2011. Some states also have enacted similar statutes, which may include criminal penalties, substantial fines, and treble damages.

COMPLIANCE PROGRAM

Our Compliance Program. The ongoing success of our Company depends upon our reputation for quality service and ethical business practices. Our Company operates in a highly regulated environment with many federal, state and local laws and regulations. We take a proactive interest in understanding and complying with the laws and regulations that apply to our business.

Our Board of Directors (the Board) has adopted a Code of Business Conduct and Ethics to clarify the ethical standards under which the Board and management carry out their duties. In addition, the Board has created a Corporate Compliance Sub-Committee of the Board s Audit Committee (Compliance Committee) whose purpose is to assist the Board and its Audit Committee (Audit Committee) in discharging their oversight responsibilities with respect to compliance with federal and state laws and regulations relating to healthcare.

We have issued an Ethics and Compliance Manual, created a compliance DVD, hand-outs and an on-line testing program. These tools were prepared to ensure that each clinic as well as every employee of our Company and subsidiaries has a clear understanding of our mutual commitment to high standards of professionalism, honesty, fairness and compliance with the law in conducting business. These standards are administered by our Compliance Officer (CO), who has the responsibility for the day-to-day oversight, administration and development of our compliance program. The CO, internal and external counsel, management and the Compliance Committee review our policies and procedures for our compliance program from time to time in an effort to improve operations and to ensure

compliance with requirements of standards, laws and regulations and to reflect the on-going compliance focus areas which have been identified by the

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Compliance Committee. We also have established systems for reporting potential violations, educating our employees, monitoring and auditing compliance and handling enforcement and discipline.

Committees. Our Compliance Committee, appointed by the Board, consists of four independent directors. The Compliance Committee has general oversight of our Company s compliance with the legal and regulatory requirements regarding healthcare operations. The Compliance Committee relies on the expertise and knowledge of management, the CO and other compliance and legal personnel. The CO regularly communicates with the Chairman of the Compliance Committee. The Compliance Committee meets at least four times a year or more frequently as necessary to carry out its responsibilities and reports regularly to the Board regarding its actions and recommendations.

In addition, management has appointed a team to address our Company s compliance with HIPAA. The HIPAA team consists of a security officer and employees from our legal, information systems, finance, operations, compliance, business services and human resources departments. The team prepares assessments and makes recommendations regarding operational changes and/or new systems, if needed, to comply with HIPAA.

Each clinic certified as a Medicare Rehabilitation Agency has a formally appointed governing body composed of a member of management of the Company and the director/administrator of the clinic. The governing body retains legal responsibility for the overall conduct of the clinic. The members confer regularly and discuss, among other issues, clinic compliance with applicable laws and regulations. In addition, there are Professional Advisory Committees which serve as Infection Control Committees. These committees meet in the facilities and function as advisors.

The Company has in place a Risk Management Committee consisting of the CO, the Corporate in-house Legal Counsel and the Corporate Vice President of Administration. This committee reviews and monitors all employee and patient incident reports and provides clinic personnel with actions to be taken in response to the reports.

Reporting Violations. In order to facilitate our employees ability to report in confidence, anonymously and without retaliation any perceived improper work-related activities, accounting irregularities and other violations of our compliance program, we have set up an independent national compliance hotline. The compliance hotline is available to receive confidential reports of wrongdoing Monday through Friday (excluding holidays), 24 hours a day. The compliance hotline is staffed by experienced third party professionals trained to utilize utmost care and discretion in handling sensitive issues and confidential information. The information received is documented and forwarded timely to the CO, who, together with the Compliance Committee, has the power and resources to investigate and resolve matters of improper conduct.

Educating Our Employees. We utilize numerous methods to train our employees in compliance related issues. The directors/administrators of each clinic are responsible to conduct the initial training sessions on compliance with existing employees. Training is based on our Ethics and Compliance Manual, inclusive of HIPAA information, and our compliance DVD. The directors/administrators also provide periodic refresher training for existing employees and one-on-one comprehensive training with new hires. The corporate compliance group responds to questions from clinic personnel and will conduct frequent teleconference meetings on topics as deemed necessary.

When a clinic opens, the CO provides a package of compliance materials containing manuals and detailed instructions for meeting Medicare Conditions of Participation Standards and other compliance requirements. During follow up training with the director/administrator of the clinic, the CO explains various details regarding requirements and compliance standards. The CO and the compliance staff will remain in contact with the director/administrator while the clinic is implementing compliance standards and will provide any assistance required. All new office managers receive training (including Medicare, regulatory and corporate compliance, insurance billing, charge entry and transaction posting and coding, daily, weekly and monthly accounting reports) from the training staff at the corporate

office. The corporate compliance group will assist in continued compliance, including guidance to the clinic staff with regard to Medicare certifications, state survey requirements and responses to any inquiries from regulatory agencies.

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Monitoring and Auditing Clinic Operational Compliance. Our Company has in place audit programs and other procedures to monitor and audit clinic operational compliance with applicable policies and procedures. We employ internal auditors who, as part of their job responsibilities, conduct periodic audits of each clinic. Each clinic is audited at least once every 18 months and additional focused audits are performed as deemed necessary. During these audits, particular attention is given to compliance with Medicare and internal policies, Federal and state laws and regulations, third party payor requirements, and patient chart documentation, billing, reporting, record keeping, collections and contract procedures. The audits are conducted on site and include interviews with the employees involved in management, operations, billing and accounts receivable. Formal audit reports are prepared and reviewed with corporate management and the Compliance Committee. Each clinic director/administrator receives a letter instructing them of any corrective measures required. Each clinic director/administrator then works with the compliance team and operations to ensure such corrective measures are achieved.

Handling Enforcement and Discipline. It is our policy that any employee who fails to comply with compliance program requirements or who negligently or deliberately fails to comply with known laws or regulations specifically addressed in our compliance program should be subject to disciplinary action up to and including discharge from employment. The Compliance Committee, compliance staff, human resources staff and management investigate violations of our compliance program and impose disciplinary action as considered appropriate.

EMPLOYEES

At December 31, 2010, we employed 2,338 people, of which 1,876 were full-time employees. At that date, no Company employees were governed by collective bargaining agreements or were members of a union. We consider our relations with our employees to be good.

In the states in which our current clinics are located, persons performing designated physical therapy services are required to be licensed by the state. Based on standard employee screening systems in place, all persons currently employed by us who are required to be licensed are licensed. We are not aware of any federal licensing requirements applicable to our employees.

AVAILABLE INFORMATION

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act are made available free of charge on our internet website at www.usph.com as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC.

ITEM 1A. *RISK FACTORS*

Our business, operations and financial condition are subject to various risks. Some of these risks are described below, and readers of this Annual Report on Form 10-K should take such risks into account in evaluating our Company or making any decision to invest in us. This section does not describe all risks applicable to our Company, our industry or our business, and it is intended only as a summary of material factors affecting our business.

Risks related to our business and operations

The uncertain economic conditions and the historically high unemployment rate may have material adverse impacts on our business and financial condition that we currently cannot predict.

Unemployment in the United States has remained high while business and consumer confidence is relatively low. Although it is difficult to predict with any degree of certainty the impact on our business, these factors could materially and adversely affect our business and financial condition.

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We depend upon reimbursement by third-party payors.

Substantially all of our revenues are derived from private and governmental third-party payors. In 2010, approximately 77% of our revenues were derived collectively from managed care plans, commercial health insurers, workers compensation payors, and other private pay revenue sources and approximately 23% of our revenues were derived from Medicare and Medicaid. Initiatives undertaken by industry and government to contain healthcare costs affect the profitability of our clinics. These payors attempt to control healthcare costs by contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursement for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services, our profit margins may decline, or we may lose patients if we choose not to renew our contracts with these insurers at lower rates. In addition, in certain geographical areas, our clinics must be approved as providers by key health maintenance organizations and preferred provider plans. Failure to obtain or maintain these approvals would adversely affect our financial results.

Since 1999, reimbursement for outpatient therapy services provided to Medicare beneficiaries has been made according to a MPFS published by the HHS. Under the Balanced Budget Act of 1997, the total amount paid by Medicare in any one year for outpatient physical therapy or occupational therapy (including speech-language pathology) to any one patient is subjected to a stated dollar amount, except for services provided in hospitals. Outpatient therapy services rendered to Medicare beneficiaries by the Company s therapists are subject to the Medicare Cap, except for services provided in hospitals. In 2006, Congress passed the DRA, which allowed CMS to grant exceptions to the Medicare Cap for services provided during the year, as long as those services met certain qualifications. The exception process initially allowed for automatic and manual exceptions to the Medicare Cap for medically necessary services. The Temporary Extension Act of 2010, enacted on March 2, 2010, extended the therapy cap exceptions process through March 31, 2010, retroactive to January 1, 2010. With respect to the MPFS, in April, the Continuing Extension Act of 2010 was signed into law which extended the zero percent update through May 31, 2010. On March 23, 2010, the President signed into law the PPACA, which extended the exceptions process for the outpatient therapy Medicare Cap. Outpatient therapy service providers may continue to submit claims when an exception is appropriate beyond the allotted Medicare Cap for services furnished on or after January 1, 2010 through December 31, 2010. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2010 is $1,860. On June 25, 2010, the President signed into law the PACMBPRA. The legislation increased reimbursement to providers of outpatient physical therapy for Medicare patients by 2.2% effective June 1, 2010 through November 30, 2010.

On November 2, 2010 CMS released a final ruling on the Multiple Procedure Payment Reduction (MPPR) that includes changes to the reimbursement for Medicare related therapy services that will become effective January 1, 2011. Under MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 25%. This reduction will result in an estimated 7% rate reduction for therapy services provided in calendar year 2011 for Medicare. In addition, CMS will make changes to the Relative Value Units (RVUs) and the Geographic Practice Costs Index (GPCI) to the Resource Based Relative Value System (RBRVS) that would potentially mitigate the 7% rate reduction, assuming that Congress acts with regard to the pending Sustainable Growth Rate (SGR) Physician Fee Schedule reduction.

On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA) which tabled for one year the scheduled Medicare rate reduction for physicians, physical therapists and various other healthcare service providers. Further, under the Physician Fee Schedule, during the week of December 27, 2010, CMS released corrected payment amounts for 2011 that incorporates the changes included in the MMEA. Effective January 1, 2011 pursuant to CMS s ruling on the MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 20% to 25%. This reduction will result in an estimated 5% to 7% rate reduction for our reimbursement for therapy services provided in calendar year 2011 for Medicare patients. For

physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2011 is $1,870.

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Since the Medicare Cap was implemented, patients who have been impacted by the cap and those who do not qualify for an exception may choose to pay for services in excess of the cap themselves; however, it is assumed that the Medicare Cap will continue to result in some lost revenues to our Company.

For a further description of this and other laws and regulations involving governmental reimbursements, see Business Sources of Revenue and Regulation and Healthcare Reform in Item 1.

We depend upon the cultivation and maintenance of relationships with the physicians in our markets.

Our success is dependent upon referrals from physicians in the communities our clinics serve and our ability to maintain good relations with these physicians and other referral sources. Physicians referring patients to our clinics are free to refer their patients to other therapy providers or to their own physician owned therapy practice. If we are unable to successfully cultivate and maintain strong relationships with physicians and other referral sources, our business may decrease and our net operating revenues may decline.

We also depend upon our ability to recruit and retain experienced physical therapists.

Our revenue generation is dependent upon referrals from physicians in the communities our clinics serve, and our ability to maintain good relations with these physicians. Our therapists are the front line for generating these referrals and we are dependent on their talents and skills to successfully cultivate and maintain strong relationships with these physicians. If we cannot recruit and retain our base of experienced and clinically skilled therapists, our business may decrease and our net operating revenues may decline. Periodically, we have clinics in isolated communities that are temporarily unable to operate due to the unavailability of a therapist who satisfies our standards.

Our revenues may fluctuate due to weather.

We have a significant number of clinics in states that normally experience snow and ice during the winter months. Also, a significant number of our clinics are located in states along the Gulf Coast and Atlantic Coast which are subject to periodic winter storms, hurricanes and other severe storm systems. Periods of severe weather may cause physical damage to our facilities or prevent our staff or patients from traveling to our clinics, which may cause a decrease in our net operating revenues.

Our operations are subject to extensive regulation.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to:

- facility and professional licensure/permits, including certificates of need;
- conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse, and physician self-referral;
- addition of facilities and services; and
- billing and payment for services.

In recent years, there have been heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry. We believe we are in substantial compliance with all laws, but differing interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our methods of operations, facilities,

equipment, personnel, services and capital expenditure programs and increase our operating expenses. If we fail to comply with these extensive laws and government regulations, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. For a more complete description of certain of these laws and regulations, see Business Regulation and Healthcare Reform in Item 1.

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Healthcare reform legislation may affect our business.

In recent years, many legislative proposals have been introduced or proposed in Congress and in some state legislatures that would affect major changes in the healthcare system, either nationally or at the state level. At the federal level, Congress has continued to propose or consider healthcare budgets that substantially reduce payments under the Medicare programs. The ultimate content, timing or effect of any healthcare reform legislation and the impact of potential legislation on us is uncertain and difficult, if not impossible to predict. That impact may be material to our business, financial condition or results of operations.

We operate in a highly competitive industry.

We encounter competition from local, regional or national entities, some of which have superior resources or other competitive advantages. Intense competition may adversely affect our business, financial condition or results of operations. For a more complete description of this competitive environment, see Business Competition in Item 1. An adverse effect on our business, financial condition or results of operations may require us to write-down goodwill.

We may incur closure costs and losses.

The competitive, economic or reimbursement conditions in our markets in which we operate may require us to reorganize or to close certain clinics. In the event a clinic is reorganized or closed, we may incur losses and closure costs. The closure costs and losses may include, but are not limited to, lease obligations, severance, and write-down or write-off of goodwill and other intangible assets.

Future acquisitions may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we intend to continue pursuing acquisitions of outpatient physical therapy clinics. Acquisitions may involve significant cash expenditures, potential debt incurrence and operational losses, dilutive issuances of equity securities and expenses that could have an adverse effect on our financial condition and results of operations. Acquisitions involve numerous risks, including:

- the difficulty and expense of integrating acquired personnel into our business;
- the diversion of management s time from existing operations;
- the potential loss of key employees of acquired companies;
- the difficulty of assignment and/or procurement of managed care contractual arrangements; and
- the assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We may not be successful in obtaining financing for acquisitions at a reasonable cost, or such financing may contain restrictive covenants that limit our operating flexibility. We also may be unable to acquire outpatient physical therapy clinics or successfully operate such clinics following the acquisition.

