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New Rec: Psychiatric Solutions (PSYS: \$39.68)	July 13, 2008
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Position: Sell

Target: \$25

\$M	2Q08e	3Q08e	4Q08e	1Q09e	2008e	2009e
Revenue	446.1	451.8	448.6	463.6	1,776.1	1,864.8
EPS	0.50	0.49	0.48	0.51	1.93	2.05
Y/Y Gro	36%	31%	14%	11%	29%	6%
PE	n/a	n/a	n/a	n/a	21	19
PSR	n/a	n/a	n/a	n/a	1.2	1.2
Consen	0.50	0.52	0.54	0.56	2.01	2.36

Shares Out: 55.8M

Market Cap: \$2.2B

FYE: Dec

Summary: Psychiatric Solutions (PSYS) is the largest operator of freestanding psychiatric facilities in the U.S. As of March 31, 2008, the company operated 95 facilities in 31 states, with a total of 10,800 beds, giving it an estimated 19%

market share. About 54% of its beds are in acute inpatient facilities to treat acute psychiatric episodes with an average length of stay (LOS) of 10 days, while 46% of beds are in residential treatment centers (RTC) for children/adolescents with behavioral issues (e.g., substance abuse, sexual aggression, reactive attachment disorders), with an average LOS of 180 days. In 2007, 32% of revenue came from Medicaid, 33% from HMOs and other commercial insurers, 16% from state funded programs, 13% from Medicare, and 6% from other sources.

Bulls view PSYS as “largely immune” from the economic and Medicare risks currently facing other companies in the health care facilities space. They even quietly tout the benefits that could accrue to the company from more patient admissions due to the stresses of the poor economy (ignoring the loss of health benefits that comes from job losses) and from returning veterans of the wars in Iraq and Afghanistan (most of whom would likely be treated at VA hospitals). They also point to numerous reports of constrained supply in the number of beds available in many states, while neglecting to mention that these beds are primarily needed by patients PSYS has chosen to not serve (long term psychiatric care, and/or patients not covered by Medicaid, Medicare, or commercial insurance). Finally, they point to potential passage of a mental health parity bill by Congress, but, as we discuss later, this would be of minimal benefit to PSYS.

Our research suggests that PSYS has benefited from some significant structural changes to Medicaid funding that are now fully realized. States have shifted behavioral programs for children/adolescents from state funding to Medicaid funding, which is funded 50% by the federal government. This has allowed a significant expansion in the number of people receiving benefits. But as we discuss, states are now looking for ways to rein in this spending. Tools used to shore up Medicaid in the 2001-2003 downturn (federal funds, cuts to higher education funding) may not be as readily available this time around. Finally, the Prescription Drug Plan of 2006 generated unprecedented savings for state Medicaid budgets, some of which funded increases in psychiatric programs. No new measures to shift costs from Medicaid to Medicare are on the horizon.

With significant amounts of revenue coming from the states through Medicaid and state programs, state tax revenues are very important to PSYS. The current economic downturn is being felt particularly hard by states, most of which rely on sales and personal income taxes for revenue. State tax revenues were down 5.3% y-y on an inflation adjusted basis in 1Q08, even before the effects of \$4 gas were fully felt. About 25% of PSYS’ beds are in states considered to be in recession, and more likely fell into that category in 2Q08.

PSYS will also likely be impacted by the significant challenges facing the nation's health insurers (33% of revenue), who are seeing their operating margins compress as the generous benefits packages they offered to gain share are not adequately funded by premiums. Employers are not willing to accept increased premiums, with many opting instead to offer fewer benefits or drop coverage altogether. When PSYS' new payment rates are set for 2009, industry sources with whom we have spoken expect plans to offer increases well below the 7%-8% they had seen from insurers in 2008. They also expect utilization management (LOS, admissions) to become more restrictive.

A structural change in Medicare (13% of revenue) payments to psychiatric facilities also benefited PSYS over the past three years, but is now fully realized. In January 2005, CMS began a three year transition from cost-plus payments for inpatient psychiatric services to a prospective payment system (PPS) that pays a set amount per day based on diagnosis. Freestanding psychiatric hospitals benefited from the change, since their lower overheads and lack of bad debt made these patients more profitable than they were for general hospitals' psychiatric wards. General hospitals began to close their units, driving patients to freestanding hospitals, increasing occupancy and margins. Further margin expansion, an important part of the bull story on PSYS, will be difficult to find from Medicare patients, in our view.

While industry sources tell us they are just beginning to see the impact of payors' financial strains on rates and occupancy, our analysis suggests there is already weakness appearing in PSYS' LOS and occupancy rates. As we discuss, same store and total facility LOS has been flat-to-down for the past four quarters, and occupancy rates have been falling. While the company blames this weakness on the recent acquisition of Horizon Health, our analysis suggests the core business is also experiencing weakness.

PSYS has grown largely by acquisitions made with borrowed cash, posting top line growth of 43% in 2006 and 45% in 2007 versus same store growth of 9% and 6.5%. As we show in detail below, acquisitions have become increasingly expensive on a per bed and revenue multiple basis, and quality is deteriorating, as evidenced by lower EBITDA margins for acquired facilities. Moreover, after the May 2007 acquisition of 1,600 bed Horizon (HORC), few large acquisitions remain. With 19% of the market and no remaining large players (except for UHS' 7,573 psychiatric beds), we think it will be increasingly difficult for PSYS to find meaningful growth from acquisitions.

Even if more large acquisition candidates can be found, however, financing should be a challenge. The company has rapidly levered its balance sheet to

execute its roll-up strategy, increasing its debt to total capitalization ratio to 62% at March 31, 2008. Approximately 40% of its \$1.3B in debt is at a floating rate, and the company currently has only about \$100M in liquidity (cash and a remaining revolving credit line), a tiny sum for a company that has spent \$400M-\$500M per year for acquisitions over the past three years.

