HEALTHSOUTH CORP
Form 10-K/A
March 22, 2007
UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K/A

Amendment No. 1

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)**
OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2006

OR

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

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)**

Registrant s telephone number, including area code **(205) 967-7116**

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, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act.

Large accelerated filer x Accelerated filer o Non-Accelerated filer 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 $1.4 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 78,684,549 shares of common stock of the registrant outstanding, net of treasury shares, as of February 15, 2007.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant s 2007 Annual Meeting of Stockholders is incorporated by reference in Part III to the extent described therein.

EXPLANATORY NOTE

HealthSouth Corporation is filing this Amendment No. 1 on Form 10-K/A to its Annual Report on Form 10-K for the fiscal year ended December 31, 2006 for the purpose of (1) amending Item 7 to correct figures included in the line entitled Interest on long-term debt in the consolidated contractual obligations table included in the section entitled Contractual Obligations (this change is reflected on page 47 of this Form 10-K/A) and (2) updating Exhibit 12 *Computation of Ratios* to include amounts for the interest portion of rental expense and interest costs associated with discontinued operations. No other changes are being made to the original Form 10-K filing other than updating of the Exhibits to include updated Certifications of the Chief Executive and Chief Financial Officers in accordance with Rule 13a-14(a).

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PART II

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. The discussion also provides information about the financial results of the various segments of our business to provide a better understanding of how those segments and their results affect the financial condition and results of operations of HealthSouth as a whole.

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 detail in Item 1, *Business*, 2006 was a year in which we put many of the legal, financial and operational rocks in the road behind us and began implementing our plan to reposition the company as a pure play provider of post-acute health care services for the future, with an immediate focus on rehabilitative health care. In 2006:

- We announced our intent to seek strategic alternatives for our surgery centers and outpatient divisions, along with our diagnostic division (previously designated as non-core), and to use the net proceeds from any disposition of those divisions to pay down debt. On January 29, 2007, we announced that we had entered into a Stock Purchase Agreement with Select Medical Corporation (Select Medical) to sell our outpatient division, marking the first step in our repositioning and deleveraging plan.
- We prepaid substantially all of our previously existing indebtedness with proceeds from a series of recapitalization transactions and replaced it with approximately $3.0 billion of new long-term debt, which we believe will produce enhanced operational flexibility, reduced refinancing risk, and an improved credit profile. See this Item, Liquidity and Capital Resources, and Note 9*Long-term Debt*, to our accompanying consolidated financial statements.
- We received final court approval of our settlement with the lead plaintiffs in the federal securities class actions and the derivative litigation, as well as with our insurance carriers, concluding the last of the major litigation pending against us. See Note 24, *Securities Litigation Settlement*, to our accompanying consolidated financial statements.
- We reached a non-prosecution agreement with the United States Department of Justice (the DOJ) with respect to the accounting fraud committed by members of our former management.
- We remediated numerous internal control deficiencies.
- We recruited the remaining members of our senior management team, including senior vice presidents for development, payor contracting, and supply chain management.
- Our common stock was relisted on the New York Stock Exchange.

We continue to face operational challenges, but we believe our accomplishments in 2006 have positioned us to capitalize on our core competencies and move forward with implementing our repositioning and deleveraging plan.

Our Business

Our business is currently divided into four primary operating divisions inpatient, surgery centers, outpatient, and diagnostic and a fifth division that manages certain other revenue producing activities and corporate functions.

These five divisions correspond to our five reporting segments discussed later in this Item and throughout this report.

Inpatient. Our inpatient division, which represented 58% of 2006 *Net operating revenues* and 79% of 2006 operating earnings from our four primary operating divisions, provides treatment at (as of December 31, 2006) 92 freestanding inpatient rehabilitation facilities (IRFs), 10 long-term acute care hospitals (LTCHs), and 81 outpatient facilities located within or near our IRFs. In addition to the facilities in which we have an ownership interest, our inpatient division operated 11 inpatient rehabilitation units, 3 outpatient facilities, and 2 gamma knife radiosurgery centers through management contracts as of December 31, 2006. This division continues to be the market leader in inpatient rehabilitation services in terms of revenues, number of IRFs, and patients treated. Between 2005 and 2006, *Net operating revenues* and operating earnings declined slightly due to the continued phase-in of the 75% Rule. We anticipate increasing volumes in many of our inpatient facilities through the first three quarters of 2007 because most of our IRFs currently operate at, and have maintained since 2006, the 60% minimum qualifying patient mix threshold under the 75% Rule. In the fourth quarter of 2007, as most of our IRFs approach a new cost reporting year, we anticipate declining volumes as we work to achieve compliance with the 65% threshold. We are actively engaged with other health care providers to modify this rule and ensure Medicare recipients receive appropriate care in an appropriate environment.