Certain of our internal controls, particularly as they relate to billings and cash collections, are largely decentralized at our clinic locations.

Our clinic operations are largely decentralized and certain of our internal controls, particularly the processing of billings and cash collections, occur at the clinic level. Taken as a whole, we believe our internal controls for these functions at our clinics are adequate. Our controls for billing and cash collections largely depend on compliance with our written policies and procedures and separation of functions among clinic personnel. We also maintain corporate level controls, including an audit compliance program, that are intended to mitigate and detect any potential deficiencies in internal controls at the clinic level. The effectiveness of these controls to future periods are subject to the risk that controls may become inadequate because of changes in conditions or the level of compliance with our policies and procedures deteriorates.

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Risks Relating to Our Outstanding Common Stock

Our stock price could be volatile, which could cause you to lose part or all of your investment.

The stock market has from time to time experienced significant price and volume fluctuations that may be unrelated to the operating performance of particular companies. In particular, the market price of our common stock has been and may continue to be highly volatile. During 2010, our stock price ranged from a low of $14.97 per share (on January 28, 2010) to a high of $20.92 per share (on December 22, 2010). Factors, such as announcements concerning changes in revenues and earnings expectations, regulatory conditions, including federal and state regulations, and economic and other external factors, as well as period-to-period fluctuations and financial results, may have a significant effect on the market price of our common stock.

From time to time, there has been limited trading volume in our common stock. In addition, there can be no assurance that there will continue to be a trading market or that any securities research analysts will continue to provide research coverage with respect to our common stock. It is possible that such factors will adversely affect the market for our common stock.

Issuance of shares in connection with financing transactions or under stock incentive plans will dilute current stockholders.

Pursuant to our stock incentive plans, our Compensation Committee of the Board of Directors, consisting solely of independent directors, is authorized to grant stock awards to our employees, directors and consultants. You will incur dilution upon the exercise of any outstanding stock awards or the grant of any restricted stock. In addition, if we raise additional funds by issuing additional common stock, or securities convertible into or exchangeable or exercisable for common stock, further dilution to our existing stockholders will result, and new investors could have rights superior to existing stockholders.

The number of shares of our common stock eligible for future sale could adversely affect the market price of our stock.

At December 31, 2010, we had reserved approximately 725,000 shares of common stock for issuance under outstanding options. All of these shares of common stock are registered for sale or resale on currently effective registration statements. We may issue additional restricted securities or register additional shares of common stock under the Securities Act in the future. The issuance of a significant number of shares of common stock upon the exercise of stock options or the availability for sale, or sale, of a substantial number of the shares of common stock eligible for future sale under effective registration statements, under Rule 144 or otherwise, could adversely affect the market price of the common stock.

Provisions in our articles of incorporation and bylaws could delay or prevent a change in control of our company, even if that change would be beneficial to our stockholders.

Certain provisions of our articles of incorporation and bylaws may delay, discourage, prevent or render more difficult an attempt to obtain control of our company, whether through a tender offer, business combination, proxy contest or otherwise. These provisions include the charter authorization of blank check preferred stock and a restriction on the ability of stockholders to call a special meeting.

Item 1B. ***UNRESOLVED STAFF COMMENTS.***

Not Applicable.

ITEM 2. ***PROPERTIES.***

We lease the properties used for our clinics under non-cancelable operating leases with terms ranging from one to five years, with the exception of the property for one clinic which we own. We intend to lease the premises for any new clinics locations except in rare instances where leasing is not a cost-effective alternative. Our typical clinic occupies 1,500 to 3,000 square feet.

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We also lease our executive offices located in Houston, Texas, under a non-cancelable operating lease expiring in June 2015. We currently occupy approximately 37,537 square feet of space (including allocations for common areas) at our executive offices.

ITEM 3. ***LEGAL PROCEEDINGS.***

We are involved in litigation and other proceedings arising in the ordinary course of business. While the ultimate outcome of lawsuits or other proceedings cannot be predicted with certainty, we do not believe the impact of existing lawsuits or other proceedings will have a material impact on our business, financial condition or results of operations.

ITEM 4. ***(REMOVED AND RESERVED)***

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PART II

ITEM 5. *MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.*

PRICE QUOTATIONS

Our common stock is traded on the Nasdaq Global Select Market (Nasdaq) under the symbol USPH. As of March 9, 2011, there were 61 holders of record of our outstanding common stock. The table below indicates the high and low sales prices of our common stock reported for the periods presented.

	2010		2009	
Quarter	**High**	**Low**	**High**	**Low**
First	$ 19.22	$ 14.97	$ 14.05	$ 6.71
Second	19.38	15.52	15.24	9.32
Third	18.73	15.30	17.42	13.52
Fourth	20.92	16.71	17.30	13.46

On March 3, 2011, we announced that we are initiating a quarterly dividend. USPH shareholders of record as of March 15, 2011 will be paid an initial quarterly dividend of $.08 per share on March 30, 2011.

We are currently restricted from paying dividends in excess of $5,000,000 in any fiscal year on our common stock by our bank credit facility.

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FIVE YEAR PERFORMANCE GRAPH

The following performance graph compares the cumulative total stockholder return of our common stock to The Nasdaq Stock Market United States Index and The Nasdaq Stock Market Healthcare Index for the period from December 31, 2005 through December 31, 2010. The graph assumes that $100 was invested in our common stock and the common stock of the companies listed on The Nasdaq Stock Market United States Index and The Nasdaq Stock Market Healthcare Index on December 31, 2009 and that any dividends were reinvested.

Comparison of Five Years Cumulative Total Return
For the Year Ended December 31, 2010

	12/05	12/06	12/07	12/08	12/09	12/10
U. S. Physical Therapy, Inc.	100	66	78	72	92	107
The Nasdaq Stock Market United States Index	100	110	119	57	83	98
The Nasdaq Stock Market Healthcare Index	100	100	131	95	126	152

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ITEM 6. ***SELECTED FINANCIAL DATA.***

The following selected financial data should be read in conjunction with the description of our critical accounting policies set forth in Item 7. During 2006, the Company closed 31 unprofitable clinics and sold one. In accordance with current accounting literature, for all periods presented, the results of operations and closure costs for these closed clinics and the results of operations for the clinic sold in the fourth quarter of 2006 are presented in the consolidated statements of net income, as Discontinued Operations , net of the tax benefit. The closure costs and operating results for clinics closed or sold in other years were deemed immaterial and therefore not reported as discontinued operations.

	For the Years Ended December 31,				
	2010	2009	2008	2007	2006
	($ in thousands, except per share data)				
Net revenues	$ 211,233	$ 201,409	$ 187,686	$ 151,686	$ 135,194
Income from continuing operations including noncontrolling interests, net of tax	$ 24,700	$ 19,974	$ 17,089	$ 14,542	$ 13,840
Discontinued operations, net of tax	$	$	$	$ (77)	$ (1,897)
Net income including noncontrolling interests	$ 24,700	$ 19,974	$ 17,089	$ 14,465	$ 11,943
Net income attributable to common shareholders	$ 15,645	$ 11,767	$ 10,004	$ 8,738	$ 6,296
Per common share					
Net income from continuing operations attributable to common shareholders:					
Basic	$ 1.34	$ 1.01	$ 0.84	$ 0.76	$ 0.70
Diluted	$ 1.32	$ 1.00	$ 0.83	$ 0.75	$ 0.70
Net income attributable to common shareholders:					
Basic	$ 1.34	$ 1.01	$ 0.84	$ 0.75	$ 0.54
Diluted	$ 1.32	$ 1.00	$ 0.83	$ 0.75	$ 0.54

	On December 31,				
	2010	2009	2008	2007	2006
	($ in thousands)				
Total assets	$ 140,861	$ 111,429	$ 118,247	$ 96,252	$ 71,457
Long-term debt, less current portion	$ 5,750	$ 400	$ 12,412	$ 7,959	$ 797
Working capital	$ 25,053	$ 18,255	$ 24,108	$ 24,595	$ 26,811
Current ratio	2.76	2.24	2.65	3.15	3.92
Total long-term debt to total capitalization	0.05		0.15	0.11	0.01

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ITEM 7. *MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.*

EXECUTIVE SUMMARY

Our Business. We operate outpatient physical therapy clinics that provide preventative and post-operative care for a variety of orthopedic-related disorders and sports-related injuries, treatment for neurologically-related injuries and rehabilitation of injured workers.

During the last three years, we completed the following acquisitions:

Acquisition	Date	% Interest Acquired	Number of Clinics
	2010		
Northeast Acquisition	February 26	70%	5
2010 Mid-Atlantic Acquisition	December 21	70%	6
Southeast Acquisition	December 31	65%	14
	2009		
No clinics were acquired			
	2008		
Michigan Acquisition	January 1	100%	1
2008 Mid-Atlantic Acquisition	June 11	65%	9
San Antonio Acquisition	November 18	65%	4

The results of operations of the acquired clinics have been included in our consolidated financial statements since the date of their acquisition. We also operate two clinics which specialize in the outpatient, non-surgical treatment of osteo arthritis, degenerative joint disease and other musculoskeletal conditions (the OA Centers). The first OA Center opened in June 2008.

In October 2008, we acquired a 65% interest in Rehab Management Group (RMG) which provides physicians and their patients with clinical services including electro-diagnostic analysis (EDX) as well as intra articular joint (IAJP Direct) and lumbar osteoarthritis (LOP Direct) programs.

At December 31, 2010, we operated 392 clinics, inclusive of the two OA centers, in 42 states. The average age of our clinics at December 31, 2010, was 7.5 years. Of the 392 clinics, we developed 287 of the clinics and acquired 105. In 2010, we opened 19 clinics, acquired 25, closed 15 and sold 5.

In addition to our owned clinics, we also manage physical therapy facilities for third parties, primarily physicians, with 15 third-party facilities under management as of December 31, 2010.

CRITICAL ACCOUNTING POLICIES

Critical accounting policies are those that have a significant impact on our results of operations and financial position involving significant estimates requiring our judgment. Our critical accounting policies are:

Revenue Recognition. Revenues are recognized in the period in which services are rendered. Net patient revenues (patient revenues less estimated contractual adjustments) are reported at the estimated net realizable amounts from insurance companies, third-party payors, patients and others for services rendered. The Company has agreements with third-party payors that provide for payments to the Company at contracted amounts different from its established rates. The allowance for estimated contractual adjustments is based on terms of payor contracts and historical collection and write-off experience.

Contractual Allowances. Contractual allowances result from the differences between the rates charged for services performed and expected reimbursements by both insurance companies and government sponsored healthcare programs for such services. Medicare regulations and the various third party payors and managed care contracts are often complex and may include multiple reimbursement mechanisms payable for the services provided in our clinics. We estimate contractual allowances based on our interpretation of the applicable

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regulations, payor contracts and historical calculations. Each month the Company estimates its contractual allowance for each clinic based on payor contracts and the historical collection experience of the clinic and applies an appropriate contractual allowance reserve percentage to the gross accounts receivable balances for each payor of the clinic. Based on our historical experience, calculating the contractual allowance reserve percentage at the payor level is sufficient to allow us to provide the necessary detail and accuracy with our collectibility estimates. However, the services authorized and provided and related reimbursement are subject to interpretation that could result in payments that differ from our estimates. Payor terms are periodically revised necessitating continual review and assessment of the estimates made by management. Our billing system may not capture the exact change in our contractual allowance reserve estimate from period to period. Therefore, in order to assess the accuracy of our revenues and hence our contractual allowance reserves, our management regularly compares its cash collections to corresponding net revenues measured both in the aggregate and on a clinic-by-clinic basis. In the aggregate, the historical difference between net revenues and corresponding cash collections has generally reflected a difference within approximately 1% of net revenues. Additionally, analysis of subsequent period s contractual write-offs on a payor basis reflects a difference within approximately 1% between the actual aggregate contractual reserve percentage as compared to the estimated contractual allowance reserve percentage associated with the same period end balance. As a result, we believe that a reasonable likely change in the contractual allowance reserve estimate would not likely be more than 1% at December 31, 2010. For purposes of demonstrating the sensitivity of this estimate on the Company s financial condition, a one percent increase or decrease in our aggregate contractual allowance reserve percentage would decrease or increase, respectively, net patient revenue by approximately $586,000 for the year ended December 31, 2010. Management believes the changes in the estimate of the contractual allowance reserve for the periods ended December 31, 2010, 2009 and 2008 have not been material to the statement of operations.

The following table sets forth information regarding our patient accounts receivable as of the dates indicated (in thousands):

	December 31,	
	2010	2009
Gross accounts receivable	$ 58,552	$ 52,763
Less contractual allowances	31,548	28,633
Subtotal accounts receivable	27,004	24,130
Less allowance for doubtful accounts	2,190	1,830
Net patient accounts receivable	$ 24,814	$ 22,300

The following table presents our patient accounts receivable aging by payor class as of the dates indicated (in thousands):

	December 31, 2010			December 31, 2009		
Payor	Current to 120 Days	120+ Days	Total	Current to 120 Days	120+ Days	Total
Managed Care/ Commercial Plans	$ 9,001	$ 1,972	$ 10,973	$ 8,861	$ 1,848	$ 10,709

Medicare/Medicaid	5,328	1,408	6,736	4,293	1,476	5,769
Workers Compensation*	4,952	814	5,766	3,705	624	4,329
Self-pay	872	857	1,729	613	680	1,293
Other**	1,012	788	1,800	1,113	917	2,030
Totals	$ 21,165	$ 5,839	$ 27,004	$ 18,585	$ 5,545	$ 24,130

* Workers compensation is paid by state administrators or their designated agents.

** Other includes primarily litigation claims and, to a lesser extent, vehicular insurance claims.

Reimbursement for Medicare beneficiaries is based upon a fee schedule published by HHS. For a more complete description of our third party revenue sources, see Business Sources of Revenue in Item 1.

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Allowance for Doubtful Accounts. We determine allowances for doubtful accounts based on the specific agings and payor classifications at each clinic. We review the accounts receivable aging and rely on prior experience with particular payors to determine an appropriate reserve for doubtful accounts. Historically, clinics that have a large number of aged accounts generally have less favorable collection experience, and thus, require a higher allowance. Accounts that are ultimately determined to be uncollectible are written off against our bad debt allowance. The amount of our aggregate allowance for doubtful accounts is regularly reviewed for adequacy in light of current and historical experience.