Perhaps realizing that the acquisition game has just about played out, PSYS has begun spending more on building new beds, either at existing facilities or *de novo*. The company plans to add 600 beds in 2008, above historic levels of 100-200 per year. At an estimated cost of \$200K per bed, the company will have to spend \$120M for 600 beds, well above the company's current run rate of \$100M per year in capex spending, which includes about \$36M per year in maintenance capex. We expect this spending to significantly pressure FCF, which we expect to be \$33M in 2008 and \$36M in 2009.

While we expect deterioration in PSYS' fundamentals to soon become evident on the income statement, its balance sheet and cash flow are already showing the stress on the business. ROIC is falling. CFO is growing much more slowly than net income. FCF growth is deteriorating. The company's current pre-acquisition expense FCF yield is just 1.5%.

We expect the impact of tighter admissions standards and LOS restrictions to begin to be felt in 2H08 with lower occupancy rate trends continuing. We forecast hospital revenue of \$1.6B, up 19% y-y versus the "street's" 23% expected growth. We expect lower occupancy trends to continue in 2009, and project hospital revenue of \$1.697B, up 5% y-y (4% increase in revenue per day, 1% increase in patient days), versus the 7% increase to \$1.787B expected by the "street." We think 2009 management contract revenue will be flat versus 2008 as more hospital psychiatric units close. The "street" is even more bearish, forecasting a 4% y-y decline. We think higher costs on lower occupancy will keep EBIT flat y-y in 2009 at 14.5% despite continued synergies from acquisitions. The "street" is expecting further EBIT margin expansion from 14.6% in 2008 to 15.5% in 2009. Of course, bulls are likely banking on more acquisitions to make this margin expansion unnecessary to meet EPS growth expectations, but further sizable acquisitions will be difficult to finance and difficult to find. We expect EPS of \$1.93 in 2008 and \$2.05 in 2009 versus the "street's" \$2.02 and \$2.38.

PSYS "Street" vs. OWS Expectations

\$M	F2007a	"Street" F2008e	"Street" F2009e	OWS F2008e	OWS F2009e
Freestanding Hosp Rev	1,354	1,661	1,787	1,609	1,697
Management Contracts	124	164	157	167	168
Total Revenue	1,482	1,825	1,944	1,776	1,865
EBIT	209	267	300	258	271
Interest Expense	75	84	85	83	84
Net Income	83	113	133	108	116
EPS	1.49	2.02	2.38	1.93	2.05

Y-Y chng	F2007a	"Street" F2008e	"Street" F2009e	OWS F2008e	OWS F2009e
Freestanding Hosp Rev	39%	23%	8%	19%	5%
Management Contracts	143%	32%	-4%	35%	0%
Total Revenue	45%	23%	7%	20%	5%
EBIT	49%	28%	13%	23%	5%
Interest Expense	86%	12%	1%	11%	1%
Net Income	33%	37%	18%	31%	7%
EPS	31%	35%	18%	29%	6%

% Total Rev	F2007a	"Street" F2008e	"Street" F2009e	OWS F2008e	OWS F2009e
Freestanding Hosp Rev	91.4%	91.0%	91.9%	90.6%	91.0%
Management Contracts	8.4%	9.0%	8.1%	9.4%	9.0%
Total Revenue	100.0%	100.0%	100.0%	100.0%	100.0%
EBIT	14.1%	14.6%	15.5%	14.5%	14.5%
Interest Expense	5.1%	4.6%	4.4%	4.7%	4.5%
Net Income	5.6%	6.2%	6.8%	6.1%	6.2%

Our target of \$25 is 12x our 2009 EPS estimate. This multiple is in line with that of hospital facility management companies such as CYH (12x), HMA (11x), and LPNT (11x), but a discount to UHS' current multiple (15x). At our target, the company would be valued at an EV/EBITDA multiple of 9x our expected 2009 EBITDA versus its current valuation of 10x the "street's" 2009 EBITDA.

Background

Psychiatric Solutions (PSYS) is the largest operator of freestanding psychiatric facilities in the U.S. The company went public in 2002 with its reverse acquisition of publicly traded PMR Corporation, a provider of outpatient and disease management services for patients with severe mental illness. Since the

acquisition, PSYS has exited the outpatient and disease management businesses, and pursued a roll up strategy, acquiring 8,686 inpatient psychiatric beds in 72 facilities around the US. Revenue from inpatient facilities represented 91% of revenue in 2007. The remaining 9% of revenue is from contracts to manage psychiatric units in general hospitals, and from employee assistance programs that assist employees and their dependents with mental health issues.

The acute inpatient/residential treatment center (RTC) psychiatric treatment market is very fragmented. After PSYS, with 10,800 beds and 19% share, United Health Services (UHS) is the next largest operator, with 7,573 beds and 13% share. The remaining 68% of the market is split among smaller operators and psychiatric units in general hospitals. Remaining operators are small. Multiple site providers include Youth & Family Centered Services, Phoenix Care Systems, and Liberty Behavioral Management.

About 54% of PSYS' beds are in acute inpatient facilities offering short term treatment for serious psychiatric episodes (e.g., major depression, schizophrenia), with an average length of stay (LOS) of 10 days. Forty-six percent of beds are in RTCs for children/adolescents with behavioral issues (e.g., substance abuse, sexual aggression, reactive attachment disorders), with an average LOS of 180 days. Average revenue per day is about \$566, and is higher for acute inpatient days than for RTC days.

PSYS Facility Bed Mix and Characteristics

Facility Type	Beds (3/31/08)	% Total Beds	LOS	Avg Rev/Day	Primary Funding Sources
Acute Inpatient	5,832	54%	10	\$620*	HMOs/Insur, State funding, Medicare
RTC	4,968	46%	180	\$394*	Medicaid
Total	10,800	100%	17†	\$559**	--

Sources: PSYS, National Association of Psychiatric Health Systems (NAPHS)

*NAPHS data 2006 (latest available)

**PSYS 2007

†According to management, total LOS cannot be calculated from bed mix due to large q-q variation in RTC LOS.

PSYS relies heavily on revenue from state funded programs. In 2007, 32% of revenue came from Medicaid (funded 50% by states and 50% by the federal government). Another 16% of revenue came from programs funded solely by states. Thirty-three percent of revenue came from HMOs and other commercial insurers. Only 13% of revenue came from Medicare and 6% from other sources, such as out-of-pocket payments by patients.