Surgery Centers. Our surgery centers division, which is our second largest division in terms of *Net operating revenues*, operates (as of December 31, 2006) 144 freestanding ambulatory surgery centers (ASCs) and 3 surgical hospitals. In 2006, our focus within our surgery centers division was on resyndication activities in existing centers, portfolio rationalization, and operational improvements. During the latter part of 2006, we began to see margin expansion through improved revenues and expense management initiatives, including the standardization of non-physician preference items. However, this margin expansion was negatively impacted by an increase in minority interests from our resyndication efforts. We believe, however, that our resyndication efforts helped stabilize our portfolio of surgery centers and will add value to the division over time. Our surgery centers division s *Net operating revenues* declined slightly from 2005 to 2006, resulting primarily from certain consolidated affiliates that became equity method affiliates as a result of changes in ownership and facility closures that did not qualify as discontinued operations. However, operating earnings increased over that same period as a result of improved cost control, better pricing, and increased volumes at certain facilities. We expect this division to benefit as outpatient procedures continue to migrate to the more efficient ASC environment. However, potential benefits from industry growth may be offset by physician partners who are demanding a higher ownership interest in our partnerships, thereby lowering our share of partnership earnings.

Outpatient. Our outpatient division currently provides outpatient therapy services (as of December 31, 2006) at 582 facilities. This division s performance declined between 2005 and 2006 due primarily to continued volume declines resulting from competition from physician-owned physical therapy sites and Medicare therapy caps, as discussed below. On January 29, 2007, we announced that we have entered into a definitive agreement with Select Medical, a privately owned operator of specialty hospital and outpatient rehabilitation facilities, to sell our outpatient division for approximately $245 million in cash, subject to certain adjustments. The closing is anticipated to occur on or before April 30, 2007, and is subject to customary closing conditions, including regulatory approval. See Note 3, *Subsequent Event Divestiture*, to our accompanying consolidated financial statements for additional information regarding this disposition.

Diagnostic. Our diagnostic division operates (as of December 31, 2006) 61 diagnostic imaging centers. This division has struggled over the past several years due to poor margins for the diagnostic market in general, strong competition from physician-owned diagnostic equipment, increased pricing pressure from payors, and the age of equipment in our installed base. Competition in 2006 remained strong as diagnostic equipment manufacturers continued to lower prices and offer special financing to encourage physicians to purchase equipment through their own practices, resulting in a decline in the number of procedures performed at our diagnostic centers. In 2006, the division completed the implementation of a new enterprise software platform that provides enhanced administrative, clinical, and revenue cycle functionality. We believe the implementation of this software will assist the segment in increasing referral volume, as well as improve the segment s collection activities at a reduced cost. While these actions should result in improvement in the segment s operating results going forward, our operating performance during 2006 was negatively impacted by the nonrecurring costs associated with these changes.

We believe the aging of the U.S. population, changes in technology, and the continuing growth in health care spending will increase demand for the types of services we provide. First, many of the health conditions associated with aging like stroke and heart attacks, neurological disorders, and diseases and injuries to the muscles, bones, and joints will increase the demand for ambulatory surgery and rehabilitative services. Second, pressure from payors to provide efficient, high-quality health care services is forcing many procedures traditionally performed in acute care hospitals out of the acute care environment. We believe these market factors align with our strengths and our planned focus on post-acute care services.

Key Challenges

Although our business is continuing to generate substantial revenues, and market factors appear to favor our outpatient and post-acute care business model, we still have several immediate internal and external challenges to overcome before we can realize significant improvements in our business, including:

Divestitures. Our attempt to seek strategic alternatives for three of our four operating divisions necessarily creates new operational challenges for us such as retaining key employees, combating uncertainty in our workforce, and continuing to provide necessary corporate support and other services to each division during this transition period. These issues will pose challenges for us in 2007.

Single-Payor Exposure. Medicare comprises approximately 47% of our consolidated *Net operating revenues* and approximately 70% of our largest division s revenues. Consequently, single-payor exposure presents a serious risk. In particular, as discussed in Item 1, *Business*, Sources of Revenues, changes to the 75% Rule and pricing pressure have combined to create a very challenging operating environment for our inpatient division. The volume volatility created by the 75% Rule has had a significantly negative impact on our inpatient division s *Net operating revenues* in 2006. Thus far, we have been able to partially mitigate the impact of the 75% Rule on our inpatient division s operating earnings by implementing the mitigation strategies discussed in Item 1, *Business*, Inpatient Division. However, the combination of volume volatility created by the 75% Rule and pricing pressure resulting from changes to the prospective payment system applicable to IRFs (IRF-PPS) reduced our operating earnings in 2006. Because we receive a significant percentage of our revenues from our inpatient division, and because our inpatient division receives a significant percentage of its revenues from Medicare, our inability to achieve continued compliance with or continue to mitigate the negative effects of the 75% Rule could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Leverage. Although we have completed a series of recapitalization transactions that have eliminated significant uncertainty regarding our capital structure and have improved our financial position, we remain highly leveraged. Our high leverage increases our cost of capital and decreases our net income. If we are unable to divest our surgery centers, outpatient, and diagnostic divisions as planned through a spin-off, sale, or other transaction, and use the net proceeds from those transactions to pay down debt, we may be unable to take advantage of growth and consolidation opportunities in the inpatient rehabilitation industry.