Accounting for Income Taxes. We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

The Company recognizes the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For tax positions meeting the more-likely-than-not threshold, the amount to be recognized in the financial statements is the largest benefit that has a greater than 50 percent likelihood of being realized upon ultimate settlement with the relevant tax authority.

The Company does not believe that it has any significant uncertain tax positions at December 31, 2010, nor is this expected to change within the next twelve months due to the settlement and expiration of statutes of limitation.

The Company did not have any accrued interest or penalties associated with any unrecognized tax benefits nor was any interest expense recognized during the twelve months ended December 31, 2010 and 2009.

Carrying Value of Long-Lived Assets. Our property and equipment, intangible assets and goodwill (collectively, our long-lived assets) comprise a significant portion of our total assets. The accounting standards require that we periodically, and upon the occurrence of certain events, assess the recoverability of our long-lived assets. If the carrying value of our property and equipment exceeds their undiscounted cash flows, we are required to write the carrying value down to estimated fair value.

Goodwill. The fair value of goodwill and other intangible assets with indefinite lives are tested for impairment at least annually and upon the occurrence of certain events, and are written down to fair value if considered impaired. The Company evaluates goodwill and other intangible assets with indefinite lives for impairment on at least an annual basis (in its third quarter) by comparing the fair value of each reporting unit to the carrying value of the reporting unit including related goodwill and other intangible assets with indefinite lives. A reporting unit refers to the acquired interest of a single clinic or group of clinics. Local management typically continues to manage the acquired clinic or group of clinics. For each clinic or group of clinics, the Company maintains discrete financial information and both corporate and local management regularly review the operating results. For each purchase of the equity interest, goodwill and other intangible assets, if any, with indefinite lives are assigned to the respective clinic or group of clinics, if deemed appropriate. If the carrying value of our goodwill and other intangible assets with indefinite lives exceeds the estimated fair value, we are required to allocate the estimated fair value to our assets and liabilities, as if we had just acquired it in a business combination. We then write-down the carrying value of our goodwill and other intangible assets with indefinite lives to the implied fair value. Any such write-down is included as an impairment loss in our consolidated statement of net income. Judgment is required to estimate the fair value of our long-lived assets. We may use quoted market prices, prices for similar assets, present value techniques and other valuation techniques to prepare these estimates. In addition, we may obtain independent appraisals in certain circumstances. We may need to

make estimates of future cash flows and discount rates as well as other assumptions in order to apply these valuation techniques. Irrespective of our valuation analysis, future market conditions may deteriorate. Accordingly, any value ultimately derived from our long-lived assets may differ

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from our estimate of fair value. In 2008, the evaluation of goodwill yielded an impairment charge of $49,000 on a clinic purchased in 1994. The evaluation of goodwill in 2010 and 2009 did not result in any goodwill amounts that were deemed to be impaired. See Note 2 Significant Accounting Policies Goodwill to the Consolidated Financial Statements in Item 8.

SELECTED OPERATING AND FINANCIAL DATA

The following table and discussion relates to continuing operations unless otherwise noted. The defined terms with their respective description used in the following discussion are listed below:

2010	Year ended December 31, 2010
2009	Year ended December 31, 2009
2008	Year ended December 31, 2008
New Clinics	Clinics opened during the year ended December 31, 2010
Mature Clinics	Clinics opened or acquired prior to January 1, 2010
2009 New Clinics	Clinics opened during the year ended December 31, 2009
2009 Mature Clinics	Clinics opened or acquired prior to January 1, 2009
2008 New Clinics	Clinics opened or acquired during the year ended December 31, 2008
2008 Mature Clinics	Clinics opened or acquired prior to January 1, 2008

	For the Years Ended December 31,		
	2010	**2009**	**2008**
Number of clinics, at the end of period	392	368	360
Working Days	254	255	256
Average visits per day per clinic	20.5	20.4	20.4
Total patient visits	1,926,892	1,899,123	1,865,787
Net patient revenue per visit	$ 105.92	$ 102.85	$ 98.05
Statement of operations per visit:			
Net revenues	$ 109.63	$ 106.05	$ 100.59
Salaries and related costs	57.54	55.67	53.74
Rent, clinic supplies, contract labor and other	21.25	21.33	21.33
Provision for doubtful accounts	1.68	1.76	1.65
Closure costs	0.09	0.05	0.23
Contribution from clinics	29.07	27.24	23.64
Corporate office costs	11.84	12.36	10.84
Operating income from continuing operations	$ 17.23	$ 14.88	$ 12.80

RESULTS OF OPERATIONS

FISCAL YEAR 2010 COMPARED TO FISCAL 2009

Net revenues rose 4.9% to $211.2 million for 2010 from $201.4 million for 2009 due to a 3.0% increase in net patient revenue per visit to $105.92 from $102.85 for 2009 while the number of patient visits increased by

1.5% from 1,899,000 to 1,927,000. Our net patient revenue per visit has increased due to our continuing efforts to provide additional services and to negotiate more favorable reimbursement rates with payors. The 2010 results include 10 months of operations for the clinics acquired in the Northeast Acquisition and eight days of operations for the clinics acquired in the 2010 Mid-Atlantic Acquisition. The 2010 and 2009 results include 254 days and 255 days of operations, respectively.

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Net income attributable to common shareholders increased 33.0% to $15.6 million for 2010 from $11.8 million. Earnings per diluted share increased to $1.32 from $1.00. Total diluted shares for the years ended December 31, 2010 and 2009 were 11.9 million and 11.8 million, respectively.

Net Patient Revenues

Net patient revenues increased to $204.1 million for 2010 from $195.3 million for 2009, an increase of $8.8 million, or 4.5%, primarily due to an increase of $3.07 in patient revenues per visit to $105.92 as previously mentioned.

Total patient visits increased to 1,927,000 for 2010 from 1,899,000 for 2009. New Clinics accounted for 62,000 additional visits in 2010 while Mature Clinics accounted for a decrease of 34,000 visits. For 2009 New Clinics, the number of visits increased by 35,000 from 2009 to 2010 due to a full year of activity in 2010. For 2009 Mature Clinics, the number of visits decreased by 69,000 in 2010 as compared to 2009.

Net patient revenues are based on established billing rates less allowances and discounts for patients covered by contractual programs and workers compensation. Net patient revenues reflect contractual and other adjustments, which we evaluate monthly, relating to patient discounts from certain payors. Payments received under these programs are based on predetermined rates and are generally less than the established billing rates of the clinics.

Management Contract Revenues and Other Revenues

Revenues from management contracts and other revenues increased by approximately $1.0 million from 2009 to 2010 due to additional management contracts in place.

Clinic Operating Costs

Clinic operating costs were 73.5% of net revenues for 2010 and 74.3% of net revenues for 2009. Each component of clinic operating costs is discussed below:

Clinic Operating Costs Salaries and Related Costs

Salaries and related costs increased to $110.9 million for 2010 from $105.7 million for 2009, an increase of $5.2 million, or 4.9%. Approximately $4.1 million of the increase was attributable to New Clinics. The remaining $1.1 million of the increase was due to $2.1 million in higher costs at various 2009 New Clinics offset by a decrease of $1.0 million in costs at various 2009 Mature Clinics. Salaries and related costs as a percentage of net revenues was 52.5% for 2010 and 2009.

Clinic Operating Costs Rent, Clinic Supplies and Other

Rent, clinic supplies and other costs increased to $40.9 million for 2010 from $40.5 million for 2009, an increase of $0.4 million, or 1.1%. For 2010, New Clinics accounted for approximately $1.9 million of the increase and 2009 New Clinics accounted for approximately $0.7 million of the increase due to a full year of activity in 2010. Rent, clinic supplies and other costs for 2009 Mature Clinics decreased $2.2 million in 2010 as compared to 2009 due to cost containment efforts. Rent, clinic supplies and other costs as a percent of net revenues was 19.4% for 2010 and 20.1% for 2009.

Clinic Operating Costs Provision for Doubtful Accounts

The provision for doubtful accounts for net patient receivables as a percentage of net patient revenues was 1.6% for 2010 and 1.7% for 2009. Our allowance for bad debts as a percentage of total patient accounts receivable was 8.1% at December 31, 2010 and 7.6% at December 31, 2009. The allowance for doubtful accounts at the end of each period is based on a detailed, clinic-by-clinic review of overdue accounts and is regularly reviewed in the aggregate in light of historical experience.

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The accounts receivable days outstanding were 45 days at December 31, 2010 and December 31, 2009. Receivables in the amount of $2.8 million and $3.8 million were written-off in 2010 and 2009, respectively.

Closure Costs

In 2010, 15 clinics were closed with closure costs amounting to $163,000. For 2009, closure costs amounted to $91,000 related to the closure of 10 clinics.

Corporate Office Costs

Corporate office costs, consisting primarily of salaries, benefits and equity based compensation of corporate office personnel and directors, rent, insurance costs, depreciation and amortization, travel, legal, compliance, professional, marketing and recruiting fees, were $22.8 million for 2010 and $23.5 million for 2009, a decrease of $0.7 million. This decrease is primarily due to lower incentive compensation, including the long-term incentive plan. Corporate office costs as a percentage of net revenues were 10.8% for 2010 and 11.7% for 2009.

Interest and Other Income, net

Interest and other income for 2010 included a pre-tax gain of $578,000 from the sale of our 51.0% interest in a five clinic Texas joint venture.

Interest Expense

Interest expense decreased to $236,000 for 2010 from $352,000 for 2009 primarily due to lower average borrowings. At December 31, 2010, $5.5 million was outstanding under our revolving credit facility. See Liquidity and Capital Resources below for a discussion of the terms of our revolving credit facility.

Provision for Income Taxes

The provision for income taxes increased to $8.8 million for 2010 from $7.9 million for 2009, an increase of approximately $0.9 million, primarily as a result of higher pre-tax income. During the fourth quarter of 2010, we completed a process to perform a detailed reconciliation of our federal and state taxes payable and receivable accounts along with our federal and state deferred tax asset and liability accounts. Historically, calculations of these tax-related accounts were performed through summary estimates and analysis. As a result of this detailed analysis, we recorded a reduction in our current state income tax provision of $814,000. We consider this reconciliation process to be an annual control and, in the future, we will perform a similar reconciliation process during the fourth quarter of each year. Without the effect of the $814,000, during 2010, we accrued state and federal income taxes at an effective tax rate (provision for taxes divided by the difference between income from operations and net income attributable to noncontrolling interest) of 39.4%. The Company continues to evaluate the effective state tax rate used. For 2009, the results included certain incentive compensation that was not tax deductible thereby slightly increasing the effective income tax rate to 40.3%.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $9.1 million in 2010 compared to $8.2 million in 2009. As a percentage of operating income before corporate office costs, net income attributable to noncontrolling interests was 16.2% in 2010 compared to 15.9% in 2009.

FISCAL YEAR 2009 COMPARED TO FISCAL 2008

Net revenues rose 7.3% to $201.4 million for 2009 from $187.7 million for 2008 due to a 4.9% increase in net patient revenue per visit to $102.85 from $98.05 for 2008 while the number of patient visits increased by 1.8% from 1,866,000 to 1,899,000. Our net patient revenue per visit increased due to our efforts to provide additional services and to negotiate more favorable reimbursement rates with payors. The 2009 results include a full year of operations for the clinics acquired in 2008. For 2008,

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the results include 61/2 months of operations for the clinics acquired in the 2008 Mid-Atlantic Acquisition and 11/2 months of operations for the clinics acquired in the San Antonio Acquisition. The 2009 results include 255 days of operations as compared to 256 days for 2008.

Net income attributable to common shareholders increased 17.6% to $11.8 million for 2009 from $10.0 million. Earnings per diluted share increased to $1.00 from $0.83. Total diluted shares for the years ended December 31, 2009 and 2008 were 11.8 million and 12.1 million, respectively.

Net Patient Revenues

Net patient revenues increased to $195.3 million for 2009 from $182.9 million for 2008, an increase of $12.4 million, or 6.8%, primarily due to an increase of $4.80 in patient revenues per visit to $102.85 as previously mentioned.

Total patient visits increased to 1,899,000 for 2009 from 1,866,000 for 2008. 2009 New Clinics accounted for 24,000 of the increase and 2009 Mature Clinics accounted for 9,000 of the increase. For 2008 New Clinics, the number of visits increased by 98,000 for 2009 as compared to 2008 due to an increase in business for developed clinics and a full year of activity for those acquired in 2008. For 2008 Mature Clinics, the number of visits decreased by 107,000 in 2009 as compared to 2008.

Net patient revenues are based on established billing rates less allowances and discounts for patients covered by contractual programs and workers compensation. Net patient revenues reflect contractual and other adjustments, which we evaluate monthly, relating to patient discounts from certain payors. Payments received under these programs are based on predetermined rates and are generally less than the established billing rates of the clinics.

Management Contract Revenues and Other Revenues

Revenues from management contracts and other revenues increased by approximately $1.3 million from 2008 to 2009 due to the inclusion of revenues for the complete year in 2009 from the RMG acquisition.

Clinic Operating Costs

Clinic operating costs were 74.3% of net revenues for 2009 and 76.5% of net revenues for 2008. Each component of clinic operating costs is discussed below:

Clinic Operating Costs Salaries and Related Costs

Salaries and related costs increased to $105.7 million for 2009 from $100.3 million for 2008, an increase of $5.5 million, or 5.5%. Approximately 27.9% of the increase, or $1.5 million, was attributable to the 2009 New Clinics. The remaining increase of $4.0 million was due to $4.8 million in higher costs at various 2008 New Clinics and a decrease of $0.8 million in costs at various 2008 Mature Clinics. Salaries and related costs as a percentage of net revenues was 52.5% for 2009 and 53.4% for 2008.

Clinic Operating Costs Rent, Clinic Supplies and Other

Rent, clinic supplies and other costs increased to $40.5 million for 2009 from $39.8 million for 2008, an increase of $0.7 million, or 1.7%. For 2009, 2009 New Clinics accounted for approximately $1.1 million of the increased costs and the 2008 New Clinics accounted for approximately $2.2 million of the increased costs due to a full year of activity for clinics acquired and developed in 2008. Rent, clinic supplies and other costs for 2008 Mature Clinics decreased

$2.5 million in 2009 as compared to 2008 due to cost containment efforts. Rent, clinic supplies and other costs as a percentage of net revenues was 20.1% for 2009 and 21.2% for 2008.

