HEALTHSOUTH CORP
Form 10-K
February 26, 2008

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)

OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2007

Commission File Number 000-14940

HealthSouth Corporation

(Exact Name of Registrant as Specified in its Charter)

Delaware	**63-0860407**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
One HealthSouth Parkway Birmingham, Alabama	**35243**
(Address of Principal Executive Offices)	**(Zip Code)**

(205) 967-7116

(Registrant s telephone number)

Securities Registered Pursuant to Section 12(b) of the Act:

Common Stock, $0.01 Par Value

Securities Registered Pursuant to Section 12(g) of the 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 x No o

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 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 x 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. x

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.

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

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

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant s most recently completed second fiscal quarter was approximately $1.3 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 78,853,675 shares of common stock of the registrant outstanding, net of treasury shares, as of February 15, 2008.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant s 2008 Annual Meeting of Stockholders is incorporated by reference in Part III to the extent described therein.

TABLE OF CONTENTS

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to future events, our future financial performance, or our projected business results. In some cases, you can identify forward-looking statements by terminology such as may, will, should, expects, plans, anticipates, believes, estimates, predicts, targets, potential, or cont these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ materially from those estimated by us include:

- each of the factors discussed in Item 1A, *Risk Factors*;
- changes or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors;
- our ability to attract and retain nurses, therapists, and other health care professionals in a highly competitive environment with often severe staffing shortages;
- changes in the regulations of the health care industry at either or both of the federal and state levels;
- competitive pressures in the health care industry and our response to those pressures; and
- general conditions in the economy and capital markets.

The cautionary statements referred to in this section also should be considered in connection with any subsequent written or oral forward-looking statements that may be issued by us or persons acting on our behalf. We undertake no duty to update these forward-looking statements, even though our situation may change in the future. Furthermore, we cannot guarantee future results, events, levels of activity, performance, or achievements.

PART I

Item 1. Business

General

HealthSouth Corporation was organized as a Delaware corporation in February 1984. As used in this report, the terms HealthSouth, we, us, our, and the Company refer to HealthSouth Corporation and its subsidiaries, unless otherwise stated or indicated by context. In addition, we use the term HealthSouth Corporation to refer to HealthSouth Corporation alone wherever a distinction between HealthSouth Corporation and its subsidiaries is required or aids in the understanding of this filing. Our principal executive offices are located at One HealthSouth Parkway, Birmingham, Alabama 35243, and the telephone number of our principal executive offices is (205) 967-7116.

HealthSouth is the largest provider of inpatient rehabilitative health care services in the United States, with 94 inpatient rehabilitation hospitals, 6 long-term acute care hospitals (LTCHs), 60 outpatient rehabilitation satellites located within or near (and operated by) our hospitals, and 25 licensed, hospital-based home health agencies. Our consolidated *Net operating revenues* approximated $1.8 billion, $1.7 billion, and $1.8 billion for the years ended December 31, 2007, 2006, and 2005, respectively. We had approximately 22,000 full- and part-time employees as of December 31, 2007.

Recent Significant Events

We have spent considerable effort in 2007 strategically repositioning the Company through divestitures and reduction of debt to be the largest pure-play provider in the inpatient rehabilitation industry. We achieved a number of goals in 2007 that reinforce our role as the nation s preeminent provider of inpatient rehabilitative services.

- We completed the divestitures of our surgery centers, outpatient, and diagnostic divisions. In connection with the divestitures, we amended our Credit Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements), which lowered our applicable interest rates and provided us with the appropriate lender approvals for our divestiture activities.
- We settled all federal income tax issues outstanding with the Internal Revenue Service (the IRS) for the tax years 1996 through 1999 and received a $440 million federal income tax recovery from the IRS for overstatements of taxable income attributable to the financial fraud perpetrated by members of prior management.
- We used the net proceeds from our divestitures and the majority of our income tax recovery to reduce our total debt outstanding from $3.4 billion to $2.0 billion, which sets the platform for us to pursue growth opportunities in inpatient rehabilitative care.
- We made the final payments pursuant to our settlements with the United States Securities and Exchange Commission (the SEC) and the Department of Justice, which will allow us to redirect our operating cash elsewhere.
- We settled certain matters with the United States Department of Health and Human Services (HHS) Office of the Inspector General (HHS-OIG) which previously had been self-disclosed in 2004 by agreeing to pay a penalty in the amount of $14.2 million. We paid $7.1 million of this penalty in the fourth quarter of 2007 and will pay the remaining $7.1 million in the first quarter of 2008.

In addition to our own accomplishments in 2007, new legislation was signed into law on December 29, 2007 that permanently set the compliance threshold for the 75% Rule at 60%, which gives permanent relief from the primary regulatory uncertainties that faced the industry and the Company.

While we have achieved significant milestones in 2007, we continue to face challenges. We encourage you to read the discussions contained in Item 1A, *Risk Factors*, and in Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, which highlight additional considerations about HealthSouth.

Strategic Repositioning

In 2007, we completed our strategic repositioning of the Company as the largest provider of post-acute rehabilitation services. Our determination to undertake this restructuring was based on a number of factors, including:

- Our realization that we had excessive debt for a health services company of our size and our desire to reduce our debt with the net proceeds received from the divestitures, allowing us to pursue growth opportunities in the inpatient rehabilitation and post-acute care industries;
- Our determination that our high leverage precluded appropriate investment in our businesses, limiting our ability to pursue growth opportunities;
- Our belief that a post-acute strategy would build on our core competencies in the area of inpatient rehabilitative care and would be responsive to industry trends;
- Our conclusion that there were very few strategic or financial synergies in operating our divisions as one company, and, in some instances, our recognition that the strategic interests of the divisions were at cross purposes with one another; and
- Our opportunity to benefit from the strong credit markets existing at the time to divest our non-core assets.

The results of the repositioning are summarized in the table below and described in greater detail in Note 1, *Summary of Significant Accounting Policies,* and Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

DIVISION	BUYER	CLOSE DATE	NET PROCEEDS[1]
Outpatient	Select Medical Corporation	May 1, 2007[2]	$223.8 million
Surgery Centers	An affiliate of Texas Pacific Group	June 29, 2007[2]	$876.9 million
Diagnostic	An affiliate of The Gores Group	July 31, 2007[2]	$39.7 million

(1) After deducting deal and separation costs, purchase price adjustments, and any debt assumed by the respective purchaser; also includes net proceeds received for facilities sold after the initial close date.

(2) Other than with respect to certain facilities for which regulatory approvals had not yet been received.

Historically, we reported five segments: inpatient, surgery centers, outpatient, diagnostic, and corporate and other. Based on our strategic focus in the inpatient rehabilitation industry and the reclassification of our surgery centers, outpatient, and diagnostic divisions to discontinued operations, we modified our segment reporting from five reportable segments to one reportable segment in the first quarter of 2007. Amounts historically reported as part of our corporate and other segment, which primarily represented the corporate overhead costs associated with our operating divisions, are no longer considered a reportable segment by our chief operating decision maker due to our strategic repositioning as a pure-play post-acute care provider and the change in the manner in which we now manage the Company. Rather, these corporate overhead costs are now presented on the line entitled *General and administrative expenses* in our consolidated statements of operations. Therefore, the consolidated results of operations of the Company presented herein represent the continuing operations of our inpatient division, including corporate overhead. For additional information, see Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, and Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements.

Leverage and Liquidity

Many of the transactions in which we engaged in 2007 improved our leverage and liquidity. During 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions to pay

down debt. In addition, in October 2007, we used approximately $405 million of our $440 million income tax recovery from the IRS (see Note 8, *Long-term Debt*, and Note 17, *Income Taxes*, to our accompanying consolidated financial statements) to further reduce our outstanding debt. During the third and fourth quarters of 2007, we also used available cash and borrowings on our revolving credit facility to redeem approximately $59.1 million of our 10.75% Senior Notes due 2016, which carry a higher interest rate than borrowings under our Credit Agreement (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements).

Although we remain highly leveraged, our total debt outstanding has decreased from $3.4 billion as of December 31, 2006 to $2.0 billion as of December 31, 2007. We also made the final payments related to our Medicare Program Settlement and our SEC Settlement (see Note 20, *Settlements*, to our accompanying consolidated financial statements) in 2007. With these settlement payments behind us, we now will be able to redirect our operating cash elsewhere in the Company. Based on our current borrowing capacity and leverage ratio required under our Credit Agreement, we do not believe there is significant risk in our ability to make additional draws under our revolving credit facility, if needed.

Our long-term debt (excluding notes payable to banks and others and capital lease obligations) as of December 31, 2007 and 2006 is summarized in the following table:

	As of December 31, 2007	**As of December 31, 2006**
	(In Millions)	
Revolving credit facility	$ 75.0	$ 170.0
Term loan facility	862.8	2,039.8
Bonds payable	979.7	1,037.3
	$ 1,917.5	$ 3,247.1

As of December 31, 2007, we had approximately $19.8 million in cash and cash equivalents. This amount excludes approximately $63.6 million in restricted cash and $28.9 million of restricted marketable securities, which are assets whose use is restricted because of various obligations we have under lending agreements, partnership agreements, and other arrangements primarily related to our captive insurance company.

