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.

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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					(0.03)
Net income (loss) per share available to common shareholders	$ 7.97	$ (8.14)	$ (5.62)	$ (2.20)	$ (5.49)
Diluted:					
Income (loss) from continuing operations available to common shareholders	$ 2.16	$ (7.03)	$ (4.87)	$ (0.82)	$ (2.66)
Income (loss) from discontinued operations, net of tax	4.94	(1.11)	(0.75)	(1.38)	(2.80)
Cumulative effect of accounting change, net of tax					(0.03)
Net income (loss) per share available to common shareholders	$ 7.10	$ (8.14)	$ (5.62)	$ (2.20)	$ (5.49)

	December 31, 2007	2006	2005	2004	2003
	(In Millions)				
Balance Sheet Data:					
Cash and marketable securities	$ 19.8	$ 27.1	$ 190.4	$ 425.1	$ 425.4
Restricted cash	63.6	60.3	179.4	190.2	119.8
Restricted marketable securities	28.9	71.1			
Working capital (deficit)	(333.1)	(381.3)	(235.5)	(3.8)	167.0
Total assets	2,050.6	3,360.8	3,595.3	4,084.8	4,211.7
Long-term debt, including current portion	2,042.7	3,376.7	3,360.6	3,428.5	3,428.6
Convertible perpetual preferred stock	387.4	387.4			
Shareholders deficit	(1,554.5)	(2,184.6)	(1,540.7)	(1,109.4)	(963.8)

Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations

The following Management s Discussion and Analysis of Financial Condition and Results of Operations (MD&A) is designed to provide the reader with information that will assist in understanding our consolidated financial statements, the changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes, as well as how certain accounting principles affect our consolidated financial statements.

Forward Looking Information

This MD&A should be read in conjunction with our accompanying consolidated financial statements and related notes. See Cautionary Statement Regarding Forward-Looking Statements on page ii of this report for a description of important factors that could cause actual results to differ from expected results. See also Item 1A, *Risk Factors*.

Executive Overview

As described in Item 1, *Business*, we have spent considerable effort in 2007 strategically repositioning HealthSouth through divestitures and debt reduction, both of which reinforce our role as the nation s preeminent provider of inpatient rehabilitative services. In 2007:

We entered into an agreement with Select Medical Corporation (Select Medical), a privately owned operator of specialty hospitals and outpatient rehabilitation facilities, to sell our outpatient rehabilitation division for approximately $245 million in cash, subject to certain adjustments. This transaction closed on May 1, 2007, other than with respect to certain facilities for which approvals for the transfer to Select Medical had not yet been received as of such date. Subsequent to closing, we received approval and transferred the remaining facilities to Select Medical.

We entered into an agreement to sell our surgery centers division to ASC Acquisition LLC (ASC), a Delaware limited liability company and newly formed affiliate of TPG Partners V, L.P. (TPG), a private investment partnership. The purchase price consisted of cash consideration of $920 million, subject to certain adjustments, and a contingent option to acquire up to a 5% equity interest of the new company. This transaction closed on June 29, 2007, other than with respect to certain facilities for which approvals for the transfer to ASC had not yet been received as of such date. During the third and

fourth quarters of 2007, we received approval and transferred a portion of these facilities, but others remained pending as of December 31, 2007.

- We entered into an agreement with an affiliate of The Gores Group, a private equity firm, to sell our diagnostic division for approximately $47.5 million, subject to certain adjustments. This transaction closed on July 31, 2007, other than with respect to one facility for which approval for the transfer had not yet been received as of such date.
- We settled all federal income tax issues outstanding with the Internal Revenue Services (the IRS) for the tax years 1996 through 1999, and the Joint Committee of Congress reviewed and approved the associated tax refunds due to the Company. In October 2007, we received a total cash refund of approximately $440 million, including $296 million of federal income tax refunds and $144 million of associated interest.
- We used the net proceeds from our divestitures and the majority of our federal income tax recovery to reduce our total debt outstanding from $3.4 billion as of December 31, 2006 to $2.0 billion as of December 31, 2007. This decrease in average borrowings year over year reduced our interest expense by approximately $62.5 million in 2007 compared to 2006.
- We made the final payments under our Medicare Program Settlement and United States Securities and Exchange Commission (SEC) Settlement (see Note 20, *Settlements*, to our accompanying consolidated financial statements).
- 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 had faced the Company and its industry for the past few years (see the Regulatory Challenges to the Inpatient Rehabilitation Industry section below). With this regulatory uncertainty resolved, our repositioning complete, and our deleveraging plan on track, we are well positioned for the future.

Changes to the Historic Presentation of our Financial Statements

As a result of the divestitures discussed above, our surgery centers, outpatient, and diagnostic divisions are reported as held for sale in our consolidated balance sheets and in discontinued operations in our consolidated statements of operations and consolidated statements of cash flows in accordance with Financial Accounting Standards Board (FASB) Statement No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*. See Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements for additional information related to these transactions.

In addition, we historically 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.

See also Note 1, *Summary of Significant Accounting Policies*, Reclassifications, to our accompanying consolidated financial statements.

Regulatory Challenges to the Inpatient Rehabilitation Industry

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.

See Item 1, *Business*, for additional information regarding industry regulations.

Our Business

We are the nation s largest provider of inpatient rehabilitation hospital services in terms of revenues, number of hospitals, and patients treated. 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 (LTCHs) and provide treatment on both an inpatient and outpatient basis. As of December 31, 2007, we operated 94 inpatient rehabilitation hospitals (including 3 hospitals which we account for using the equity method of accounting), 6 freestanding LTCHs, 60 outpatient satellites located within or near (and operated by) our hospitals, and 25 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. Our inpatient 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.

Net patient revenues from our hospitals increased by 4.0% from 2006 to 2007 due primarily to an increase in our patient case mix index and compliant case growth, both of which increased our revenue per discharge. Operating earnings (as defined in Note 22, *Quarterly Data (Unaudited)*, to our accompanying consolidated financial statements) increased by approximately $62.5 million during 2007 due to the increased revenues discussed above and decreased professional fees. See the Results of Operations section of this Item for additional information.

Key Challenges

While we achieved significant milestones in 2007, we continue to face challenges, including:

Leverage and Liquidity. We are highly leveraged. Our high leverage increases our cost of borrowing and decreases our *Net income*. However, our leverage and liquidity are improving.

During 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions, as well as the majority of our federal income tax recovery, to pay down debt. 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. As a result of these transactions, 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 have scheduled principal payments of $68.3 million and $23.4 million in 2008 and 2009 related to long-term debt obligations. In the fourth quarter of 2007, we made the final payments related to our Medicare Program Settlement and SEC Settlement (see Note 20, *Settlements*, to our accompanying consolidated financial statements). With these settlement payments behind us, we are now able to redirect our operating cash elsewhere in the Company. In addition, we expect to use cash flows from the expected sale of our corporate campus (see Note 5, *Property and Equipment*, to our accompanying consolidated financial statements) and the receipt of additional federal and state income tax refunds to further reduce our long-term debt outstanding. However, no assurances can be given as to whether or when such cash flows will be received. 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.

As with any company carrying significant debt, our primary risk relating to our high leverage is the possibility that a down-turn in operating earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement. 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. 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.

For additional information regarding our leverage and liquidity, see the Liquidity and Capital Resources section of this Item and Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

Reimbursement. 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. For example, and as discussed below, while the freeze at the 60% compliance threshold under the 2007 Medicare Act is a long-term positive for us, the pricing roll-back is a short-term negative in 2008 and 2009.

Because Medicare comprises approximately 68% of our *Net operating revenues* for the year ended December 31, 2007, single-payor exposure and any potential legislative changes present risks to us. Also, because we receive a significant percentage of our revenues from Medicare, our inability to achieve continued compliance with the 60% threshold under the 2007 Medicare Act could have a material adverse effect on our financial position, results of operations, and cash flows.

In addition to government payors, our relationships with managed care and non-governmental third-party payors are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. If we are unable to negotiate and maintain favorable agreements with these payors, our financial position, results of operations, and cash flows could be adversely impacted.

Staffing. 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. If we are unable to recruit and retain qualified management, physical therapists, nurses, and other medical support personnel, or to control our labor costs, our financial position, results of operations, and cash flows could be adversely impacted.

The lack of availability of physical therapists, nurses, and other medical support personnel continues to plague our Company and the industry. This shortage has required, and continues to require, us to enhance wages and increase our use of higher-priced contract labor. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along these increased costs is limited. This will be especially true during the 2008 and 2009 pricing roll-back period under the 2007 Medicare Act, as discussed above.

We are focused on finding a long-term solution for recruiting and retaining qualified personnel for our hospitals. As discussed in more detail in the Business Outlook section below, we are making an investment, in the form of enhanced benefits programs, in our employees in 2008 in an effort to reduce turnover at our hospitals and attract qualified health care professionals to our business.

Business Outlook

With our turnaround and divestitures complete and the regulatory uncertainty surrounding the 75% Rule resolved, our focus is now on executing our strategic plan and growing earnings per share. We can now focus entirely on operating our hospitals and growing our inpatient rehabilitation business.

We believe the demand for inpatient rehabilitation services will increase as the U.S. population ages. In addition, Medicare compliant cases are expected to grow approximately 2% per year for the foreseeable future, creating an attractive market. We believe these market factors align with our strengths and focus in inpatient rehabilitative care. Unlike an acute care hospital that may offer inpatient rehabilitation as one of many secondary services, inpatient rehabilitation is our core business.

Strategic Outlook

As the nation s largest provider of inpatient rehabilitation services, we believe we differentiate ourselves from our competitors based on the quality of our clinical protocols, our broad base of clinical experience, our ability to create and leverage rehabilitative technology, and our ability to standardize practices and take advantage of efficiencies that result in cost effective, high quality care for our patients.

In 2008 and 2009, we will ensure the operational initiatives we have launched over the past few years (from the building of our internal audit function and development of our internal control structure to our TeamWorks initiative, as discussed below) remain and/or become fully embedded at our hospitals and in our overall corporate culture, as it is these operational initiatives that allow us to continue providing high-quality care to our patients and set the platform for future growth. We will seek growth by expanding our market share in existing markets, building new hospitals in new markets, and acquiring or joint-venturing with competitors. However, given the current credit markets and our leverage compared to other health care providers, we recognize that paying down debt and the continued deleveraging of the Company is important and may take precedence over immediate growth opportunities. However, there are ways to expand that require minimal initial cash outlays, such as joint ventures and other transactions, and should allow us to use the majority of our free cash flow for debt reduction.

Operating Outlook

In 2007, we launched a multi-year operational initiative designed to identify best practices in a number of key areas and standardize those practices across all our hospitals. This initiative is known as TeamWorks. During the start-up phase of this project, we chose two areas as our initial focus:

Sales and Marketing. Increasing the number of patient discharges is critical to maintaining and improving our profitability, particularly in light of the high percentage of fixed costs at our hospitals and the Medicare pricing roll-back discussed earlier.
Non-Clinical Support Costs. Over the past few years, we have tightly managed the non-clinical expenses of our hospitals due to the regulatory uncertainty that was caused by the 75% Rule and rising employee costs resulting from shortages of therapists and nurses. Although we have generally reduced most categories of expenses, there is a high degree of variability from hospital to hospital. As a result,

the non-clinical support costs project was chosen in order to further standardize our best practices in this area.

In 2008, we expect to complete the implementation of the above two areas, and we will begin looking at ways we can improve our retention and increase the productivity of our most valuable asset our employees.

We understand and recognize the importance our employees play in helping us reach our goals. With this in mind, along with our desire to reduce turnover at our hospitals, we made an investment in our people in 2008 by increasing the employer matching contributions to our 401(k) savings plan, providing benefits to part-time employees (which we have never done before), and enhancing the benefits provided under certain medical plans (without passing the costs of such enhancements to our employees). We believe we can build on this investment as we examine our clinical productivity and human capital going forward as part of the TeamWorks initiative.

Pricing will be flat to slightly down in 2008 due to the pricing roll-back resulting from the 2007 Medicare Act (the pricing roll-back is effective from April 1, 2008 until September 30, 2009) and the significance of Medicare as a payor to our *Net operating revenues*. However, we expect the freeze at the 60% compliance threshold resulting from the 2007 Medicare Act, as well as our TeamWorks initiative, to result in a year-over-year increase in patient discharges in 2008. While increasing our volumes will be important in 2008, generating free cash flow to further reduce our debt will also be a major operational focus.

In summary, we are focused on building volumes and improving the overall effectiveness of our operations. On a go-forward basis, we anticipate we will be able to generate cash flows to fund debt pre-payments and our growth strategy, with the primary emphasis in 2008 being debt reduction. However, we believe we can bring immediate and sustainable growth and return to our stockholders. We are the new HealthSouth, and we are well-positioned to meet the challenges in this industry in 2008 and going forward.

Results of Operations

During 2007, 2006, and 2005, we derived consolidated *Net operating revenues* from the following payor sources:

	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%

Our payor mix is weighted heavily towards Medicare. Our hospitals receive Medicare reimbursements under the prospective payment system applicable to inpatient rehabilitation facilities (IRF-PPS). Under IRF-PPS, our hospitals receive fixed payment amounts per discharge based on certain rehabilitation impairment categories established by the United States Department of Health and Human Services. With IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being high quality, low cost providers. For additional information regarding Medicare reimbursement, please see the Sources of Revenues section of Item 1, *Business*.