Clinic Operating Costs Provision for Doubtful Accounts

The provision for doubtful accounts remained relatively stable as a percentage of net revenues for 2009 and 2008. The provision for doubtful accounts for net patient receivables as a percentage of net patient

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revenues was 1.7% for 2009 and 2008. Our allowance for bad debts as a percentage of total patient accounts receivable was 7.6% at December 31, 2009 and 8.1% at December 31, 2008. The allowance for doubtful accounts at the end of each period is based on a detailed, clinic-by-clinic review of overdue accounts and is regularly reviewed in the aggregate in light of historical experience.

The accounts receivable days outstanding were 45 days at December 31, 2009 and 51 days December 31, 2008. This decrease in days outstanding was due to our increased collection efforts. Receivables in the amount of $3.8 million and $3.0 million were written-off in 2009 and 2008, respectively.

Closure Costs

In 2009, 10 clinics were closed with closure costs amounting to $91,000. For 2008, closure costs amounted to $432,000 related to the closure of 18 clinics. 2008 closure costs include $342,000 related to lease obligations and facilities costs, $77,000 related to write-off of unamortized leasehold improvements and $13,000 in severance and salary costs.

Corporate Office Costs

Corporate office costs, consisting primarily of salaries, benefits and equity based compensation of corporate office personnel and directors, rent, insurance costs, depreciation and amortization, travel, legal, compliance, professional, marketing and recruiting fees, were $23.5 million for 2009 and $20.2 million for 2008, an increase of $3.3 million. This increase was primarily due to increased incentive compensation, including the long-term incentive plan, related to increased profits. Corporate office costs as a percentage of net revenues were 11.7% for 2009 and 10.8% for 2008.

Interest and Other Income, net

Interest and other income for 2008 included a pre-tax gain of $193,000 from the sale of a 49.0% interest in two of our Texas partnerships.

Interest Expense

Interest expense decreased to $352,000 for 2009 from $542,000 for 2008 due to lower borrowing costs and lower average borrowings. At December 31, 2009, $0.4 million was outstanding under our revolving credit facility.

Provision for Income Taxes

The provision for income taxes increased to $7.9 million for 2009 from $6.5 million for 2008, an increase of approximately $1.4 million primarily as a result of higher pre-tax income. During 2009 and 2008, we accrued state and federal income taxes at an effective tax rate (provision for taxes divided by the difference between income from operations and net income attributable to noncontrolling interest) of 40.3% for 2009 and 39.4% for 2008. This increase in the effective rate was due to the non-tax deductible portion of the expense related to the long-term incentive plan.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $8.2 million in 2009 compared to $7.1 million in 2008. As a percentage of operating income before corporate office costs, net income attributable to noncontrolling interests was 15.9% in 2009 compared to 16.1% in 2008.

LIQUIDITY AND CAPITAL RESOURCES

We believe that our business is generating sufficient cash flow from operating activities to allow us to meet our short-term and long-term cash requirements, other than those with respect to future significant acquisitions. At December 31, 2010, we had $9.2 million in cash and cash equivalents compared to $6.4 million at December 31, 2009. Although the start-up costs associated with opening new clinics and our

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planned capital expenditures are significant, we believe that our cash and cash equivalents and availability under our revolving credit facility are sufficient to fund the working capital needs of our operating subsidiaries, future clinic development and investments through at least December 2011. The amount outstanding under our revolving credit facility was $5.5 million at December 31, 2010 compared to $400,000 at December 31, 2009. At December 31, 2010, we had $44.5 million available under our revolving credit facility. Significant acquisitions would likely require financing under our revolving credit facility.

The increase in cash and cash equivalents of $2.8 million from December 31, 2009 to December 31, 2010 was due primarily to $30.5 million provided by operations, $5.1 million of net proceeds on our revolving credit facility, $0.9 million of proceeds on the sale of business and fixed assets and $0.7 million of proceeds and tax benefit related to the exercise of stock options. The major uses of cash for investing and financing activities included: purchase of businesses and earnout payments on a previously acquired business ($18.2 million), distributions to noncontrolling interests ($9.6 million), purchases of fixed assets ($3.7 million), purchases of our common stock ($1.4 million), payments on notes payable ($1.0 million) and purchases of noncontrolling interests ($0.7 million).

Effective August 27, 2007, we entered into a credit agreement with a commitment for a $30.0 million revolving credit facility which was increased to $50.0 million effective June 4, 2008 (Credit Agreement). Effective March 18, 2009, we amended the Credit Agreement to permit the Company to purchase up to $15,000,000 of its common stock subject to compliance with certain covenants, including the requirement that after giving effect to any stock purchase, our consolidated leverage ratio (as defined in the Credit Agreement) be less than 1.0 to 1.0 and that any stock repurchased be retired within seven days of purchase. Effective October 13, 2010, we amended the Credit Agreement to extend the maturity date from August 31, 2011 to August 31, 2015. In addition, the Credit Agreement was amended to adjust the pricing grid which is based on our consolidated leverage ratio with the applicable spread over LIBOR ranging from 1.6% to 2.5% or the applicable spread over the Base Rate, as defined in the Credit Agreement, ranging from .1% to 1%. The Credit Agreement is unsecured and has loan covenants, including requirements that we comply with a consolidated fixed charge coverage ratio and consolidated leverage ratio. Proceeds from the Credit Agreement may be used for working capital, acquisitions, purchases of our common stock, dividend payments to our common stockholders, capital expenditures and other corporate purposes. Fees under the Credit Agreement include an unused commitment fee ranging from .1% to .25% depending on our consolidated leverage ratio and the amount of funds outstanding under the Credit Agreement. On December 31, 2010, $5.5 million was outstanding on the revolving credit facility resulting in $44.5 million of availability, and we were in compliance with all of the covenants thereunder.

Historically, we have generated sufficient cash from operations to fund our development activities and to cover operational needs. We plan to continue developing new clinics and making additional acquisitions in selected markets. We have from time to time purchased the noncontrolling interests of limited partners in our Clinic Partnerships. We may purchase additional noncontrolling interests in the future. Generally, any acquisition or purchase of noncontrolling interests is expected to be accomplished using a combination of cash and financing. Any large acquisition would likely require financing.

We make reasonable and appropriate efforts to collect accounts receivable, including applicable deductible and co-payment amounts, in a consistent manner for all payor types. Claims are submitted to payors daily, weekly or monthly in accordance with our policy or payor s requirements. When possible, we submit our claims electronically. The collection process is time consuming and typically involves the submission of claims to multiple payors whose payment of claims may be dependent upon the payment of another payor. Claims under litigation and vehicular incidents can take a year or longer to collect. Medicare and other payor claims relating to new clinics awaiting Medicare Rehab Agency status approval initially may not be submitted for six months or more. When all reasonable internal collection efforts have been exhausted, accounts are written off prior to sending them to outside collection firms. With managed care, commercial health plans and self-pay payor type receivables, the write-off generally occurs after the account receivable has been outstanding for 120 days.

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We have future obligations for debt repayments, employment agreements and future minimum rentals under operating leases. The obligations as of December 31, 2010 are summarized as follows (in thousands):

Contractual Obligation	Total	2011	2012	2013	2014	2015	Thereafter
Notes Payable	$ 6,000	$ 250	$ 250	$	$	$ 5,500	$
Interest Payable	$ 26	17	9				
Employee Agreements	$ 23,932	18,624	3,371	1,447	296	179	15
Operating Leases	$ 42,292	15,435	10,778	7,382	4,559	2,757	1,381
	$ 72,250	$ 34,326	$ 14,408	$ 8,829	$ 4,855	$ 8,436	$ 1,396

We generally enter into various notes payable as a means of financing our acquisitions. Our presently outstanding notes payable relate only to our 2010 acquisitions. For those acquisitions, we entered into several notes payables aggregating to $500,000. The notes are payable in equal annual installments of principal over two years plus any accrued and unpaid interest. Interest accrues at various interest rates ranging from 3.25% to 4.0% per annum. In addition, we assumed leases with remaining terms of 1 month to 6 years for the operating facilities. At December 31, 2010, the balance on these notes payable was $500,000.

In conjunction with the above mentioned acquisitions, in the event that a limited minority partner s employment ceases at any time after three years from the acquisition date, we have agreed to repurchase that individual s noncontrolling interest at a predetermined multiple of earnings before interest and taxes.

The purchase agreement related to the RMG acquisition provides for possible contingent consideration of up to $3,781,000 based on the achievement of a designated level of operating results within a three-year period following the acquisition. In 2009 and 2010, we paid $1,200,000 and $1,080,000, respectively, of additional consideration related to RMG s operating results for the first and second years. Such amounts were recorded as additional goodwill.

The purchase agreement related to the 2008 Mid-Atlantic Acquisition also provides for possible contingent consideration of up to $1,500,000 based on the achievement of a designated level of operating results within a three-year period following the acquisition. There was no contingent consideration earned based on the operating results of this acquisition during the first two years.

From September 2001 through December 31, 2008, the Board authorized us to purchase, in the open market or in privately negotiated transactions, up to 2,250,000 shares of our common stock. As of December 31, 2008, there were approximately 50,000 shares remaining that could be purchased under these programs. In March 2009, the Board authorized the repurchase of up to 10% or approximately 1,200,000 shares of our common stock (March 2009 Authorization). In connection with the March 2009 Authorization, we amended our bank credit agreement to permit the share repurchases of up to $15,000,000. We are required to retire shares purchased under the March 2009 Authorization. Since there is no expiration date for these share repurchase programs, additional shares may be purchased from time to time in the open market or private transactions depending on price, availability and our cash position. During 2010, we purchased 86,522 shares of our common stock for a aggregate price of $1.4 million. During 2009, the Company purchased 518,335 shares for an aggregate price of $5.6 million. Using the December 31, 2010 closing price of $19.82 per share, there were approximately 405,500 shares remaining that could be purchased under these programs as of December 31, 2010.

Off Balance Sheet Arrangements

With the exception of operating leases for its executive offices and clinic facilities discussed in Note 13 to our consolidated financial statements included in Item 8, we have no off-balance sheet debt or other off-balance sheet financing arrangements.

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FACTORS AFFECTING FUTURE RESULTS

The risks related to our business and operations include:

The uncertain economic conditions and the historically high unemployment rate in the United States may have material adverse impacts on our business and financial condition that we currently cannot predict.

We depend upon reimbursement by third-party payors including Medicare and Medicaid.

Changes as a result of healthcare reform legislation may affect our business.

We depend upon the cultivation and maintenance of relationships with the physicians in our markets.

We also depend upon our ability to recruit and retain experienced physical therapists.

Our revenues may fluctuate due to weather.

Our operations are subject to extensive regulation.

We operate in a highly competitive industry.

We may incur closure costs and losses.

Future acquisitions may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

Certain of our internal controls, particularly as they relate to billings and cash collections, are largely decentralized at our clinic locations.

See Risk Factors in Item 1A of this Annual Report on Form 10-K.

ITEM 7A. ***QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK***

We do not maintain any derivative instruments, interest rate swap arrangements, hedging contracts, futures contracts or the like. Our only indebtedness as of December 31, 2010 was seller notes of $0.5 million and an outstanding balance on our revolving credit facility of $5.5 million. The outstanding balance under our revolving credit facility is subject to fluctuating interest rates. A 1% change in the interest rate would yield an additional $55,000 of interest expense. See Note 7 of the Notes to the Consolidated Financial Statements in Item 8.

ITEM 8. ***FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.***

U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS AND RELATED INFORMATION

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and
Shareholders of U.S. Physical Therapy, Inc.

We have audited the accompanying consolidated balance sheets of U.S. Physical Therapy, Inc. (a Nevada corporation) and subsidiaries (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of net income, shareholders equity, and cash flows for each of the three years in the period ended December 31, 2010. These financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of U.S. Physical Therapy, Inc. and subsidiaries as of December 31, 2010 and 2009, and the results of their consolidated operations and their cash flows for each of the three years in the period ended December 31, 2010 in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2 to the consolidated financial statements, effective January 1, 2009, the Company adopted new accounting and reporting guidance related to noncontrolling interests.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), U.S. Physical Therapy, Inc. and subsidiaries internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and our report dated March 10, 2011, expressed an unqualified opinion.

/s/ GRANT THORNTON LLP

Houston, Texas
March 10, 2011

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and
Shareholders of U.S. Physical Therapy, Inc.

We have audited U.S. Physical Therapy, Inc. (a Nevada Corporation) and subsidiaries internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control Integrated Frame*work issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). U.S. Physical Therapy, Inc. and subsidiaries management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management s Report appearing under Item 9A on Internal Control over Financial Reporting. Our responsibility is to express an opinion on U.S. Physical Therapy, Inc. s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, based on our audit, U.S. Physical Therapy, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control Integrated Framework* issued by COSO.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of U.S. Physical Therapy, Inc. and subsidiaries as of December 31, 2010 and 2009, and the related consolidated statements of net income, shareholder s equity, and cash flows for each of the three years in the period ended December 31, 2010, and our report dated March 10, 2011 expressed an unqualified opinion.