While acute inpatient revenue comes primarily from HMOs/insurers, Medicare, and state funded programs, RTC revenue comes largely from Medicaid. Federal law prohibits the use of Medicaid funds for psychiatric treatment of people aged 22-64 in facilities with more than 16 beds, so states must fund their own programs for the poor in that age range. Not surprisingly, without federal matching dollars, these programs are chronically under funded, making them less attractive to PSYS. In contrast, RTC programs for children/adolescents have seen relatively generous funding and rapid growth over the past 20 years. States have shifted children's social services from state funded community-based programs to federal/state funded Medicaid programs.

The inpatient psychiatric industry experienced a significant tightening of benefits in the early 1990s, when recession forced states and other payors to cut expenditures. These cuts seem to disproportionately impact spending on mental health. As explained in a recent paper by the National Policy Health Forum (www.nhpf.org/pdfs_ib/IB823_InpatientPsych_08-01-07.pdf), psychiatric benefits are particularly responsive to positive and negative financial incentives, perhaps because delivery is inefficient, appropriate treatment approaches are not well defined, and quality of care is difficult to measure. In other words, while a heart attack is easily diagnosed and treatment protocols are well defined, depression or other behavioral issues are less easily diagnosed and treated, leading to large variations in care that readily change depending on how "flush" a payor is at a particular moment in time. In our view, while PSYS and other inpatient psychiatric providers are unlikely to experience the kind of cuts seen in the early 1990s, we think growth will slow, and will fall below current bullish expectations.

Discussion:

1. Medicaid revenue (32% total revenue) tailwinds ending

PSYS has benefited from a number of structural changes to Medicaid over the past several years that have expanded both the number of individuals qualifying for Medicaid programs and the ability of states to fund these programs. In our view, these favorable factors have now played out, and the fiscal pressures facing state budgets that have thus far not impacted Medicaid will now begin to be felt. Our view is confirmed by discussions we have had with industry experts. These individuals are expecting just 2%-3% increases in Medicaid payment rates next year versus the 4%-5% they have seen in recent years. With costs, especially fuel and food, increasing rapidly, these insiders are bracing for a difficult 2009.

Shift of programs from states to Medicaid: States have been able to increase funds for social services by making them Medicaid programs, where each dollar of state

funding is matched by at least one dollar in federal funding. According to a report by The Rockefeller Institute, this shifting has been particularly widespread in mental health, mental retardation, and special education programs like those provided by PSYS' RTCs. The shift has fueled growth in patient days and in improved facility occupancy levels.

There are signs that states have realized nearly all of the budget benefits they can from shifting services, and are now looking for ways to provide these services at a lower cost. For example, Virginia (representing 11% of PSYS' beds) is experimenting with a Medicaid waiver program that encourages people with disabilities to receive care in their homes and communities rather than in an institutional setting. Moving programs outside of institutions would, of course, be a negative for PSYS.

State budgets in 2001-2003 downturn saved by federal funds, increases in higher education tuition: States made few cuts to Medicaid in the 2001-2003 economic downturn, and bulls anticipate a similar result this time around. Early in the cycle, states were able to draw upon reserves to fund Medicaid and other programs. In 2003, the Jobs and Growth Tax Relief Act provided access to \$10B in one time federal funding allocated to Medicaid. Tax revenues then rebounded on a stronger economy and rising property values.

Interestingly, the area of spending that states cut most in the last economic downturn was public higher education, with funding cuts compensated for by significant increases in tuition rates. This was possible, at least in part, because of the easy credit environment that prevailed during this period. Students could easily access private loans to cover higher tuition. With credit tighter, we think it will be difficult for states to push through comparable tuition increases without driving students out of the system, meaning states will have to look elsewhere for budget cuts.

Prescription Drug Plan of 2006: The federal government's Medicare prescription drug plan provides drug coverage for Medicare/Medicaid dual eligible beneficiaries who previously received the benefit from Medicaid. According to the Rockefeller Institute, the savings to Medicaid was so significant that Medicaid spending actually declined y-y in FY2006 (only the second decline in the program's 40 year history).

With prescription drug costs shifted out of Medicaid budgets, there was more latitude to fund other types of Medicaid programs, such as behavioral health. The problem, however, is the magnitude of savings from the cost shifting will not repeat, and costs are rising off the new base.

2. States appear to be at the beginning of a significant economic downturn

The finances of states are very important to PSYS, since about 50% of Medicaid revenue comes from state tax revenue. In addition, PSYS gets about 16% of its revenue directly from states, which fund programs for indigent patients who do not qualify for Medicaid benefits. This group includes nearly all of those aged 22-64, since Medicaid regulations prohibit the use of funds for these individuals unless they are in facilities with less than 16 beds.

State tax revenue is derived primarily from sales and personal income taxes, with smaller contributions from corporate and property taxes. Lower consumer spending, combined with lower capital gains, has taken a significant bite out of nominal state tax revenue. In addition, since states spend disproportionately large amounts on fuel and construction, they are facing inflation rates much higher than that of the general economy, significantly impacting budgets. The Rockefeller Institute estimates that the state inflation rate in 1Q08 was 6.2% versus 2.2% for the economy as a whole.

On an inflation-adjusted basis, quarterly state tax revenues were down 5.3% in 1Q08, representing the third straight quarter of declines. With gas prices only recently reaching \$4 per gallon, one would expect the inflation rate to increase even further over the next few quarters. Combined with continuing lower sales and personal income taxes, the state revenue and budget picture for 2008-2009 looks bleak.