We expect our cash flow to improve, which should allow us to further reduce our debt. Any proceeds we may receive from additional income tax refunds, the expected sale of the corporate campus (see Note 5, *Property and Equipment*, to our accompanying consolidated financial statements), and certain derivative litigation (see Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements) will also be used to further pay down our debt. While we intend to direct a portion of our free cash flow into our development activities, focusing on joint ventures and other transactions that require a minimal initial outlay of cash, our primary focus in 2008 will be to pay down debt.

For a more detailed discussion of our liquidity, see Item 1A, *Risk Factors*, Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, Liquidity and Capital Resources, and also Note 2, *Liquidity*, to our accompanying consolidated financial statements.

Securities Litigation Settlement

On January 11, 2007, we received final court approval of the previously announced settlement agreements (collectively, the Settlement Agreement) with the lead plaintiffs in the federal securities class actions and the derivative actions, as well as certain of our insurance carriers (collectively, the Carriers), to settle litigation filed against us, certain of our former directors and officers and certain other parties in the United States District Court for the Northern District of Alabama and the Circuit Court in Jefferson County, Alabama relating to financial reporting and related activity that occurred at HealthSouth during periods ended in March 2003. The $445 million settlement includes HealthSouth common stock and warrants valued at $215 million and cash payments by certain of our insurance carriers of $230 million, with a contingent payout to the federal securities class of certain amounts that may be recovered by HealthSouth in the future. Pursuant to the Settlement Agreement, we are also required to indemnify the Carriers, to the extent permitted by law, for any amounts that they become legally obligated to pay to any non-settling defendants. For additional information about the Settlement Agreement, the shares of common

stock and warrants to purchase shares of common stock underlying the Settlement Agreement, and the underlying legal proceedings, see Note 18, *Earnings (Loss) per Common Share*, Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Income Tax Recovery

In the third quarter of 2007, we settled all federal income tax issues outstanding with the IRS for the tax years 1996 through 1999, and the Joint Committee of Congress reviewed and approved the associated income tax refunds due to the Company. In October 2007, we received a total cash refund of approximately $440 million, including $296 million in federal income tax refunds and $144 million of associated interest. Approximately $405 million of this federal income tax recovery was used to pay down long-term debt, as discussed in Note 8, *Long-term Debt,* and in Note 17, *Income Taxes,* to our accompanying consolidated financial statements.

Inpatient Rehabilitation Business

We are the nation s largest provider of inpatient rehabilitation services. Our inpatient rehabilitation hospitals provide comprehensive services to patients who require intensive institutional rehabilitation care. Patient care is provided by nursing and therapy staff as directed by a physician order. Internal case managers monitor each patient s progress and provide documentation of patient status, achievement of goals, functional outcomes and efficiency.

We operate inpatient rehabilitation hospitals and long-term acute care hospitals and provide treatment on both an inpatient and outpatient basis. As of December 31, 2007, our inpatient rehabilitation hospitals and LTCHs had 6,679 licensed beds.

As of December 31, 2007, we operated 94 inpatient rehabilitation hospitals (including 3 hospitals which we account for using the equity method of accounting). We are the sole owner of 66 of these hospitals. We retain a 50% to 97.5% ownership in the remaining 28 jointly owned hospitals. Our inpatient rehabilitation hospitals are located in 26 states, with a concentration of hospitals in Texas, Pennsylvania, Florida, Tennessee, and Alabama. As of December 31, 2007, we also had two hospitals in Puerto Rico, one of which began accepting patients in April 2007.

As of December 31, 2007, we also operated 6 freestanding LTCHs, 5 of which we own and one of which is a joint venture in which we have retained an 80% ownership interest. We also operated 60 outpatient satellites located within or near (and operated by) our hospitals, 46 of which are wholly owned and 14 of which are jointly owned.

Of these 160 facilities, 44 are located on property owned by us and the remaining locations are leased.

We also provide home health services through 25 hospital-based home health agencies. In addition to HealthSouth hospitals, we manage 11 inpatient rehabilitation units, 3 outpatient satellites, and one gamma knife radiosurgery center through management contracts.

Because of our size, we believe we differentiate ourselves from our competitors in the following ways:

Quality. Our hospitals provide a broad base of clinical experience from which we have developed clinical best practices and protocols. We believe these clinical best practices and protocols help ensure the delivery of consistently high quality rehabilitative services across all of our hospitals.

Technology. As a market leader in inpatient rehabilitation, we have devoted substantial resources to creating and leveraging rehabilitative technology. For example, we have developed an innovative therapeutic device called the AutoAmbulator, which can help advance the rehabilitative process for patients who experience difficulty walking. In addition to clinical technology, we have also improved our business technology by migrating to one common billing and collections system, which has improved our administrative efficiency.

Efficiency and Cost Effectiveness. Our size helps us provide inpatient rehabilitative services on a very cost-effective basis. Specifically, because of our large number of inpatient hospitals, we can utilize standardized staffing models and take advantage of certain supply chain efficiencies. We have also

developed a program called TeamWorks, which is an operations-focused initiative using identified best practices to reduce inefficiencies and improve performance across a wide spectrum of operational areas.

Now that we have concluded our strategic repositioning, we will focus on enhancing the operations of our inpatient rehabilitation hospitals and growing our inpatient rehabilitation business through bed expansion, consolidation in existing markets (through joint venturing or acquisition), de-novo projects in existing and new markets, and acquisitions in new markets. For the next two years, we will focus on growing our inpatient rehabilitation business. Once we reduce our leverage and have a balance sheet capable of withstanding additional risk, we will consider growth opportunities in other post-acute services complementary to our existing services such as long-term acute care, home health, and hospice.

In focusing on our inpatient rehabilitation business, we commenced or completed the following development projects:

- We opened our second inpatient rehabilitation hospital in Puerto Rico in April 2007.
- In April 2007, we signed an agreement to partner with Wellmont Health System (Wellmont) to own and operate a new inpatient rehabilitation hospital in Bristol, Virginia and to partner with Wellmont at our existing inpatient rehabilitation hospital in Kingsport, Tennessee. Although the certificate of need (CON) application for the Virginia hospital was denied on December 18, 2007, we have appealed this decision and meanwhile are continuing to operate the Tennessee hospital on a stand-alone basis.
- We opened a new 40-bed inpatient rehabilitation hospital in Fredericksburg, Virginia in July 2007.
- We filed a CON application for a new 40-bed rehabilitation hospital in Louden County, Virginia on October 31, 2007, and have signed an agreement to acquire the property on which the hospital will be built.

Regulatory Challenges to the Inpatient Rehabilitation Industry

Our inpatient rehabilitation hospitals provide services to patients who require intensive inpatient rehabilitative care. Inpatient rehabilitation patients typically experience significant physical disabilities due to various conditions, such as head injury, spinal cord injury, stroke, certain orthopedic problems, and neuromuscular disease. Our inpatient rehabilitation hospitals provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations and, for some facilities, the Commission on Accreditation of Rehabilitation Facilities.

Over the last several years, changes in regulation governing inpatient rehabilitation reimbursement have created a challenging operating environment for inpatient rehabilitation services. Specifically, on May 7, 2004, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, known as the 75% Rule, stipulating that to qualify as an inpatient rehabilitation hospital under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any inpatient rehabilitation hospital that failed to meet the requirements of the 75% Rule would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. However, the impact of the 75% Rule was significantly greater than CMS initially envisioned, and it required us to deny admissions to our hospitals.

The compliance threshold of the 75% Rule was in the process of being phased-in over time, and was already at 60% or higher for all of our hospitals at the end of 2007. However, on December 29, 2007, The Medicare, Medicaid and State Children s Health Insurance Program (SCHIP) Extension Act of 2007 (the 2007 Medicare Act) was signed, permanently setting the compliance threshold at 60% instead of 75%, and allowing hospitals to continue using a patient s secondary medical conditions, or comorbidities, to determine whether a patient qualifies for inpatient rehabilitation care under the rule. We believe the freeze at the 60% compliance threshold will stabilize much of the volatility in patient volumes created by the 75% Rule. An additional element to the 2007 Medicare Act is a reduction in the pricing of services eligible for Medicare reimbursement to a pricing level that

existed in the third quarter of 2007 (the Medicare pricing roll-back). The roll-back is effective from April 1, 2008 until September 30, 2009. The long-term impact of the freeze at the 60% compliance threshold is positive, and we expect the negative impact of the pricing roll-back to be offset by volume increases created by the fact that more patients now have access to our high quality inpatient rehabilitation services.

Although the volume volatility created by the 75% Rule has had a significant negative impact on our *Net operating revenues* over the past few years (see Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations),* we have been able to partially mitigate the impact of the 75% Rule on our operating earnings by implementing the following strategies:

Refocused Marketing. The 75% Rule reduced the number of patients seeking treatment for orthopedic and other diagnostic conditions that we could accept in our inpatient rehabilitation hospitals. Consequently, we focused our marketing efforts on neurologists, neurosurgeons, and internists who could refer patients that require treatment for one of the 13 designated medical conditions identified by the 75% Rule, such as stroke, spinal cord injury, brain injury, and various neurological disorders.

Broadened Services. To make up for a potentially reduced inpatient rehabilitation patient census, we increased the number of other post-acute care services performed at or complementary to our inpatient rehabilitation hospitals, such as home health services.

Reduced Costs. We aggressively reduced our costs in proportion to patient census declines in our inpatient rehabilitation hospitals.