/s/ GRANT THORNTON LLP

Houston, Texas

March 10, 2011

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

	December 31, 2010	December 31, 2009
	(In thousands, except per share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 9,179	$ 6,429
Patient accounts receivable, less allowance for doubtful accounts of $2,190 and $1,830, respectively	24,814	22,300
Accounts receivable other, less allowance for doubtful accounts of $83 and $42, respectively	1,555	1,331
Other current assets	3,736	2,959
Total current assets	39,284	33,019
Fixed assets:		
Furniture and equipment	33,563	31,973
Leasehold improvements	19,590	19,012
	53,153	50,985
Less accumulated depreciation and amortization	39,230	36,646
	13,923	14,339
Goodwill	79,424	57,247
Other intangible assets, net	7,308	5,955
Other assets	922	869
	$ 140,861	$ 111,429
LIABILITIES AND SHAREHOLDERS EQUITY		
Current liabilities:		
Accounts payable trade	$ 1,237	$ 1,292
Accrued expenses	12,744	12,459
Current portion of notes payable	250	1,013
Total current liabilities	14,231	14,764
Notes payable	250	
Revolving line of credit	5,500	400
Deferred rent	966	1,027
Other long-term liabilities	3,531	3,013
Total liabilities	24,478	19,204
Commitments and contingencies		

Shareholders equity:		
U. S. Physical Therapy, Inc. shareholders equity:		
Preferred stock, $.01 par value, 500,000 shares authorized, no shares issued and outstanding		
Common stock, $.01 par value, 20,000,000 shares authorized, 13,893,157 and 13,828,470 shares issued, respectively	139	138
Additional paid-in capital	45,570	43,210
Retained earnings	89,876	75,632
Treasury stock at cost, 2,214,737 shares	(31,628)	(31,628)
Total U. S. Physical Therapy, Inc. shareholders equity	103,957	87,352
Noncontrolling interests	12,426	4,873
Total equity	116,383	92,225
	$ 140,861	$ 111,429

See notes to consolidated financial statements.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF NET INCOME

	Year Ended December 31,		
	2010	2009	2008
	(In thousands, except per share data)		
Net patient revenues	$ 204,101	$ 195,322	$ 182,939
Management contract revenues and other revenues	7,132	6,087	4,747
Net revenues	211,233	201,409	187,686
Clinic operating costs:			
Salaries and related costs	110,872	105,737	100,269
Rent, clinic supplies, contract labor and other	40,944	40,502	39,814
Provision for doubtful accounts	3,241	3,348	3,073
Closure costs	163	91	432
Total clinic operating costs	155,220	149,678	143,588
Corporate office costs	22,823	23,479	20,222
Operating income	33,190	28,252	23,876
Interest and other income, net	586	8	260
Interest expense	(236)	(352)	(542)
Income from operations	33,540	27,908	23,594
Provision for income taxes	8,840	7,934	6,505
Net income including noncontrolling interests	24,700	19,974	17,089
Less: net income attributable to noncontrolling interests	(9,055)	(8,207)	(7,085)
Net income attributable to common shareholders	$ 15,645	$ 11,767	$ 10,004
Earnings per share attributable to common shareholders:			
Basic	$ 1.34	$ 1.01	$ 0.84
Diluted	$ 1.32	$ 1.00	$ 0.83
Shares used in computation:			
Basic	11,638	11,703	11,907
Diluted	11,870	11,807	12,055

See notes to consolidated financial statements.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF SHAREHOLDERS EQUITY

	U. S. Physical Therapy, Inc.								
	Common Stock		Additional Paid-In	Retained	Treasury Stock		Total Shareholders	Noncontrolling	
	Shares	Amount	Capital	Earnings	Shares	Amount	Equity	Interests	Total
	(In thousands)								
Balance December 31, 2007	14,053	$ 141	$ 41,452	$ 59,442	(2,215)	$ (31,628)	$ 69,407	$ 5,648	$ 75,055
Purchase of business								776	776
Proceeds from exercise of stock options	48	1	494				495		495
Tax benefit from exercise of stock options			128				128		128
Issuance of restricted stock	160								
Cancellation of restricted stock	(9)								
Compensation expense restricted stock			679				679		679
Compensation expense stock options			895				895		895
Distributions to noncontrolling interest partners								(7,295)	(7,295)
Net income				10,004			10,004	7,085	17,089
Balance December 31, 2008	14,252	$ 142	$ 43,648	$ 69,446	(2,215)	$ (31,628)	$ 81,608	$ 6,214	$ 87,822
Proceeds from exercise of stock options	11	1	56				57		57
Tax benefit from exercise of									

stock options			44				44		44
Issuance of restricted stock	97								
Cancellation of restricted stock	(13)								
Compensation expense restricted stock			974				974		974
Compensation expense stock options			599				599		599
Purchase of noncontrolling interests			(2,111)				(2,111)	(83)	(2,194)
Purchase and retirement of treasury stock	(518)	(5)		(5,581)			(5,586)		(5,586)
Distributions to noncontrolling interest partners								(9,465)	(9,465)
Net income				11,767			11,767	8,207	19,974
Balance December 31, 2009	13,829	$ 138	$ 43,210	$ 75,632	(2,215)	$ (31,628)	$ 87,352	$ 4,873	$ 92,225
Proceeds from exercise of stock options	68	1	419				420		420
Tax benefit from exercise of stock options			336				336		336
Issuance of restricted stock	93								
Cancellation of restricted stock	(10)								
Compensation expense restricted stock			1,245				1,245		1,245
Compensation expense stock options			47				47		47
Purchase of business								8,133	8,133
Sale of business								(92)	(92)
Purchase of noncontrolling			313				313	37	350

interests									
Purchase and retirement of treasury stock	(87)			(1,401)			(1,401)		(1,401)
Distributions to noncontrolling interest partners								(9,580)	(9,580)
Net income				15,645			15,645	9,055	24,700
Balance December 31, 2010	13,893	$ 139	$ 45,570	$ 89,876	(2,215)	$ (31,628)	$ 103,957	$ 12,426	$ 116,383

See notes to consolidated financial statements.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2010	2009	2008
	(In thousands)		
OPERATING ACTIVITIES			
Net income including noncontrolling interests	$ 24,700	$ 19,974	$ 17,089
Adjustments to reconcile net income including noncontrolling interests to net cash provided by operating activities:			
Depreciation and amortization	5,667	5,897	5,966
Provision for doubtful accounts	3,241	3,348	3,073
Equity-based awards compensation expense	1,292	1,573	1,574
Loss (gain) on sale of business and fixed assets	(333)	122	247
Excess tax benefit from exercise of stock options	(336)	(44)	(128)
Recognition of deferred rent subsidies	(414)	(492)	(431)
Deferred income tax	452	714	1,922
Other			88
Changes in operating assets and liabilities:			
(Increase) decrease in patient accounts receivable	(4,169)	165	(1,566)
(Increase) decrease in accounts receivable other	(297)	(468)	252
Decrease (increase) in other assets	206	(855)	(257)
(Decrease) increase in accounts payable and accrued expenses	(292)	595	1,873
Increase in other liabilities	804	415	470
Net cash provided by operating activities	30,521	30,944	30,172
INVESTING ACTIVITIES			
Purchase of fixed assets	(3,673)	(3,876)	(4,299)
Purchase of businesses, net of cash acquired	(18,197)	(1,178)	(19,589)
Acquisitions of noncontrolling interests	(682)	(2,329)	(1,096)
Proceeds on sale of business and fixed assets, net	919	57	108
Net cash used in investing activities	(21,633)	(7,326)	(24,876)
FINANCING ACTIVITIES			
Distributions to noncontrolling interests	(9,580)	(9,438)	(7,295)
Purchase and retire of common stock	(1,401)	(5,586)	
Proceeds from revolving line of credit	46,300	24,450	20,900
Payments on revolving line of credit	(41,200)	(35,450)	(16,500)
Payment of notes payable	(1,013)	(1,379)	(887)
Excess tax benefit from stock options exercised	336	44	128
Proceeds from exercise of stock options	420	57	495
Net cash used in financing activities	(6,138)	(27,302)	(3,159)
Net increase (decrease) in cash and cash equivalents	2,750	(3,684)	2,137
Cash and cash equivalents beginning of period	6,429	10,113	7,976

Cash and cash equivalents end of period	$ 9,179	$ 6,429	$ 10,113
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION			
Cash paid during the period for:			
Income taxes	$ 7,804	$ 8,445	$ 4,400
Interest	$ 179	$ 324	$ 484
Non-cash investing and financing transactions during the period:			
Purchase of business seller financing portion	$ 525	$	$ 1,507

See notes to consolidated financial statements.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2010

1. Organization, Nature of Operations and Basis of Presentation

U.S. Physical Therapy, Inc. and its subsidiaries (the Company) operate outpatient physical therapy clinics that provide pre- and post-operative care and treatment for orthopedic-related disorders, sports-related injuries, preventative care, rehabilitation of injured workers and neurological-related injuries. As of December 31, 2010, the Company owned and operated 392 clinics in 42 states. The clinics business primarily originates from physician referrals. The principal sources of payment for the clinics services are managed care programs, commercial health insurance, Medicare/Medicaid, workers compensation insurance and proceeds from personal injury cases. In addition to the Company s ownership of clinics, it also manages physical therapy facilities for third parties, including physicians, with 15 such third-party facilities under management as of December 31, 2010.

The consolidated financial statements include the accounts of U.S. Physical Therapy, Inc. and its subsidiaries. All significant intercompany transactions and balances have been eliminated. The Company primarily operates through subsidiary clinic partnerships in which the Company generally owns a 1% general partnership interest and a 64% limited partnership interest. The managing therapist of each clinic owns the remaining limited partnership interest in the majority of the clinics (hereinafter referred to as Clinic Partnership). To a lesser extent, the Company operates some clinics through wholly-owned subsidiaries under profit sharing arrangements with therapists (hereinafter referred to as Wholly-Owned Facilities).

During 2010, we opened 19 clinics, acquired 25, closed 15 and sold 5. Of the 19 clinics opened, seven were with new partners and 12 were satellites of existing partnerships.

During 2010, we acquired a majority interest in 25 clinics in three separate transactions. On February 26, 2010, we acquired a 70% interest in five clinics in the northeast (Northeast Acquisition). On December 21, 2010, we acquired a 70% interest in a six clinic physical therapy group in the mid-Atlantic region (Mid-Atlantic Acquisition). On December 31, 2010, we acquired a 65% interest in a 14 clinic physical therapy group located in the Southeast (Southeast Acquisition).

Effective November 18, 2008, the Company acquired a 65% interest in an outpatient rehabilitation practice with four clinics in San Antonio, TX (San Antonio Acquisition), and effective June 11, 2008, the Company acquired a 65% interest in a multi-partner outpatient rehabilitation practice with nine clinics located in the Mid-Atlantic region (2008 Mid-Atlantic Acquisition). In both cases, the existing partners retained a 35% interest. Effective January 1, 2008, the Company acquired a physical therapy practice located in Michigan (Michigan Acquisition).

During 2008, the Company formed a new venture, OsteoArthritis Centers of America (OA Centers). The business specializes in the outpatient, non-surgical treatment of osteo arthritis, degenerative joint disease and other musculoskeletal conditions which affect the lives of millions of active Americans. These services are delivered by specially trained physicians and physical therapists. The Company provides physician services to third parties and operates two OA Centers. In October, 2008, the Company acquired a 65% interest in Rehab Management Group (RMG). The founders of RMG are partners of the Company in the two OA Centers. RMG provides physicians and their patients with clinical services including electro-diagnostic analysis (EDX) as well as intra articular joint (IAJP Direct) and lumbar osteoarthritis (LOP Direct) programs. EDX produces real time physiologic data about nerve and muscle function. IAJP Direct involves viscosupplementation injections used in conjunction with specialized outpatient rehabilitation programs. LOP Direct is a unique procedure for the treatment of osteoarthritis of the spine.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Clinic Partnerships

For Clinic Partnerships, the earnings and liabilities attributable to the noncontrolling interest, typically owned by the managing therapist, directly or indirectly, are recorded within the statements of net income and balance sheets as noncontrolling interests.

Wholly-Owned Facilities

For Wholly-Owned Facilities with profit sharing arrangements, an appropriate accrual is recorded for the amount of profit sharing due the clinic partners/directors. The amount is expensed as compensation and included in clinic operating costs salaries and related costs. The respective liability is included in current liabilities accrued expenses on the balance sheet.

Management Contract Revenues

Management contract revenues are derived from contractual arrangements whereby the Company manages a clinic for third party owners. The Company does not have any ownership interest in these clinics. Typically, revenues are determined based on the number of visits conducted at the clinic and recognized when services are performed. Costs, typically salaries for the Company s employees, are recorded when incurred.

2. Significant Accounting Policies

Cash Equivalents

The Company maintains its cash and cash equivalents at financial institutions. The combined account balances at several institutions typically exceed Federal Deposit Insurance Corporation (FDIC) insurance coverage and, as a result, there is a concentration of credit risk related to amounts on deposit in excess of FDIC insurance coverage. Management believes that this risk is not significant.

Long-Lived Assets

Fixed assets are stated at cost. Depreciation is computed on the straight-line method over the estimated useful lives of the related assets. Estimated useful lives for furniture and equipment range from three to eight years and for software purchased from three to seven years. Leasehold improvements are amortized over the shorter of the related lease term or estimated useful lives of the assets, which is generally three to five years.

Impairment of Long-Lived Assets and Long-Lived Assets to Be Disposed Of

The Company reviews property and equipment and intangible assets with finite lives for impairment upon the occurrence of certain events or circumstances that indicate the related amounts may be impaired. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

Goodwill

Goodwill represents the excess of costs over the fair value of the acquired business assets. Historically, goodwill has been derived from acquisitions and, prior to 2009, from the purchase of some or all of a particular local management s equity interest (noncontrolling interests) in an existing clinic. Effective January 1, 2009, if the purchase price of a noncontrolling interest by the Company exceeds or is less than the book value at the time of purchase, any excess or shortfall is recognized as an adjustment to additional paid-in capital.

The fair value of goodwill and other intangible assets with indefinite lives are tested for impairment annually and upon the occurrence of certain events, and are written down to fair value if considered impaired. The Company evaluates goodwill for impairment on at least an annual basis (in its third quarter) by comparing

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

the fair value of each reporting unit to the carrying value of the reporting unit including related goodwill. The Company operates a one segment business which is made up of various clinics within partnerships. A reporting unit refers to the acquired interest of a single clinic or group of clinics. Local management typically continues to manage the acquired clinic or group of clinics. For each clinic or group of clinics, the Company maintains discrete financial information and both corporate and local management regularly review the operating results. The Company did not combine any of the reporting units for impairment testing in any year presented because they did not meet the criteria for aggregation. For each purchase of the equity interest, goodwill, if any, is assigned to the respective clinic or group of clinics, if deemed appropriate. The evaluation of goodwill in 2010 and 2009 did not result in any goodwill amounts that were deemed impaired. The evaluation of goodwill in 2008 yielded an impairment charge of $49,000 on a clinic purchased in 1994.

An impairment loss generally would be recognized when the carrying amount of the net assets of the reporting unit, inclusive of goodwill and other intangible assets, exceed the estimated fair value of the reporting unit. The estimated fair value of a reporting unit is determined using two factors: (i) earnings prior to taxes, depreciation and amortization for the reporting unit multiplied by a price/earnings ratio used in the industry and (ii) a discounted cash flow analysis. A weight is assigned to each factor and the sum of the each weight times the factor is considered the estimated fair value. For 2010, the factors (ie. price/earnings ratio, discount rate and residual capitalization rate) were updated to reflect current market conditions.