The percent of our *Net operating revenues* attributable to Medicare has decreased over the past few years due to an increase in managed Medicare and private fee-for-service plans that are included in the managed care and other discount plans and other third-party payors categories in the above chart. As part of the Balanced Budget Act of 1997, Congress created a program of private, managed health care coverage for Medicare beneficiaries. This program has been referred to as Medicare Part C, Medicare+Choice, or Medicare Advantage. The program offers beneficiaries a range of Medicare coverage options by providing a choice between the traditional fee-for-service program (under Medicare Parts A and B) or enrollment in a health maintenance organization, preferred provider

organization, point-of-service plan, provider sponsored organization or an insurance plan operated in conjunction with a medical savings account. While we expect our payor mix will remain heavily weighted towards Medicare, we expect this shift in Medicare patients into managed Medicare and private fee-for-service plans to continue.

Due to the significance of Medicare payments to our hospitals, the number of patient discharges is a key metric utilized by management to monitor and evaluate our performance. The number of outpatient visits is also tracked in order to measure the volume of outpatient activity each period.

Certain 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 FASB Statement No. 144, as well as four LTCHs, 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 sheet as of December 31, 2006 to show the assets and liabilities of these qualifying divisions and facilities as held for sale. We also reclassified our consolidated statements of operations and consolidated statements of cash flows for the years ended December 31, 2006 and 2005 to show the results of those qualifying divisions and facilities as discontinued operations. In addition, we 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.

Because we did not allocate corporate overhead by division, our operating results reflect overhead costs associated with managing and providing shared services to our surgery centers, outpatient, and diagnostic divisions, through their respective dates of sale, even though these divisions qualify as discontinued operations. For the year ended December 31, 2007, *General and administrative expenses* approximated 7.7% of consolidated *Net operating revenues*. However, this percentage decreases by 200 basis points if you include the revenues of the divisions and facilities reported in discontinued operations. We plan to continue to rationalize our *General and administrative expenses* in relation to the size of our operations post-repositioning in 2008.

As discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, due to the requirements under our Credit Agreement to use the net proceeds from each divestiture to repay obligations outstanding under our Credit Agreement, and in accordance with Emerging Issues Task Force (EITF) No. 87-24, Allocation of Interest to Discontinued Operations, we allocated the interest expense on the debt that was required to be repaid as a result of the divestiture transactions to discontinued operations.

From 2005 through 2007, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2007	2006	2005	2007 vs. 2006	2006 vs. 2005
	(In Millions)				
Net operating revenues	$1,752.5	$1,711.6	$1,750.9	2.4%	(2.2%)
Operating expenses:					
Salaries and benefits	869.1	824.4	811.9	5.4%	1.5%
Other operating expenses	243.3	225.5	257.8	7.9%	(12.5%)
General and administrative expenses	134.8	144.5	171.7	(6.7%)	(15.8%)
Supplies	100.7	100.9	102.6	(0.2%)	(1.7%)
Depreciation and amortization	77.5	86.8	89.6	(10.7%)	(3.1%)
Impairment of long-lived assets	15.1	9.7	34.7	55.7%	(72.0%)
Recovery of amounts due from Richard M. Scrushy		(47.8)		(100.0%)	N/A
Recovery of amounts due from Meadowbrook			(37.9)	N/A	(100.0%)
Occupancy costs	52.4	54.5	11.7	(3.9%)	365.8%
Provision for doubtful accounts	34.4	45.6	32.4	(24.6%)	40.7%
Loss on disposal of assets	5.9	6.4	11.6	(7.8%)	(44.8%)
Government, class action, and related settlements	(2.8)	(4.8)	215.0	(41.7%)	(102.2%)
Professional fees accounting, tax, and legal	51.6	161.4	169.1	(68.0%)	(4.6%)
Total operating expenses	1,582.0	1,607.1	1,870.2	(1.6%)	(14.1%)
Loss on early extinguishment of debt	28.2	365.6		(92.3%)	N/A
Interest expense and amortization of debt discounts and fees	229.9	234.8	234.8	(2.1%)	0.0%
Other income	(15.5)	(9.4)	(16.5)	64.9%	(43.0%)
Loss on interest rate swap	30.4	10.5		189.5%	N/A
Equity in net income of nonconsolidated affiliates	(10.3)	(8.7)	(12.3)	18.4%	(29.3%)
Minority interests in earnings of consolidated affiliates	31.4	26.3	41.7	19.4%	(36.9%)
Loss from continuing operations before income tax (benefit) expense	(123.6)	(514.6)	(367.0)	(76.0%)	40.2%
Provision for income tax (benefit) expense	(322.4)	22.4	19.6	(1,539.3%)	14.3%
Income (loss) from continuing operations	198.8	(537.0)	(386.6)	(137.0%)	38.9%
Income (loss) from discontinued operations, net of income tax benefit (expense)	454.6	(88.0)	(59.4)	(616.6%)	48.1%
Net income (loss)	$ 653.4	$ (625.0)	$ (446.0)	(204.5%)	40.1%

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2007	**2006**	**2005**
Salaries and benefits	49.6%	48.2%	46.4%
Other operating expenses	13.9%	13.2%	14.7%
General and administrative expenses	7.7%	8.4%	9.8%
Supplies	5.7%	5.9%	5.9%
Depreciation and amortization	4.4%	5.1%	5.1%
Impairment of long-lived assets	0.9%	0.6%	2.0%
Recovery of amounts due from Richard M. Scrushy	0.0%	(2.8%)	0.0%
Recovery of amounts due from Meadowbrook	0.0%	0.0%	(2.2%)
Occupancy costs	3.0%	3.2%	0.7%
Provision for doubtful accounts	2.0%	2.7%	1.9%
Loss on disposal of assets	0.3%	0.4%	0.7%
Government, class action, and related settlements	(0.2%)	(0.3%)	12.3%
Professional fees accounting, tax, and legal	2.9%	9.4%	9.7%
Total	90.3%	93.9%	106.8%

Additional information regarding our operating results for the years ended December 31, 2007, 2006, and 2005 is as follows:

	For the Year Ended December 31,		
	2007	**2006**	**2005**
	(In Millions)		
Net patient revenue inpatient	$ 1,557.4	$ 1,497.7	$ 1,530.9
Net patient revenue outpatient and other revenues	195.1	213.9	220.0
Net operating revenues	$ 1,752.5	$ 1,711.6	$ 1,750.9
	(Actual Amounts)		
Discharges	101,462	101,421	104,721
Outpatient visits	1,325,396	1,446,816	1,624,869
Average length of stay	15.1 days	15.2 days	15.6 days
Occupancy %	63.0%	64.4%	68.6%
# of licensed beds	6,679	6,566	6,540
Full-time equivalents*	15,484	15,650	16,412

* Excludes 707, 860, and 783 full-time equivalents for the years ended December 31, 2007, 2006, and 2005, respectively, who are considered part of corporate overhead with their salaries and benefits included in *General and administrative expenses* in our consolidated statements of operations. Full-time equivalents included in the above table represent those who participate in or support the operations of our hospitals.

Net Operating Revenues

Our consolidated *Net operating revenues* consist primarily of revenues derived from patient care services. *Net operating revenues* also include other revenues generated from management and administrative fees, operation of the conference center located on our corporate campus, and other non-patient care services. These other revenues approximated 2.5%, 2.8%, and 2.4% of consolidated *Net operating revenues* for the years ended December 31, 2007, 2006, and 2005, respectively.

Net patient revenue from our hospitals was 4.0% higher for the year ended December 31, 2007 than 2006. The increase was primarily attributable to an increase in our patient case mix index and compliant case growth, both of which increased our revenue per discharge.

Inpatient volumes were relatively flat year over year due primarily to nine hospitals that moved from a 60% compliance threshold to a 65% compliance threshold under the 75% Rule on July 1, 2007. Discharges for the year were also negatively impacted by 16 of our hospitals that moved from a 50% compliance threshold to a 60% compliance threshold under the 75% Rule on June 1, 2006.

Increased revenues attributable to our inpatient hospitals were offset by decreased revenues from outpatient visits. Decreased outpatient volumes resulted from the closure of outpatient satellites, changes in patient program mix, shortages in therapy staffing, and continued competition from physicians offering physical therapy services within their own offices. As of December 31, 2007, we operated 60 outpatient satellites, while as of December 31, 2006, we operated 81 outpatient satellites.

Net patient revenue from our hospitals was 2.2% lower in 2006 than in 2005 due primarily to a reduction of non-compliant case volumes that resulted from the continued phase-in of the 75% Rule. In 2005, our hospitals were required to operate at a 50% compliance threshold under the 75% Rule. In 2006, the minimum compliance threshold increased to 60% causing reductions of non-compliant case volumes. We also experienced a decrease in outpatient volumes from 2005 to 2006 due to the decrease in our inpatient volumes, as well as the reasons discussed above for the decrease in outpatient volumes from 2006 to 2007. Certain regulatory pricing changes implemented as of October 1, 2005 also negatively impacted *Net operating revenues* for the first three quarters of 2006.

As discussed in the Executive Overview Business Outlook section of this Item, we expect pricing will be flat to slightly down in 2008 due to the pricing roll-back resulting from the 2007 Medicare Act and the significance of Medicare as a payor to our *Net operating revenues*. However, we expect the freeze at the 60% compliance threshold resulting from the 2007 Medicare Act, as well as our TeamWorks initiative, to result in a year-over-year increase in discharges in 2008.

Salaries and Benefits

Salaries and benefits represent the most significant cost to us and include all amounts paid to full- and part-time employees who directly participate in or support the operations of our hospitals, including all related costs of benefits provided to employees. It also includes amounts paid for contract labor.

Salaries and benefits increased in each year presented. Annual merit increases given to employees in each year contributed to the increase. In addition, shortages of therapists and nurses caused us to raise salaries to retain current employees and to increase our utilization of higher-priced contract labor to properly care for our patients in each year. Finally, as a result of our efforts to comply with the 75% Rule, in each year, we increasingly treated higher acuity patients, which resulted in increased labor costs.

We are focused on finding a long-term solution for recruiting and retaining qualified personnel for our hospitals. We will continue to monitor the labor market, and we will make any necessary adjustments in order to remain competitive in this highly competitive environment. As discussed in the Executive Overview Business Outlook section of this Item, in an effort to address our recruiting and retention concerns, we made certain enhancements to our benefits programs in January 2008.

Other Operating Expenses

Other operating expenses include costs associated with managing and maintaining our hospitals. These expenses include such items as repairs and maintenance, utilities, contract services, professional fees, and insurance.

In 2007 and 2006, we experienced a reduction in self-insurance costs driven by current claims history and revised actuarial estimates that resulted from fewer full-time equivalents and our exit from the acute care business. These reductions are primarily included in *Other operating expenses* in our consolidated statements of operations for the years ended December 31, 2007 and 2006.

Other operating expenses were higher in 2007 than in 2006. Now that we are a pure-play provider of post-acute health care services, we are able to focus exclusively on the operations of our hospitals. As part of this focus, during 2007, we incurred professional fees with a consulting firm associated with our TeamWorks initiative described earlier in this Item. Also, as discussed in more detail in Note 19, *Related Party Transactions*, to our

accompanying consolidated financial statements, *Other operating expenses* for the year ended December 31, 2006 included a $6.9 million gain related to the repayment of a formerly fully reserved note receivable from Source Medical Solutions, Inc. (Source Medical).

Other operating expenses were lower in 2006 compared to 2005 due to declining inpatient volumes, decreased fees associated with the use of accounting and consulting firms during our reconstruction and restatement process in 2005, the Source Medical gain recorded in 2006, and the reduction in self-insurance expenses discussed above.

General and Administrative Expenses

General and administrative expenses primarily include administrative expenses such as corporate accounting, internal controls, legal, and information technology services that are managed from our corporate headquarters in Birmingham, Alabama. These expenses include the salaries and benefits of 707, 860, and 783 full-time equivalents for the years ended December 31, 2007, 2006, and 2005, respectively, who perform these administrative functions.

In addition, because we did not allocate corporate overhead by division, our *General and administrative expenses* include costs associated with managing and providing shared services to our surgery centers, outpatient, and diagnostic divisions, through their respective dates of sale, even though these divisions qualify as discontinued operations. For the year ended December 31, 2007, *General and administrative expenses* approximated 7.7% of consolidated *Net operating revenues*. However, this percentage decreases by 200 basis points if you include the revenues of the divisions reported in discontinued operations. Until we are able to rationalize our corporate overhead in relation to the size of our operations now that our divestitures are complete, our *General and administrative expenses* will reflect unusually high costs.

Our *General and administrative expenses* were lower in 2007 compared to 2006 due to the divestitures of our surgery centers, outpatient, and diagnostic divisions in the second and third quarters of 2007 (See the Executive Overview section of this Item for more information on the timing of each divestiture). The reduction in *General and administrative expenses* resulting from our divestiture transactions was offset by our investment in a development function and costs associated with installing new accounting systems. Also, given the uncertainty surrounding our repositioning efforts in the first half of 2007, we experienced attrition of corporate employees who supported our surgery centers, outpatient, and diagnostic divisions. As this attrition occurred, we chose to utilize higher-priced contract labor to temporarily fill certain corporate positions rather than hiring new employees to fill the open positions.