Competition

The inpatient rehabilitation industry is highly fragmented, and we have no single, similar direct competitor. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units and skilled nursing units, many of which are within acute care hospitals in the markets we serve. Our LTCHs compete with other LTCHs or with intensive care units also within acute care hospitals in the markets we serve. Several smaller privately held companies are beginning to compete with us in select geographic markets in Texas and the west. In addition, there are public companies that operate inpatient rehabilitation hospitals and LTCHs, but these are generally secondary services to their core businesses. Because of the attractiveness of the industry, other providers of post acute-care services may also become competitors in the future. For example, over the past few years, the number of nursing homes marketing themselves as rehabilitation providers has increased.

In some states where we operate, the construction or expansion of facilities, the acquisition of existing facilities, or the introduction of new beds or services may be subject to review by and prior approval of state regulatory agencies under a certificate of need or CON program. See this Item, Regulation Certificates of Need. We potentially face opposition any time we initiate a certificate of need project or seek to acquire an existing facility or certificate of need. This opposition may arise either from competing national or regional companies or from local hospitals or other providers which file competing applications or oppose the proposed certificate of need project. The necessity for these approvals serves as a barrier to entry and has the potential to limit competition. We have generally been successful in obtaining certificates of need or similar approvals when required, although there can be no assurance we will achieve similar success in the future.

We rely significantly on our ability to attract, develop, and retain nurses, therapists, and other clinical personnel for our hospitals. We compete for these professionals with other health care companies, hospitals, and potential clients and partners. In addition, the lifting by CMS of the moratorium on new specialty hospitals has enabled physicians and others to open inpatient rehabilitation hospitals in direct competition with us, particularly in states in which a CON is not required to build a hospital, which has made it more difficult and expensive to hire the necessary personnel for our hospitals.

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), state governments (under their respective Medicaid or similar programs), managed care plans, private

insurers, and directly from patients. In addition, we receive payment for non-patient care activities from various sources. The following table identifies the sources and relative mix of our revenues for the periods stated:

	For the Year Ended December 31,		
	2007	**2006**	**2005**
Medicare	67.5%	68.6%	70.5%
Medicaid	2.0%	2.0%	2.4%

Workers compensation	2.4%	2.6%	2.9%
Managed care and other discount plans	18.7%	18.4%	16.1%
Other third-party payors	6.3%	5.1%	5.3%
Patients	0.6%	0.5%	0.4%
Other income	2.5%	2.8%	2.4%
Total	100.0%	100.0%	100.0%

Revenues and receivables from government agencies have always been significant to our operations. Our focus on the post-acute care sector and inpatient rehabilitation services subsequent to our divestiture transactions has increased this significance. For example, prior to our divestitures, approximately 47% of our 2006 *Net operating revenues* related to patients participating in the Medicare program (as reported in our Form 10-K for the fiscal year ended December 31, 2006 and prior to the reclassification of our surgery centers, outpatient and diagnostic divisions to discontinued operations). As can be seen in the table above, subsequent to our divestiture transactions and the associated reclassification of our surgery centers, outpatient, and diagnostic divisions to discontinued operations, this percent increased to approximately 69% of our 2006 *Net operating revenues*.

Unlike health care providers who rely heavily on managed care and other discount plans, we should always be able to participate in the Medicare program, as long as we continue to maintain the required certifications (as discussed below in the Regulation section). With managed care and other discount plans, health care providers may not be successful in negotiating contracts and may be unable to provide services to patients participating in those plans. In addition, with Medicare s prospective payment system, our hospitals benefit from being high quality, low cost providers.

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including Blue Cross and Blue Shield (BCBS), other private insurance companies, employers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other managed care plans. These discount programs, which are often negotiated for multi-year terms, limit our ability to increase revenues in response to increasing costs.

Patients are generally not responsible for the difference between established gross charges and amounts reimbursed for such services under Medicare, Medicaid, BCBS plans, HMOs, or PPOs, but are responsible to the extent of any exclusions, deductibles, copayments, or coinsurance features of their coverage. The amount of such exclusions, deductibles, copayments, and coinsurance has been increasing each year. Collection of amounts due from individuals is typically more difficult than from governmental or third-party payors.

Medicare Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a jointly administered federal and state program that provides hospital and medical benefits to qualifying individuals who are unable to afford health care.

Medicare, through statutes and regulations, establishes reimbursement methodologies for various types of health care facilities and services. These methodologies have historically been subject to periodic revisions that can have a substantial impact on existing health care providers. In accordance with authorization from Congress, CMS generally makes annual upward or downward adjustments to Medicare payment rates in most areas. The 2007 Medicare Act includes a roll-back in pricing for the period from April 1, 2008 through September 30, 2009, which will result in a decrease in actual reimbursement dollars per discharge despite increases in costs.

We expect Congress and CMS will continue to address reimbursement rates for a variety of health care settings over the next several years. Any downward adjustment to rates for the types of facilities we operate could have a material adverse effect on our business, financial position, results of operations, and cash flows.

A basic summary of current Medicare reimbursement in our service areas follows:

Inpatient Rehabilitation and the 75% Rule. On August 7, 2007, CMS published a final rule that updates the inpatient rehabilitation facility prospective payment system for the federal fiscal year 2008 (covering discharges occurring on or after October 1, 2007 and on or before September 30, 2008). Specifically, the final rule included a market basket update of 3.2% to the standard payment rate. We estimated this final rule would have increased our *Net operating revenue* by approximately $7.0 million per quarter for federal fiscal year 2008 as compared to federal fiscal year 2007. However, due to the Medicare pricing roll-back effective from April 1, 2008 to September 30, 2009, we will only receive the benefits of the update in the fourth quarter of 2007 and the first quarter of 2008.

As discussed previously in this Item at Inpatient Rehabilitation Business Regulatory Challenges to the Inpatient Rehabilitation Industry, the 2007 Medicare Act recently amended the 75% Rule to permanently establish a 60% compliance threshold, to include comorbidities as a qualifying factor, and to temporarily roll-back the pricing of services. Although the refocus of admissions we undertook during the past few years resulted in volume volatility, it has resulted in our achieving full compliance with the 60% compliance level during 2007. The freeze at 60% should provide us with permanent relief from much of the volume volatility we have experienced since May 2004, and should allow us to increase patient volumes going forward.

Anticipated increases in patient revenues may be offset in the short-term due to the Medicare pricing roll-back under the 2007 Medicare Act. As noted above, this roll-back applies to the period from April 1, 2008 through September 30, 2009. While the short-term effect of this amendment will be the roll-back of Medicare pricing to the levels existing in the third quarter of 2007, the long-term effects of the 2007 Medicare Act will be positive due to the increased number of patients we will be able to serve.

Although reductions or changes in reimbursement from governmental or third-party payors and regulatory changes affecting our business represent the most significant challenges to our business, coverage policies can also affect our operations. For example, Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. In the absence of a national coverage determination, local Medicare contractors may specify more restrictive criteria than otherwise would apply nationally. We cannot predict how these local coverage rules will affect us.

On December 8, 2003, The Medicare Modernization Act of 2003 authorized CMS to conduct a demonstration program known as the Medicare Recovery Audit Contractor (RAC) program. This demonstration was first initiated in three states (California, Florida, and New York) and authorizes CMS to contract with private companies to conduct claims and medical record audits. These audits are in addition to those conducted by existing Medicare contractors, and the contracted RACs are paid a percentage of the overpayments recovered. RACs receive claims data directly from Medicare contractors on a quarterly basis and, after October 1, 2007, are authorized to review claims up to three years from the date a claim was paid. On December 20, 2006, the Tax Relief & Health Care Act of 2006 directed CMS to expand the RAC program to the rest of the country by 2010. We cannot predict how this new program will affect us.

Outpatient Services Provided by our Hospitals. On November 27, 2007, CMS issued a final rule that will update payments under the Physician Fee Schedule beginning January 1, 2008. Specifically, the rule would reduce the standard conversion factor by 10.1% to $34.0682. Further, the rule provided for a negative budget neutrality factor of 11.94% to the work relative value unit. These changes will result in lower reimbursement to us for outpatient services. However, the 2007 Medicare Act amended the Physician Fee Schedule pricing reduction to provide for an increase in the standard conversion factor of 0.5% for the period January 1, 2008 through June 30, 2008. Absent Congressional intervention, the pricing reductions discussed above would be reinstated on July 1, 2008.

Long-Term Acute Care Hospitals. LTCHs provide medical treatment to patients with chronic diseases and/or complex medical conditions. In order for a hospital to qualify as an LTCH, patients discharged from the

hospital in any given cost reporting year must have an average length-of-stay in excess of 25 days, among other requirements. LTCHs are currently reimbursed under a prospective payment system (LTCH-PPS) pursuant to which Medicare classifies patients into distinct Medicare Severity diagnosis-related groups (MS-LTC-DRGs) based upon specific clinical characteristics and expected resource needs.

On May 11, 2007, CMS issued final regulations that updated payment rates under the LTCH-PPS for rate year 2008, which are effective for discharges occurring on or after July 1, 2007 through June 30, 2008. This rule implements various payment changes and also indicates that a budget neutrality requirement will be implemented starting with the October 1, 2007 update to the LTC-DRGs, relative weights and average length of stays. This rule also extended the 25% hospital-within-hospital referral limitation to freestanding, satellite and grandfathered LTCHs (See this Item, Regulation Hospital Within Hospital Rules for a further discussion of this rule change). This final rule did not materially impact our *Net operating revenues* in 2007, nor is it expected to materially impact our 2008 *Net operating revenues*.