As of September 30, 2010, the date of testing, the Company had 34 reporting units, with 11 reporting units accounting for approximately 92 percent of the goodwill. For the remaining 23 reporting units, the fair value for each of the reporting units was greater than 34 percent of the carrying value. Of the 11 reporting units, the fair value for each of seven of the reporting units, which had recorded goodwill of $39.7 million, was greater than 20 percent of the carrying value. For the four reporting units in which the fair value for each is less than 20 percent greater than the carrying value, the total recorded goodwill was approximately $26.6 million. The Company closely monitors the performance of these reporting units. The Company has not identified any triggering events occurring after the testing date that would impact the impairment testing results obtained. Factors which could result in future impairment charges include but are not limited to:

- revenue and earnings expectations;
- general economic conditions;
- regulatory conditions including federal and state regulations;
- changes as the result of government enacted national healthcare reform;
- availability and cost of qualified physical therapists;
- personnel productivity;
- changes in Medicare guidelines and reimbursement or failure of our clinics to maintain their Medicare certification status;

competitive, economic or reimbursement conditions in our markets which may require us to reorganize or close certain clinics and thereby incur losses and/or closure costs;

changes in reimbursement rates or payment methods from third party payors including government agencies and deductibles and co-pays owed by patients;

maintaining adequate internal controls;

availability, terms, and use of capital;

acquisitions and the successful integration of the operations of the acquired businesses; and

weather and other seasonal factors.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The Company will monitor the reporting units in 2011 for any triggering events or other indicators of impairment.

Noncontrolling Interests

The Company recognizes noncontrolling interests as equity in the consolidated financial statements separate from the parent entity s equity. The amount of net income attributable to noncontrolling interests is included in consolidated net income on the face of the income statement. Changes in a parent entity s ownership interest in a subsidiary that do not result in deconsolidation are treated as equity transactions if the parent entity retains its controlling financial interest. The Company recognizes a gain or loss in net income when a subsidiary is deconsolidated. Such gain or loss is measured using the fair value of the noncontrolling equity investment on the deconsolidation date.

When the purchase price of a noncontrolling interest by the Company exceeds the book value at the time of purchase, any excess or shortfall is recognized as an adjustment to additional paid-in capital. Additionally, operating losses are allocated to noncontrolling interests even when such allocation creates a deficit balance for the noncontrolling interest partner.

Revenue Recognition

Revenues are recognized in the period in which services are rendered. Net patient revenues (patient revenues less estimated contractual adjustments) are reported at the estimated net realizable amounts from third-party payors, patients and others for services rendered. The Company has agreements with third-party payors that provide for payments to the Company at amounts different from its established rates. The allowance for estimated contractual adjustments is based on terms of payor contracts and historical collection and write-off experience.

The Company determines allowances for doubtful accounts based on the specific agings and payor classifications at each clinic. The provision for doubtful accounts is included in clinic operating costs in the statement of net income. Net accounts receivable, which are stated at the historical carrying amount net of contractual allowances, write-offs and allowance for doubtful accounts, includes only those amounts the Company estimates to be collectible.

Since 1999, reimbursement for outpatient therapy services provided to Medicare beneficiaries has been made according to a Medicare Physician Fee Schedule (MPFS) published by the Department of Health and Human Services (HHS). Under the Balanced Budget Act of 1997, the total amount paid by Medicare in any one year for outpatient physical therapy or occupational therapy (including speech-language pathology) to any one patient is subjected to a stated dollar amount (the Medicare Cap or Limit), except for services provided by hospitals. Outpatient therapy services rendered to Medicare beneficiaries by the Company s therapists are subject to the Medicare Cap, except to the extent these services are rendered pursuant to certain management and professional services agreements with inpatient facilities. In 2006, Congress passed the Deficit Reduction Act (DRA), which allowed the Centers for Medicare & Medicaid Services (CMS) to grant exceptions to the Medicare Cap for services provided during the year, as long as those services met certain qualifications. The exception process initially allowed for automatic and manual exceptions to the Medicare Cap for medically necessary services. The Temporary Extension Act of 2010, enacted on March 2, 2010, extended the therapy cap exceptions process through March 31, 2010, retroactive to January 1, 2010. With respect to the MPFS, in April, the Continuing Extension Act of 2010 was signed into law which extended the zero percent update through May 31, 2010. On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which extended the exceptions process for the outpatient therapy Medicare Cap.

Outpatient therapy service providers may continue to submit claims when an exception is appropriate beyond the allotted Medicare Cap for services furnished on or after January 1, 2010 through December 31, 2010. For physical therapy and speech language pathology service combined, and for occupational therapy

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

services, the Medicare Cap for 2010 is $1,860. On June 25, 2010, the President signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PACMBPRA). The legislation increased reimbursement to providers of outpatient physical therapy for Medicare patients by 2.2% effective June 1, 2010 through November 30, 2010.

On November 2, 2010 CMS released a final ruling on the Multiple Procedure Payment Reduction (MPPR) that includes changes to the reimbursement for Medicare related therapy services that will become effective January 1, 2011. Under MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 25%. This reduction will result in an estimated 7% rate reduction for therapy services provided in calendar year 2011 for Medicare. In addition, CMS will make changes to the Relative Value Units (RVUs) and the Geographic Practice Costs Index (GPCI) to the Resource Based Relative Value System (RBRVS) that would potentially mitigate the 7% rate reduction, assuming that Congress acts with regard to the pending Sustainable Growth Rate (SGR) Physician Fee Schedule reduction.

On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA) which tabled for one year the scheduled Medicare rate reduction for physicians, physical therapists and various other healthcare service providers. Further, under the Physician Fee Schedule, during the week of December 27, 2010, CMS released corrected payment amounts for 2011 that incorporates the changes included in the MMEA. Effective January 1, 2011 pursuant to CMS s ruling on the MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 20% to 25%. This reduction will result in an estimated 5% to 7% rate reduction for the Company s reimbursement for therapy services provided in calendar year 2011 for Medicare patients. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2011 is $1,870.

Laws and regulations governing the Medicare program are complex and subject to interpretation. The Company believes that it is in compliance in all material respects with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company s financial statements as of December 31, 2010. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare program.

Management contract revenues are derived from contractual arrangements whereby we manage a clinic for third party owners. The Company does not have any ownership interest in these clinics. Typically, revenues are determined based on the number of visits conducted at the clinic and recognized when services are performed. Other revenues are recognized as services are performed.

Contractual Allowances

Contractual allowances result from the differences between the rates charged for services performed and expected reimbursements by both insurance companies and government sponsored healthcare programs for such services. Medicare regulations and the various third party payors and managed care contracts are often complex and may include multiple reimbursement mechanisms payable for the services provided in Company clinics. The Company estimates contractual allowances based on its interpretation of the applicable regulations, payor contracts and historical calculations. Each month the Company estimates its contractual allowance for each clinic based on payor contracts and the historical collection experience of the clinic and applies an appropriate contractual allowance reserve

percentage to the gross accounts receivable balances for each payor of the clinic. Based on the Company s historical experience, calculating the contractual allowance reserve percentage at the payor level is sufficient to allow the Company to provide the necessary detail and accuracy with its collectibility estimates. However, the services authorized and provided and related reimbursement are subject to interpretation that could result in payments that differ from the Company s estimates. Payor terms are periodically revised necessitating continual review and assessment of the estimates made by management. The Company s billing system does not capture the exact change in its contractual allowance reserve estimate

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

from period to period in order to assess the accuracy of its revenues and hence its contractual allowance reserves. Management regularly compares its cash collections to corresponding net revenues measured both in the aggregate and on a clinic-by-clinic basis. In the aggregate, historically the difference between net revenues and corresponding cash collections has generally reflected a difference within approximately 1% of net revenues. Additionally, analysis of subsequent period s contractual write-offs on a payor basis reflects a difference within approximately 1% between the actual aggregate contractual reserve percentage as compared to the estimated contractual allowance reserve percentage associated with the same period end balance. As a result, the Company believes that a change in the contractual allowance reserve estimate would not likely be more than 1% at December 31, 2010.

Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

The Company recognizes the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For tax positions meeting the more-likely-than-not threshold, the amount to be recognized in the financial statements is the largest benefit that has a greater than 50 percent likelihood of being realized upon ultimate settlement with the relevant tax authority.

The Company did not have any accrued interest or penalties associated with any unrecognized tax benefits nor was any interest expense recognized during the twelve months ended December 31, 2010 and 2009. The Company will book any interest or penalties, if required, in interest and/or other income/expense as appropriate.

Fair Values of Financial Instruments

The carrying amounts reported in the balance sheet for cash and cash equivalents, accounts receivable, accounts payable and notes payable approximate their fair values due to the short-term maturity of these financial instruments. The carrying amount of the revolving credit facility approximates its fair value. The interest rate on the revolving credit facility, which is tied to the Eurodollar Rate, is set at various short-term intervals, as detailed in the credit agreement.

Segment Reporting

Operating segments are components of an enterprise for which separate financial information is available that is evaluated regularly by chief operating decision makers in deciding how to allocate resources and in assessing performance. The Company identifies operating segments based on management responsibility and believes it meets the criteria for aggregating its operating segments into a single reporting segment.

Use of Estimates

In preparing the Company s consolidated financial statements, management makes certain estimates and assumptions, especially in relation to, but not limited to, goodwill impairment, allowance for receivables, tax provision and contractual allowances, that affect the amounts reported in the consolidated financial statements and related disclosures. Actual results may differ from these estimates.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Self-Insurance Program

The Company utilizes a self insurance plan for its employee group health insurance coverage administered by a third party. Predetermined loss limits have been arranged with the insurance company to minimize the Company s maximum liability and cash outlay. Accrued expenses include the estimated incurred but unreported costs to settle unpaid claims and estimated future claims. Management believes that the current accrued amounts are sufficient to pay claims arising from self insurance claims incurred through December 31, 2010.

Stock Options

The Company measures and recognizes compensation expense for all stock-based payments at fair value. Compensation cost recognized includes compensation for all stock-based payments granted prior to, but not yet vested on January 1, 2006, based on the grant-date fair value estimated at the time of grant and compensation cost for the stock-based payments granted subsequent to January 1, 2006, based on the grant-date fair value. No stock options were granted during the years ended December 31, 2010, 2009 and 2008.

Prior to October 1, 2005, the Company utilized Black-Scholes, a standard option pricing model, to measure the fair value of stock options granted to employees. The Black-Scholes model does not provide for the interaction among economic and behavioral assumptions. In the fourth quarter of 2005, the Company determined that the Trinomial Lattice Model was the best available measure of the fair value of employee stock options. The Trinomial Lattice Model accounts for changing employee behavior as the stock price changes. The use of a lattice model captures the observed pattern of increasing rates of exercise as the stock price increases.

As of December 31, 2010, there were no nonvested stock options.

Restricted Stock

Restricted stock issued to employees and directors is subject to continued employment or continued service on the board, respectively. Typically, the transfer restrictions for shares granted to employees lapse in equal installments on the following four or five annual anniversaries of the date of grant. Compensation expense for grants of restricted stock is recognized based on the fair value per share on the date of grant amortized over the vesting period. The restricted stock issued is included in basic and diluted shares for the earnings per share computation.

Recently Promulgated Accounting Pronouncements

In December 2010, the Financial Accounting Standards Board (the FASB) issued changes to the disclosure of pro forma information for business combinations. These changes clarify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination that occurred during the current year had occurred as of the beginning of the comparable prior annual reporting period only. Also, the existing supplemental pro forma disclosures were expanded to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. These changes became effective for the Company beginning January 1, 2011. Upon adoption, management has determined these changes will not have an impact on the Consolidated Financial Statements; however, in the event of a material acquisition, the Company will be required to provide additional disclosures.

In December 2010, the FASB issued changes to the testing of goodwill for impairment. These changes require an entity to perform all steps in the test for a reporting unit whose carrying value is zero or negative if it is more likely than not (more than 50%) that a goodwill impairment exists based on qualitative factors,

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

resulting in the elimination of an entity s ability to assert that such a reporting unit s goodwill is not impaired and additional testing is not necessary despite the existence of qualitative factors that indicate otherwise. These changes became effective for the Company beginning January 1, 2011. Based on the most recent impairment review of the Company s goodwill (2010 third quarter), management does not expect that these changes will have an impact on the Consolidated Financial Statements upon adoption.

In October 2009, the FASB issued changes to revenue recognition for multiple-deliverable arrangements. These changes require separation of consideration received in such arrangements by establishing a selling price hierarchy (not the same as fair value) for determining the selling price of a deliverable, which will be based on available information in the following order: vendor-specific objective evidence, third-party evidence, or estimated selling price; eliminate the residual method of allocation and require that the consideration be allocated at the inception of the arrangement to all deliverables using the relative selling price method, which allocates any discount in the arrangement to each deliverable on the basis of each deliverable s selling price; require that a vendor determine its best estimate of selling price in a manner that is consistent with that used to determine the price to sell the deliverable on a standalone basis; and expand the disclosures related to multiple-deliverable revenue arrangements. These changes became effective for the Company on January 1, 2011. Management does not expect that the adoption of these changes will have a material impact on the Consolidated Financial Statements.

3. Acquisitions and Divestiture

Acquisition of Businesses

During 2010, the Company completed the following multi-clinic acquisitions of physical therapy practices:

Acquisition	Date	% Interest Acquired	Number of Clinics
Northeast Acquisition	February 26	70%	5
2010 Mid-Atlantic Acquisition	December 21	70%	6
Southeast Acquisition	December 31	65%	14

In addition to the above multi-clinic acquisitions, on March 1, 2010, a subsidiary of the Company purchased an outpatient therapy practice for $100,000, which consisted of $75,000 of cash and a payable of $25,000. The purchase price was allocated $30,000 to non-current assets and $70,000 to goodwill. Effective July 1, 2010, a subsidiary of the Company purchased an outpatient therapy practice for $100,000, which consisted of $50,000 cash and a payable of $50,000, of which $25,000 was paid in December 2010. The purchase price was allocated $30,000 to non-current assets, $20,000 to non-competition agreement and $50,000 to goodwill. Both practices were consolidated into existing Company clinics. The Company did not acquire any clinics in 2009.