Settlement Costs. We have significant cash obligations we must meet in the near future as a result of settlements with various federal agencies. Specifically, we will pay the remaining balance of our $325 million settlement to the United States in quarterly installments ending in the fourth quarter of 2007 to satisfy our obligations under a settlement described in Note 22, *Medicare Program Settlement*, to our accompanying consolidated financial statements. Furthermore, we will pay the remaining balance of our $100 million settlement to the United States Securities and Exchange Commission (the SEC) in four installments ending in the fourth quarter of 2007, as described in Note 23, *SEC Settlement*, to our accompanying consolidated financial statements. Our final payments in 2007 due under these settlement agreements are $86.7 million for the Medicare Program Settlement and $50.0 million for the SEC Settlement.

Consolidated Results of Operations

HealthSouth is the largest provider of rehabilitative health care and ambulatory surgery services in the United States, with 978 facilities and approximately 33,000 full- and part-time employees. We provide these services

through a national network of inpatient and outpatient rehabilitation facilities, outpatient surgery centers, diagnostic centers, and other health care facilities.

During 2006, 2005, and 2004, we derived consolidated *Net operating revenues* from the following payor sources:

	For the year ended December 31,		
	2006	**2005**	**2004**
Medicare	47.4%	47.7%	48.0%
Medicaid	2.3%	2.4%	2.5%
Workers' compensation	6.8%	7.5%	8.1%
Managed care and other discount plans	34.8%	33.3%	31.5%
Other third-party payors	4.7%	4.9%	4.9%
Patients	1.4%	1.8%	2.9%
Other income	2.6%	2.4%	2.1%
Total	100.0%	100.0%	100.0%

We provide our patient care services through four primary operating divisions and certain other services through a fifth division. These five divisions correspond to our five reporting segments discussed in this Item, Segment Results of Operations, and throughout this report.

When reading our consolidated statements of operations, it is important to recognize the following items included within our results of operations:

Stock-Based Compensation. During 2006, stock-based compensation increased by approximately $12.1 million due to our adoption of Financial Accounting Standards Board (FASB) Statement No. 123(R), *Share-Based Payment*, on January 1, 2006. These increased costs are included in *Salaries and benefits* in our 2006 consolidated statement of operations.

Restructuring charges. In our continuing efforts to streamline operations, we closed underperforming facilities or consolidated similar facilities within the same market in 2006, 2005, and 2004. As a result of these facility closures or consolidations, we recorded certain restructuring charges approximating $5.1 million, $8.1 million, and $4.0 million in 2006, 2005, and 2004, respectively, for one-time termination benefits and contract termination costs under the guidance in FASB Statement No. 146, *Accounting for Costs Associated with Exit or Disposal Activities*. The majority of these costs represent contract termination costs associated with leased facilities and are included in *Occupancy costs* in our consolidated statements of operations. See Note 11, *Restructuring Charges*, to our accompanying consolidated financial statements for additional information.

Changes in ownership of certain inpatient rehabilitation facilities. As discussed in this Item, Segment Results of Operations Inpatient, and Note 2 *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 facilities and placed us as the manager, rather than the owner, of these two facilities. Accordingly, our results of operations include only the $4.0 million and $5.4 million management fee we earned for operating these facilities on behalf of the landlord during the nine months ended September 30, 2006 and the year ended December 31, 2005, respectively. In 2004, the results of operations of these two facilities 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, in 2005, as a result of the change in ownership of these two facilities. In September 2006, we completed the transition of these two facilities to the landlord.

The lease associated with the Braintree and Woburn facilities was for a period of ten years with rent obligations of approximately $8.7 million per year, which included additional payments relating to rent payable for a group of nursing home facilities owned by the owner of the Braintree and Woburn facilities that HealthSouth had sold but remained liable for as a guarantor. We accounted for the rent on the

Braintree and Woburn facilities as rent expense in our inpatient segment. However, the rent expense paid above the negotiated rent for these facilities was recorded as an obligation of our corporate and other segment. As a result of the lease termination associated with the Braintree and Woburn facilities, our corporate and other segment recorded a $30.5 million net gain on lease termination during 2005. This net gain is included in *Occupancy costs* in our consolidated statement of operations and represents the difference between the $42 million liability that remained under the lease when the lease was terminated and the remaining liability on the date the judgment was entered against us in 2005.

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, *Related Party Transactions*, and Note 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements for additional information regarding Meadowbrook.