On August 22, 2007, CMS issued final regulations that updated the inpatient hospital prospective payment system (IPPS) and LTCH-PPS. The final rule implemented the MS-LTC-DRG system by expanding the current number of DRGs from 538 to 745, resulting in changes to the LTCH relative payment weights and average lengths of stay. These changes were effective beginning October 1, 2007. This final rule is not expected to have a material impact on our *Net operating revenues* during federal fiscal year 2008.

However, the 2007 Medicare Act provides regulatory relief, for a three year period to LTCHs to ensure continued access to current long-term care hospital services, while also imposing a limited moratorium on the development of new long-term care hospitals. Specifically, the legislation would freeze the market basket update for LTCHs for the last quarter of Rate Year 2008. Additionally, the 2007 Medicare Act would prevent CMS from implementing the new payment provision for short stay outlier cases and the extension of the 25% referral limitation to freestanding, satellite and grandfathered LTCHs that was included in the Rate Year 2008 final rule. See this Item, Regulation Hospital Within Hospital Rules for a further discussion of this rule.

Medicaid Reimbursement

Medicaid programs are jointly funded by federal and state governments. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of certain services. Continuing downward pressure on Medicaid payment rates could cause a decline in our *Net operating revenues*.

Cost Reports

Because of our participation in Medicare, Medicaid, and certain Blue Cross plans, we are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenue, costs, and expenses associated with the services provided by our inpatient hospitals to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due HealthSouth under these reimbursement programs. These audits are used for determining if any under- or over-payments were made to these programs and to set payment levels for future years. The majority of our revenues are derived from prospective payment system payments, and even if we amend previously filed cost reports we do not expect the impact of those amendments to materially affect our results of operations.

Managed Care and Other Discount Plans

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans, BCBS, other private insurance companies, and employers. Managed care contracts typically have terms of between one and three years, although we have a number of managed care

contracts that automatically renew each year unless a party elects to terminate the contract. While some of our contracts provide for annual rate increases of three to five percent, we cannot provide any assurance we will continue to receive increases.

Regulation

The health care industry is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our hospitals, regulating the use of our properties, and controlling our growth.

Corporate Integrity Agreement

On December 30, 2004, we entered into a corporate integrity agreement (the CIA) with the HHS-OIG. The CIA has an effective date of January 1, 2005 and a term of five years from that effective date. It incorporated a number of compliance program changes already implemented by us and required, among other things, that not later than 90 days after the effective date we:

- form an executive compliance committee (made up of our compliance officer and other executive management members), which shall participate in the formulation and implementation of HealthSouth s compliance program;
- require certain independent contractors to abide by our Standards of Business Conduct;
- provide general compliance training to all HealthSouth personnel as well as specialized training to personnel responsible for billing, coding, and cost reporting relating to federal health care programs;
- report and return overpayments received from federal health care programs;
- notify the HHS-OIG of any new investigations or legal proceedings initiated by a governmental entity involving an allegation of fraud or criminal conduct against HealthSouth;
- notify the HHS-OIG of the purchase, sale, closure, establishment, or relocation of facilities furnishing items or services that are reimbursed under federal health care programs; and
- submit annual reports to the HHS-OIG regarding our compliance with the CIA.

The CIA also required that we engage an Independent Review Organization (IRO) to assist us in assessing and evaluating: (1) our billing, coding, and cost reporting practices with respect to our inpatient rehabilitation hospitals; (2) our billing and coding practices for outpatient items and services furnished by outpatient departments of our inpatient rehabilitation hospitals; and (3) certain other obligations pursuant to the CIA and the related settlement agreement. We engaged PricewaterhouseCoopers LLP to serve as our IRO.

On April 28, 2005, we submitted an implementation report to the HHS-OIG stating we had, within the 90-day time frame, materially complied with the initial requirements of the CIA. Since that time, we have reported annually to the HHS-OIG regarding our compliance with the CIA, including the submission of an annual report by our IRO.

As discussed in Note 20, *Settlements*, to our accompanying consolidated financial statements, we entered into a first addendum to our CIA which requires additional compliance training and annual audits of billing practices relating to prosthetic and orthotic devices. The addendum has a term of three years and will run concurrently with our existing five-year CIA. On December 14, 2007, we entered into a second addendum to our CIA, which requires additional compliance training and annual audits related to arrangements with referral sources. This addendum also runs concurrently with our existing five-year CIA.

Failure to meet our obligations under our CIA could result in stipulated financial penalties. Failure to comply with material terms, however, could lead to exclusion from further participation in federal health care programs, including Medicare and Medicaid, which currently account for a substantial portion of our revenues.

Licensure and Certification

Health care facility construction and operation are subject to numerous federal, state, and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, fire prevention, and compliance with building codes and environmental protection laws. Our hospitals are subject to periodic inspection by governmental and non-governmental certification authorities to ensure continued compliance with the various standards necessary for facility licensure. All of our inpatient hospitals are currently required to be licensed.

In addition, hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. All of our inpatient hospitals participate in (or are awaiting the assignment of a provider number to participate in) the Medicare program. Our Medicare-certified hospitals undergo periodic on-site surveys in order to maintain their certification.

Failure to comply with applicable certification requirements may make our hospitals ineligible for Medicare or Medicaid reimbursement. In addition, Medicare or Medicaid may seek retroactive reimbursement from noncompliant facilities or otherwise impose sanctions on noncompliant facilities. Non-governmental payors often have the right to terminate provider contracts if a facility loses its Medicare or Medicaid certification. We have developed operational systems to oversee compliance with the various standards and requirements of the Medicare program and have established ongoing quality assurance activities; however, given the complex nature of governmental health care regulations, there can be no assurance that Medicare, Medicaid, or other regulatory authorities will not allege instances of noncompliance.

Certificates of Need

In some states where we operate, the construction or expansion of facilities, the acquisition of existing facilities, or the introduction of new beds or services may be subject to review by and prior approval of state regulatory agencies under certificate of need laws. Certificate of need laws often require the reviewing agency to determine the public need for additional or expanded health care facilities and services. Certificate of need laws generally require approvals for capital expenditures involving inpatient rehabilitation hospitals, LTCHs, and acute care hospitals, if such capital expenditures exceed certain thresholds. In addition, the certificate of need laws in some states require us to abide by certain charity commitments as a condition for approving a certificate of need. Any time a certificate of need is required, we must obtain it before acquiring, opening, reclassifying, or expanding a health care facility or starting a new health care program.

False Claims Act

Over the past several years, an increasing number of health care providers have been accused of violating the federal False Claims Act. That act prohibits the knowing presentation of a false claim to the United States government, and provides for penalties equal to three times the actual amount of any overpayments plus up to $11,000 per claim. In addition, the False Claims Act allows private persons, known as relators, to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. Because of the sealing provisions of the False Claims Act, it is possible for health care providers to be subject to False Claims Act suits for extended periods of time without notice of such suits or an opportunity to respond to them. Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties under the False Claims Act or other laws. Due to the actions of prior management, we have entered into substantial settlements of claims under the False Claims Act, as discussed in Note 21, *Contingencies and Other Commitments*, Certain Regulatory Actions. See also Note 20, *Settlements*, to our accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

The Anti-Kickback Law. Various state and federal laws regulate relationships between providers of health care services, including employment or service contracts and investment relationships. Among the most important of these restrictions is a federal criminal law prohibiting (1) the offer, payment, solicitation, or receipt of remuneration

by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs or (2) the leasing, purchasing, ordering, arranging for, or recommending the lease, purchase, or order of any item, good, facility, or service covered by such programs (the Anti-Kickback Law). In addition to federal criminal sanctions, including penalties of up to $50,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. In 1991, the HHS-OIG issued regulations describing compensation arrangements that are not viewed as illegal remuneration under the Anti-Kickback Law (the 1991 Safe Harbor Rules). The 1991 Safe Harbor Rules create certain standards (Safe Harbors) for identified types of compensation arrangements that, if fully complied with, assure participants in the particular arrangement that the HHS-OIG will not treat that participation as a criminal offense under the Anti-Kickback Law or as the basis for an exclusion from the Medicare and Medicaid programs or the imposition of civil sanctions.

The HHS-OIG closely scrutinizes health care joint ventures involving physicians and other referral sources for compliance with the Anti-Kickback Law. In 1989, the HHS-OIG published a Fraud Alert that outlined questionable features of suspect joint ventures, and has continued to rely on such Fraud Alert in later pronouncements. We currently operate some of our rehabilitation hospitals as general partnerships, limited partnerships, or limited liability companies (collectively, partnerships) with third-party investors, including other institutional health care providers but also including, in one case, physician investors. Some of these partners may be deemed to be in a position to make or influence referrals to our hospitals. Those partnerships that are providers of services under the Medicare program, and their owners, are subject to the Anti-Kickback Law. A number of the relationships we have established with physicians and other health care providers do not fit within any of the Safe Harbors. The 1991 Safe Harbor Rules do not expand the scope of activities the Anti-Kickback Law prohibits, nor do they provide that failure to fall within a Safe Harbor constitutes a violation of the Anti-Kickback Law; however, the HHS-OIG has indicated failure to fall within a Safe Harbor may subject an arrangement to increased scrutiny. While we do not believe our rehabilitation hospital partnerships engage in activities that violate the Anti-Kickback Law, there can be no assurance such violations may not be asserted in the future, nor can there be any assurance that our defense against any such assertion would be successful.