The purchase price for the 70% interest acquired in the Northeast Acquisition was $8.9 million, net of cash acquired, which consisted of $8,718,000 in cash and $200,000 in seller notes. The purchase price for the 70% interest acquired in the 2010 Mid-Atlantic Acquisition was $4.0 million, net of cash acquired, which consisted of $3,874,000 in cash and $100,000 in a seller note. The purchase price for the 65% interest acquired in the Southeast Acquisition was

$4.6 million, net of cash acquired, which consisted of $4,355,000 in cash and $200,000 in a seller note.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

During 2008, the Company completed the following acquisitions of physical therapy practices:

Acquisition	Date	% Interest Acquired	Number of Clinics
Michigan Acquisition	January 1	100%	1
2008 Mid-Atlantic Acquisition	June 11	65%	9
San Antonio Acquisition	November 18	65%	4

The purchase price of $2.8 million for the Michigan Acquisition was paid in cash. The purchase price for the 65% interest acquired in the 2008 Mid-Atlantic Acquisition was $9.5 million which consisted of $8,545,625 in cash and $950,625 in seller notes. If the practice achieves certain levels of operating results within the three years after the closing, an earn-out of up to $1,500,000 may be payable as additional purchase consideration. The purchase price for the 65% interest acquired in the San Antonio Acquisition was $5.0 million which consisted of $4,605,000 in cash and $400,400 in a seller note.

For certain acquisitions, in the event that a limited minority partner s employment ceases at any time after three years from the acquisition date, the Company agreed to repurchase that individual s noncontrolling interest at a predetermined multiple of earnings before interest and taxes.

In addition to the interests acquired in the above physical therapy practices, the Company acquired a 65% interest in RMG in October 2008. The purchase price for the 65% interest was $3.1 million which consisted of $2,985,000 in cash and $157,100 in a seller note. If the practice achieves certain levels of operating results within the three years after the closing, an earn-out of up to $3,781,000 may be payable as additional purchase consideration. In December 2009 and 2010, the Company paid additional consideration based on the achievement of operating results for the first and second years of operations in the amounts of $1,178,000 and $1,080,000, respectively. These amounts were capitalized as goodwill and are tax deductible.

The consideration paid for each of the acquisitions was derived through arm s length negotiations. Funding for the cash portions was derived from proceeds from the Company s revolving credit facility. The results of operations of the acquisitions have been included in the Company s consolidated financial statements since their respective date acquired.

For the 2008 acquisitions and the Northeast Acquisition, the purchase prices were allocated to the fair value of the assets acquired including tradenames, non-competition agreements and referral relationships, and to the liabilities assumed based on the estimates of the fair values at the acquisition date, with the amount exceeding the estimated fair values being recorded as goodwill. For the 2010 Mid-Atlantic Acquisition and the Southeast Acquisition (December Acquisitions), the purchase prices were allocated to the fair value of the tangible assets acquired and to the liabilities assumed based on the estimates of the fair values at the acquisition date, with the amount exceeding the estimated fair values being recorded as goodwill. Due to the December Acquisitions being completed near year end, the Company will finalize its valuations in 2011. Thus, the final allocations of the purchase prices may differ from preliminary estimates used at December 31, 2010. Goodwill for the 2010 and 2008 acquisitions is tax deductible.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The purchase prices allocated for the 2010 multi-clinic acquisitions in aggregate were as follows (in thousands):

Cash paid, net of cash acquired	$ 16,947
Seller notes	500
Total consideration	$ 17,447
Estimated fair value of net tangible assets acquired:	
Total current assets	$ 1,826
Total non-current assets	1,415
Total liabilities	(575)
Net tangible assets acquired	$ 2,666
Referral relationships	700
Non compete, 6 years	190
Tradename	1,000
Goodwill	21,022
Fair value of noncontrolling interest	(8,131)
	$ 17,447

The purchase prices (exclusive of the additional consideration paid in 2009 and 2010) allocated for the 2008 acquisitions in aggregate were as follows (in thousands):

Cash paid and cost incurred, net of cash acquired	$ 19,237
Seller notes	1,507
Total consideration	$ 20,744
Estimated fair value of net tangible assets acquired:	
Total current assets	$ 1,127
Total non-current assets	502
Total liabilities	(237)
Net tangible assets acquired	$ 1,392
Referral relationships	1,170
Non compete, ranging from 5 to 51/2 years	916
Tradename	750
Goodwill	16,516
	$ 20,744

For the 2010 multi-clinic and 2008 acquisitions, total current assets primarily represent patient accounts receivable of $2.9 million. Total non current assets are fixed assets, primarily equipment, used in the practices. For the 2008 acquisitions, the value assigned to (i) referral relationships is amortized to expense equally over the respective estimated original life which ranges from six to 12 years for these acquisitions, (ii) non compete agreements is amortized over five to five and one-half years and (iii) goodwill and tradenames are tested at least annually for impairment. For the Northeast Acquisition, the value assigned to (i) referral relationships is amortized to expense equally over the respective estimated original life which is 12 years, (ii) non compete agreements is amortized over six years and (iii) goodwill and tradenames are tested at least annually for impairment. For the acquisitions that occurred in December 2010, a review of referral relationships, non compete agreements and tradenames has not yet been completed. Goodwill acquired is tax deductible.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited proforma consolidated financial information for the 2010 and 2008 acquisitions have not been included as the results, individually and in the aggregate, were not material to current operations.

Acquisitions of Noncontrolling Interests

During 2010, the Company purchased noncontrolling interests in nine partnerships for an aggregate purchase price of $682,000. The amount paid plus a net deficit of $37,000 in limited partners equity, less tax benefits of $217,000, was recognized as an adjustment to additional paid-in capital.

During 2009, the Company purchased 15% of the 25% noncontrolling interest in certain clinics related to a partnership. In addition, the Company purchased noncontrolling interests in five other partnerships. The total paid, which amounted to $2,200,000, less the tax benefit of $816,000 and the book value related to the purchases of $90,000 was recognized as an adjustment to additional paid-in capital. During 2009, the Company paid $133,000 related to contingent payments for noncontrolling interests purchased prior to 2009.

During 2008, the Company purchased a portion of the noncontrolling interest in three partnerships and purchased the noncontrolling interest in four partnerships for an aggregate purchase price of $1.4 million. The purchases yielded $1.2 million of goodwill related to three partnerships. The remaining $0.2 million represented payment of undistributed earnings to the noncontrolling interest partners. In addition, during 2008, the Company paid $0.2 million related to contingent payments for noncontrolling interests purchased in previous years, and accrued $0.4 million for contingent payments related to 2008 results. The accrued contingent payments were paid in early 2010. The 2008 purchases of minority interest do not contain any future contingent payments. The contingent payments made and accrued during 2008 had the effect of increasing goodwill.

The results of operations of the acquired noncontrolling interests are included in the accompanying financial statements from the dates of purchase in the net income attributable to common shareholders.

Divestiture of Business

On March 31, 2010, the Company sold its 51% interest in a joint venture of five Texas clinics for $974,000. The Company recorded a pre-tax gain of $578,000, which is included in interest and other income, net in the consolidated statement of net income.

The operating results of these locations were not material to the operations of the Company, and therefore, the operating results of these clinics were not reclassified and reported as discontinued operations. The cash flow impact of these clinics was determined to be immaterial to the consolidated statements of cash flows.

4. Goodwill

The changes in the carrying amount of goodwill as of December 31, 2010 and 2009 consisted of the following (in thousands):

	Year Ended December 31

	2010	2009
Beginning balance	$ 57,247	$ 55,886
Goodwill acquired during the year	22,222	1,312
Adjustment	(45)	49
Ending balance	$ 79,424	$ 57,247

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

5. Intangible Assets, net

Intangible assets, net as of December 31, 2010 and 2009 consisted of the following (in thousands):

	December 31, 2010	2009
Tradename	$ 4,373	$ 3,373
Referral relationships, net of accumulated amortization of $479 and $266, respectively	2,082	1,595
Non compete agreements, net of accumulated amortization of $1,053 and $709, respectively	853	987
	$ 7,308	$ 5,955

Tradenames and referral relationships are related to the businesses acquired. The value assigned to tradenames has an indefinite life and is tested at least annually for impairment in conjunction with the Company s annual goodwill impairment test. The value assigned to referral relationships is being amortized over their respective estimated useful lives which range from six to 16 years. Non compete agreements are amortized over the respective term of the agreements which range from five to six years.

The following table details the amount of amortization expense recorded for intangible assets for the years ended December 31, 2010, 2009 and 2008 (in thousands):

	Year Ended December 31, 2010	2009	2008
Referral relationships	$ 213	$ 163	$ 89
Non compete agreements	344	134	225
	$ 557	$ 297	$ 314

The remaining balance of referral relationships and non compete agreements is expected to be amortized as follows (in thousands):

Referral Relationships		Non Compete Agreements	
Years	Annual Amount	Years	Annual Amount
2011 -2013	$222	2011	$327
2014	$219	2012	$269
2015-2017	$198	2013	$168

2018	$162	2014	$32
2019	$133	2015	$32
2020	$126	2016	$5
2021	$102		
2022	$52		
2023	$28		

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

6. Accrued Expenses

Accrued expenses as of December 31, 2010 and 2009 consisted of the following (in thousands):

	Year Ended December 31	
	2010	**2009**
Salaries and related costs	$ 8,989	$ 9,133
Group health insurance claims	1,324	977
Credit balances due to patients and payors	702	1,283
Other	1,729	1,066
Total	$ 12,744	$ 12,459

7. Notes Payable

Notes payable as of December 31, 2010 and 2009 consisted of the following ($ in thousands):

	2010	**2009**
Revolving credit agreement average effective interest rate of 3.25% inclusive of unused fee	$ 5,500	$ 400
Various promissory notes payable in annual installments of an aggregate of $100 plus accrued interest through February 26, 2012, interest accrues at 3.25% per annum	200	
Promissory note payable in annual installments of $100 plus accrued interest through December 31, 2012, interest accrues at 3.25% per annum	200	
Promissory note payable in annual installments of $50 plus accrued interest through December 21, 2012, interest accrues at 4.00% per annum	100	
Various promissory notes payable in annual installments of an aggregate of $475 plus accrued interest through June 11, 2010, interest accrued at 5.00% per annum		475
Various promissory notes payable in annual installments of an aggregate of $333 plus accrued interest through September 6, 2010, interest accrued at 8.25% per annum		259
Promissory note payable in annual installments of $200 plus accrued interest through November 18, 2010, interest accrued at 4.00% per annum		200
Promissory note payable in annual installments of $79 plus accrued interest through October 8, 2010, interest accrued at 5.00% per annum		79
	6,000	1,413
Less current portion	(250)	(1,013)
	$ 5,750	$ 400

Effective August 27, 2007, the Company entered into a credit agreement with a commitment for a $30.0 million revolving credit facility which was increased to $50.0 million effective June 4, 2008 (Credit Agreement). Effective March 18, 2009, the Credit Agreement was amended to permit the Company to purchase up to $15,000,000 of its common stock subject to compliance with certain covenants, including the requirement that after giving effect to any stock purchase, the Company s consolidated leverage ratio (as defined in the Credit Agreement) be less than 1.0 to 1.0 and that any stock repurchased be retired within seven days of purchase. Effective October 13, 2010, the Credit Agreement was amended to extend the maturity date from August 31, 2011 to August 31, 2015. In addition, the Credit Agreement was amended to adjust the

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

pricing grid which is based on the Company s consolidated leverage ratio with the applicable spread over LIBOR ranging from 1.6% to 2.5% or the applicable spread over the Base Rate, as defined in the Credit Agreement, ranging from .1% to 1%. The Credit Agreement is unsecured and has loan covenants, including requirements that the Company comply with a consolidated fixed charge coverage ratio and consolidated leverage ratio. Proceeds from the Credit Agreement may be used for working capital, acquisitions, purchases of the Company s common stock, dividend payments to the Company s common stockholders, capital expenditures and other corporate purposes. Fees under the Credit Agreement include an unused commitment fee ranging from .1% to .25% depending on the Company s consolidated leverage ratio and the amount of funds outstanding under the Credit Agreement. On December 31, 2010, $5.5 million was outstanding on the revolving credit facility resulting in $44.5 million of availability, and the Company was in compliance with all of the covenants thereunder.

In conjunction with the 2010 multi-clinic acquisitions, the Company entered into various notes payable aggregating $500,000. The notes are payable in equal annual installments of principal over two years plus any accrued and unpaid interest. Interest accrues at rates ranging from 3.25% to 4.0% per annum.

Aggregate annual payments of principal required pursuant to the revolving credit facility and the above notes payable subsequent to December 31, 2010 are as follows:

During the year ended December 31, 2011	$ 250
During the year ended December 31, 2012	250
During the year ended December 31, 2013	
During the year ended December 31, 2014	
During the year ended December 31, 2015	5,500
	$ 6,000

8. Income Taxes

Significant components of deferred tax assets included in the consolidated balance sheets at December 31, 2010 and 2009 were as follows (in thousands):

	2010	2009
Deferred tax assets:		
Compensation	$ 1,375	$ 1,471
Allowance for doubtful accounts	740	572
Lease obligations closed clinics	47	11
Other	40	227
Deferred tax assets	$ 2,202	$ 2,281
Deferred tax liabilities:		
Depreciation and amortization	$ (3,970)	$ (3,761)

Other	(164)	
Deferred tax liabilities	$ (4,134)	$ (3,761)
Net deferred tax liabilities	$ (1,932)	$ (1,480)
Amount included in:		
Other current assets	$ 921	$ 970
Long term liabilities	$ (2,853)	$ (2,450)

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The differences between the federal tax rate and the Company s effective tax rate for results of continuing operations for the years ended December 31, 2010, 2009 and 2008 were as follows (in thousands):

	2010		2009		2008	
U. S. tax at statutory rate	$ 8,570	35.0%	$ 6,895	35.0%	$ 5,750	34.8%
State income taxes, net of federal benefit	185	0.7%	762	3.9%	683	4.1%
Nondeductible expenses	85	0.4%	277	1.4%	89	0.5%
Tax exempt interest income		0.0%		0.0%	(17)	0.0%
	$ 8,840	36.1%	$ 7,934	40.3%	$ 6,505	39.4%

Significant components of the provision for income taxes for continuing operations for the years ended December 31, 2010, 2009 and 2008 were as follows (in thousands):

	2010	2009	2008
Current:			
Federal	$ 7,730	$ 6,002	$ 3,693
State	658	1,218	890
Total current	8,388	7,220	4,583
Deferred:			
Federal	392	611	1,592
State	60	103	330
Total deferred	452	714	1,922
Total income tax provision for continuing operations	$ 8,840	$ 7,934	$ 6,505

During the fourth quarter of 2010, the Company completed a process to perform a detailed reconciliation of its federal and state taxes payable and receivable accounts along with its federal and state deferred tax asset and liability accounts. Historically, calculations of these tax-related accounts were performed through summary estimates and analysis. As a result of this detailed analysis, the Company recorded a reduction in its current state income tax provision of $814,000. In addition, the Company adjusted its deferred tax asset for the tax benefit of $816,000 related to the purchase of a non controlling interest in 2009. This tax benefit is reflected as an offset to the purchase of non controlling interests in the Consolidated Statement of Shareholders Equity. The Company considers this reconciliation process to be an annual control and, in the future, will perform a similar reconciliation process during the fourth quarter of each year.