Recovery of amounts due from Richard M. Scrushy. On January 3, 2006, the Alabama Circuit Court in the *Tucker* action (as defined in Note 25, *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 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 as *Interest income*. As of December 31, 2006, we have an approximate $4.9 million receivable related to this award included in *Other current assets* in our consolidated balance sheet.

Amounts owed to derivative plaintiffs attorneys. 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 24, *Securities Litigation Settlement*, and as discussed in Note 25, *Contingencies and Other Commitments*). Under this agreement, we agreed to pay the derivative plaintiffs attorneys $32.5 million on an aggregate basis for both claims. We will pay this amount primarily from cash and other properties received from Mr. Scrushy in the above referenced award. As of December 31, 2006, we owed approximately $21.0 million to the derivative plaintiffs attorneys, which is included in *Other current liabilities* in our consolidated balance sheet.

Impairments. During 2006, we recorded an impairment charge of approximately $15.2 million to reduce the carrying value of certain long-lived and intangible assets of certain operating facilities to their estimated fair market value. During 2005, we recorded an impairment charge of approximately $43.3 million to reduce the carrying value of long-lived assets to their estimated fair market value. During 2004, we recorded an impairment charge of approximately $36.5 million to reduce the carrying value of property and equipment and amortizable intangibles of certain operating facilities to their estimated fair market value. These charges are discussed in more detail in this Item, Segment Results of Operations, and Note 6, *Property and Equipment*, to our accompanying consolidated financial statements.

Government, class action, and related settlements expense. Our *Net loss* for 2006 includes a $1.0 million charge related to our Employee Retirement Income Security Act of 1974 (ERISA) litigation, a $5.7 million charge to settle disputes related to our former Braintree and Woburn facilities, and a $1.9 million charge related to the Goodreau litigation in *Government, class action, and related settlements expense*. *Government, class action, and related settlements expense* for 2006 also includes a charge of

approximately $47.9 million, a portion of which will not require a cash outflow, related to ongoing settlement negotiations with our subsidiary partnerships related to the restatement of their historical financial statements. *Government, class action, and related settlements expense* for 2006 also includes 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. Our *Net loss* for 2006 also includes a $3.0 million charge in *Government, class action, and related settlements expense* 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 DOJ. These expenses for 2006 also include charges of approximately $6.5 million for certain settlements and other ongoing settlement negotiations.

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 expense* 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. This reduction in 2006 is included in *Government, class action, and related settlements expense* 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 24, *Securities Litigation Settlement*, and Note 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Professional fees accounting, tax, and legal. As noted in this filing, 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 2006, *Professional fees accounting, tax, and legal* approximated $163.6 million and related primarily 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 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements. During 2005, *Professional fees accounting, tax, and legal* approximated $169.8 million and related primarily to the preparation of our comprehensive Form 10-K for the years ended December 31, 2003 and 2002, including the restatement of our previously issued 2001 and 2000 consolidated financial statements, as well as professional services to support the preparation of our Form 10-K for the year ended December 31, 2004. During 2004, *Professional fees accounting, tax, and legal* approximated $206.2 million and 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. These fees in 2004 also included professional services associated with the reconstruction and restatement of our previously issued consolidated financial statements.

Loss on early extinguishment of debt. 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.

On June 14, 2006, we completed a private offering of $1.0 billion aggregate principal amount of senior notes, the proceeds of which, together with cash on hand, were used to repay all borrowings outstanding under our Interim Loan Agreement (as defined in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements). As a result of this transaction, our net loss on early extinguishment of

debt for 2006 includes a charge of approximately $4.1 million. On March 10, 2006, we completed the last of a series of recapitalization transactions enabling us to prepay substantially all of our prior indebtedness and replace it with approximately $3 billion of new long-term debt. As a result of these transactions, our net loss on early extinguishment of debt for 2006 includes a charge of approximately $361.1 million. The remainder of our net loss on early extinguishment of debt for 2006 was due to the repayment of certain bonds payable during the second quarter of 2006.

For more information regarding these transactions, see Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

Loss on interest rate swap. As discussed in more detail in Note 9, *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 2006, we recorded a net loss of approximately $10.5 million related to the mark-to-market adjustments, quarterly settlements, and accrued interest recorded for the swap. During 2006, we made approximately $0.6 million in net cash settlement payments to our counterparties.

Reclassifications. Certain previously reported financial results have been reclassified to conform to the current year presentation. Such reclassifications relate to facilities we closed or sold in 2006 that qualify under FASB Statement No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, to be reported as discontinued operations. We also reclassified rent associated with leased facilities, including common area maintenance and similar charges, from *Other operating expenses* into *Occupancy costs* in our consolidated statements of operations.