Y-Y Change in Quarterly State Tax Revenue/State Inflation Rate

	1Q07a	2Q07a	3Q07a	4Q07a	1Q08a
Adj Nominal Chng	5.8%	7.2%	4.3%	1.8%	0.6%
Inflation Rate	5.2%	5.1%	5.2%	6.1%	6.2%
Adj Real Chng	0.6%	2.0%	(0.8%)	(4.1%)	(5.3%)

Source: Nelson A. Rockefeller Institute of Government Revenue Report Database

The downturn has been particularly severe in states rely more on sales revenue (e.g., Florida), or personal income taxes (e.g., South Carolina). For example, Florida's tax revenue was down 10.3% y-y in 1Q08, while South Carolina's was down 8.1%. According to Moody's, six states in which PSYS operates are currently in recession, accounting for 25% of PSYS' beds, as shown in the table below.

PSYS Total Bed Distribution by State

State	PSYS Beds	% Total	
Texas	1,401	14%	
Virginia	1,079	11%	
Florida	989	10%	Recession
S. Carolina	502	5%	
Illinois	486	5%	
Indiana	421	4%	
California	402	4%	Recession
Ohio	376	4%	Recession
Pennsylvania	365	4%	
Georgia	362	4%	
Mississippi	351	3%	
Utah	298	3%	
Alabama	291	3%	
Nevada	272	3%	Recession
New Mexico	265	3%	
Puerto Rico	243	2%	
Louisiana	200	2%	
North Carolina	196	2%	
W Virginia	187	2%	
Michigan	182	2%	Recession
Tennessee	175	2%	Recession
Oklahoma	160	2%	
Missouri	159	2%	
Other	793	8%	
Total	10,155	100%	

Sources: PSYS filings, Moody's

While our industry sources do not expect states to actually cut their Medicaid budgets, they say that it will be difficult for them to increase Medicaid and state funded indigent program payment rates, and enrollment criteria may tighten.

3. Growth in health plan revenue (33% total revenue) likely to be constrained by health plan margin compression, employer resistance to higher costs

The financial health of the nation's health insurers has taken a decided turn for the worse over the past several quarters. Plans that were offering generous benefits packages in a fight for market share now find their operating margins compressing. Bears on the "street" see recent weak financial results at publicly traded health plans as the beginning of a protracted down cycle in margins.

Employers, on the other hand, are not willing to accept the premium increases health plans are demanding for the same package of benefits. As a result, many are choosing lower price point plans with fewer benefits, or are passing more of the cost of health care on to consumers through higher co-pays. Some small employers are dropping coverage altogether. According to the Henry J. Kaiser Family Foundation, the percentage of business with fewer than 200 employees offering insurance fell to 59% in 2007, down from 66% in 2002.

In this environment, it will be difficult for PSYS to get the 7%-8% increases in revenue per day it has been seeing from commercial insurers. Industry sources with whom we have spoken expect much smaller increases in the benefit year beginning January 2009. Moreover, our sources tell us that plans are likely to become more restrictive on admissions and LOS, which would impact PSYS' occupancy levels.

Some bulls have pointed to potential passage of the Mental Health Parity Bill currently pending in Congress as bullish for PSYS. The bill would require health insurers to offer mental health benefits equal in cost and scope to offered medical and surgical benefits. This will prevent insurers from requiring larger co-payments or imposing lower reimbursement ceilings for mental health and addiction conditions. Our discussions with the National Association of Psychiatric Health Systems suggests it will have little impact on PSYS, since the typical health plan already offers 30 days of inpatient care per year. Since the average LOS in an acute inpatient facility is 10 days, and a small percentage of people are admitted more than once in any one year, the existing benefit is not being fully utilized.

4. Benefits of Medicare transition (13% total revenue) to PPS are complete

Beginning in January 2005, CMS began transitioning payments for inpatient psychiatric services from a cost plus system to a prospective payment system (PPS) that pays a set amount per day based on a patient's diagnosis. This benefited freestanding psychiatric hospitals, which have lower overheads and lower bad debt, since most admissions are preauthorized and they have no emergency departments that treat the uninsured. Many general hospitals, on the other hand, have found that psychiatric admissions are less profitable than medical/surgical admissions, prompting many to close their psychiatric units.

The three year transition to PPS will be complete in 2008. As a result, PSYS has just about fully realized the benefits of the transition, which are primarily higher occupancies and margins caused by hospital psychiatric unit closures. Further margin expansion, an important part of the bull story for PSYS, is unlikely in our view.

The switch to PPS was a negative for PSYS' management contract revenue (10% of total revenue), which has been flat on a y-y pro forma basis since 2006. These contracts are primarily for the management of psychiatric units in general hospitals, and employee assistance programs which assist employees and their dependents with mental health issues. The closing of hospital psychiatric wards has meant less management contract revenue for PSYS, and management expects this revenue to continue to dwindle going forward.

5. Evidence of strains appearing in LOS, occupancy rates

The strains on state budgets and health plans may already be evident in PSYS' numbers, which have shown weakness in terms of LOS and average occupancy. Our industry contacts tell us that payors have more immediate flexibility to impact costs by reducing admissions and LOS than they do rates per day, which are typically set in annual contracts.

Length of Stay (LOS): As shown in the table below, LOS has declined from 17.2 days in 1Q07 to 16.8 days in 1Q08, down 2%. This continues a downward trend in LOS seen in the prior three quarters.

Total Facility LOS (Patient Days/Admissions)

	1Q07	2Q07	3Q07	4Q07	1Q08
LOS	17.2	17.2	17.5	17.8	16.8
Y-Y chng	3%	-1%	0%	-3%	-2%

Same store results appear to be somewhat better, with LOS basically flat for the past four quarters, as shown in the table below.

Same Facility LOS

	1Q07	2Q07	3Q07	4Q07	1Q08
LOS	17.1	16.5	17.5	18.2	17.1
Y-Y chng	4%	-2%	1%	-1%	0%

However, we note that the company changed its definition of same-facility growth beginning with its 2007 10-K, causing us to wonder if some changes were made that might make same store results appear better.

PSYS Description of Same-Facility Growth

2007 10-K	Same-facility revenue refers to the comparison of the inpatient facilities we owned during a prior period with the comparable period in the subsequent period, <i>adjusted for closures and combinations for comparability purposes.</i> (Italics added.)
2006 10-K	Same-facility revenue refers to the comparison of the inpatient facilities we owned during a prior period with the comparable period in the subsequent period.