Our *General and administrative expenses* were lower in 2006 compared to 2005 due to decreased professional fees associated with projects related to our compliance with the Sarbanes-Oxley Act of 2002 and other similar services from accounting and consulting firms. *General and administrative expenses* in 2006 also included a gain related to the elimination of our former guarantee of a promissory note for Source Medical (See Note 19, *Related Party Transactions*, to our accompanying consolidated financial statements). These reductions in *General and administrative expenses* in 2006 were offset by expenses associated with our adoption of FASB Statement No. 123 (Revised 2004), *Share-Based Payment*, on January 1, 2006.

We will continue to rationalize our *General and administrative expenses* in relation to the size of our operations post-repositioning in 2008.

Supplies

Supplies expense includes all costs associated with supplies used while providing patient care. These costs include pharmaceuticals, needles, bandages, food, and other similar items.

While *Supplies* expense did not change significantly in terms of dollars from 2006 to 2007, it did decrease as a percent of *Net operating revenues* year over year. This decrease is due to our supply chain management efforts and our increasing revenue base. *Supplies* expense did not change significantly from 2005 to 2006.

Depreciation and Amortization

The decrease in *Depreciation and amortization* in each year presented was due to the decreased depreciable base of our assets due to the level of our capital expenditures over the past few years.

Impairment of Long-Lived Assets

On June 1, 2007, we entered into an agreement with an investment fund sponsored by Trammell Crow Company (Trammell Crow) pursuant to which Trammell Crow agreed to acquire our corporate campus for a purchase price of approximately $60 million, subject to certain adjustments. During the year ended December 31, 2007, we wrote the Digital Hospital (as defined in Note 5, *Property and Equipment*, to our accompanying consolidated financial statements) down by $14.5 million to its estimated fair value based on the estimated net proceeds we expected to receive from this sale. The agreement to sell our corporate campus to Trammell Crow was terminated on August 7, 2007, pursuant to an opt-out provision in the agreement.

Of the total asset impairment amounts for the years ended December 31, 2006 and 2005, approximately $8.6 million and $24.4 million, respectively, relate to the Digital Hospital and represent the excess of costs incurred during the construction of the Digital Hospital over the estimated fair 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 2006 and 2005 was determined using a weighted-average fair value approach that considered an alternative use appraisal and other potential scenarios.

The remainder of the 2007, 2006, and 2005 impairment charges 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.

Recovery of Amounts Due from Richard M. Scrushy

On January 3, 2006, the Alabama Circuit Court in the *Tucker* case (as defined in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements) granted the plaintiff s motion for summary judgment against Richard M. Scrushy, our former chairman and chief executive officer, on a claim for the 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. On August 25, 2006, the Alabama Supreme Court affirmed the Circuit Court s order granting summary judgment against Mr. Scrushy on the unjust enrichment claim, and on October 27, 2006, the Alabama Supreme Court denied Mr. Scrushy s motion for rehearing. On November 16, 2006, Mr. Scrushy signed an agreement indicating his desire and intent to pay the entire amount owed under the judgment.

Based on the above, we recorded approximately $47.8 million during 2006 as *Recovery of amounts due from Richard M. Scrushy*, excluding approximately $5.0 million of post-judgment interest recorded in *Other income*.

Recovery of Amounts Due from Meadowbrook

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.

See Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements for additional information regarding Meadowbrook.

Occupancy Costs

Occupancy costs include amounts paid for rent associated with leased hospitals, including common area maintenance and similar charges. In 2005, *Occupancy costs* included a $30.5 million net gain on lease termination associated with our Braintree and Woburn hospitals. See Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements for additional information regarding these hospitals.

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Provision for Doubtful Accounts

Our *Provision for doubtful accounts* decreased as a percent of *Net operating revenues* from 2006 to 2007. Distractions associated with the installation of new collections software negatively impacted collection activity during the latter half of 2006. This year-over-year improvement in our *Provision for doubtful accounts* was reflective of the benefits of the new billing and collections software that was installed in 2006, as well as the standardization of certain business office processes.

While we are beginning to see the improvements noted above, throughout 2007, we have experienced the continued denial of certain billings by one of our Medicare contractors denying claims related to medical necessity. We appeal most of these denials and have experienced a strong success rate for claims that have completed the appeals process. While our success rate is a positive reflection of the medical necessity of the applicable patients, the appeals process can take in excess of one year, and we cannot provide assurance as to the ongoing and future success of our appeals. As such, we have provided reserves for these receivables in accordance with our accounting policy that necessarily considers the age of the receivables under appeal as part of our *Provision for doubtful accounts*. During the third quarter of 2007, the negative impact of these denials became level, year over year.

The increase in our *Provision for doubtful accounts* as a percent of *Net operating revenues* from 2005 to 2006 was due to the distractions associated with the installation and implementation of new collections software and processes during 2006, as noted above. It was also negatively impacted by the billing denials discussed above.

Loss on Disposal of Assets

The *Loss on disposal of assets* in each year primarily resulted from various equipment disposals throughout each period.

Government, Class Action, and Related Settlements

During 2007, we reached a final settlement related to certain self-disclosures made to the HHS-OIG, and we recorded a charge of approximately $14.2 million related to these negotiations and ultimate settlement as part of *Government, class action and related settlements* in our 2007 consolidated statement of operations. *Government, class action, and related settlements* also included a net charge of approximately $7.0 million during the year ended December 31, 2007 for certain settlements and other ongoing settlement negotiations. See Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Government, class action, and related settlements for the year ended December 31, 2006 included a $1.0 million charge related to our Employee Retirement Income Security Act of 1974 (ERISA) litigation and a $5.7 million charge to settle disputes related to our former Braintree and Woburn hospitals. *Government, class action, and related settlements* for 2006 also included a $4.0 million charge related to our agreement with the United States to settle civil allegations brought in federal False Claims Act lawsuits regarding alleged improper billing practices relating to certain orthotic and prosthetic devices. In addition, *Government, class action, and related settlements* for 2006 included a $3.0 million charge related to a payment made to the U.S. Postal Inspection Services Consumer Fraud Fund in connection with the execution of the non-prosecution agreement reached with the United States Department of Justice. These expenses for 2006 also included charges of approximately $12.7 million for certain settlements and other settlement negotiations that were ongoing as of December 31, 2006.

Government, class action, and related settlements for the year ended December 31, 2005 included a $215.0 million charge, to be paid in the form of common stock and common stock warrants under the 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. In January 2007, the proposed settlement received final court approval, and, based on the value of our common stock and the associated common stock warrants on the date the settlement was approved, we reduced this liability by approximately $31.2 million as of December 31, 2006. Based on the value of our common stock and the associated common stock warrants as of December 31, 2007, we reduced this liability by an additional $24.0 million during the year ended December 31, 2007. The reductions in 2007 and 2006 are included in *Government, class action, and related settlements* in our consolidated statement of operations. The charge for this settlement will be

revised in future periods to reflect additional changes in the fair value of the common stock and warrants until they are issued.

For additional information regarding these settlements, ongoing discussions, and litigation, see Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Professional Fees Accounting, Tax, and Legal

As previously reported, 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. During the year December 31, 2007, these fees primarily related to income tax consulting fees for various tax projects (including tax projects associated with our filing of amended income tax returns for 1996 through 2003), fees paid to consultants supporting our divestiture activities, and legal fees for continued litigation defense and support matters arising from our prior reporting and restatement issues discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements. During the year ended December 31, 2006, these fees primarily related to professional services to support the preparation of our 2005 Form 10-K, professional services to support the preparation of our Form 10-Qs for 2006 (including the preparation of quarterly information for 2005, which had never been presented), tax preparation and consulting fees for various tax projects, and legal fees for continued litigation defense and support matters (including $32.5 million of fees to the derivative plaintiffs attorneys to resolve the amount 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) discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements. During 2005, *Professional fees accounting, tax, and legal* related primarily to professional fees resulting from the steps taken to stabilize our business and operations, provide vital management assistance, and coordinate our legal strategy as a result of the fraud mentioned above.

Loss on Early Extinguishment of Debt

As discussed throughout this report, 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 (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). 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 the year ended December 31, 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.

Interest Expense and Amortization of Debt Discounts and Fees

As discussed earlier in this Item, due to the requirements under our Credit Agreement to use the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions to repay obligations outstanding under our Credit Agreement, and in accordance with EITF Issue No. 87-24, we allocated interest expense on the debt that was required to be repaid as a result of the divestiture transactions to discontinued operations. However, the discussion that follows related to *Interest expense and amortization of debt discounts and fees* is based on total interest expense, including the amounts allocated to discontinued operations. For additional

information regarding the allocated amounts, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

Interest expense and amortization of debt discounts and fees decreased by $62.4 million from 2006 to 2007 due to lower amortization charges and decreased average borrowings offset by a higher average interest rate for 2007. Amortization of debt discounts and fees was approximately $10.5 million less during 2007 compared to 2006. Amortization in 2006 included the amortization of loan fees associated with our Interim Loan Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) and the amortization of consent fees associated with the debt that was extinguished as part of the March 2006 recapitalization transactions discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements. Decreased average borrowings, which resulted from our use of the net proceeds from our divestiture transactions and the majority of our federal income tax recovery in 2007 to reduce long-term debt, during 2007 compared to 2006 resulted in decreased interest expense of approximately $62.5 million year over year. Due to the recapitalization transactions and the private offering of senior notes described in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, our average interest rate for 2007 approximated 9.9% compared to an average interest rate of 9.5% for 2006. This increase in average interest rates contributed to an approximate $10.6 million of increased interest expense in 2007.

Interest expense and amortization of debt discounts and fees decreased by approximately $4.9 million from 2005 to 2006 as a result of decreased amortization charges offset by increased interest expense. Amortization of debt discounts and fees was approximately $20.6 million less during 2006 compared to 2005. Amortization in 2005 included the amortization of consent fees associated with debt that was extinguished as part of the 2006 recapitalization transactions discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements. Amortization in 2005 also included the amortization related to our 6.875% Senior Notes that were repaid in June 2005. Due to the recapitalization transactions and the private offering of senior notes described in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, our average interest rate for 2006 approximated 9.5% compared to an average interest rate of 9.0% for 2005. This increase in average interest rates contributed to an approximate $18.0 million of increased interest expense during 2006. The impact of the increase in average interest rates was offset by lower average borrowings, which decreased interest expense by approximately $2.3 million during 2006.

For more information regarding the above changes in debt, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

Other Income

During 2007, we sold our remaining investment in Source Medical to Source Medical and recorded a gain on sale of approximately $8.6 million. This gain is included in *Other income* in our consolidated statement of operations for the year ended December 31, 2007. See Note 19, *Related Party Transactions*, to our accompanying consolidated financial statements for more information on Source Medical. As a result of this transaction, we have no further affiliation or material related-party contracts with Source Medical.

In 2006, *Other income* included $5.0 million of post-judgment interest recorded on our recovery of incentive bonuses from Mr. Scrushy, as discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Other income was higher in 2005 than in 2006 due to higher average cash balances throughout 2005 that yielded higher interest income amounts year over year.

Loss on Interest Rate Swap

Our *Loss on interest rate swap* in each year represents amounts recorded related to the mark-to-market adjustments, quarterly settlements, and accrued interest recorded for our interest rate swap. The loss recorded in each year presented represents the market s outlook for interest rates over the remaining term of our swap agreement. To the extent the market believes interest rates will rise above our fixed rate of 5.2%, we will record gains. When the market believes interest rates will fall below our fixed rate of 5.2%, we will record losses. During the year ended December 31, 2007, we received approximately $3.2 million in net cash settlement payments from

our counterparties under the interest rate swap agreement. During the year ended December 31, 2006, we made approximately $0.6 million in net cash settlement payments to our counterparties under the interest rate swap agreement. For additional information regarding our interest rate swap, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

Per the underlying swap agreement, the notional amount of our interest rate swap was scheduled to be reduced from $1.9 billion to $1.1 billion in March 2008. However, due to the pre-payments discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements and current market conditions, we decreased the notional amount of our interest rate swap to $1.1 billion in October 2007. Fees associated with this transaction were not material to our results of operations, financial position, or cash flows. See Item 7A, *Quantitative and Qualitative Disclosures About Market Risk*, for additional information.

Minority Interests in Earnings of Consolidated Affiliates

Minority interests in earnings of consolidated affiliates represent the share of net income or loss allocated to members or partners in our consolidated affiliates. Fluctuations in *Minority interests in earnings of consolidated affiliates* are primarily driven by the financial performance of the applicable hospital population each year.

Loss from Continuing Operations Before Income Tax (Benefit) Expense

Our *Loss from continuing operations before income tax (benefit) expense* (pre-tax loss from continuing operations) for 2006 included a $365.6 million *Loss on early extinguishment of debt* related primarily to our private offering of senior notes in June 2006 and a series of recapitalization transactions in the first quarter of 2006. Our pre-tax loss from continuing operations for 2005 included a $215.0 million settlement associated with our securities litigation. If we exclude these items, our pre-tax loss from continuing operations for 2006 was $149.0 million, and our pre-tax loss from continuing operations for 2005 was $152.0 million, resulting in a $25.4 million net decrease in our pre-tax loss from continuing operations from 2006 to 2007 and a $3.0 million net decrease in our pre-tax loss from continuing operations from 2005 to 2006.