From 2004 through 2006, our consolidated results of operations were as follows:

	For the year ended December 31,			Percentage Change	
	2006	2005	2004	2006 vs. 2005	2005 vs. 2004
		(In Millions)			
Net operating revenues	$3,000.1	$3,117.0	$3,409.7	(3.8%)	(8.6%)
Operating expenses:					
Salaries and benefits	1,398.4	1,386.1	1,571.8	0.9%	(11.8%)
Professional and medical director fees	72.0	71.6	72.3	0.6%	(1.0%)
Supplies	287.8	294.2	318.2	(2.2%)	(7.5%)
Other operating expenses	457.2	540.4	428.2	(15.4%)	26.2%
Provision for doubtful accounts	119.3	94.3	109.6	26.5%	(14.0%)
Depreciation and amortization	148.2	162.6	172.2	(8.9%)	(5.6%)
Occupancy costs	141.4	113.1	152.4	25.0%	(25.8%)
Recovery of amounts due from Richard M. Scrushy	(47.8)			N/A	N/A
Recovery of amounts due from Meadowbrook		(37.9)		(100.0%)	N/A
(Gain) loss on disposal of assets	(4.5)	16.6	10.2	(127.1%)	62.7%
Impairment of intangible and long-lived assets	15.2	43.3	36.5	(64.9%)	18.6%
Government, class action, and related settlements expense	38.8	215.0		(82.0%)	N/A
Professional fees accounting, tax, and legal	163.6	169.8	206.2	(3.7%)	(17.7%)
Total operating expenses	2,789.6	3,069.1	3,077.6	(9.1%)	(0.3%)
Loss on early extinguishment of debt	365.6			N/A	N/A
Interest expense and amortization of debt discounts and fees	335.1	337.5	301.4	(0.7%)	12.0%
Interest income	(15.7)	(17.1)	(13.1)	(8.2%)	30.5%
Loss (gain) on sale of investments	1.9	0.1	(4.0)	1,800.0%	(102.5%)
Loss on interest rate swap	10.5			N/A	N/A
Equity in net income of nonconsolidated Affiliates	(21.3)	(29.4)	(9.9)	(27.6%)	197.0%
Minority interests in earnings of consolidated affiliates	92.3	97.2	95.0	(5.0%)	2.3%
Loss from continuing operations before income tax expense	(557.9)	(340.4)	(37.3)	63.9%	812.6%
Provision for income tax expense	41.1	38.4	11.9	7.0%	222.7%
Loss from continuing operations	(599.0)	(378.8)	(49.2)	58.1%	669.9%
Loss from discontinued operations, net of income tax expense	(26.0)	(67.2)	(125.3)	(61.3%)	(46.4%)
Net loss	(625.0)	(446.0)	(174.5)	40.1%	155.6%

Operating Expenses as a % of Net Operating Revenues

	For the year ended December 31,		
	2006	**2005**	**2004**
Salaries and benefits	46.6%	44.5%	46.1%
Professional and medical director fees	2.4%	2.3%	2.1%
Supplies	9.6%	9.4%	9.3%
Other operating expenses	15.2%	17.3%	12.6%
Provision for doubtful accounts	4.0%	3.0%	3.2%
Depreciation and amortization	4.9%	5.2%	5.1%
Occupancy costs	4.7%	3.6%	4.5%
Recovery of amounts due from Richard M. Scrushy	(1.6%)	0.0%	0.0%
Recovery of amounts due from Meadowbrook	0.0%	(1.2%)	0.0%
(Gain) loss on disposal of assets	(0.1%)	0.5%	0.3%
Impairment of intangible assets and long-lived assets	0.5%	1.4%	1.1%
Government, class action, and related settlements expense	1.3%	6.9%	0.0%
Professional fees accounting, tax, and legal	5.5%	5.4%	6.0%
Total operating expenses as a % of net operating revenues	93.0%	98.5%	90.3%

Net Operating Revenues

Our consolidated *Net operating revenues* consist primarily of revenues derived from patient care services provided by our four primary operating segments. *Net operating revenues* also include other revenues generated from management and administrative fees, trainer income, operation of the conference center located on our corporate campus, and other non-patient care services.

Volume decreases in our operating segments was the primary factor that contributed to the declining *Net operating revenues* in 2006. Our inpatient segment reduced its non-compliant case volumes (i.e., cases involving diagnoses not included on the list of 13 qualifying medical conditions under the 75% Rule) due to the continued phase-in of the 75% Rule. Surgery centers that became equity method investments rather than consolidated entities in 2006 and 2005 as a result of ownership changes, facility closures that did not qualify as discontinued operations, and market competition negatively impacted volumes in our surgery centers segment. Competition from physician-owned similar sites, the nationwide physical therapist shortage, closure of underperforming facilities that did not qualify as discontinued operations, and the annual per beneficiary limitations on Medicare outpatient therapy services that became effective January 1, 2006 continued to negatively impact volumes in our outpatient segment. Competition from physician-owned diagnostic equipment and the closure of underperforming facilities that did not qualify as discontinued operations continued to negatively impact volumes in our diagnostic segment.