We have entered into agreements to manage many of our hospitals that are owned by partnerships. Most of these agreements incorporate a percentage-based management fee. Although there is a safe harbor for personal services and management contracts, this safe harbor requires, among other things, the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, the fee arrangement may not meet this requirement. However, we believe our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and they comply with the Anti-Kickback Law. The HHS-OIG has taken the position that percentage-based management agreements are not protected by a safe harbor, and consequently, may violate the Anti-Kickback Law. On April 15, 1998, the HHS-OIG issued Advisory Opinion 98-4 which reiterates this position. This opinion focused on areas the HHS-OIG considers problematic in a physician practice management context, including financial incentives to increase patient referrals, no safeguards against overutilization, and incentives to increase the risk of abusive billing. The opinion reiterated that proof of intent to violate the Anti-Kickback Law is the central focus of the HHS-OIG. We have implemented programs designed to safeguard against overbilling and otherwise to achieve compliance with the Anti-Kickback Law and other laws, but there can be no assurance the HHS-OIG would find our compliance programs to be adequate.

While several federal court decisions have aggressively applied the restrictions of the Anti-Kickback Law, they provide little guidance as to the application of the Anti-Kickback Law to our partnerships, and we cannot provide any assurances a federal or state agency charged with enforcement of the Anti-Kickback Law and similar laws might not claim some of our partnerships have violated or are violating the Anti-Kickback Law. Such a claim could adversely affect relationships we have established with physicians or other health care providers or result in the imposition of penalties on us or on particular HealthSouth hospitals. Any conviction of a partnership for violations of the Anti-Kickback Law would have severe consequences on that partnership s ability to be a viable entity and our ability to attract investors to other partnerships and could result in substantial fines as well as our exclusion from Medicare and Medicaid. Moreover, even the assertion of a violation of the Anti-Kickback Law by one or more of our partnerships could have a material adverse effect upon our business, financial position, results of operations, or cash flows.

Stark Exceptions. The Stark provisions of the Omnibus Budget Reconciliation Act of 1993 amend the federal Medicare statute to prohibit the making by a physician of referrals for designated health services including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, or radiation therapy, to an entity in which the physician has an investment interest or other financial relationship, subject to certain exceptions. Such prohibition took effect on January 1, 1995 and applies to our partnerships with physician partners and to our other financial relationships with physicians. Final Phase I Stark Regulations were published in the Federal Register on January 4, 2001 and had an effective date of January 4, 2002. Final Phase II Stark Regulations were published in the Federal Register on March 26, 2004 and had an effective date of July 26, 2004. Final Phase III Stark Regulations were published in the Federal Register on September 5, 2007, and had an effective date of December 4, 2007. The final regulations substantially clarified compensation arrangements with physicians and recruitment arrangements among health care facilities, individual physicians, and group practices.

While we do not believe our financial relationships with physicians violate the Stark statute or the associated regulations, no assurances can be given that a federal or state agency charged with enforcement of the Stark statute and regulations or similar state laws might not assert a contrary position or that new federal or state laws governing physician relationships, or new interpretations of existing laws governing such relationships, might not adversely affect relationships we have established with physicians or result in the imposition of penalties on us or on particular HealthSouth hospitals. Even the assertion of a violation could have a material adverse effect upon our business, financial position, results of operations or cash flows. In addition, a number of states have passed or are considering statutes which prohibit or limit physician referrals of patients to facilities in which they have an investment interest. Any actual or perceived violation of these state statutes could have a material adverse effect on our business, financial position, results of operations, and cash flows.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) broadened the scope of certain fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. Federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers, and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud.

HIPAA also contains certain administrative simplification provisions that require the use of uniform electronic data transmission standards for certain health care claims and payment transactions submitted or received electronically. HHS has issued regulations implementing the HIPAA administrative simplification provisions and compliance with these regulations became mandatory for our hospitals on October 16, 2003. Although HHS temporarily agreed to accept noncompliant Medicare claims, CMS stopped processing non-HIPAA-compliant Medicare claims beginning October 1, 2005. We believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial position, results of operations, and cash flows.

HIPAA also requires HHS to adopt standards to protect the privacy and security of individually identifiable health-related information. HHS released regulations containing privacy standards in December 2000 and published revisions to the regulations in August 2002. Compliance with these regulations became mandatory on April 14, 2003. The privacy regulations regulate the use and disclosure of individually identifiable health-related information, whether communicated electronically, on paper, or orally. The regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. HHS released security regulations on February 20, 2003. The security regulations became mandatory on April 20, 2005 and require health care providers to implement administrative, physical, and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically. The privacy regulations and security regulations have increased costs on our hospitals in order to comply with these standards.

Penalties for violations of HIPAA include civil and criminal monetary penalties. In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional penalties.

Hospital Within Hospital Rules

Effective October 1, 2004, CMS enacted final regulations that provide if a long-term acute care hospital within hospital has Medicare admissions from its host hospital that exceed 25% (or an adjusted percentage for certain rural or Metropolitan Statistical Area (MSA) dominant hospitals) of its Medicare discharges for its cost-reporting period, the LTCH will receive an adjusted payment for its Medicare patients of the lesser of (1) the otherwise full payment under the LTCH-PPS or (2) a comparable payment that Medicare would pay under the acute care inpatient prospective payment system. In determining whether an LTCH meets the 25% criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host facility would not count as part of the host hospital s allowable percentage. Cases admitted from the host hospital before the LTCH crosses the 25% threshold will be paid under the LTCH-PPS. Under the final regulation, this 25% Rule is being phased in over a four year period which began on October 1, 2004.

On May 11, 2007, CMS published a final rule that would extend the hospital-within-hospital patient threshold to freestanding, satellite and grandfathered LTCHs. These new LTCH requirements are phased in over a 3-year period beginning with cost report periods beginning on or after July 1, 2007. The first year of the phase-in would limit referrals to the lesser of 75% or the percentage of referrals in the cost report period ending in Rate Year 2005. Upon completion of the full phase-in, rural, urban single and MSA dominant LTCHs shall not be subject to any payment adjustment if no more than 50% of the hospital s Medicare discharges are admitted from a co-located hospital. Urban LTCH hospitals shall not be subject to any payment adjustment if no more than 25% of the hospital s Medicare discharges are admitted from a co-located hospital.

The 2007 Medicare Act made certain changes to the hospital-within-hospital rules. Specifically, the Bill would prevent application of the 25% patient threshold payment adjustment to freestanding, satellite, and grandfathered LTCHs. Further, the Bill increases the percentage that hospital-within-hospital LTCHs may admit from a co-located hospital. Rural, urban single and MSA dominant LTCH hospitals shall not be subject to any payment adjustment if no more than 75% of the hospital s Medicare discharges are admitted from another hospital. Urban LTCH hospitals shall not be subject to any payment adjustment if no more than 50% of the hospital s Medicare discharges are admitted from another hospital. These provisions are effective for cost report periods beginning on or after December 29, 2007 for a three-year period.

Additionally, other excluded hospitals or units of a host hospital, such as inpatient rehabilitation facilities and/or units, must meet certain hospital within hospital requirements in order to maintain their excluded status and not be subject to IPPS.

Risk Management and Insurance

We insure a substantial portion of our professional, general liability, and workers compensation risks through a self-insured retention program underwritten by our wholly owned offshore captive insurance subsidiary, HCS Limited (HCS), which we fund annually. For 2007, HCS provided our first layer of insurance coverage for professional and general liability risks and workers compensation claims. We maintained professional and general liability insurance and workers compensation insurance with unrelated commercial carriers for losses in excess of amounts insured by HCS. HealthSouth and HCS maintained reserves for professional, general liability, and workers compensation risks. Management considers such reserves, which are based on actuarially determined estimates, to be adequate for those liability risks. However, there can be no assurance the ultimate liability will not exceed management s estimates. See Note 1*Summary of Significant Accounting Policies*, Self-Insured Risks, to our accompanying consolidated financial statements for a description of these reserves.

We also maintain director and officer, property, and other typical insurance coverages with unrelated commercial carriers. Our director and officer liability insurance coverage for our current officers and directors includes coverage for individual directors and officers in circumstances where we are legally or financially unable to indemnify these individuals. Examples of a company s inability to indemnify would include judgments in

connection with shareholder derivative lawsuits, bankruptcy/financial restraints, and claims that are against public policy. Within our coverage, we have a self-insured retention for indemnifiable loss. See Note 20, *Settlements*, Insurance Coverage Litigation, for a description of various lawsuits that have been filed to contest coverage under certain directors and officers insurance policies.

Employees

As of December 31, 2007, we employed approximately 22,000 individuals, of whom approximately 14,000 were full-time employees. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 70 employees at one inpatient rehabilitation hospital (about 17% of that hospital s workforce), none of our employees are represented by a labor union. We are not aware of any current activities to organize our employees at other hospitals. We believe our relationship with our employees is satisfactory. Like most health care providers, our labor costs are rising faster than the general inflation rate. In some markets, the lack of availability of nurses and other medical support personnel has become a significant operating issue to health care providers. To address this challenge, we are implementing initiatives to improve retention, recruiting, compensation programs, and productivity. The shortage of nurses and other medical support personnel, including physical therapists, may require us to increase utilization of more expensive temporary personnel.