Our pre-tax loss from continuing operations decreased from 2006 to 2007 due primarily to a reduction in *General and administrative expenses* and decreased professional fees. Our pre-tax loss from continuing operations for the year ended December 31, 2007 included an $8.6 million gain related to the sale of our remaining investment in Source Medical (see Note 19, *Related Party Transactions*, to our accompanying consolidated financial statements).

From 2005 to 2006, our pre-tax loss from continuing operations decreased due to a reduction in *General and administrative expenses* and decreased impairment charges year over year. Our pre-tax loss from continuing operations for 2006 included a $47.8 million recovery of incentive bonuses from Mr. Scrushy, as discussed above. Our 2005 pre-tax loss from continuing operations for 2005 included a $37.9 million recovery of bad debt associated with Meadowbrook, as discussed above. Also, as discussed earlier in this Item, we recorded a $30.5 million net gain on lease termination during 2005.

Provision for Income Tax (Benefit) Expense

The change in our *Provision for income tax (benefit) expense* from 2006 to 2007 was due primarily to the recovery of federal income taxes, and related interest, for tax years 1996 through 1999, as discussed in Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

From 2005 to 2006, our *Provision for income tax expense* increased due to an increase in noncurrent deferred taxes associated with certain indefinite-lived assets partially offset by a decrease in state tax expense and by an increase in interest income recorded on our income tax receivable. During 2006, we filed a request for a tax accounting method change which accelerated the amortization of certain indefinite-lived assets. This tax accounting method change gave rise to an additional difference between the book and tax bases of the assets effected and, accordingly, resulted in our recording an additional deferred tax liability and deferred tax expense of approximately $8.3 million related to these indefinite-lived assets during 2006.

Impact of Inflation

The health care industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers pass along rising costs to us in the form of higher prices. Although we cannot predict our ability to cover future cost increases, we believe that through adherence to cost containment policies and labor and supply management, the effects of inflation on future operating results should be manageable.

However, we have little or no ability to pass on these increased costs associated with providing services to Medicare and Medicaid patients due to federal and state laws that establish fixed reimbursement rates. In addition, as a result of increasing regulatory and competitive pressures and a continuing industry-wide shift of patients to managed care plans, our ability to maintain margins through price increases to non-Medicare patients is limited.

Relationships and Transactions with Related Parties

Related party transactions are not material to our operations, and therefore, are not presented as a separate discussion within this Item. When these relationships or transactions were significant to our results of operations during the years ended December 31, 2007, 2006, and 2005, information regarding the relationship or transaction(s) have been included within this Item. For additional information, see Note 19, *Related Party Transactions*, to our accompanying consolidated financial statements.

Results of Discontinued Operations

As discussed earlier in this Item and in Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements, our surgery centers, outpatient, and diagnostic divisions are reported as held for sale in our consolidated balance sheets and discontinued operations in our consolidated statements of operations. In addition, during the year ended December 31, 2007, four LTCHs, our electro-shock wave lithotripter units, and one other entity qualified under FASB Statement No. 144 to be reported as held for sale and discontinued operations. We reclassified our consolidated balance sheet as of December 31, 2006 to show the assets and liabilities of these qualifying divisions and facilities as held for sale. We also reclassified our consolidated statements of operations and statements of cash flows for the years ended December 31, 2006 and 2005 to show the results of those qualifying divisions and facilities as discontinued operations.

The operating results of discontinued operations, by division and in total, are as follows (in millions):

	For the Year Ended December 31,		
	2007	2006	2005
HealthSouth Corporation:			
Net operating revenues	$ 24.1	$ 83.5	$ 156.0
Costs and expenses	25.0	99.5	207.9
Impairments		2.1	7.2
Loss from discontinued operations	(0.9)	(18.1)	(59.1)
Gain (loss) on disposal of assets of discontinued operations	1.6	(6.9)	0.6
Income tax benefit (expense)	0.2	(0.3)	(1.4)
Income (loss) from discontinued operations, net of tax	$ 0.9	$ (25.3)	$ (59.9)
Surgery Centers:			
Net operating revenues	$ 381.7	$ 746.3	$ 790.2
Costs and expenses	359.6	774.3	779.7
Impairments	4.8	2.4	4.4
Income (loss) from discontinued operations	17.3	(30.4)	6.1
Gain on disposal of assets of discontinued operations	1.9	17.3	5.3
Gain on divestiture of division	314.9		
Income tax benefit (expense)	18.4	(18.1)	(34.5)
Income (loss) from discontinued operations, net of tax	$ 352.5	$ (31.2)	$ (23.1)
Outpatient:			
Net operating revenues	$ 127.3	$ 329.8	$ 391.7
Costs and expenses	110.1	321.5	374.1
Impairments	0.2	1.0	0.7
Income from discontinued operations	17.0	7.3	16.9
(Loss) gain on disposal of assets of discontinued operations	(1.3)	0.3	(2.5)
Gain on divestiture of division	145.3		
Income tax (expense) benefit	(16.0)	(0.4)	15.7
Income from discontinued operations, net of tax	$ 145.0	$ 7.2	$ 30.1
Diagnostic:			
Net operating revenues	$ 92.0	$ 197.8	$ 220.5
Costs and expenses	97.2	237.8	222.7
Impairments	33.2	4.5	5.0
Loss from discontinued operations	(38.4)	(44.5)	(7.2)
Gain on disposal of assets of discontinued operations	2.9	5.9	0.7
Loss on divestiture of division	(8.3)		
Income tax expense		(0.1)	
Loss from discontinued operations, net of tax	$ (43.8)	$ (38.7)	$ (6.5)
Total:			
Net operating revenues	$ 625.1	$ 1,357.4	$ 1,558.4
Costs and expenses	591.9	1,433.1	1,584.4
Impairments	38.2	10.0	17.3
Loss from discontinued operations	(5.0)	(85.7)	(43.3)
Gain on disposal of assets of discontinued operations	5.1	16.6	4.1
Gain on divestitures of divisions	451.9		
Income tax benefit (expense)	2.6	(18.9)	(20.2)
Income (loss) from discontinued operations, net of tax	$ 454.6	$ (88.0)	$ (59.4)

HealthSouth Corporation. Our results of discontinued operations primarily included the operations of the following hospitals: Cedar Court hospital in Australia (sold in October 2006 as we divested our international operations), Central Georgia Rehabilitation Hospital (lease expired on September 30, 2006 and was not extended), Union LTCH (closed February 2007 due to poor performance), Alexandria LTCH (sold in May 2007), Winnfield LTCH (sold in August 2007), and Terre Haute LTCH (closed in August 2007).

Our results of discontinued operations also included the operations of one of our former acute care hospitals. On July 20, 2005, we executed an asset purchase agreement with The Board of Trustees of the University of Alabama (the University of Alabama) for the sale of the real property, furniture, fixtures, equipment and certain related assets associated with our only remaining operating acute care hospital, which had 219 licensed beds located in Birmingham, Alabama (the Birmingham Medical Center). Simultaneously with the execution of this purchase agreement with the University of Alabama, we executed an agreement with an affiliate of the University of Alabama whereby this entity provided certain management services to the Birmingham Medical Center. On December 31, 2005, we executed an amended and restated asset purchase agreement with the University of Alabama. This amended and restated agreement provided that the University of Alabama purchase the Birmingham Medical Center and associated real and personal property as well as our interest in the gamma knife partnership associated with this hospital. This transaction closed on March 31, 2006.

From 2006 to 2007, the decrease in net operating revenues related primarily to the performance and eventual sale or closure of the Union, Alexandria, Winnfield, and Terre Haute LTCHs along with the timing of closures of our Cedar Court hospital and Central Georgia Rehabilitation Hospital. From 2005 to 2006, the decrease in net operating revenues related primarily to the performance and eventual sale of the Birmingham Medical Center. The change in costs and expenses in each year followed these same trends.

The net loss on disposal of assets in 2006 was primarily the result of our sale of the Birmingham Medical Center and lease termination fees associated with certain properties adjacent to the Birmingham Medical Center.

Surgery Centers. We closed the transaction to sell our surgery centers division to ASC on June 29, 2007, other than with respect to certain facilities for which approvals for the transfer to ASC had not yet been received as of such date. In August and November 2007, we received approval and transferred the applicable facilities in Connecticut and Rhode Island, respectively, but approval for the applicable facilities in Illinois remained pending as of December 31, 2007 (see Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements). No portion of the purchase price was withheld at closing pending the transfer of these facilities. As of December 31, 2007, we have deferred approximately $66.3 million of cash proceeds received at closing associated with the facilities that were still awaiting approval for transfer to ASC as of December 31, 2007.

During the third quarter of 2007, we also reached an agreement with certain of our remaining partners to sell an additional facility to ASC. This facility was an opt-out partnership at the time the original transaction closed with ASC. After deducting deal and separation costs, we received approximately $16.2 million of net cash proceeds in conjunction with the sale of this facility.

As a result of the disposition of our surgery centers division, including the opt-out partnership discussed above, we recorded gains on disposal of approximately $376.3 million, including an approximate $61.4 million income tax benefit primarily related to the reversal upon sale of deferred tax liabilities arising from indefinite-lived intangible assets of the division, during the year ended December 31, 2007. We expect to record an additional gain of approximately $30 million to $40 million for the facilities that remained pending in Illinois as of December 31, 2007. For additional information, see Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

From 2006 to 2007, the decrease in net operating revenues related primarily to the divestiture of the division on June 29, 2007, as discussed previously. From 2005 to 2006, the decrease in net operating revenues related primarily to surgery centers that became equity method investments rather than consolidated entities during these periods, as well as market competition and physician turnover. The change in costs and expenses in each year generally followed these same trends. Costs and expenses in 2006 included approximately $43.9 million of expenses, a portion of which did not require a cash outflow, related to settlement negotiations with our subsidiary partnerships related to the restatement of their historical financial statements. The net gain on asset disposals in 2006 related to various facility sales and asset disposals that occurred during the year.

Outpatient. We closed the transaction to sell our outpatient division to Select Medical on May 1, 2007, other than with respect to certain facilities for which approvals for the transfer to Select Medical had not yet been received as of such date. Approximately $24 million of the $245 million purchase price was withheld pending the transfer of these facilities. Subsequent to closing, we received approval and transferred the remaining facilities to

Select Medical, and we received additional sale proceeds in November 2007. As a result of the disposition of our outpatient division, we recorded an approximate $145.7 million post-tax gain on disposal during the year ended December 31, 2007. For additional information, see Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

From 2006 to 2007, the decrease in net operating revenues related to the divestiture of the division on May 1, 2007, as discussed previously. From 2005 to 2006, the decrease in net operating revenues related primarily to a year-over-year decline in patient visits that resulted from competition from physician-owned physical therapy sites and the nationwide physical therapist shortage. In addition, the volume decrease from 2005 to 2006 was also due to the annual per-beneficiary limitations on Medicare outpatient therapy services that became effective on January 1, 2006. The change in costs and expenses in each year followed these same trends.

Diagnostic. We closed the transaction to sell our diagnostic division to The Gores Group on July 31, 2007, other than with respect to one facility for which approval for the transfer had not yet been received as of such date. The net cash proceeds received at closing, after deducting deal and separation costs and purchase price adjustments, approximated $39.7 million. As a result of the disposition of our diagnostic division, we recorded an approximate $8.3 million post-tax loss on disposal during the year ended December 31, 2007. This loss primarily resulted from working capital adjustments based on the final balance sheet. For additional information, see Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

The net operating revenues and costs and expenses for the year ended December 31, 2007 were lower than those in 2006 due to the closing of the transaction to sell our diagnostic division to The Gores Group on July 31, 2007, as discussed above, lower scan volumes due to new restrictions imposed by certain payors, and the negative impact on pricing of the Deficit Reduction Act for diagnostic imaging services effective January 1, 2007. The net operating revenues for 2006 were lower than those of 2005 due to lower scan volumes that resulted primarily from new restrictions imposed by certain payors and competition from physician-owned diagnostic equipment and a shift in case mix to lower-paying modalities. Costs and expenses in each period generally followed these same trends. However, 2006 included costs associated with the implementation of a new enterprise information technology system and costs associated with the outsourcing of collection activities.

During the year ended December 31, 2007, we wrote the intangible assets and certain long-lived assets of our diagnostic division down to their estimated fair value based on the estimated net proceeds we expected to receive from the divestiture of the division. This charge is included in impairments in the above results of operations of our diagnostic division.

Liquidity and Capital Resources

Our principal sources of liquidity are cash on hand, cash from operations, and Revolving Loans under our Credit Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements).

We are highly leveraged. However, our leverage and liquidity are improving. During the year ended December 31, 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions to pay down debt. We also 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 pay down amounts outstanding under our Credit Agreement. Also, we used drawings under our revolving credit facility and available cash to redeem approximately $59.1 million of our 10.75% Senior Notes due 2016. As a result of these transactions, our total debt outstanding has decreased from $3.4 billion as of December 31, 2006 to $2.0 billion as of December 31, 2007.

Approximately $75.0 million of our $2.0 billion of long-term debt outstanding as of December 31, 2007 represents amounts drawn under our $400 million revolving credit facility (excluding approximately $21.5 million utilized under the revolving letter of credit subfacility). Amounts were drawn from the revolving credit facility primarily due to the timing of interest payments and government settlement payments (as discussed in Note 20, *Settlements*, to our accompanying consolidated financial statements). 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.