Interestingly, acquired facility LOS dropped significantly in 1Q08, despite the fact that there was only one small 400 bed acquisition in March 2008, seemingly supporting our speculation that the company may be “adjusting” same facility results in its favor. A more transparent LOS should be reported for 2Q08, since the large Horizon acquisition was completed on May 31, 2007.

Acquired Facility LOS

	1Q07	2Q07	3Q07	4Q07	1Q08
LOS	18.8	20.0	17.4	16.5	15.4

Occupancy Rate:

PSYS has experienced declining occupancy levels for the past four quarters, with occupancy down from 77.9% in 1Q07 to 72.9% in 1Q08.

Total Facility Occupancy Rates ((Patient Days/90)/ Avg Licensed Beds)

	1Q07	2Q07	3Q07	4Q07	1Q08
Occup Rate	77.9%	74.6%	73.3%	73.1%	72.9%
Y-Y bp chng	145	(343)	(287)	(302)	(494)

The company has blamed the lower occupancy rates on the May 2007 acquisition of Horizon Health, particularly focusing on one facility (The Pines) that it says is undergoing extensive renovations. Since PSYS does not provide same-facility occupancy data, we cannot use it to corroborate management’s statements. We note, however, that in F2006 HORC had an occupancy rate of 74.1%, and in the two quarters preceding the acquisition, it had occupancy rates of 73.1%. At only 16% of PSYS beds after the acquisition, HORC should not have been a significant drag on PSYS’ results, as shown in our pro forma calculation below.

Pro Forma Occupancy Calculation

	PSYS 10/1/06-3/30/07	HORC 9/1/06-2/28/07	Pro Forma
Pt Days	1,072,698	188,495	1,261,193
Avg Beds	7,735	1,417	9,152
Occupancy	77.0%	73.1%	76.6%

Sources: PSYS and HORC filings, OWS estimates

Interestingly, the NAPHS reported that from 2005-2006, occupancy in RTCs fell 330 bp, from 78.5% to 75.9%. Data is not yet available for 2007. When we asked the NAPHS representative why this decline might have occurred, he commented that some states are moving toward more community based programs, which would lower inpatient demand. A RTC CEO with whom we have spoken confirmed this trend, commenting that those remaining in RTC facilities are often the hardest cases, and require higher staffing levels. Should the trend to community services for less severe cases continue, occupancies and margins would be negatively impacted.

6. Growth through acquisition increasingly expensive, lower quality

PSYS has grown largely by acquisition, posting top line growth of 43% in 2006 and 45% in 2007 versus same store growth of 9% and 6.5%. Acquisitions have accounted for 25%-33% of total revenue for the past four years, as shown in the table below.

Same Facility and Acquired Facility Revenue Distribution

\$M	2004a	2005a	2006a	2007a
Same Facility Rev	280	453	723	1,018
Acquired Facility Rev	139	216	254	340
Total Facility Rev	420	670	976	1,358

% Total Revenue	2004a	2005a	2006a	2007a
Same Facility Rev	67%	68%	74%	75%
Acquired Facility Rev	33%	32%	26%	25%
Total Facility Rev	100%	100%	100%	100%

Source: PSYS filings

The company has paid increasingly more for its acquisitions, both on a revenue per bed and a revenue multiple basis. As shown below, cost per bed has increased fairly steadily over the past two years, and reached \$303K in 1Q08. This price is quite high, in our view, especially in light of comments from industry insiders who tell us it is now a buyer's market due to a dearth of buyers with available capital.

PSYS Acquisition Cost Per Bed 2006-1Q08

	1Q06	2Q06	3Q06	4Q06	1Q07	2Q07	3Q07	4Q07	1Q08
Beds Acquired	236	50	444	1,050	86	1,571	0	0	400
Acquis. Cost, net cash acquired	\$38M	\$6M	\$123M	\$218M	\$25M	\$427M	\$10M	n/a	\$121M
Acquits. Cost Per Bed	\$162,288	\$123,400	\$276,126	\$207,629	\$293,488	\$271,878	n/a	n/a	\$303,125

Source: PSYS filings

Prices have also been increasing as a multiple of revenue. In 2005 and 2006, PSYS was paying about 1.1x ttm revenue for its acquisitions. The exception was Ardent Health in March 2005, its largest acquisition to date, for which it paid 1.9x ttm revenue. The revenue multiple for the December 2006 acquisition of Horizon Health was 1.4x, and then moved up to 1.8x with the January 2008 acquisition of 400 beds from UMC.

These more recent acquisitions also appear to be of increasingly lower quality. As shown below, EBITDA margins from acquired revenue declined from 19.2% in 2006 to 15.9% in 2007 and 15% in 1Q08. With the large and apparently low margin Horizon acquisition lapping in May 2008, same store EBITDA margins should begin to show the drag on EBITDA apparent in acquired facility results.

PSYS Same Facility/Acquired Revenue and EBITDA (ex stock comp exp) 2005-1Q08

\$M	2005	2006	2007	1Q08
Same Facil Rev	453	723	1,018	327
Acq Facil Rev	211	251	340	62
Tot Facil Rev	664	974	1,358	388
Same Facil EBITDA	81	145	219	72
Acqu Facil EBITDA	40	48	54	9
Total Facil EBITDA	121	193	273	81
Same Facil EBITDA margin	17.8%	20.0%	21.5%	21.9%
Acqu Facility EBITDA margin	19.1%	19.2%	15.9%	15.0%
Total Facil EBITDA margin	18.2%	19.8%	20.1%	20.8%

Source: PSYS SEC filings

It appears that management has, in the past, succeeded in increasing margins in acquired facilities. We expect some continued improvement in facilities acquired in 2007 and 1Q08, but think that these will be offset by higher operating

costs across the whole organization (e.g., food, fuel, maintenance expenses), keeping EBITDA margins flat y-y in 2009.