Available Information

Our website address is www.healthsouth.com. We make available through our website the following documents, free of charge: our annual reports (Form 10-K), our quarterly reports (Form 10-Q), our current reports (Form 8-K), and any amendments we file with respect to any such reports promptly after we electronically file such material with, or furnish it to, the SEC. In addition to the information that is available on our website, you may read and copy any materials we file with or furnish to the SEC at the SEC s Public Reference Room at 100 F Street, N.E., Room 1580, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC also maintains a website, www.sec.gov, which includes reports, proxy, and information statements, and other information regarding us and other issuers that file electronically with the SEC.

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and you should take such risks into account in evaluating HealthSouth or any investment decision involving HealthSouth. This section does not describe all risks that may be applicable to our Company, our industry, or our business, and it is intended only as a summary of certain material risk factors. More detailed information concerning the risk factors described below is contained in other sections of this annual report.

We are highly leveraged. As a consequence, a down-turn in earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement and could impair our ability to obtain additional financing, if necessary.

Although we improved our leverage and liquidity during 2007, we remain highly leveraged. As discussed in Item 1, *Business*, Recent Significant Events, we reduced our long-term debt from $3.4 billion to approximately $2.0 billion during 2007. We believe the reduction in our long-term debt has eliminated significant uncertainty regarding our capital structure, improved our financial position, increased our liquidity and enhanced our operational flexibility. Based on the current borrowing capacity and leverage ratio required under our Credit Agreement, we do not believe there is significant risk in our ability to make additional draws under our revolving credit facility, if needed.

We are required to use a substantial portion of our cash flow to service our debt. A down-turn in earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement and impair our ability to obtain additional financing, if necessary. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might not be on terms as favorable to those in our existing Credit Agreement. The recent tightening in the credit markets will make additional financing more expensive and difficult to obtain. A default due to violation of the covenants contained within our Credit Agreement could require us to immediately repay all amounts then outstanding under the Credit Agreement. Certain trends in our business, including acute care volume weakness and pricing pressure, have created a challenging operating environment, and future changes could place additional pressure on our revenues and cash flow. In addition, we are subject to numerous contingent liabilities, to prevailing economic conditions, and to financial, business, and other factors beyond our control. Although we expect to make scheduled interest payments and principal reductions, we cannot assure you that changes in our business or other factors will not occur that may have the effect of preventing us from satisfying obligations under our debt.

Reductions or changes in reimbursement from government or third-party payors and other regulatory changes affecting our industry could adversely affect our operating results.

We derive a substantial portion of our *Net operating revenues* from the Medicare and Medicaid programs. See Item 1, *Business*, Sources of Revenues, for a table identifying the sources and relative payor mix of our revenues. Historically, Congress and some state legislatures have periodically proposed significant changes in regulations governing the health care system. Many of these changes have resulted in limitations on and, in some cases, significant reductions in the levels of, payments to health care providers for services under many government reimbursement programs. The recent 2007 Medicare Act has frozen the increase in Medicare payments to inpatient rehabilitation hospitals from April 1, 2008 through September 30, 2009. If we are not able to increase our volumes sufficiently to offset this price reduction, our operating results could be adversely affected. Our results could be further adversely affected by other changes in laws or regulations governing the Medicare and Medicaid programs, as well as possible changes to or expansion of the audit processes conducted by Medicare contractors or Medicare recovery audit contractors. For a discussion of the 75% Rule and other factors affecting reimbursement for our services, see Item 1, *Business*, Sources of Revenues Medicare Reimbursement.

In addition, there are increasing pressures from many third-party payors to control health care costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and non-governmental third-party payors, such as health maintenance organizations and preferred provider organizations, are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

Additionally, our third-party payors may, from time to time, request audits of the amounts paid to us under our agreements with them. We could be adversely affected in some of the markets where we operate if the audits uncover substantial overpayments made to us.

Competition for staffing may increase our labor costs and reduce profitability.

Our operations are dependent on the efforts, abilities, and experience of our management and medical support personnel, such as physical therapists, nurses, and other health care professionals. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals. In some markets, the lack of availability of physical therapists, nurses, and other medical support personnel has become a significant operating issue to health care providers. This shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. Our failure to recruit and retain qualified management, physical therapists, nurses, and other medical support personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

The adoption of more restrictive Medicare coverage policies at the national or local levels could have an adverse impact on our ability to obtain Medicare reimbursement for inpatient rehabilitation services.

Medicare providers also can be negatively affected by the adoption of coverage policies, either at the national or local levels, describing whether an item or service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. In the absence of a national coverage determination, local Medicare contractors and carriers may specify more restrictive criteria than otherwise would apply nationally. For instance, Cahaba Government Benefit Administrators, the Medicare contractor for many of our hospitals, has issued a local coverage determination setting forth very detailed criteria for determining the medical appropriateness of services provided by inpatient rehabilitation hospitals. We cannot predict whether other Medicare contractors will adopt additional local coverage determinations or other policies or how these will affect us.

If we fail to comply with our Corporate Integrity Agreement, or if the HHS-OIG determines we have violated federal laws governing kickbacks and self-referrals, we could be subject to severe sanctions, including substantial civil money penalties.

In December 2004, we entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services (HHS) Office of the Inspector General (HHS-OIG) to promote our compliance with the requirements of Medicare, Medicaid, and all other federal health care programs. We have also entered into two addendums to this agreement. Under the agreement and addendums, which are effective for five years from January 1, 2005, we are subject to certain administrative requirements and are subject to review of certain Medicare cost reports and reimbursement claims by an Independent Review Organization. Our failure to comply with the material terms of the Corporate Integrity Agreement could lead to suspension or exclusion from further participation in federal health care programs, including Medicare and Medicaid, which currently account for a substantial portion of our revenues. Further, if the HHS-OIG determines that we have violated the Anti-Kickback Law or the federal Stark statute s general prohibition on physician self-referrals, we may be subject to significant civil monetary penalties, and may be excluded from further participation in federal health care programs. Any of these sanctions would have a material adverse effect on our business, financial position, results of operations, and cash flows.

If we fail to comply with the extensive laws and government regulations applicable to health care providers, we could suffer penalties or be required to make significant changes to our operations.

As a health care provider, we are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

licensure, certification, and accreditation,
coding and billing for services,

requirements of the 60% compliance threshold,
relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws,
quality of medical care,
use and maintenance of medical supplies and equipment,
maintenance and security of medical records,
acquisition and dispensing of pharmaceuticals and controlled substances, and
disposal of medical and hazardous waste.

In the future, changes in these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our investment structure, facilities, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements.

Although we have invested substantial time, effort, and expense in implementing internal controls and procedures designed to ensure regulatory compliance, if we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state health care programs.

Our hospitals face national, regional, and local competition for patients from other health care providers.

We operate in a highly competitive industry. Although we are the largest provider of rehabilitative health care services, in any particular market we may encounter competition from local or national entities with longer operating histories or other competitive advantages. There can be no assurance that this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, weakening certificate of need laws in some states could potentially increase competition in those states.

We remain a defendant in a number of lawsuits, and may be subject to liability under *qui tam* cases, the outcome of which could have a material adverse effect on us.

Although we have settled the major litigation pending against us, we remain a defendant in numerous lawsuits which are discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements. Substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal executive offices are located in Birmingham, Alabama, where, as of December 31, 2007, we owned and maintained a headquarters building of approximately 200,000 square feet located on an 85-acre corporate campus. In addition to our headquarters building, as of December 31, 2007, we leased or owned 160 business locations through various consolidated entities to support our operations. Our hospital leases, which represent the largest portion of our rent expense, generally have initial terms of 15 years. Most of our leases contain one or more options to extend the lease period for up to five additional years for each option. Our consolidated entities are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses, particularly in our leased hospitals. Other than our headquarters campus and a contiguous 19-acre tract of land that includes an incomplete 13-story building formerly called the Digital Hospital, none of our other properties is materially important.

We and those of our subsidiaries that are guarantors under our Credit Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) have pledged substantially all of our property as collateral to secure the performance of our obligations under our Credit Agreement. In addition, we and our subsidiary guarantors have agreed to enter into mortgages with respect to certain of our material real property (excluding real property subject to preexisting liens and/or mortgages) in connection with the Credit Agreement. For additional information about our Credit Agreement, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

Prior to 2006, we marketed the Digital Hospital for sale extensively as a hospital but were unable to find a buyer. Following the March 31, 2006 sale of our acute care hospital located in Birmingham, Alabama, we no longer owned the certificate of need that would enable us to market the Digital Hospital as a hospital. See Note 5, *Property and Equipment*, to our accompanying consolidated financial statements, for a discussion of the impairment charges we recognized in 2007, 2006, and 2005 relating to the Digital Hospital.