We have scheduled principal payments of $68.3 million and $23.4 million in 2008 and 2009, respectively, related to long-term debt obligations (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). In the fourth quarter of 2007, we made the final payments related to our Medicare Program Settlement and our SEC Settlement (see Note 20, *Settlements*, to our accompanying consolidated financial statements).With these settlement payments behind us, we are now able to redirect our operating cash elsewhere in the Company. In addition, we expect to use cash flows from the expected sale of our corporate campus (see Note 5, *Property and Equipment*, to our accompanying consolidated financial statements) and the receipt of additional income tax refunds (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements) to further reduce our long-term debt outstanding. However, no assurances can be given as to whether or when such cash flows will be received.

As with any company carrying significant debt, our primary risk relating to our high leverage is the possibility that a down-turn in operating earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement. 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. 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. See Item 1A, *Risk Factors*, of this Form 10-K and Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements for a discussion of risks and uncertainties facing us. Changes in our business or other factors may occur that might have a material adverse impact on our financial position, results of operations, and cash flows.

Sources and Uses of Cash

Our primary sources of funding are cash flows from operations and borrowings under long-term debt agreements. Over the past three years, our funds were used primarily to fund working capital requirements, make capital expenditures, and make payments under various settlement agreements. The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2007, 2006, and 2005, as well as the effect of exchange rates for those same years (in millions):

	As of December 31,		
	2007	**2006**	**2005**
Net cash provided by (used in) operating activities	$ 230.7	$ (129.8)	$ (26.7)
Net cash provided by (used in) investing activities	1,184.5	61.9	(100.0)
Net cash used in financing activities	(1,436.6)	(69.8)	(148.4)
Effect of exchange rate changes on cash and cash equivalents	0.1	0.1	(1.2)
Decrease in cash and cash equivalents	$ (21.3)	$ (137.6)	$ (276.3)

2007 Compared to 2006

Operating activities. *Net cash provided by operating activities* increased by $360.5 million from 2006 to 2007. This increase resulted from higher *Net operating revenues* and lower operating expenses year over year. Specifically, we experienced a $109.8 million reduction in *Professional fees accounting, tax, and legal* from 2006 to 2007. In addition, we received a $440 million federal income tax recovery in October 2007 (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements). *Net cash provided by operating activities* in 2007 and 2006 also included payments of approximately $171.4 million and $132.8 million, respectively, related to government, class action, and related settlements.

Investing activities. The increase in *Net cash provided by investing activities* from 2006 to 2007 was due to the cash proceeds received from the divestitures of our surgery centers, outpatient, and diagnostic divisions during 2007 (see Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements).

Financing activities. The increase in *Net cash used in financing activities* was due to the use of the net cash 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 recovery (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements), to reduce debt outstanding under our Credit Agreement during 2007. During 2007, we made approximately $1.3 billion of net debt payments, while during 2006, we made approximately $246.3 million of net debt payments. Financing activities for 2006 also included approximately $387.4 million of net proceeds from the issuance of *Convertible perpetual preferred stock* (see Note 9, *Convertible Perpetual Preferred Stock*, to our accompanying consolidated financial statements).

2006 Compared to 2005

Operating activities. *Net cash used in operating activities* increased from 2005 to 2006 due to volume declines year over year, as discussed above. *Net cash used in operating activities* in 2006 and 2005 included payments of approximately $132.8 million and $165.4 million, respectively, related to government, class action, and related settlements.

Investing activities. *Net cash provided by investing activities* increased from 2005 to 2006 due primarily to a reduction in restricted cash and proceeds from asset disposals for facilities in discontinued operations. In prior years, the cash of certain partnerships in which we participate was restricted because one or more external partners requested, and we agreed, not to commingle the partnership s cash with other corporate cash accounts. During 2006, we were able to eliminate many of these restrictions through discussions and negotiations with our external partners.

Financing activities. The decrease in *Net cash used in financing activities* from 2006 compared to 2005 was due to the recapitalization transactions and private offering of senior notes in 2006 (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). As a result of these transactions, net payments on debt, increased by approximately $183.8 million for 2006. We also paid approximately $61.9 million more in debt issuance costs during 2006 over 2005 due to these transactions. These increased payments were offset by approximately $387.4 million in net proceeds from the issuance of *Convertible perpetual preferred stock* (see Note 9, *Convertible Perpetual Preferred Stock*, to our accompanying consolidated financial statements) in 2006. We also paid approximately $15.7 million in dividends on our *Convertible perpetual preferred stock* during 2006.

Adjusted Consolidated EBITDA

Management continues to believe Adjusted Consolidated EBITDA under our Credit Agreement is a measure of leverage capacity, our ability to service our debt, and our ability to make capital expenditures. However, as we continue to deleverage our balance sheet and the large, non-ordinary course charges related to the sins of the past are behind us, this measure will become less significant.

We use Adjusted Consolidated EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our Credit Agreement, which is discussed in more detail in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements. These covenants are material terms of the Credit Agreement, and the Credit Agreement represents a substantial portion of our capitalization. Non-compliance with these financial covenants under our Credit Agreement our interest coverage ratio and our leverage ratio could result in our lenders requiring us to immediately repay all amounts borrowed. 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. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our Credit Agreement from engaging in certain activities, such as incurring additional indebtedness, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted Consolidated EBITDA is critical to our assessment of our liquidity.

In general terms, the definition of Adjusted Consolidated EBITDA, per our Credit Agreement, allows us to add back to Adjusted Consolidated EBITDA all unusual non-cash items or non-recurring items. These items include, but may not be limited to, (1) amounts associated with government, class action, and related settlements, (2) fees, costs, and expenses related to our recapitalization transactions, (3) any losses from discontinued operations and closed locations, (4) charges in respect of professional fees for reconstruction and restatement of financial statements, including fees paid to outside professional firms for matters related to internal controls and legal fees for continued litigation defense and support matters discussed in Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements, (5) compensation expenses recorded in accordance with FASB

Statement No. 123(R), (6) investment and other income (including interest income), and (7) fees associated with our divestiture activities. We reconcile Adjusted Consolidated EBITDA to *Net income (loss)*.

However, Adjusted Consolidated EBITDA is not a measure of financial performance under generally accepted accounting principles in the United States of America (GAAP), and the items excluded from Adjusted Consolidated EBITDA are significant components in understanding and assessing financial performance. Therefore, Adjusted Consolidated EBITDA should not be considered a substitute for *Net income (loss)* or cash flows from operating, investing, or financing activities. Because Adjusted Consolidated EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, Adjusted Consolidated EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. Revenues and expenses are measured in accordance with the policies and procedures described in Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements.

Our Adjusted Consolidated EBITDA for the years ended December 31, 2007, 2006, and 2005 was as follows (in millions):

Reconciliation of Net Income (Loss) to Adjusted Consolidated EBITDA

	For the Year Ended December 31,		
	2007	**2006**	**2005**
Net income (loss)	$ 653.4	$ (625.0)	$ (446.0)
(Income) loss from discontinued operations	(454.6)	88.0	59.4
Provision for income tax (benefit) expense	(322.4)	22.4	19.6
Loss on interest rate swap	30.4	10.5	
Interest expense and amortization of debt discounts and fees	229.9	234.8	234.8
Loss on early extinguishment of debt	28.2	365.6	
Government, class action, and related settlements	(2.8)	(4.8)	215.0
Net noncash loss on disposal of assets	5.9	6.4	11.6
Impairment charges	15.1	9.7	34.7
Depreciation and amortization	77.5	86.8	89.6
Professional fees accounting, tax, and legal	51.6	161.4	169.1
Compensation expense under FASB Statement No. 123(R)	10.6	15.5	
Restructuring activities under FASB Statement No. 146	0.1	0.3	
Sarbanes-Oxley related costs	0.3	4.8	32.2
Adjusted Consolidated EBITDA	$ 323.2	$ 376.4	$ 420.0

After consummation of the divestitures discussed earlier in this Item, and in accordance with our Credit Agreement (including the March 2007 amendment to the Credit Agreement discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements), Adjusted Consolidated EBITDA is calculated to give effect to each divestiture, including adjustments for the allocation of corporate overhead to each divested division. Therefore, for purposes of covenant calculations reported to our lenders under the Credit Agreement, we add back a corporate overhead allocation for each divested division in the quarter in which the applicable transaction closes. However, while these allocations are additive to Adjusted Consolidated EBITDA under our Credit Agreement, these allocations are estimates and are not necessarily indicative of the Adjusted Consolidated EBITDA that would have resulted had the applicable divisions been divested as of the beginning of each period presented. Accordingly, they have not been added back to *Net income (loss)* in the table above and are not included in the above calculation of Adjusted Consolidated EBITDA. In addition, we are allowed to add other income, including interest income, to the calculation of Adjusted Consolidated EBITDA under our Credit Agreement. This includes the interest income associated with our federal income tax recovery, as discussed in Note 17, *Income Taxes*, to our accompanying consolidated financial statements. This amount has not been included in the above calculation, as it would not be indicative of our Adjusted Consolidated EBITDA for future periods.

Reconciliation of Adjusted Consolidated EBITDA to Net Cash Provided by (Used in) Operating Activities

	For the Year Ended December 31,		
	2007	**2006**	**2005**
Adjusted Consolidated EBITDA	$ 323.2	$ 376.4	$ 420.0
Compensation expense under FASB Statement No. 123(R)	(10.6)	(15.5)	
Sarbanes-Oxley related costs	(0.3)	(4.8)	(32.2)
Provision for doubtful accounts	34.4	45.6	32.4
Professional fees accounting, tax, and legal	(51.6)	(161.4)	(169.1)
Interest expense and amortization of debt discounts and fees	(229.9)	(234.8)	(234.8)
(Gain) loss on sale of investments	(12.3)	1.2	(3.3)
Equity in net income of nonconsolidated affiliates	(10.3)	(8.7)	(12.3)
Minority interests in earnings of consolidated affiliates	31.4	26.3	41.7
Amortization of debt discounts and fees	7.8	18.3	38.9
Distributions from nonconsolidated affiliates	5.3	6.1	11.4
Stock-based compensation	7.7	12.1	
Current portion of income tax benefit (expense)	330.4	(6.1)	(20.0)
Change in assets and liabilities	(7.9)	(141.3)	(70.8)
Change in government, class action, and related settlements liability	(171.4)	(132.8)	(165.4)
Other operating cash (used in) provided by discontinued operations	(16.3)	86.9	135.1
Other	1.1	2.7	1.7
Net Cash Provided by (Used in) Operating Activities	$ 230.7	$ (129.8)	$ (26.7)

Adjusted Consolidated EBITDA for the year ended December 31, 2007 included the gain on the sale of our investment in Source Medical, as discussed above. Adjusted Consolidated EBITDA for the year ended December 31, 2006 included the recovery of incentive bonuses from Mr. Scrushy, as discussed above. Adjusted Consolidated EBTIDA for the year ended December 31, 2005 included the bad debt recovery from Meadowbrook and the net gain on lease termination associated with our former Braintree and Woburn hospitals, as discussed above.

Adjusted Consolidated EBITDA decreased from 2006 to 2007 due primarily to the recovery from Mr. Scrushy recorded in 2006. The decrease in Adjusted Consolidated EBITDA from 2006 to 2007 was also due to higher *Salaries and benefits* and *Other operating expenses*, as discussed above. Adjusted Consolidated EBITDA decreased from 2005 to 2006 due to the decline in inpatient discharges we experienced year over year and the increase to our *Provision for doubtful accounts*, as discussed above.

Current Liquidity and Capital Resources

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. As of December 31, 2006, we had approximately $27.1 million in *Cash and cash equivalents*, $60.3 million in restricted cash, and $71.1 million of restricted marketable securities. See Note 1, *Summary of Significant Accounting Policies*, Marketable Securities to our accompanying consolidated financial statements.

As noted above and throughout this report, we used the net proceeds from our divestiture transactions and the majority of our federal income tax recovery to reduce our long-term debt during 2007. As of December 31, 2007 and 2006, our long-term debt consists of the following (excluding notes payable to banks and others and capital lease obligations) (in millions):

	December 31, 2007	2006
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

The anticipated cash flows from the expected sale of our corporate campus and additional income tax recoveries will be used primarily to further reduce debt. However, no assurances can be given as to whether or when such cash flows will be received.

In March 2007, we amended our existing Credit Agreement (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) to lower the applicable interest rates and modify certain other covenants. The amendment and related supplement reduced the interest rate on our Term Loan Facility to LIBOR plus 2.5% (formerly LIBOR plus 3.25%), as well as reduced the applicable participation rate on the $100 million synthetic letter of credit facility to 2.5% (formerly 3.25%). The amendment also gave us the appropriate approvals for our divestiture activities.

Funding Commitments

We have scheduled principal payments of $68.3 million and $23.4 million in 2008 and 2009, respectively, related to long-term debt obligations. For additional information about our long-term debt obligations, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

During the year ended December 31, 2007, we made capital expenditures of approximately $39.4 million. The total amounts expected for capital expenditures and development efforts for 2008 approximate $50 million to $85 million. Actual amounts spent will be dependent upon the timing of development projects and receipt of the cash flows from the expected sale of our corporate campus and additional income tax refunds. These expenditures include IT initiatives, new business opportunities, and equipment upgrades and purchases. Approximately $40 million of this budgeted amount is non-discretionary.