There appears to be very few acquisitions of size left in the market. This is evident when reviewing the Officers of the industry's trade group, the National Association of Psychiatric Health Systems. Of the eight officers, two are from PSYS, and one is from UHS. Two others run large, well established nonprofits that seem unlikely to sell themselves to a for-profit entity. Other officers include the CEO of Youth & Family Centered Services, which has about \$210M in annual revenue, but is primarily lower margin RTCs dealing with difficult adolescent populations, while the other two run smaller companies that appear to be geared more toward treatment of adult substance abuse. It seems, therefore, that to come up with significant acquisition revenue, PSYS will likely have to do multiple deals, adding to integration risk and using significant amounts of management time and resources.

7. Highly levered balance sheet, limited liquidity

Even if more large acquisitions can be found, financing them will be a challenge. The company has rapidly levered its balance sheet to execute its roll-up strategy, increasing its debt to total capitalization ratio to 62% at March 31, 2008. Approximately 40% of its \$1.3B in debt is floating rate, and the company currently has only about \$100M in liquidity (cash and a remaining revolving credit line), a tiny sum for a company that has spent \$400M-\$500M per year for acquisitions over the past three years. The company could sell shares to raise capital, but generating \$500M at the current share price would increase the share count by 23%. Such dilution would likely be unacceptable to shareholders, especially considering the company's already poor ROIC (discussed below).

PSYS Debt-to-Total Capitalization Ratio, 1Q06-1Q08

	1Q06	2Q06	3Q06	4Q06	1Q07	2Q07	3Q07	4Q07	1Q08
Debt (\$M)	486	486	538	741	761	1,198	1,177	1,166	1,300
Debt + Equity (\$M)	1,048	1,069	1,142	1,369	1,427	1,886	1,896	1,921	2,083
Debt/Cap	46%	45%	47%	54%	53%	64%	62%	61%	62%

Source: PSYS filings

8. Building new beds very expensive

Perhaps recognizing that the acquisition game has just about played out, PSYS has begun spending more on building new beds, either at existing facilities or *de novo*. The company plans to grow beds by 6% y-y in 2008 through building, above its historic targets of 2%-3% per year. While the company has said it spends about \$100K-\$200K per new bed, we think that the actual cost per bed is much

higher. If the cost were indeed so low, we wonder why the company would be willing to pay \$200K-\$300K per acquired bed. We note, moreover, one state facility in Nevada recently estimated that its cost to add 14 beds to an existing adolescent inpatient psychiatric facility would be about \$714K per bed.

PSYS is planning to add 600 beds in 2008. At \$200K per bed, the cost would be \$120M. At present, the company is spending about \$100M per year in capex, with about \$36M of that representing maintenance capex. Thus, even at a conservative \$200K per bed, the company will need to increase its capex spending by \$56M per year to maintain its facilities and add 600 beds per year.

Our discussions with industry participants suggest that adding new beds to existing facilities may become more difficult as higher gas prices limit the distance people are willing/able to travel. This is particularly important for RTCs, where children may be admitted for 6-9 months, with family members visiting numerous times during this period. If PSYS must build *de novo* facilities closer to potential patients, its operating costs will increase.

9. Poor ROIC, FCF

While we expect deterioration in PSYS' fundamentals to soon become evident on the income statement, even in today's relatively healthy reimbursement environment the company's return on invested capital has been deteriorating, declining from 8.6% in 1Q06 to 7.7% in 1Q08, as shown in the table below. ROIC may worsen in future quarters, given the high prices PSYS is paying for recent acquisitions, and the high cost of building new beds.

PSYS ROIC, 1Q06-1Q08

\$M	1Q06	2Q06	3Q06	4Q06	1Q07	2Q07	3Q07	4Q07	1Q08
After Tax Op Inc	18	22	22	26	27	31	35	37	38
Invested Capital	1,108	1,136	1,203	1,444	1,496	1,975	1,988	2,003	2,163
ROIC	8.6%	9.8%	7.2%	6.9%	7.4%	6.8%	7.4%	7.5%	7.7%

Source: PSYS filings

This return is well below that of PSYS' closest comparable, UHS, which has a ROIC of 9.7%.

The problems with PSYS' roll up strategy are also evident in the mismatch between the company's net income growth and growth in cash from operations. In 2006, net income grew 53% y-y compared to CFO growth of just 16%. In 2007, net income grew 33%, but cash from operations grew just 1%. A similar mismatch exists between EBITDA and CFO. CFO has declined from 77% of EBITDA in 2006 to just 52% in 2007.

PSYS Net Income and CFO Growth, CFO as % of EBITDA

	2006	2007
Y-Y Net Inc Growth	54%	33%
Y-Y CFO Growth	16%	1%
CFO/EBITDA	77%	52%

Source: PSYS filings

Weak CFO combined with increasing capex expense related to building new beds is pressuring FCF, which has declined by 23%-37% y-y on a ttm basis. The company's current pre-acquisition expense FCF yield is just 1.5%. This calculation, by the way, gives the company the benefit of the cash flow from acquisitions without penalizing it for the expense.

PSYS Rolling ttm FCF before Acquisition Spending

	1Q07	2Q07	3Q07	4Q07	1Q08
Rolling ttm Pre-acquisition FCF	50.4	40.6	37.1	34.1	31.6
Y-Y change	31%	-8%	-23%	-28%	-37%

Source: PSYS filings

10. Valuation

PSYS shares currently trade at 17x 2009 EPS. This is a significant premium to that of hospital management companies such as such as CYH (12x), HMA (11x), and LPNT (11x), and is even higher than that of closest comp UHS (15x).

Shares are also expensive on an EV/EBITDA basis, at 10x "street" 2009 EBITDA versus 7x for its peer group.

PSYS Valuation vs. Peers

	Current Price	"Street" 2009 EPS	PE	Current EV	"Street" 2009 EBITDA	EV/EBITDA
PSYS	39.68	2.36	17	3,493	345	10.1
UHS	61.00	4.16	15	4,362	650	6.7
CYH	34.85	2.93	12	12,479	1,715	7.3
LPNT	29.13	2.58	11	3,079	469	6.6
HMA	6.11	0.54	11	4,854	711	6.8

Our target of \$25 is 12x our 2009 EPS estimate. At our target, the company would be valued at an EV/EBITDA multiple of 9x our expected 2009 EBITDA versus its current valuation of 10x the "street's" 2009 EBITDA.