In January 2008, we entered into an agreement to sell our corporate campus, including the Digital Hospital, to Daniel Corporation, a Birmingham-based, full-service real estate organization for $43.5 million in cash and a 40% residual interest in the Digital Hospital. Under the terms of the agreement, we entered into a long-term lease arrangement to maintain our corporate headquarters on the corporate campus. The transaction is scheduled to close by the end of the first quarter of 2008. See Note 5, *Property and Equipment*, to our accompanying consolidated financial statements.

During 2007, in transactions other than the divestitures of our outpatient, surgery centers, and diagnostic divisions and other sales of operating facilities, we sold non-core properties and buildings for net proceeds of $5.3 million. Additionally, on October 5, 2007, we closed a transaction for the property associated with our new hospital in Fredericksburg, Virginia. We received net proceeds of $12.4 million in this transaction and entered into a lease with a base term of 15 years for the property.

Our headquarters, hospitals, and other properties are suitable for their respective uses and are, in general, adequate for our present needs. Our properties are subject to various federal, state, and local statutes and ordinances regulating their operation. Management does not believe compliance with such statutes and ordinances will materially affect our business, financial position, results of operations, or cash flows.

Item 3. Legal Proceedings

Information relating to certain legal proceedings in which we are involved is included in Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements, each of which is incorporated herein by reference.

Item 4. Submission of Matters to a Vote of Security Holders

None.

PART II

Item 5. Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

On March 19, 2003, after the United States Securities and Exchange Commission (the SEC) issued an Order of Suspension of Trading, the New York Stock Exchange (NYSE) suspended trading in our common stock, which was then listed under the symbol HRC. That same day, Standard & Poor s announced that it removed our common stock from the S&P 500 Index. The NYSE continued the trading halt and eventually delisted our common stock. On March 25, 2003, immediately following the delisting from the NYSE, our stock began trading in the over-the-counter Pink Sheets market under the symbol HLSH. On August 14, 2006, we announced we had been cleared to submit an application for the listing of our common stock on the NYSE. Shares of our common stock began trading on the NYSE on October 26, 2006, under the ticker symbol HLS.

The following table sets forth the high and low bid quotations per share of HealthSouth common stock as reported on the over-the-counter market from January 1, 2006 through October 25, 2006, as well as the high and low sales prices per share for HealthSouth common stock as reported on the NYSE from October 26, 2006 through December 31, 2007. The stock price information is based on published financial sources. Over-the-counter market quotations reflect inter-dealer prices, without retail mark-up, mark-down, or commissions, and may not necessarily represent actual transactions. All quotations per share have been adjusted to reflect the reverse stock split that became effective on October 25, 2006.

	Market	High	Low
2006			
First Quarter	OTC	$ 26.25	$ 22.50
Second Quarter	OTC	24.60	21.50
Third Quarter	OTC	25.05	17.50
Fourth Quarter (through October 25, 2006)	OTC	26.65	24.10
Fourth Quarter (from October 26 through December 31, 2006)	NYSE	26.25	19.80
2007			
First Quarter	NYSE	$ 25.89	$ 20.51
Second Quarter	NYSE	21.70	16.59
Third Quarter	NYSE	19.33	14.84
Fourth Quarter	NYSE	23.02	17.03

Holders

As of February 15, 2008, there were 78,853,675 shares of HealthSouth common stock issued and outstanding, net of treasury shares, held by approximately 2,935 holders of record.

Dividends

We have never paid cash dividends on our common stock, and we do not anticipate paying cash dividends on our common stock in the foreseeable future. In addition, the terms of our Credit Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) restrict us from declaring or paying cash dividends on our common stock unless: (1) we are not in default under our Credit Agreement and (2) the amount of the dividend, when added to the aggregate amount of certain other defined payments made during the same fiscal year, does not exceed certain maximum thresholds. We currently anticipate that any future earnings will be retained to finance our operations and reduce debt. However, our 6.50% Series A Convertible Perpetual Preferred Stock generally provides for the payment of cash dividends subject to certain limitations. See Note 9, *Convertible Perpetual Preferred Stock*, to our accompanying consolidated financial statements.

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

The information required by Item 201(d) of Regulation S-K is provided under Item 12, *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*, which is incorporated herein by reference.

Purchases of Equity Securities

None.

Company Stock Performance

Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor s 500 Index (S&P 500), and the Morgan Stanley Health Care Provider Index (RXH), an equal-dollar weighted index of 16 companies involved in the business of hospital management and medical/nursing services. The graph assumes $100 invested on December 31, 2002 in HealthSouth common stock and each of the indices. We did not pay dividends during that time period and do not plan to pay dividends.

The information contained in the performance graph shall not be deemed soliciting material or to be filed with the SEC nor shall such information be deemed incorporated by reference into any future filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent that we specifically incorporate it by reference into such filing.

The comparisons in the graph below are based upon historical data and are not indicative of, nor intended to forecast, future performance of HealthSouth s common stock.

	Fiscal Year Ended December 31,					
	Base Period	**Cumulative Total Return**				
Company/Index Name	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
HealthSouth Corporation	100.00	109.29	149.52	116.67	107.86	100.00
Standard & Poor s 500 Index	100.00	126.38	137.75	141.88	161.20	166.89
Morgan Stanley Health Care Provider Index	100.00	131.70	143.02	164.11	166.60	155.35

Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2007, 2006, and 2005 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below for the year ended December 31, 2004, as adjusted for discontinued operations, from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2004. We derived the selected historical consolidated financial data presented below for the year ended December 31, 2003, as adjusted for discontinued operations, from our consolidated financial statements and related notes included in our comprehensive Form 10-K for the years ended December 31, 2003 and 2002. You should refer to Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations,* and the notes to our accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations. In addition, you should note the following information regarding the selected historical consolidated financial data presented below:

Certain previously reported financial results have been reclassified to conform to the current year presentation. Such reclassifications include the qualification of our surgery centers, outpatient, and diagnostic divisions as assets held for sale and discontinued operations under Financial Accounting Standards Board (FASB) Statement No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, as well as four long-term acute care hospitals, our electro-shock wave lithotripter units, and one other entity we closed or sold in 2007 that also qualified under FASB Statement No. 144. We reclassified our consolidated balance sheets as of December 31, 2006, 2005, 2004, and 2003 to show the assets and liabilities of these qualifying divisions and facilities as held for sale. We also reclassified our consolidated statements of operations for the years ended December 31, 2006, 2005, 2004, and 2003 to show the results of those qualifying divisions and facilities as discontinued operations. We also reclassified certain expenses considered to be corporate overhead historically reported primarily within the lines entitled *Salaries and benefits* and *Other operating expenses* into *General and administrative expenses* in our consolidated statements of operations. These expenses primarily include administrative expenses such as corporate accounting, internal controls, legal, and information technology services.

On January 1, 2006, we adopted FASB Statement No. 123(Revised 2004), *Share-Based Payment*. As a result of our adoption of this statement, our results of operations for 2007 and 2006 included approximately $7.7 million and $12.1 million of compensation expense related to stock options. These costs are included in *General and administrative expenses* in our consolidated statements of operations for the years ended December 31, 2007 and 2006.

As discussed in more detail in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements, we were involved in a legal dispute regarding the lease of Braintree Rehabilitation Hospital in Braintree, Massachusetts and New England Rehabilitation Hospital in Woburn, Massachusetts. In 2005, a judgment was entered against us that upheld the landlord s termination of our lease of these two hospitals and placed us as the manager, rather than the owner, of these two hospitals. Accordingly, our 2006 and 2005 results of operations include only the $4.0 million and $5.4 million management fee we earned for operating these hospitals during the nine months ended September 30, 2006 and the year ended December 31, 2005, respectively. In 2004 and 2003, the results of operations of these two hospitals were included in our consolidated statements of operations on a gross basis. Our consolidated *Net operating revenues* and consolidated operating earnings were negatively impacted by approximately $106.3 million and $3.6 million, respectively, (excluding the lease termination gain described below) in 2005 as a result of the change in ownership of these two hospitals. In September 2006, we completed the transition of these two hospitals to the landlord.

Also, as a result of the lease termination associated with the Braintree and Woburn hospitals, we recorded a $30.5 million net gain on lease termination during 2005. This net gain is included in *Occupancy costs* in our 2005 consolidated statement of operations. See Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, for additional information regarding this gain.

In 2001 and 2002, we reserved approximately $38.0 million related to amounts due from Meadowbrook Healthcare, Inc. (Meadowbrook), an entity formed by one of our former chief financial officers related to net working capital advances made to Meadowbrook in 2001 and 2002. In August 2005, we received a payment of $37.9 million from Meadowbrook. This cash payment is included as *Recovery of amounts due from Meadowbrook* in our 2005 consolidated statement of operations. For more information regarding Meadowbrook, see Note 19, *Related Party Transactions*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

During 2006, an Alabama Circuit Court issued a summary judgment against Richard M. Scrushy, our former chairman and chief executive officer, on a claim for restitution of incentive bonuses Mr. Scrushy received for years 1996 through 2002. Including pre-judgment interest, the court s total award was approximately $48 million. Based on this judgment, we recorded $47.8 million during 2006 as *Recovery of amounts due from Richard M. Scrushy*, excluding approximately $5.0 million of post-judgment interest recorded as interest income. For additional information, see Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

On December 8, 2006, we entered into an agreement with the derivative plaintiffs attorneys to resolve the amounts owed to them as a result of the award given to us under the claim for restitution of incentive bonuses Mr. Scrushy received in previous years and the Securities Litigation Settlement (as defined in Note 20, *Settlements*, and as discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements). Under this agreement, we agreed to pay the derivative plaintiffs attorneys $32.5 million on an aggregate basis for both claims. We paid approximately $11.5 million of this amount in 2006, with the remainder paid in 2007, using amounts received from Mr. Scrushy in the above referenced award.