Our inpatient segment was also negatively impacted by certain regulatory pricing changes implemented as of October 1, 2005. We were able to partially mitigate the negative impact of these pricing changes due to an increase in patient acuity that resulted from our efforts to comply with the 75% Rule and compliant case growth. In our surgery centers and outpatient segments, we were able to partially offset the negative impact of declining volumes through improvement in net revenue per case or visit.

Volume decreases in each of our operating segments and the change in ownership of certain facilities within our inpatient segment were the primary factors that contributed to the declining *Net operating revenues* in 2005. Our inpatient segment experienced volume decreases due to the continued phase-in of the 75% Rule. Volumes in our surgery centers segment declined due to the limited resyndication activities that took place from 2003 through the first half of 2005. Competition from physician-owned similar sites continued to negatively impact volumes in our outpatient and diagnostic segments. The change in ownership of our Braintree and Woburn inpatient rehabilitation facilities contributed approximately $106.3 million to the decline in *Net operating revenues* in 2005.

The change in *Net operating revenues* by segment is discussed in more detail in this Item, Segment Results of Operations.

Salaries and Benefits

Salaries and benefits represent the most significant cost to us and include all amounts paid to full- and part-time employees, including all related costs of benefits provided to employees. It also includes amounts paid for contract labor.

During 2006, *Salaries and benefits* grew as a percent of *Net operating revenues* due to various factors. First, shortages of therapists and nurses have 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. Second, as a result of our efforts to comply with the 75% Rule, we are increasingly treating higher acuity (i.e., sicker) patients, which has resulted in increased labor costs in our inpatient segment. These increased labor costs resulting from higher salaries, greater reliance on contract labor, and higher case-mix acuity, along with routine inflationary increases, are occurring in a flat or declining unit pricing environment. In addition, as noted earlier in this Item, stock-based compensation increased by approximately $12.1 million during 2006 due to our adoption of FASB Statement No. 123(R) on January 1, 2006. As a result of these factors, *Salaries and benefits* increased as a percent of *Net operating revenues* in 2006.

In 2005, our segments demonstrated their ability to manage employee-related costs during periods of declining volumes, with *Salaries and benefits* decreasing as a percent of *Net operating revenues*. Approximately $66.1 million of the decrease from 2004 to 2005 was due to the change in ownership of our Braintree and Woburn inpatient rehabilitation facilities. In addition, our inpatient and surgery centers segments reduced their full-time equivalents as their volumes declined throughout the year, and our outpatient segment reduced its full-time equivalents through the closure of underperforming facilities that did not qualify as discontinued operations.

Professional and Medical Director Fees

Professional and medical director fees include professional consulting fees associated with operational initiatives, such as strategic planning and process standardization of billing and collecting procedures. These fees also include fees paid under contracts with radiologists, medical directors, and other clinical professionals at our centers for services provided.

Professional and medical director fees have increased as a percent of *Net operating revenues* since 2004 due to fees paid to consultants for various projects. In 2006, the increase was due primarily to increased professional fees in our inpatient segment due to fees paid to a consulting firm for process standardization of billing and collection procedures and assistance with technology enhancements with installation of upgraded patient accounting systems. In 2005, these fees increased due to fees paid to consulting firms for corporate strategy and other projects.

Supplies

Supplies include costs associated with supplies used while providing patient care at our facilities. Examples include pharmaceuticals, implants, bandages, food, and other similar items. In each year, our inpatient and surgery centers segments comprise over 95% of our *Supplies* expense.

The decrease in *Supplies* expense in each year was due to the decline in volumes in our inpatient and surgery centers segments in each year. In 2005, the decrease also resulted from the change in ownership of our Braintree and Woburn facilities in our inpatient segment, as discussed above.

Supplies expense is increasing as a percent of *Net operating revenues* due primarily to the reasons discussed above under Salaries and Benefits. As a result of our efforts to comply with the 75% Rule in our inpatient segment, we are increasingly treating higher acuity patients, which has resulted in increased supply costs for the segment. These increased supply costs are occurring in a flat or declining unit pricing environment. As a result, our *Supplies* expense is increasing as a percent of *Net operating revenues*.

Other Operating Expenses

Other operating expenses include costs associated with managing and maintaining our operating facilities as well as the general and administrative costs related to the operation of our corporate office. These expenses include such items as repairs and maintenance, utilities, contract services, professional fees, and insurance.

Other operating expenses were lower in 2006 compared to 2005 due to declining volumes in our inpatient segment, facility closures that did not qualify as discontinued operations throughout 2005 in our outpatient segment, decreased professional fees associated with projects related to our compliance with the Sarbanes-Oxley Act of 2002 (Sarbanes-Oxley) and other similar services from accounting and consulting firms, and a reduction in self-insurance expenses driven by current claims history, exit from the acute care business, and fewer full-time equivalents. *Other operating expenses* in 2006 also include a gain related to the repayment of a formerly fully reserved note receivable from Source Medical and a gain related to the elimination of our former guarantee of a promissory note for Source Medical. See Note 8, *Investment in and Advances to Nonconsolidated Affiliates*, to our accompanying consolidated financial statements for additional information related to Source Medical.