The Company is required to establish a valuation allowance for deferred tax assets if, based on the weight of available evidence, it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the projected future taxable income and tax planning strategies in making this assessment. Based upon the level of historical taxable income and projections for future taxable income in the periods which the deferred tax assets are deductible, management believes that a valuation allowance is not required, as it is more likely than not that the results of future operations will generate sufficient taxable income to realize the deferred tax assets.

The Company s U.S. federal returns remain open to examination for 2007 through 2009 and U.S. state jurisdictions are open for periods ranging from 2003 through 2009.

The Company does not believe that it has any significant uncertain tax positions at December 31, 2010, nor is this expected to change within the next twelve months due to the settlement and expiration of statutes of limitation.

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The Company did not have any accrued interest or penalties associated with any unrecognized tax benefits nor was any interest expense recognized during the years ended December 31, 2010 and 2009.

9. Equity Based Plans

The Company has the following equity based plans:

The 1992 Stock Option Plan, as amended (the 1992 Plan), permitted the Company to grant to key employees and outside directors of the Company incentive and non-qualified options to purchase up to 3,495,000 shares of common stock (subject to proportionate adjustments in the event of stock dividends, splits, and similar corporate transactions). The 1992 Plan expired in 2002 and no new option grants can be awarded subsequent to this date.

Incentive stock options (those intended to satisfy the requirements of the Internal Revenue Code) granted under the 1992 Plan were granted at an exercise price not less than the fair market value of the shares of common stock on the date of grant. The exercise prices of options granted under the 1992 Plan were determined by the Compensation Committee. The period within which each option is exercisable was determined by the Compensation Committee (however, in no event may the exercise period of an incentive stock option extend beyond 10 years from the date of grant).

The Amended and Restated 1999 Employee Stock Option Plan (the Amended 1999 Plan) permits the Company to grant to non-employee directors and employees of the Company up to 600,000 non-qualified options to purchase shares of common stock and restricted stock (subject to proportionate adjustments in the event of stock dividends, splits, and similar corporate transactions). The exercise prices of options granted under the Amended 1999 Option Plan are determined by the Compensation Committee. The period within which each option will be exercisable is determined by the Compensation Committee. The Amended 1999 Plan was approved by the shareholders of the Company at the 2008 Shareholders Meeting on May 20, 2008.

During 2003, the Board of Directors of the Company (the Board) granted inducement options covering 145,000 options, respectively, to five individuals in connection with their offers of employment. As of December 31, 2010, 124,000 of the 145,000 options are outstanding. Inducement options may be exercised for a 10 year term from the date of the grant.

The Amended and Restated 2003 Stock Option Plan (the Amended 2003 Plan) permits the Company to grant to key employees and outside directors of the Company incentive and non-qualified options and shares of restricted stock covering up to 1,250,000 shares of common stock (subject to proportionate adjustments in the event of stock dividends, splits, and similar corporate transactions). The Amended 2003 Plan was approved by the shareholders of the Company at the 2010 Shareholders Meeting on May 18, 2010.

A cumulative summary of equity plans as of December 31, 2010 follows:

Equity Plans	Authorized	Restricted	Outstanding	Stock Options Exercised	Stock Options Exercisable	Shares Available for Grant

		Stock Issued	Stock Options			
1992 Plan	3,495,000		15,000	2,781,012	15,000	
Amended 1999 Plan	600,000	370,900	43,390	96,621	43,390	89,089
Amended 2003 Plan	1,250,000	21,000	541,500	236,800	541,500	450,700
Inducements	164,000		124,000	40,000	124,000	
	5,509,000	391,900	723,890	3,154,433	723,890	539,789

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

A summary of the status of the Company s stock options granted under the plans as of December 31, 2010, 2009 and 2008 and the changes during the years then ended is presented below:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (000 s)
Outstanding at December 31, 2007	946,900	13.95		
Granted				
Exercised	(48,561)	10.15		
Cancelled	(3,522)	16.48		
Forfeited	(2,508)	16.56		
Outstanding at December 31, 2008	892,309	14.14		
Granted				
Exercised	(10,752)	4.05		
Cancelled	(1,290)	18.42		
Forfeited	(6,075)	16.97		
Outstanding at December 31, 2009	874,192	14.24	4.6 Years	
Granted				
Exercised	(142,002)	13.66		
Cancelled	(160)	18.42		
Forfeited	(8,140)	18.54		
Outstanding at December 31, 2010	723,890	14.30	3.6 Years	
Exercisable at December 31, 2010	723,890	14.30	3.6 Years	$ 3,993

The changes during the year of the nonvested shares pursuant to stock options as of December 31, 2010 is as follows:

	Number of Shares	Weighted Average Grant-Date Fair Value	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (000 s)
Nonvested at January 1, 2010	16,250	$ 8.11	5.3 Years	
Granted				

Vested	(16,090)	$	8.09
Cancelled	(160)	$	10.39
Nonvested at December 31, 2010		$	

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

A summary of the intrinsic value of stock options exercised during the years ended December 31, 2010, 2009 and 2008 is as follows:

	Number of Shares	Aggregate Intrinsic Value (000 s)
2008	48,561	$ 332
2009	10,752	$ 113
2010	142,002	$ 863

The following tables summarize information about the Company s stock options outstanding as of December 31, 2010, 2009 and 2008, respectively:

	Outstanding Options as of December 31, 2010	Exercise Price	Weighted Average Remaining Contractual Life	Exercisable	Exercise Price
1992 Plan	15,000	$ 16.34	.6 Years	15,000	$ 16.34
1999 Plan	43,390	$ 12.60 - $18.42	3.9 Years	43,390	$ 12.60 - $18.42
2003 Plan	541,500	$ 12.51 - $18.80	3.8 Years	541,500	$ 12.51 - $18.80
Inducements	124,000	$ 12.75 - $14.32	2.8 Years	124,000	$ 12.75 - $14.32
	723,890	$ 12.51 - $18.80	3.6 Years	723,890	$ 12.51 - $18.80

	Outstanding Options as of December 31, 2009	Exercise Price	Weighted Average Remaining Contractual Life	Exercisable	Exercise Price
1992 Plan	15,002	$ 4.15 - $16.34	1.7 Years	15,002	$ 4.15 - $16.34
1999 Plan	57,690	$ 4.15 - $19.29	5.0 Years	50,440	$ 4.15 - $18.42
2003 Plan	677,500	$ 12.51 - $18.80	4.8 Years	668,500	$ 12.51 - $18.80
Inducements	124,000	$ 12.75 - $14.32	3.8 Years	124,000	$ 12.75 - $14.32

874,192	$ 4.15 - $19.29	4.6 Years	857,942	$ 4.15 - $18.80

	Outstanding Options as of December 31, 2008	Exercise Price	Weighted Average Remaining Contractual Life	Exercisable	Exercise Price
1992 Plan	25,004	$ 4.15 - $16.34	2.3 Years	25,004	$ 4.15 - $16.34
1999 Plan	63,805	$ 2.81 - $19.29	6.0 Years	42,765	$ 2.81 - $18.42
2003 Plan	677,500	$ 12.51 - $18.80	5.8 Years	599,500	$ 12.51 - $18.80
Inducements	126,000	$ 12.75 - $14.32	4.8 Years	126,000	$ 12.75 - $14.32
	892,309	$ 2.81 - $19.29	5.6 Years	793,269	$ 2.81 - $18.80

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The following table summarizes information about the Company s stock options outstanding and those options that are exercisable as of December 31, 2010:

Range of Exercise Prices	Outstanding Options	Exercisable Options
$12.00 $12.99	124,880	124,880
$13.00 $13.99	341,500	341,500
$14.00 $14.99	102,855	102,855
$15.00 $15.99	44,930	44,930
$16.00 $16.99	16,825	16,825
$18.00 $18.80	92,900	92,900
	723,890	723,890

During 2010, 2009 and 2008, the Company granted the following shares (net of those shares cancelled in their respective grant year due to employee terminations prior to restrictions lapsing) of restricted stock to directors, officers and employees pursuant to its equity plans as follows:

Year Granted	Number of Shares	Weighted Average Fair Value Per Share
2008	148,800	$ 14.32
2009	87,500	$ 14.76
2010	93,300	$ 16.50

Generally, restrictions on the stock granted to employees lapse in equal annual installments on the following four or five anniversaries of the date of grant. For those shares granted to directors, the restrictions will lapse in equal quarterly installments during the first year after the date of grant. For those granted to executive officers, the restriction will lapse in equal quarterly installments during the three years following the date of grant.

As of December 31, 2010, there were 245,096 shares outstanding for which restrictions had not lapsed. The restrictions will lapse in 2011 through 2014.

Compensation expense for grants of restricted stock will be recognized based on the fair value on the date of grant. Compensation expense for restricted stock grants was $1,245,000, $974,000, and $679,000, respectively, for 2010, 2009 and 2008. As of December 31, 2010, the remaining $2.6 million of compensation expense will be recognized in 2011 through 2014.

10. Preferred Stock

The Board is empowered, without approval of the shareholders, to cause shares of preferred stock to be issued in one or more series and to establish the number of shares to be included in each such series and the rights, powers, preferences and limitations of each series. There are no provisions in the Company s Articles of Incorporation specifying the vote required by the holders of preferred stock to take action. All such provisions would be set out in the designation of any series of preferred stock established by the Board. The bylaws of the Company specify that, when a quorum is present at any meeting, the vote of the holders of at least a majority of the outstanding shares entitled to vote who are present, in person or by proxy, shall decide any question brought before the meeting, unless a different vote is required by law or the Company s Articles of Incorporation. Because the Board has the power to establish the preferences and rights of each series, it may afford the holders of any series of preferred stock, preferences, powers, and rights, voting or otherwise,

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

senior to the right of holders of common stock. The issuance of the preferred stock could have the effect of delaying or preventing a change in control of the Company.

11. Common Stock

In September 2001 through December 31, 2008, the Board of Directors (Board) authorized the Company to purchase, in the open market or in privately negotiated transactions, up to 2,250,000 shares of its common stock. However, the terms of the Company s revolving credit facility had prohibited such purchases since August 2007. As of December 31, 2008, there were approximately 50,000 shares remaining that could be purchased under those programs.

In March 2009, the Board authorized the repurchase of up to 10% or approximately 1,200,000 shares of its common stock (March 2009 Authorization). In connection with the March 2009 Authorization, the Company amended its revolving credit facility to permit the share repurchases. The Company is required to retire shares purchased under the March 2009 Authorization. Since there is no expiration date for these share repurchase programs, additional shares may be purchased from time to time in the open market or private transactions depending on price, availability and the Company s cash position. During 2010, the Company purchased 86,522 shares for an aggregate purchase price of $1.4 million. During 2009, the Company purchased 518,335 shares for an aggregate price of $5.6 million. The Company did not purchase any shares of its common stock during 2008.

12. Defined Contribution Plan

The Company has a 401(k) profit sharing plan covering all employees with three months of service. The Company may make discretionary contributions of up to 50% of employee contributions. The Company did not make any discretionary contributions and recognized no contribution expense for the years ended December 31, 2010, 2009 and 2008.

13. Commitments and Contingencies

Operating Leases

The Company has entered into operating leases for its executive offices and clinic facilities. In connection with these agreements, the Company incurred rent expense of $16.8 million, $16.3 million and $15.5 million for the years ended December 31, 2010, 2009 and 2008, respectively. Several of the leases provide for an annual increase in the rental payment based upon the Consumer Price Index. The majority of the leases provide for renewal periods ranging from one to five years. The agreements to extend the leases specify that rental rates would be adjusted to market rates as of each renewal date.

The future minimum operating lease commitments for each of the next five years and thereafter and in the aggregate as of December 31, 2010 are as follows (in thousands):

2011	$ 15,435
2012	10,778
2013	7,382
2014	4,559

2015	2,757
Thereafter	1,381
	$ 42,292

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U.S. PHYSICAL THERAPY, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Employment Agreements

At December 31, 2010, the Company had outstanding employment agreements with three of its executive officers. On December 2, 2008, the employment agreements were amended to change the expiration date from December 31, 2009 to December 31, 2011. All of the agreements contain a provision for annual adjustment of salaries.

In addition, the Company has outstanding employment agreements with most of the managing physical therapist partners of the Company s physical therapy clinics and with certain other clinic employees which obligate subsidiaries of the Company to pay compensation of $17.5 million in 2011 and $5.3 million in the aggregate from 2012 through 2016. In addition, most of the employment agreements with the managing physical therapists provide for monthly bonus payments calculated as a percentage of each clinic s net revenues (not in excess of operating profits) or operating profits.

14. Earnings Per Share

The computations of basic and diluted earnings per share for the years ended December 31, 2010, 2009 and 2008 are as follows (in thousands, except per share data)

	2010	2009	2008
Numerator:			
Net income from continuing operations attributable to common shareholders	$ 15,645	$ 11,767	$ 10,004
Net loss from discontinued operations attributable to common shareholders			
Net income attributable to common shareholders	$ 15,645	$ 11,767	$ 10,004
Denominator:			
Denominator for basic earnings per share - weighted-average shares	11,638	11,703	11,907
Effect of dilutive securities - Stock options	232	104	148
Denominator for diluted earnings per share - adjusted weighted-average shares and assumed conversions	11,870	11,807	12,055
Earnings per share:			
Basic income from continuing operations attributable to common shareholders	$ 1.34	$ 1.01	$ 0.84
Basic loss from discontinued operations attributable to common shareholders			
Total basic earnings per share	$ 1.34	$ 1.01	$ 0.84
Diluted income from continuing operations attributable to common shareholders	$ 1.32	$ 1.00	$ 0.83

Diluted loss from discontinued operations attributable to common shareholders	
Total diluted earnings per share	