11. Model Assumptions

We assume that occupancy rates continue to fall by about 200 bp per year and LOS declines by 1.7%-1.8% per year in 2008 and 2009, as state governments and health plans use more frequent case reviews and other utilization management techniques to reduce admissions and LOS. We assume the company builds 600 beds in 2008 and 400 beds in 2009, and makes no further acquisitions. With these assumptions, in our model, patient days increase by 14.3% in 2008 and 1.4% in 2009.

We assume growth in revenue per day continues to decelerate as states and health plans try to rein in spending, with an increase of 3.6% in 2008 and 4.0% in 2009. With a 1.4% increase in patient days and a 4% increase in revenue per day, hospital revenue in our model increases by 5.5%. We assume management contract revenue is flat in 2009, as continued closures of general hospital inpatient facilities erode this piece of PSYS' business.

OWS Model Assumptions

	2005a	2006a	2007a	2008e	2009e
Occupancy Rate	72.9%	73.6%	71.5%	69.3%	67.4%
LOS	18.1	17.5	17.4	17.1	16.8
Patient Days	1,396,562	1,873,420	2,454,397	2,806,460	2,846,698
Revenue/Day	\$479.45	\$521.15	\$553.22	\$573.23	\$596.06
Total Hosp Rev (\$M)	664	973	1,354	1,609	1,697
Mgmt Contract Rev (\$M)	52	51	124	167	168
Total Rev (\$M)	715	1,022	1,482	1,776	1,865

Y-Y change (unless otherwise noted)

	2005a	2006a	2007a	2008e	2009e
Occup Rate (bp chng)	20	70	(210)	(220)	(190)
LOS	-10.0%	-3.3%	-0.6%	-1.7%	-1.8%
Patient Days	40.1%	34.1%	31.0%	14.3%	1.4%
Revenue/Day	13.9%	8.7%	6.2%	3.6%	4.0%
Total Hosp Rev (\$M)	58.1%	46.5%	39.2%	18.8%	5.5%
Mgmt Contr Rev (\$M)	2.0%	-1.9%	143.1%	34.7%	0.6%
Total Rev (\$M)	51.8%	42.9%	45.0%	19.8%	5.0%

12. Upside/Downside Risks

Risks to our model include 1) PSYS finding and being able to finance another large acquisition, 2) higher than expected increases in patient days due to increased demand and/or less restrictive utilization policies than we expect, 3)

higher than expected revenue/day increases from payors, and 4) higher than expected management contract revenue. In addition, the federal government may act to shore up state Medicaid financing by allocating additional funding during this economic downturn.

13. Balance sheet analysis

\$M as of March 30, 2008

Current LT debt	1,300
Current equity	783
Current tangible book value	(401)
Current market value	2,199
Current cash	15
Current DSO	53
Current DIO	n/a

	2007a	2008e	2009e
EBIT	209	258	271
EBITDA	240	296	311
FCF (Net income + D&A - Capex)	34	33	36
Capex	73	113	120
EV/EBITDA		12	9*
EV/(EBITDA-capex)		19	14*
FCF Yield		1.5%	2.6%*

*At our target price of \$25

	2007a	2008e	2009e	1Q07a	2Q07a	3Q07a	4Q07a	1Q08a	2Q08e	3Q08e	4Q08e	1Q09e	2Q09e	3Q09e	4Q09e
Freestanding Hosp Rev	1,353.9	1,608.7	1,696.8	306.4	326.8	359.3	361.4	388.3	404.1	409.8	406.6	421.6	423.7	425.9	425.5
Mgmt Contract Rev	124.1	167.3	168.0	17.3	27.3	42.7	36.8	41.3	42.0	42.0	42.0	42.0	42.0	42.0	42.0
Total Revenue	1,482.0	1,776.1	1,864.8	322.4	354.1	402.0	403.4	429.7	446.1	451.8	448.6	463.6	465.7	467.9	467.5
Salaries wages benefits	824.7	985.9	1,035.0	180.1	195.1	223.9	225.5	238.7	247.6	250.7	249.0	257.3	258.5	259.7	259.5
Professional Fees	147.5	178.1	186.5	30.9	35.2	40.6	40.9	43.5	44.6	45.2	44.9	46.4	46.6	46.8	46.7
Supplies	82.2	98.2	103.5	18.3	19.6	21.8	22.5	23.8	24.6	25.0	24.8	25.7	25.8	26.0	26.0
Rentals/Leases	21.3	25.8	27.1	4.6	5.0	5.8	5.9	6.2	6.5	6.6	6.5	6.7	6.8	6.8	6.8
Other Expenses	138.8	161.6	168.0	31.6	35.0	38.5	33.7	39.1	40.5	41.0	41.0	42.0	42.0	42.0	42.0
Bad Debt Provision	27.6	30.4	33.9	6.7	7.3	7.0	6.6	7.2	6.9	8.2	8.1	8.4	8.5	8.5	8.5
EBITDA	239.9	296.1	310.8	50.2	57.0	64.4	68.2	71.3	75.4	75.1	74.3	77.1	77.6	78.1	78.0
Depreciation/Amort.	31.1	38.4	40.0	6.3	7.3	8.5	9.0	9.4	9.5	9.6	9.7	9.8	9.9	10.0	10.1
EBIT	208.8	257.7	270.8	44.0	49.8	55.9	59.2	61.8	65.9	65.5	64.6	67.2	67.6	68.1	67.9
Interest Expense	75.1	83.4	84.0	14.4	17.0	22.3	21.4	20.4	21.0	21.0	21.0	21.0	21.0	21.0	21.0
Loss on refi LTD	8.2	0.0	0.0	0.0	8.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pretax income	133.7	174.4	186.8	29.6	32.7	33.7	37.7	41.4	44.9	44.5	43.6	46.2	46.6	47.1	46.9
Taxes	50.9	66.3	71.0	11.3	12.4	12.8	14.3	15.8	17.1	16.9	16.6	17.6	17.7	17.9	17.8
Net Income	82.8	108.1	115.8	18.2	20.3	20.8	23.4	25.6	27.8	27.6	27.0	28.7	28.9	29.2	29.1
EPS	1.49	1.93	2.05	0.33	0.37	0.38	0.42	0.46	0.50	0.49	0.48	0.51	0.51	0.52	0.51
S/O	55.4	56.0	56.5	55.2	55.4	55.4	55.5	55.8	56.0	56.1	56.2	56.3	56.4	56.5	56.6