The increase in *Other operating expenses* from 2004 to 2005 primarily related to increased professional fees associated with projects related to our compliance with Sarbanes-Oxley, strategic consulting, and other similar services from accounting and consulting firms offset by an approximate $17.2 million decrease in *Other operating expenses* due to the change in ownership of our Braintree and Woburn facilities within our inpatient segment.

Provision for Doubtful Accounts

During 2006, our *Provision for doubtful accounts* increased as a percent of *Net operating revenues* due primarily to current collection activities and payment trends in our inpatient and diagnostic segments. The installation of new collections software within our inpatient segment and the implementation of a new enterprise software platform within our diagnostic segment negatively impacted collection activity during 2006, but we believe this distraction and negative impact will be temporary. During 2005, our *Provision for doubtful accounts* decreased as a percent of *Net operating revenues* due primarily to the outsourcing of collection activities in our diagnostic segment.

Depreciation and Amortization

The decrease in *Depreciation and amortization* during each year was due to impairment charges that decreased the depreciable base of our assets and an increase in fully depreciated assets within our operating segments.

Occupancy Costs

Occupancy costs include amounts paid for rent associated with leased facilities, including common area maintenance and similar charges. The change in *Occupancy costs* in each year is a result of the $30.5 million net gain on lease termination associated with the Braintree and Woburn facilities that was recorded in 2005, as discussed above,

(Gain) Loss on Disposal of Assets

The net gain on disposal of assets in 2006 primarily resulted from various facility sales and asset disposals in our surgery centers segment. In 2005, the net loss on disposal of assets primarily resulted from asset disposals at inpatient rehabilitation facilities in Florida and Arizona. The net loss on disposal of assets in 2004 primarily resulted from facility closures in our outpatient and diagnostic segments.

Interest Expense and Amortization of Debt Discounts and Fees

The decrease in *Interest expense and amortization of debt discounts and fees* for 2006 was the result of decreased amortization charges offset by increased interest expense.

Amortization of debt discounts and fees was approximately $20.7 million less during 2006 compared to 2005. Amortization in 2005 includes the amortization of consent fees associated with debt that was extinguished as part of the 2006 recapitalization transactions discussed in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements. Amortization in 2005 also includes 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 9, *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 8.7% for 2005. This increase in average interest rates contributed to an approximate $24.7 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 $6.4 million during 2006.

Interest expense and amortization of debt discounts and fees increased from 2004 to 2005 primarily due to the amortization of consent fees and bond issue costs associated with the 2004 consent solicitation and 2005 refinancings. During 2004, consent fees paid for all of our debt issues approximated $80.2 million, and we paid approximately $11.1 million in debt issuance costs. We amortize these fees to interest expense over the remaining term of the debt. In 2004, we amortized these costs for approximately six months, as compared to a full year of amortization in 2005. We also paid approximately $17.9 million in debt issuance costs in 2005. These costs are also amortized to interest expense over the life of the related debt. As a result of the above amortization charges, interest expense increased by approximately $17.2 million in 2005. An additional $11.2 million of interest expense was recorded in 2005 related to payments under our Medicare Program Settlement (see Note 22, *Medicare Program Settlement*, to our accompanying consolidated financial statements). The remaining $7.7 million of the increase in interest expense was primarily the result of higher average borrowing rates in 2005. In 2005, our average borrowing rate was 8.7% compared to an average rate of 8.3% in 2004.

For more information regarding the above changes in debt, see Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

Interest Income

From 2005 to 2006, *Interest income* decreased due to lower average cash balances throughout 2006 and the repayment of a note receivable from Source Medical, as discussed in this Item, Segment Results of Operations Corporate and Other. As discussed earlier in this Item, *Interest income* in 2006 includes $5.0 million of post-judgment interest recorded on our recovery of incentive bonuses from Mr. Scrushy.

From 2004 to 2005, *Interest income* increased due to higher average cash balances and our investments in U.S. government and agency securities (see Note 5, *Cash and Marketable Securities*, to our accompanying consolidated financial statements).

Loss (Gain) on Sale of Investments

In each year presented in our consolidated statements of operations, the net gain or loss on sale of investments was primarily comprised of numerous individually insignificant transactions related to less than 100% owned entities, including investments in nonconsolidated affiliates. In 2005 and 2004, the net gain on sale of investments was solely comprised of these types of transactions. In 2006, the net gain or loss on sale of investments also includes the realized gains and losses recorded on the sale of marketable securities. For additional information regarding our marketable securities, please see Note 5, *Cash and Marketable Securities*, to our accompanying consolidated financial statements.