For a discussion of risk factors related to our business and our industry, please see Item 1A, *Risk Factors*, of this report and Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements.

Off-Balance Sheet Arrangements

In accordance with the definition under SEC rules, the following qualify as off-balance sheet arrangements:

- any obligation under certain guarantees or contracts;
- a retained or contingent interest in assets transferred to an unconsolidated entity or similar entity or similar arrangement that serves as credit, liquidity, or market risk support to that entity for such assets;
- any obligation under certain derivative instruments; and
- any obligation under a material variable interest held by the registrant in an unconsolidated entity that provides financing, liquidity, market risk, or credit risk support to the registrant, or engages in leasing, hedging, or research and development services with the registrant.

The following discussion addresses each of the above items for the Company.

We are secondarily liable for certain lease obligations associated with sold facilities, including the sale of our surgery centers, outpatient, and diagnostic divisions during 2007. Also, in connection with the closing of the transaction to sell our diagnostic division, HealthSouth remained as a guarantor of certain leases for properties and equipment and a guarantor to certain purchase and servicing contracts that were assigned to the buyer in connection with the sale.

As of December 31, 2007, we were secondarily liable for 184 such guarantees. The remaining terms of these guarantees range from 1 month to 219 months. If we were required to perform under all such guarantees, the maximum amount we would be required to pay approximates $131.1 million.

We have not recorded a liability for these guarantees, as we do not believe it is probable we will have to perform under these agreements. If we are required to perform under these guarantees, we could potentially have recourse against the purchaser for recovery of any amounts paid. In addition, the purchasers of our surgery centers, outpatient, and diagnostic divisions have agreed to seek releases from the lessors and vendors in favor of HealthSouth with respect to the guarantee obligations associated with these divestitures. To the extent the purchasers of these divisions are unable to obtain releases for HealthSouth, the purchasers have agreed to indemnify HealthSouth for damages incurred under the guarantee obligations, if any. For additional information regarding these guarantees, see Note 11, *Guarantees*, to our accompanying consolidated financial statements.

Also, as discussed in Note 20, *Settlements*, to our accompanying consolidated financial statements, our securities litigation settlement agreement requires us to indemnify the settling insurance carriers, to the extent permitted by law, for any amounts they are legally obligated to pay to any non-settling defendants. As of December 31, 2007, we have not recorded a liability regarding these indemnifications, as we do not believe it is probable we will have to perform under the indemnification portion of these settlement agreements, and any amount we would be required to pay is not estimable at this time.

As of December 31, 2007, we do not have any retained or contingent interest in assets as defined above.

As of December 31, 2007, we hold one derivative financial instrument, as defined by FASB Statement No. 133, *Accounting for Derivative Instruments and Hedging Activities,* as amended. In March 2006, we entered into an interest rate swap related to our Credit Agreement, as discussed in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (SPEs), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2007, we are not involved in any unconsolidated SPE transactions.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2007 are as follows (in millions):

	Total	**2008**	**2009 2010**	**2011 2012**	**2013 and Thereafter**
Long-term debt obligations:					
Long-term debt excluding revolving credit facility and capital lease obligations [a]	$ 1,859.5	$ 54.4	$ 21.4	$ 19.6	$ 1,764.1
Revolving credit facility	75.0			75.0	
Interest on long-term debt [b]	1,164.3	179.5	350.8	342.7	291.3
Capital lease obligations [c]	148.2	21.4	39.1	30.9	56.8
Operating lease obligations [d][e]	233.7	36.2	56.6	36.5	104.4
Purchase obligations [e][f]	55.9	15.6	36.0	2.2	2.1
Other long-term liabilities [g]	6.0	1.9	1.1	0.4	2.6
Total	$ 3,542.6	$ 309.0	$ 505.0	$ 507.3	$ 2,221.3

(a) Included in long-term debt are amounts owed on our bonds payable and notes payable to banks and others. These borrowings are further explained in Note 8, *Long-term Debt,* to our accompanying consolidated financial statements.

(b) Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2007. Interest related to capital lease obligations is excluded from this line. Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of operations. Amounts also exclude the impact of our interest rate swap.

(c) Amounts include interest portion of future minimum capital lease payments.

(d) We lease many of our hospitals as well as other property and equipment under operating leases in the normal course of business. Some of our hospital leases require percentage rentals on patient revenues above specified minimums and contain escalation clauses. The minimum lease payments do not include contingent rental expense. Some lease agreements provide us with the option to renew the lease or purchase the leased property. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. For more information, see Note 5, *Property and Equipment,* to our accompanying consolidated financial statements.

(e) Future operating lease obligations and purchase obligations are not recognized in our consolidated balance sheet.

(f) Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on HealthSouth and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support, medical supplies, certain equipment, and telecommunications.

(g) Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: medical malpractice and workers compensation risks, deferred income taxes, and our estimated liability for unsettled litigation. For more information, see Note 1, *Summary of Significant Accounting Policies,* Self-Insured Risks, Note 17, *Income Taxes,* and Note 21, *Contingencies and Other Commitments,* to our accompanying consolidated financial statements. Also, as discussed in Note 17, *Income Taxes*, to our accompanying consolidated financial statements, we adopted the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*, on January 1, 2007. At December 31, 2007, we had approximately $138.2 million of total gross unrecognized tax benefits. In addition, we had an accrual for related interest income of $19.5 million as of December 31, 2007. We continue to actively pursue the maximization of our remaining income tax refund claims. The process of resolving these tax matters with the applicable taxing authorities will continue throughout 2008, and will likely extend into 2009. At this time, we cannot estimate a range of the reasonably possible change that may occur.

Indemnifications

In the ordinary course of business, HealthSouth enters into contractual arrangements under which HealthSouth may agree to indemnify the third party to such arrangement from any losses incurred relating to the services they perform on behalf of HealthSouth or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses.

In December 2005, Mr. Scrushy filed a demand for arbitration with the American Arbitration Association purportedly pursuant to an indemnity agreement with us. The arbitration demand sought to require us to pay expenses incurred by Mr. Scrushy, including attorneys fees, in connection with the defense of criminal fraud claims against him and in connection with a preliminary hearing in the SEC litigation. In October 2006, the arbitrator issued a final award confirming an interim award of approximately $17.0 million to Mr. Scrushy and further ruling that Mr. Scrushy is entitled to have HealthSouth pay him a total of approximately $4.0 million in pre-judgment interest and attorneys fees and expenses incurred by Mr. Scrushy in connection with the arbitration proceeding.

Based on an agreement with Mr. Scrushy, we offset the approximate $21.5 million (including post-judgment interest) award to him in the arbitration against the approximate $48 million judgment against Mr. Scrushy in the Tucker actions for repayment of bonuses.

We accrued an estimate of these legal fees as of December 31, 2005 and 2004, which was included in *Professional fees accounting, tax, and legal* in our consolidated statements of operations for the years ended December 31, 2005 and 2004 and *Other current liabilities* in our consolidated balance sheets as of December 31, 2005 and 2004 in connection with the arbitration demand. Based on the arbitrator s ruling, we may have an obligation to indemnify Mr. Scrushy for certain costs associated with ongoing litigation. As of December 31, 2007 and 2006, an estimate of these legal fees is included in *Other current liabilities* in our consolidated balance sheets.

In addition, in connection with the divestitures of our surgery centers, outpatient, and diagnostic divisions, we have certain post-closing indemnification obligations to the respective purchasers. These indemnification obligations arose from liabilities not assumed by the purchasers, such as certain types of litigation, any breach by us of the purchase agreements, liabilities associated with assets that were excluded from the divestitures, and other types of liabilities that are customary in transactions of these types.

Critical Accounting Policies

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. In connection with the preparation of our consolidated financial statements, we are required to make assumptions and estimates about future events, and apply judgment that affects the reported amounts of assets, liabilities, revenue, expenses, and the related disclosures. We base our assumptions, estimates, and judgments on historical experience, current trends, and other factors we believe to be relevant at the time we prepared our consolidated financial statements. On a regular basis, we review the accounting policies, assumptions, estimates, and judgments to ensure our consolidated financial statements are presented fairly and in accordance with GAAP. However, because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

Our significant accounting policies are discussed in Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements. We believe the following accounting policies are the most critical to aid in fully understanding and evaluating our reported financial results, as they require management s most difficult, subjective, or complex judgments, resulting from the need to make estimates about the effect of matters that are inherently uncertain. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Revenue Recognition

We recognize net patient service revenues in the reporting period in which we perform the service based on our current billing rates (i.e., gross charges), less actual adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid, and managed care and other health plans). We record gross service charges in our accounting records on an accrual basis using our established rates for the type of service provided to the patient. We recognize an estimated contractual allowance to reduce gross patient charges to the amount we estimate we will actually realize for the service rendered based upon previously agreed to rates with a payor. Our patient accounting system calculates contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Other factors that are considered and could further influence the level of our reserves include the patient s total length of stay for in-house patients, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors, accordingly. Payors include federal and state agencies, including Medicare and Medicaid, managed care health plans, commercial insurance companies, employers, and patients.

Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. In addition, laws and regulations governing the Medicare and Medicaid programs are

complex and subject to interpretation. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation, we may receive reimbursement for health care services authorized and provided that is different from our estimates, and such differences could be material. However, we continually review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective.

Allowance for Doubtful Accounts

We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value.

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding.

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. Accounts requiring collection efforts are reviewed each 30 days via system-generated work queues that automatically stage accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine that all in-house efforts have been exhausted or that it is a more prudent use of resources, accounts may be turned over to a collection agency. Accounts are written off after all collection efforts (internal and external) have been exhausted.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. However, we continually review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective. Adverse changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer health care coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

The table below shows a summary aging of our net accounts receivable balance as of December 31, 2007 and 2006. Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, *Summary of Significant Accounting Policies*, Accounts Receivable, to our accompanying consolidated financial statements.

	As of December 31,	
	2007	**2006**
	(In Millions)	
0 30 Days	$ 154.8	$ 150.1
31 60 Days	25.4	25.2
61 90 Days	13.5	14.2
91 120 Days	6.7	8.4
120 + Days	17.0	15.2
Patient accounts receivable	217.4	213.1
Non-patient accounts receivable	2.8	0.8
Accounts receivable, net	$ 220.2	$ 213.9

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability and workers compensation risks are insured through a wholly owned insurance subsidiary. Obligations covered by reinsurance contracts remain on the balance sheet as the subsidiary remains liable to the extent reinsurers do not meet their obligations. Our reserves and provisions for professional liability and workers compensation risks are based upon actuarially determined estimates calculated by third-party actuaries. The actuaries consider a number of factors, including historical claims experience, exposure data, loss development, and geography.

Periodically, management reviews its assumptions and the valuations provided by third-party actuaries to determine the adequacy of our self-insured liabilities. Changes to the estimated reserve amounts are included in current operating results. All reserves are undiscounted.

Our self-insured liabilities contain uncertainties because management must make assumptions and apply judgment to estimate the ultimate cost to settle reported claims and claims incurred but not reported as of the balance sheet date. The reserves for professional liability risks cover approximately 1,000 individual claims as of December 31, 2007 and estimates for potential unreported claims.

The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The estimation of the timing of payments beyond a year can vary significantly.

Due to the considerable variability that is inherent in such estimates, there can be no assurance the ultimate liability will not exceed management s estimates. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Long-lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment when events or changes in circumstances indicate the carrying value of the assets contained in our financial statements may not be recoverable. When evaluating long-lived assets for potential impairment, we first compare the carrying value of the asset to the asset s estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than the carrying value of the asset, we calculate an impairment loss. The impairment loss calculation compares the carrying value of the asset to the asset s estimated fair value, which may be based on estimated future cash flows (discounted and with interest charges). We recognize an impairment loss if the amount of the asset s carrying value exceeds the asset s estimated fair value. If we recognize an impairment loss, the adjusted carrying amount of the asset will be its new cost basis. For a depreciable long-lived asset, the new cost basis will be depreciated over the remaining useful life of the asset. Restoration of a previously recognized impairment loss is prohibited.

Our impairment loss calculations require management to apply judgment in estimating future cash flows and asset fair values, including forecasting useful lives of the assets and selecting the discount rate that represents the risk inherent in future cash flows. Using the impairment review methodology described herein, we recorded long-lived asset impairment charges of approximately $15.1 million during the year ended December 31, 2007. If actual results are not consistent with our assumptions and judgments used in estimating future cash flows and asset fair values, we may be exposed to additional impairment losses that could be material to our results of operations.

Goodwill and Other Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired companies. We follow the guidance in FASB Statement No. 142, *Goodwill and Intangible Assets*, and test goodwill for impairment using a fair value approach, at the reporting unit level. We are required to test for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. On an ongoing basis, absent any impairment indicators, we perform our goodwill impairment testing as of October 1st of each year.

Our other intangible assets consist of acquired certificates of need, licenses, and noncompete agreements. We amortize these assets over periods ranging from 3 to 30 years. As of December 31, 2007, we do not have any intangible assets with indefinite useful lives. We continue to review the carrying values of amortizable intangible assets whenever facts and circumstances change in a manner that indicates their carrying values may not be recoverable.

We determine the fair value of our reporting unit using widely accepted valuation techniques, including discounted cash flow and market multiple analyses. These types of analyses require us to make assumptions and estimates regarding industry economic factors and the profitability of future business strategies.