Y-Y change	2007a	2008e	2009e	1Q07a	2Q07a	3Q07a	4Q07a	1Q08a	2Q08e	3Q08e	4Q08e	1Q09e	2Q09e	3Q09e	4Q09e
Freestanding Hosp Rev	39%	19%	5%	33%	39%	49%	35%	27%	24%	14%	13%	9%	5%	4%	5%
Mgmt Contract Rev	143%	35%	0%	37%	113%	231%	188%	139%	54%	-2%	14%	2%	0%	0%	0%
Total Revenue	45%	20%	5%	33%	43%	58%	44%	33%	26%	12%	11%	8%	4%	4%	4%
Salaries wages benefits	43%	20%	5%	29%	42%	56%	44%	32%	27%	12%	10%	8%	4%	4%	4%
Professional Fees	52%	21%	5%	37%	45%	69%	56%	41%	27%	11%	10%	7%	4%	4%	4%
Supplies	39%	19%	5%	31%	37%	51%	39%	30%	26%	15%	10%	8%	5%	4%	5%
Rentals/Leases	56%	21%	5%	38%	53%	76%	58%	35%	29%	14%	10%	8%	5%	4%	5%
Other Expenses	46%	16%	4%	34%	47%	67%	37%	24%	16%	6%	22%	7%	4%	2%	2%
Bad Debt Provision	41%	10%	12%	40%	58%	60%	14%	8%	-6%	17%	23%	18%	23%	4%	5%
EBITDA	49%	23%	5%	47%	44%	59%	47%	42%	32%	17%	9%	8%	3%	4%	5%
Depreciation/Amort.	52%	23%	4%	33%	50%	64%	58%	51%	31%	13%	8%	4%	4%	4%	4%
EBIT	49%	23%	5%	49%	43%	58%	45%	41%	32%	17%	9%	9%	3%	4%	5%
Interest Expense	86%	11%	1%	56%	84%	121%	82%	42%	23%	-6%	-2%	3%	0%	0%	0%
Loss on refi LTD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pretax income	34%	30%	7%	46%	28%	33%	31%	40%	37%	32%	16%	12%	4%	6%	8%
Taxes	35%	30%	7%	48%	28%	34%	33%	39%	37%	32%	16%	11%	4%	6%	8%
Net Income	34%	31%	7%	46%	32%	33%	29%	41%	37%	32%	15%	12%	4%	6%	8%
EPS	31%	29%	6%	42%	29%	30%	27%	39%	36%	31%	14%	11%	3%	5%	7%

% Total Sales	2007a	2008e	2009e	1Q07a	2Q07a	3Q07a	4Q07a	1Q08a	2Q08e	3Q08e	4Q08e	1Q09e	2Q09e	3Q09e	4Q09e
Freestanding Hosp Rev	91.4%	90.6%	91.0%	95.0%	92.3%	89.4%	89.6%	90.4%	90.6%	90.7%	90.6%	90.9%	91.0%	91.0%	91.0%
Mgmt Contract Rev	8.4%	9.4%	9.0%	5.4%	7.7%	10.6%	9.1%	9.6%	9.4%	9.3%	9.4%	9.1%	9.0%	9.0%	9.0%
Total Revenue	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Salaries wages benefits	55.6%	55.5%	55.5%	55.9%	55.1%	55.7%	55.9%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%	55.5%
Professional Fees	10.0%	10.0%	10.0%	9.6%	9.9%	10.1%	10.1%	10.1%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Supplies	5.5%	5.5%	5.6%	5.7%	5.5%	5.4%	5.6%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.6%	5.6%
Rentals/Leases	1.4%	1.5%	1.5%	1.4%	1.4%	1.4%	1.5%	1.4%	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Other Expenses	9.4%	9.1%	9.0%	9.8%	9.9%	9.6%	8.4%	9.1%	9.1%	9.1%	9.1%	9.1%	9.0%	9.0%	9.0%
Bad Debt Provision	1.9%	1.7%	1.8%	2.1%	2.1%	1.7%	1.6%	1.7%	1.5%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
EBITDA	16.2%	16.7%	16.7%	15.6%	16.1%	16.0%	16.9%	16.6%	16.9%	16.6%	16.6%	16.6%	16.7%	16.7%	16.7%
Depreciation/Amort.	2.1%	2.2%	2.1%	1.9%	2.1%	2.1%	2.2%	2.2%	2.1%	2.1%	2.2%	2.1%	2.1%	2.1%	2.2%
EBIT	14.1%	14.5%	14.5%	13.6%	14.1%	13.9%	14.7%	14.4%	14.8%	14.5%	14.4%	14.5%	14.5%	14.5%	14.5%
Interest Expense	5.1%	4.7%	4.5%	4.5%	4.8%	5.5%	5.3%	4.7%	4.7%	4.6%	4.7%	4.5%	4.5%	4.5%	4.5%
Loss on refi LTD	0.6%	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pretax income	9.0%	9.8%	10.0%	9.2%	9.2%	8.4%	9.4%	9.6%	10.1%	9.8%	9.7%	10.0%	10.0%	10.1%	10.0%
Taxes	3.4%	3.7%	3.8%	3.5%	3.5%	3.2%	3.6%	3.7%	3.8%	3.7%	3.7%	3.8%	3.8%	3.8%	3.8%
Net Income	5.6%	6.1%	6.2%	5.7%	5.7%	5.2%	5.8%	6.0%	6.2%	6.1%	6.0%	6.2%	6.2%	6.2%	6.2%