Included in our *Net income (loss)* for 2007, 2006, 2005, 2004, and 2003 are long-lived assets impairment charges of $15.1 million, $9.7 million, $34.7 million, $30.2 million, and $128.1 million, respectively. The majority of these charges in each year relates to the Digital Hospital and represents the excess of costs incurred during the construction of the Digital Hospital (as defined in Note 5, *Property and Equipment*, to our accompanying consolidated financial statements) over the estimated fair market value of the property, including the RiverPoint facility, a 60,000 square foot office building, which shares the construction site. The impairment of the Digital Hospital in each year was determined using either its estimated fair value based on the estimated net proceeds we expected to receive in a sale transaction or using a weighted-average fair value approach that considered an alternative use appraisal and other potential scenarios. The remainder of the impairment charges in each period relate to long-lived assets at various hospitals that were examined for impairment due to hospitals experiencing negative cash flow from operations. We determined the fair value of the impaired long-lived assets at a hospital primarily based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals. These impairment charges are shown separately as a component of operating expenses within the consolidated statements of operations, excluding $38.2 million, $10.0 million, $17.3 million, $26.4 million, and $340.2 million of impairment charges in 2007, 2006, 2005, 2004, and 2003, respectively, related to our former surgery centers, outpatient, and diagnostic divisions and certain closed hospitals which are included in discontinued operations. See Note 5, *Property and Equipment*, to our accompanying consolidated financial statements

Government, class action, and related settlements includes amounts related to litigation, settlements, and ongoing settlement negotiations with various entities and individuals. In 2007 and 2006, these amounts are net of a $24.0 million and $31.2 million, respectively, reduction to the $215.0 million charge we recorded in 2005 as a result of the final court approval of our settlement in the federal securities class actions and the derivative litigation. These reductions are attributable to the value of our common stock and the associated common stock warrants underlying the settlement as of December 31 of each year. The remainder of the amounts recorded in 2007 and 2006 related to other settlements, ongoing discussions, and litigation, as discussed in more detail in Item 7, *Management s*

Discussion and Analysis of Financial Condition and Results of Operations, and Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

In 2005, our *Net loss* includes a $215.0 million charge, to be paid in the form of common stock and common stock warrants, as *Government, class action, and related settlements* under the then-proposed settlement with the lead plaintiffs in the federal securities class actions and the derivative litigation, as well as with our insurance carriers, to settle claims filed against us, certain of our former directors and officers, and certain other parties. This settlement was finalized in January 2007, and, as noted above, adjustments were recorded to this liability in 2007 and 2006.

In 2003, our *Net loss* includes the cost related to our settlement with the United States Securities and Exchange Commission (the SEC) and certain additional settlements, as well as legal fees related to this litigation and certain other actions brought against us. See Note 20, *Settlements*, to our accompanying consolidated financial statements.

For additional information regarding these settlements, ongoing discussions, and litigation, see Item 7, *Management s Discussion and Analysis of Financial Condition and Results of Operations*, and Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Significant changes have occurred at HealthSouth since the financial fraud perpetrated by certain members of our prior management team was uncovered. The steps taken to stabilize our business and operations, provide vital management assistance, and coordinate our legal strategy came at significant financial cost. Our *Net income (loss)* in each year includes professional fees associated with professional services to support the preparation of our periodic reports filed with the SEC, tax preparation and consulting fees for various tax projects, and legal fees for litigation defense and support matters. For years prior to 2006, these fees include costs associated with the reconstruction and restatement of our previously filed consolidated financial statements for the years ended December 31, 2001 and 2000. These fees are included in our statements of operations as *Professional fees accounting, tax, and legal* and approximated $51.6 million, $161.4 million, $169.1 million, $206.2 million, and $70.6 million in 2007, 2006, 2005, 2004, and 2003, respectively. See Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements for additional information.

During 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions (See Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements), as well as the majority of our federal income tax refund (See Note 17, *Income Taxes*, to our accompanying consolidated financial statements) to pay down obligations outstanding under our Credit Agreement. Also during 2007, we used a combination of cash on hand and borrowings under our revolving credit facility to redeem approximately $59.1 million of our 10.75% Senior Notes due 2016 (See Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). As a result of these pre-payments, we allocated a portion of the debt discounts and fees associated with these agreements to the debt that was extinguished and wrote off debt discounts and fees totaling approximately $25.9 million to *Loss on early extinguishment of debt* during 2007. The remainder of the amount recorded to *Loss on early extinguishment of debt* during 2007 related to the premiums associated with the redemption of the 10.75% Senior Notes due 2016 discussed above.

During 2006, we recorded an approximate $365.6 million net loss on early extinguishment of debt due to the completion of a private offering of senior notes in June 2006 and a series of recapitalization transactions during the first quarter of 2006.

For more information regarding these transactions, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

As discussed in more detail in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, we entered into an interest rate swap in March 2006 to effectively convert a portion of our variable rate debt to a fixed interest rate. During 2007 and 2006, we recorded a net loss of approximately $30.4 million and $10.5 million, respectively, related to the mark-to-market adjustments, quarterly settlements, and accrued interest recorded for the swap.

Our *Provision for income tax benefit* in 2007 primarily resulted from our settlement of federal income taxes, including interest, for the years 1996 through 1999 in excess of the estimated amounts previously accrued. This benefit resulted from our settlement of all federal income tax issues outstanding with the Internal Revenue Service for the tax years 1996 through 1999 and the Joint Committee of Congress s approval of the associated income tax refunds due to the Company. In October 2007, we received a total cash refund of approximately $440 million. See Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

Our *Income from discontinued operations* in 2007 included a $513.7 million post-tax gain on the divestitures of our surgery centers, outpatient, and diagnostic divisions. See Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

We recorded the cumulative effect of an accounting change in 2003. Effective January 1, 2003, we adopted the provisions of FASB Statement No. 143, *Accounting for Asset Retirement Obligations*, and recorded a related charge of approximately $2.5 million.

	For the Year Ended December 31,				
	2007	2006	2005	2004	2003
	(In Millions, Except Per Share Data)				
Income Statement Data:					
Net operating revenues	$ 1,752.5	$ 1,711.6	$ 1,750.9	$ 1,951.4	$ 1,964.3
Salaries and benefits	869.1	824.4	811.9	915.2	869.2
Other operating expenses	243.3	225.5	257.8	234.6	326.8
General and administrative expenses	134.8	144.5	171.7	90.2	115.0
Supplies	100.7	100.9	102.6	123.6	109.5
Depreciation and amortization	77.5	86.8	89.6	99.7	94.5
Impairment of long-lived assets	15.1	9.7	34.7	30.2	128.1
Recovery of amounts due from Richard M. Scrushy		(47.8)			
Recovery of amounts due from Meadowbrook			(37.9)		
Occupancy costs	52.4	54.5	11.7	67.0	76.7
Provision for doubtful accounts	34.4	45.6	32.4	41.4	39.5
Loss (gain) on disposal of assets	5.9	6.4	11.6	3.3	(9.7)
Government, class action, and related settlements	(2.8)	(4.8)	215.0		170.9
Professional fees accounting, tax, and legal	51.6	161.4	169.1	206.2	70.6
Loss (gain) on early extinguishment of debt	28.2	365.6			(2.3)
Interest expense and amortization of debt discounts and fees	229.9	234.8	234.8	202.6	174.8
Other income	(15.5)	(9.4)	(16.5)	(11.9)	(12.7)
Loss on interest rate swap	30.4	10.5			
Equity in net income of nonconsolidated affiliates	(10.3)	(8.7)	(12.3)	(12.1)	(3.9)
Minority interests in earnings of consolidated affiliates	31.4	26.3	41.7	31.3	29.2
	1,876.1	2,226.2	2,117.9	2,021.3	2,176.2
Loss from continuing operations before income tax (benefit) expense	(123.6)	(514.6)	(367.0)	(69.9)	(211.9)
Provision for income tax (benefit) expense	(322.4)	22.4	19.6	(4.5)	(1.3)
Income (loss) from discontinued operations, net of income tax benefit (expense)	454.6	(88.0)	(59.4)	(109.1)	(221.5)
Cumulative effect of accounting change, net of income tax expense					(2.5)
Net income (loss)	653.4	(625.0)	(446.0)	(174.5)	(434.6)
Convertible perpetual preferred dividends	(26.0)	(22.2)			
Net income (loss) available to common shareholders	$ 627.4	$ (647.2)	$ (446.0)	$ (174.5)	$ (434.6)
Weighted average common shares outstanding:					
Basic	78.7	79.5	79.3	79.3	79.2
Diluted	92.0	90.3	79.6	79.5	81.2
Earnings (loss) per common share:					
Basic:					
Income (loss) from continuing operations available to common shareholders	$ 2.20	$ (7.03)	$ (4.87)	$ (0.82)	$ (2.66)
Income (loss) from discontinued operations, net of tax	5.77	(1.11)	(0.75)	(1.38)	(2.80)
Cumulative effect of accounting change, net of tax					