We performed our annual testing for goodwill impairment as of October 1, 2007, using the methodology described herein, and determined no goodwill impairment existed. If actual results are not consistent with our assumptions and estimates, we may be exposed to additional goodwill impairment charges. The carrying value of goodwill as of December 31, 2007 approximated $406.1 million.

Share-Based Payments

FASB Statement No. 123(R) requires all share-based payments, including grants of stock options, to be recognized in the financial statements based on their grant-date fair value. For the majority of our share-based awards, the fair value is estimated at the date of grant using a Black-Scholes option pricing model with weighted-average assumptions for the activity under our stock plans. We use a lattice model for restricted stock that vests upon the achievement of a market condition and a service condition. However, these amounts are not material to our financial position, results of operations, or cash flows.

Option pricing model assumptions such as expected term, expected volatility, risk-free interest rate, and expected dividends, impact the fair value estimate. Further, the forfeiture rate impacts the amount of aggregate compensation expense recorded in each year. These assumptions are subjective and generally require significant analysis and judgment to develop. When estimating fair value, some of the assumptions will be based on or determined from external data and other assumptions may be derived from our historical experience with share-based payment arrangements. The appropriate weight to place on historical experience is a matter of judgment based on relevant facts and circumstances.

We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We currently calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected life of the options, excluding a distinct period of extreme volatility between 2002 and 2003. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option pricing model. 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. Therefore, we do not include a dividend payment as part of our pricing model. We estimate forfeitures through an analysis of actual, historical pre-vesting option forfeiture activity.

If actual results are not consistent with our assumptions and estimates, we may be exposed to expense adjustments that could be material to our results of operations.

Income Taxes

We account for income taxes using the asset and liability method. Under the asset and liability method, deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. In addition, deferred tax assets are also recorded with respect to net operating losses and other tax attribute carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates in effect for the year in which those temporary differences are expected to be recovered or settled. Valuation allowances are established when realization of the benefit of deferred tax assets is not deemed to be more likely than not. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

We adopted FASB Interpretation No. 48 on January 1, 2007. The application of income tax law is inherently complex. Laws and regulations in this area are voluminous and are often ambiguous. As such, we are required to make many subjective assumptions and judgments regarding our income tax exposures. Interpretations of and guidance surrounding income tax laws and regulations change over time. As such, changes in our subjective assumptions and judgments can materially affect amounts recognized in our consolidated financial statements.

The ultimate recovery of certain of our deferred tax assets is dependent on the amount and timing of taxable income that we will ultimately generate in the future and other factors. A high degree of judgment is required to determine the extent that valuation allowances should be provided against deferred tax assets. We have provided valuation allowances at December 31, 2007 aggregating $1.1 billion against such assets based on our current assessment of future operating results and other factors.

As discussed in Note 17, *Income Taxes*, to our accompanying consolidated financial statements, during 2007, we settled all federal income tax issues outstanding with the IRS for the tax years 1996 through 1999, and we received an approximate $440 million income tax refund, including associated interest. We continue to actively pursue the maximization of our remaining income tax refund claims through the preparation and filing of amended federal and state income tax returns. The actual amount of the refunds will not be finally determined until all of the applicable taxing authorities have completed their review. Although management believes its estimates and judgments related to these claims are reasonable, depending on the ultimate resolution of these tax matters, actual amounts recovered could differ from management s estimates, and such differences could be material.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. We have provided for losses in situations where we have concluded it is probable a loss has been or will be incurred and the amount of the loss is reasonably estimable. A significant amount of judgment is involved in determining whether a loss is probable and reasonably estimable due to the uncertainty involved in determining the likelihood of future events and estimating the financial statement impact of such events. If further developments or resolution of a contingent matter are not consistent with our assumptions and judgments, we may need to recognize a significant charge in a future period related to an existing contingent matter.

Recent Accounting Pronouncements

In September 2006, the FASB issued FASB Statement No. 157, *Fair Value Measurements*, which establishes a framework for measuring fair value in GAAP and expands disclosures about fair value measurements. The changes to current practice resulting from the application of FASB Statement No. 157 relate to the definition of fair value, the methods used to measure fair value, and the expanded disclosures about fair value measurements. FASB Statement No. 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. The provisions of FASB Statement No. 157 should be applied prospectively as of the beginning of the fiscal year of adoption, with exceptions for certain financial instruments listed in the Statement. We will adopt the provisions of FASB Statement No. 157 on January 1, 2008. The adoption of the Statement will result only in additional disclosures in our interim and annual reports beginning with the first quarter of 2008. No impact is expected on our consolidated financial position, results of operations, or cash flows.

In February 2008, the FASB issued two Staff Positions that amended FASB Statement No. 157. FASB Staff Position No. 157-1, *Application of FASB Statement No. 157 to FASB Statement No. 13 and Other Accounting Pronouncements That Address Fair Value Measurements for Purposes of Lease Classification or Measurement under Statement 13*, amended FASB Statement No. 157 to exclude FASB Statement No. 13, *Accounting for Leases*, and its related interpretive accounting pronouncements that address leasing transactions. FASB Staff Position No. 157-2, *Effective Date of FASB Statement No. 157*, delayed the effective date of FASB Statement No. 157 by one year for nonfinancial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a nonrecurring basis. The issuance of these two Staff Positions did not change our above conclusions regarding the impact of FASB Statement No. 157 on our consolidated financial position, results of operations, or cash flows.

In February 2007, the FASB issued FASB Statement No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities*, which provides companies with an option to report selected financial assets and liabilities at fair value. The objective of the new standard is to improve financial reporting by providing companies with the

opportunity to mitigate volatility in reported earnings caused by measuring related assets and liabilities differently without having to apply complex hedge accounting provisions. The new standard establishes presentation and disclosure requirements designed to facilitate comparisons between companies that choose different measurement attributes for similar types of assets and liabilities. It also requires companies to provide additional information that will help investors and other users of financial statements more easily understand the effect of a company s choice to use fair value on its earnings. The Statement also requires entities to display the fair value of those assets and liabilities for which the company has chosen to use fair value on the face of the balance sheet. FASB Statement No. 159 does not eliminate disclosure requirements included in other accounting standards, including requirements for disclosures about fair value measurements included in FASB Statements No. 157 and FASB Statement No. 107.

FASB Statement No. 159 is effective as of the beginning of an entity s first fiscal year that begins after November 15, 2007. We did not elect the fair value option of FASB Statement No. 159 on January 1, 2008. Therefore, the Statement will have no impact on our consolidated financial position, results of operations, or cash flows.

In December 2007, the FASB issued FASB Statement No. 141(Revised 2007), *Business Combinations*. FASB Statement No. 141(R) contains significant changes in the accounting for and reporting of business acquisitions, and it continues the movement toward the greater use of fair values in financial reporting and increased transparency through expanded disclosures. It changes how business acquisitions are accounted for and will impact financial statements at the acquisition date and in subsequent periods. Further, certain of the changes will introduce more volatility into earnings and thus may impact a company s acquisition strategy. In addition, FASB Statement No. 141(R) will impact the annual goodwill impairment test associated with acquisitions that close both before and after the effective date of the new standard. FASB Statement No. 141(R) will be applied prospectively to business combinations for which the acquisition date is on or after the beginning of an entity s first annual reporting period beginning on or after December 15, 2008, or January 1, 2009 for HealthSouth. We have not begun evaluating the potential impact, if any, the adoption of FASB Statement No. 141(R) could have on our consolidated financial position, results of operations, and cash flows.

In December 2007, the FASB issued FASB Statement No. 160, *Noncontrolling Interests in Consolidated Financial Statements, an amendment of ARB No. 51*. FASB Statement No. 160 establishes accounting and reporting standards for minority interests (recharacterized as noncontrolling interests and classified as a component of equity) and for the deconsolidation of a subsidiary. FASB Statement No. 160 is effective for fiscal years beginning on or after December 15, 2008, or January 1, 2009 for HealthSouth. The Statement is to be applied prospectively, however the presentation and disclosure requirements of the Statement will need to be applied retrospectively for all periods presented. At this time, we have not completed our evaluation of the impact the adoption of FASB Statement No. 160 will have on our consolidated financial position, results of operations, and cash flows. However, at a minimum, it will change the way in which we account for and report our minority interests.

We do not believe any other recently issued, but not yet effective, accounting standards will have a material effect on our consolidated financial position, results of operations, or cash flows.

For additional information regarding recent account pronouncements, see Note 1, *Summary of Significant Policies*, to our accompanying consolidated financial statements.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our long-term debt. We use sensitivity analysis models to evaluate the impact of interest rate changes on these items.

Changes in interest rates have different impacts on the fixed and variable rate portions of our debt portfolio. A change in interest rates impacts the net market value of our fixed rate debt but has no impact on interest expense or cash flows. Interest rate changes on variable rate debt impacts our interest expense and cash flows, but does not impact the net fair value of the underlying debt instruments. Our fixed and variable rate debt as of December 31, 2007 is shown in the following table:

	As of December 31, 2007			
	Carrying Amount	% of Total	Estimated Fair Value	% of Total
	(In Millions)			
Fixed Rate Debt	$ 604.7	31.5%	$ 624.6	32.8%
Variable Rate Debt	1,312.8	68.5%	1,277.7	67.2%
Total long-term debt	$ 1,917.5	100.0%	$ 1,902.3	100.0%

As discussed in more detail in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, in March 2006, we entered into an interest rate swap to effectively convert the floating rate of a portion of our Credit Agreement to a fixed rate in order to limit our exposure to variability in interest payments caused by changes in LIBOR. Under the interest rate swap agreement, we pay a fixed rate of 5.2% on $1.1 billion of variable rate debt, while the counterparties to the interest rate swap agreement pay a floating rate based on 3-month LIBOR. As of December 31, 2007, the fair market value of our interest rate swap approximated ($43.2) million.

Per the underlying swap agreement, the notional amount of our interest rate swap was scheduled to be reduced from $1.9 billion to $1.1 billion in March 2008. However, during 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions, as well as the majority of the federal income tax refunds received from the Internal Revenue Service (See Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) to reduce debt outstanding under our Credit Agreement. Due to these pre-payments, as well as current market conditions, we decreased the notional amount of our interest rate swap to $1.1 billion in October 2007. Fees associated with this transaction were not material to our results of operations, financial position, or cash flows.

Based on the variable rate of our debt as of December 31, 2007 and inclusive of the impact of the conversion of $1.1 billion of variable rate interest to a fixed rate via an interest rate swap, as discussed above, a 1% increase in interest rates would result in an additional $1.9 million in interest expense per year, while a 1% decrease in interest rates would reduce interest expense by $1.9 million per year. A 1% increase in interest rates would result in an approximate $28.6 million decrease in the estimated net fair value of our fixed rate debt, and a 1% decrease in interest rates would result in an approximate $30.3 million increase in its estimated net fair value.

If LIBOR continues to decrease as it has early in 2008, our interest payments will decrease. However, the vast majority of these reduced interest payments will be offset by net settlement payments on our interest rate swap, which are included in the line item *Loss on interest rate swap* in our consolidated statements of operations.

Foreign operations, and the related market risks associated with foreign currencies, are currently, and have been, insignificant to our financial position, results of operations, and cash flows.

Item 8. Financial Statements and Supplementary Data

Our consolidated financial statements and related notes are filed together with this report. See the index to financial statements on page F-1 for a list of financial statements filed with this report.

Item 9. Changes in and Disagreements with Accountants and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, an evaluation was carried out by our management, including our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the Exchange Act). Our disclosure controls and procedures are designed to ensure that information required to be disclosed in reports we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2007, our disclosure controls and procedures were effective.

Management s Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States of America (GAAP). Internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company s assets that could have a material effect on its financial statements. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2007. In making this assessment, management used the criteria set forth in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission, the COSO framework. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2007, our internal control over financial reporting was effective.

The effectiveness of the Company s internal control over financial reporting as of December 31, 2007 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears herein.

Changes in Internal Control Over Financial Reporting

As of December 31, 2006, management identified a material weakness in its accounting for income taxes that was remediated as of December 31, 2007. Specifically, during the fourth quarter of 2007, the Company

implemented controls to review and monitor the accuracy of the components of the income tax provision calculations and related deferred income taxes and income taxes receivable, and to monitor the differences between the income tax basis and the financial reporting basis of assets and liabilities to reconcile the deferred income tax balances.

Item 9B. Other Information

In September 2007, the base term of the employment agreement for John L. Workman, Executive Vice President and Chief Financial Officer of the Company, expired. HealthSouth and Mr. Workman entered into an employment arrangement intended to be in place through December 2010, whereby the Company granted Mr. Workman 5,386 shares of performance-based restricted stock as of December 20, 2007. The restricted stock will vest September 20, 2010, provided (1) Mr. Workman is employed by the Company on such date, and (2) the Company s stock has reached a closing price of $24.00 per share for a period of at least 20 consecutive days during the term of the restrictions. Mr. Workman s annual salary under this arrangement is subject to review and adjustment on an annual basis. He is also eligible to participate in the Company s executive change-in-control and severance plans.

Additionally, in consideration of their efforts with, and success in, completing the Company s divestitures, restricted stock was awarded to Jay Grinney, Chief Executive Officer, John P. Whittington, Executive Vice President, Secretary, and General Counsel, and Mr. Workman in the amounts of 46,833 shares, 19,710 shares, and 22,363 shares, respectively, as closing bonuses in 2007. These shares will vest in their entirety on the first anniversary of those awards, provided those individuals continue to be employed by HealthSouth. These closing bonuses were one-time-only, transaction-specific awards that are not part of these officers ongoing direct compensation.

PART III

We expect to file a definitive proxy statement relating to our 2008 Annual Meeting of Stockholders (the 2008 Proxy Statement) with the United States Securities and Exchange Commission, pursuant to Regulation 14A, not later than 120 days after the end of our most recent fiscal year. Accordingly, certain information required by Part III has been omitted under General Instruction G(3) to Form 10-K. Only those sections of the 2008 Proxy Statement that specifically address disclosure requirements of Items 10-14 below are incorporated by reference.

Item 10. Directors and Executive Officers of the Registrant

The information required by Item 10 is hereby incorporated by reference from our 2008 Proxy Statement under the captions Proposal 1 Election of Directors, Corporate Governance and Board Structure, Certain Relationships and Related Transactions, Security Ownership of Certain Beneficial Owners and Management, Executive Officers, and Code of Ethics.

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2008 Proxy Statement under the captions Executive Compensation and Compensation of Directors.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information required by Item 12 is hereby incorporated by reference from our 2008 Proxy Statement under the caption Security Ownership of Certain Beneficial Owners and Management.

Item 13. Certain Relationships and Related Transactions

The information required by Item 13 is hereby incorporated by reference from our 2008 Proxy Statement under the caption Certain Relationships and Related Transactions.

Item 14. Principal Accountant Fees and Services

The information required by Item 14 is hereby incorporated by reference from our 2008 Proxy Statement under the caption Principal Accountant Fees and Services.

PART IV

Item 15. Exhibits and Financial Statement Schedules
Financial Statements

See the accompanying index on page F-1 for a list of financial statements filed as part of this report.

Financial Statement Schedules

None.

Exhibits

The exhibits required by Regulation S-K are set forth in the following list and are file by attachment to this annual report unless otherwise noted.

No.	Description
2.1	Stock Purchase Agreement, dated January 27, 2007, by and between HealthSouth Corporation and Select Medical Systems (incorporated by reference to Exhibit 2.1 to HealthSouth s Current Report on Form 8-K filed on January 30, 2007).
2.2	Letter Agreement, dated May 1, 2007 by and between HealthSouth Corporation and Select Medical Corporation (incorporated by reference to Exhibit 2.3 to HealthSouth s Quarterly Report on 10-Q filed on May 9, 2007).
2.3	Amended and Restated Stock Purchase Agreement dated as of March 25, 2007, by and between HealthSouth Corporation and ASC Acquisition LLC (incorporated by reference to Exhibit 2.1 to HealthSouth s Quarterly Report on 10-Q filed on August 8, 2007).
2.4	Stock Purchase Agreement, dated April 19, 2007, by and between HealthSouth Corporation and Diagnostic Health Holdings, Inc.
3.1	Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on May 21, 1998.*
3.2	Certificate of Amendment to the Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on October 25, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth s Current Report on Form 8-K filed on October 31, 2006).
3.3	Amended and Restated By-Laws of HealthSouth Corporation, effective as of September 21, 2006, as amended on February 28, 2007 and November 1, 2007 (incorporated by reference to Exhibit 3.3 to HealthSouth s Quarterly Report on Form 10-Q filed on November 6, 2007).
3.4	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth s Current Report on Form 8-K filed on March 9, 2006).
4.1	Indenture, dated as of June 14, 2006, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to $375,000,000 aggregate principal amount of Floating Rate Senior Notes due 2014 (incorporated by reference to Exhibit 4.1 to HealthSouth s Current Report on Form 8-K filed on June 16, 2006).

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4.2	Indenture, dated as of June 14, 2006, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to $625,000,000 aggregate principal amount of 10.75% Senior Notes due 2016 (incorporated by reference to Exhibit 4.2 to HealthSouth s Current Report on Form 8-K filed on June 16, 2006).
4.3	Registration Rights Agreement, dated as of June 14, 2006, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and the Initial Purchasers (as defined therein), relating to the $625,000,000 aggregate principal amount of 10.75% Senior Notes due 2016 and the $375,000,000 aggregate principal amount of Floating Rate Senior Notes due 2014 (incorporated by reference to Exhibit 4.3 to HealthSouth s Current Report on Form 8-K filed on June 16, 2006).
4.4.1	Indenture, dated as of June 22, 1998, between HealthSouth Corporation and PNC Bank, National Association, as trustee, relating to HealthSouth s 6.875% Senior Notes due 2005 and 7.0% Senior Notes due 2008.*
4.4.2	Officer s Certificate pursuant to Sections 2.3 and 11.5 of the Indenture, dated as of June 22, 1998, between HealthSouth Corporation and PNC Bank, National Association, as trustee, relating to HealthSouth s 6.875% Senior Notes due 2005 and 7.0% Senior Notes due 2008.*
4.4.3	Instrument of Resignation, Appointment and Acceptance, dated as of April 9, 2003, among HealthSouth Corporation, J.P. Morgan Trust Company, National Association (successor in interest to PNC Bank, National Association), as resigning trustee, and Wilmington Trust Company, as successor trustee, relating to HealthSouth s 6.875% Senior Notes due 2005 and 7.0% Senior Notes due 2008.*
4.4.4	First Supplemental Indenture, dated as of June 24, 2004, to the Indenture, dated as of June 22, 1998, between HealthSouth Corporation and Wilmington Trust Company, as successor trustee to J.P. Morgan Trust Company, National Association (successor in interest to PNC Bank, National Association), relating to HealthSouth s 7.0% Senior Notes due 2008 (incorporated by reference to Exhibit 99.3 to HealthSouth s Current Report on Form 8-K filed on June 25, 2004).
4.4.5	Second Supplemental Indenture, dated as of February 15, 2006, to the Indenture, dated as of June 22, 1998, between HealthSouth Corporation and Wilmington Trust Company, as successor trustee to J.P. Morgan Trust Company, National Association (successor in interest to PNC Bank, National Association), relating to HealthSouth s 7.0% Senior Notes due 2008 (incorporated by reference to Exhibit 4.3 to HealthSouth s Current Report on Form 8-K filed on February 17, 2006).
4.5.1	Indenture, dated as of September 25, 2000, between HealthSouth Corporation and The Bank of New York, as trustee, relating to HealthSouth s 10.750% Senior Subordinated Notes due 2008.*
4.5.2	Instrument of Resignation, Appointment and Acceptance, dated as of May 8, 2003, among HealthSouth Corporation, The Bank of New York, as resigning trustee, and HSBC Bank USA, as successor trustee, relating to HealthSouth s 10.750% Senior Subordinated Notes due 2008.*
4.5.3	Amendment to Indenture, dated as of August 27, 2003, to the Indenture dated as of September 25, 2000 between HealthSouth Corporation and HSBC Bank USA, as successor trustee to The Bank of New York, relating to HealthSouth s 10.750% Senior Subordinated Notes due 2008.*
4.5.4	Second Supplemental Indenture, dated as of May 14, 2004, to the Indenture dated as of September 25, 2000 between HealthSouth Corporation and HSBC Bank USA, as successor trustee to The Bank of New York, relating to HealthSouth s 10.750% Senior Subordinated Notes due 2008 (incorporated by reference to Exhibit 99.2 to HealthSouth s Current Report on Form 8-K filed on May 24, 2004).
4.5.5	Third Supplemental Indenture, dated as of February 15, 2006, to the Indenture dated as of September 25, 2000 between HealthSouth Corporation and HSBC Bank USA, as successor trustee to The Bank of New York, relating to HealthSouth s 10.750% Senior Subordinated Notes due 2008 (incorporated by reference to Exhibit 4.4 to HealthSouth s Current Report on Form 8-K filed on February 17, 2006).

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4.6.1	Indenture, dated as of February 1, 2001, between HealthSouth Corporation and The Bank of New York, as trustee, relating to HealthSouth s 8.500% Senior Notes due 2008.*
4.6.2	Amendment to Indenture, dated as of August 27, 2003, to the Indenture dated as of February 1, 2001 between HealthSouth Corporation and The Bank of New York, as trustee, relating to HealthSouth s 8.500% Senior Notes due 2008.*
4.6.3	Second Supplemental Indenture, dated as of May 14, 2004, to the Indenture dated as of February 1, 2001 between HealthSouth Corporation and The Bank of New York, as trustee, relating to HealthSouth s 8.500% Senior Notes due 2008 (incorporated by reference to Exhibit 99.1 to HealthSouth s Current Report on Form 8-K filed on May 24, 2004).
4.6.4	Third Supplemental Indenture, dated as of February 15, 2006, to the Indenture dated as of February 1, 2001 between HealthSouth Corporation and The Bank of New York, as trustee, relating to HealthSouth s 8.500% Senior Notes due 2008 (incorporated by reference to Exhibit 4.1 to HealthSouth s Current Report on Form 8-K filed on February 17, 2006).
4.7.1	Indenture, dated as of September 28, 2001, between HealthSouth Corporation and National City Bank, as trustee, relating to HealthSouth s 7.375% Senior Notes due 2006 and 8.375% Senior Notes due 2011.*
4.7.2	Instrument of Resignation, Appointment and Acceptance, dated as of April 9, 2003, among HealthSouth Corporation, National City Bank, as resigning trustee, and Wilmington Trust Company, as successor trustee, relating to HealthSouth s 7.375% Senior Notes due 2006 and 8.375% Senior Notes due 2011.*
4.7.3	Amendment to Indenture, dated as of August 27, 2003, to the Indenture dated as of September 28, 2001 between HealthSouth Corporation and Wilmington Trust Company, as successor trustee to National City Bank, relating to HealthSouth s 7.375% Senior Notes due 2006 and 8.375% Senior Notes due 2011.*
4.7.4	Second Supplemental Indenture, dated as of June 24, 2004, to the Indenture, dated as of September 28, 2001, between HealthSouth Corporation and Wilmington Trust Company, as successor trustee to National City Bank, relating to HealthSouth s 8.375% Senior Notes due 2011 (incorporated by reference to Exhibit 99.4 to HealthSouth s Current Report on Form 8-K filed on June 25, 2004).
4.7.5	Third Supplemental Indenture, dated as of February 15, 2006, to the Indenture, dated as of September 28, 2001, between HealthSouth Corporation and Wilmington Trust Company, as successor trustee to National City Bank, relating to HealthSouth s 8.375% Senior Notes due 2011 (incorporated by reference to Exhibit 4.6 to HealthSouth s Current Report on Form 8-K filed on February 17, 2006).
4.8.1	Indenture, dated as of May 22, 2002, between HealthSouth Corporation and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to HealthSouth s 7.625% Senior Notes due 2012.*
4.8.2	Amendment to Indenture, dated as of August 27, 2003, to the Indenture dated as of May 22, 2002 between HealthSouth Corporation and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to HealthSouth s 7.625% Senior Notes due 2012.*
4.8.3	First Supplemental Indenture, dated as of June 24, 2004, to the Indenture dated as of May 22, 2002 between HealthSouth Corporation and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to HealthSouth s 7.625% Senior Notes due 2012 (incorporated by reference to Exhibit 99.5 to HealthSouth s Current Report on Form 8-K filed on June 25, 2004).

4.8.4	Second Supplemental Indenture, dated as of February 15, 2006, to the Indenture dated as of May 22, 2002 between HealthSouth Corporation and The Bank of Nova Scotia Trust Company of New York, as trustee, relating to HealthSouth s 7.625% Senior Notes due 2012 (incorporated by reference to Exhibit 4.5 to HealthSouth s Current Report on Form 8-K filed on February 17, 2006).
4.9	Registration Rights Agreement, dated February 28, 2006, between HealthSouth and the purchasers party to the Securities Purchase Agreement, dated February 28, 2006, re: HealthSouth s sale of 400,000 shares of 6.50% Series A Convertible Perpetual Preferred Stock.**
10.1	Stipulation of Partial Settlement dated as of September 26, 2006, by and among HealthSouth Corporation, the stockholder lead plaintiffs named therein, the bondholder lead plaintiff named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.1 to HealthSouth s Current Report on Form 8-K filed on September 27, 2006).
10.2	Settlement Agreement and Policy Release dated as of September 25, 2006, by and among HealthSouth Corporation, the settling individual defendants named therein and the settling carriers named therein (incorporated by reference to Exhibit 10.2 to HealthSouth s Current Report on Form 8-K filed on September 27, 2006).
10.3	Stipulation of Settlement with Certain Individual Defendants dated as of September 25, 2006, by and among HealthSouth Corporation, plaintiffs named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.3 to HealthSouth s Current Report on Form 8-K filed on September 27, 2006).
10.4	HealthSouth Corporation Transitional Severance Plan Executive Employees (incorporated by reference to Exhibit 10.1 to HealthSouth s Current Report on Form 8-K filed on October 24, 2006). +
10.5	HealthSouth Corporation Transitional Severance Plan Corporate Office Employees (incorporated by reference to Exhibit 10.2 to HealthSouth s Current Report on Form 8-K filed on October 24, 2006). +
10.6	Non-Prosecution Agreement, dated May 17, 2006, between HealthSouth and the United States Department of Justice (incorporated by reference to Exhibit 10.2 to HealthSouth s Quarterly Report on Form 10-Q filed on August 14, 2006).
10.7	