Equity in Net Income of Nonconsolidated Affiliates

Our *Equity in net income of nonconsolidated affiliates* decreased from 2005 to 2006 due primarily to the year over year volume declines experienced by certain surgery centers accounted for under the equity method. *Equity in net income of nonconsolidated affiliates* increased from 2004 to 2005 due primarily to the change in five surgery centers from consolidated entities to equity method investments during 2005. Our 2005 *Equity in net income of nonconsolidated affiliates* includes the recovery of approximately $6.9 million of equity losses during the first quarter of 2005.

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. As of December 31, 2006, 2005, and 2004, the number and average external ownership interest in these consolidated affiliates were as follows:

	As of December 31,		
	2006	**2005**	**2004**
Active consolidated affiliates	251	257	276
Average external ownership interest	34.0%	33.6%	32.1%

During the years ended December 31, 2006, 2005, and 2004, approximately 97.1%, 95.2%, and 94.8% of our *Minority interest in earnings of consolidated affiliates* resulted from consolidated affiliates in our inpatient and surgery centers segments. Fluctuations in *Minority interests in earnings of consolidated affiliates* are primarily driven by trends experienced in our surgery centers segment, and, to a lesser extent, trends in our inpatient segment.

Loss from Continuing Operations Before Income Tax Expense

Our *Loss from continuing operations before income tax 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 and a $31.2 million reduction in our liability associated with our securities litigation settlement. 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 $223.5 million, and our pre-tax loss from continuing operations for 2005 was $125.4 million, resulting in an increase of $98.1 million year over year. As discussed earlier in this Item, we recorded a $30.5 million net gain on lease termination during 2005. The remainder of the difference relates primarily to the items discussed above.

As noted above, our pre-tax loss from continuing operations in 2005 includes a charge of $215.0 million associated with the settlement of our securities litigation. It also includes a $37.9 million recovery of bad debt associated with Meadowbrook, as discussed earlier in this Item. If these two items are excluded, our pre-tax loss from continuing operations becomes $163.3 million, which represents a $126.0 million increase over our 2004 pre-tax loss from continuing operations. This increase is primarily due to a decrease in *Net operating revenues* as a result of declining volumes, higher other operating expenses associated with professional service fees, and increased interest expense, as discussed above.

Provision for Income Tax Expense

We recognized a $41.1 million income tax expense from continuing operations in 2006 as compared to a $38.4 million income tax expense from continuing operations in 2005. Deferred tax expense increased by approximately $16.2 million to reflect the change in noncurrent deferred taxes associated with certain indefinite-lived assets. Additionally, HealthSouth Corporation and its subsidiaries file separate income tax returns in a number of states, some of which results in current state tax liabilities. A current federal tax expense was also charged in 2006 and 2005 associated with ownership in corporate joint ventures that are not part of our consolidated income tax return. During 2006, interest income with respect to expected income tax refunds resulting from updated prior tax filings, which are still in progress, increased by $3.7 million. Also 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.

We recognized a $38.4 million income tax expense from continuing operations in 2005 as compared to an $11.9 million income tax expense from continuing operations in 2004. Deferred tax expense increased by approximately $22.4 million to reflect the change in noncurrent deferred taxes associated with certain indefinite-lived assets. Additionally, HealthSouth Corporation and its subsidiaries file separate income tax returns in a number of states, some of which results in current state tax liabilities. A current federal tax expense was also charged in 2005 and 2004 associated with ownership in corporate joint ventures that are not part of our consolidated income tax return.

Adjusted Consolidated EBITDA

Management continues to believe Adjusted Consolidated EBITDA under our 2006 Credit Agreement is a measure of operating performance, leverage capacity, our ability to service our debt, and our ability to make capital expenditures.

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 2006 Credit Agreement, which is discussed in more detail in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements. These covenants are material terms of the 2006 Credit Agreement, and the 2006 Credit Agreement represents a substantial portion of our capitalization. Non-compliance with these financial covenants under our 2006 Credit Agreement our interest coverage ratio and our leverage ratio could result in our lenders requiring us to immediately repay all amounts borrowed. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our 2006 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.

We also use Adjusted Consolidated EBITDA to assess our operating performance. We believe it is meaningful because it provides investors with a measure used by our internal decision makers for evaluating our business. Our internal decision makers believe Adjusted Consolidated EBITDA is a meaningful measure because it represents a view of our recurring operating performance and allows management to readily view operating trends, perform analytical comparisons, and perform benchmarking between segments. Additionally, our management believes the inclusion of professional fees associated with litigation, financial restructuring, government investigations, forensic accounting, creditor advisors, accounting reconstruction, audit and tax work associated with the reconstruction process, and non-ordinary course charges incurred after March 19, 2003 (the date the SEC filed a lawsuit against us and our former chairman and chief executive officer alleging that we historically overstated earnings) and related to our overall corporate restructuring (including matters related to internal controls) distort within EBITDA their ability to efficiently assess and view the core operating trends on a consolidated basis and within segments. We reconcile Adjusted Consolidated EBITDA to *Net loss*.

In general terms, the definition of Adjusted Consolidated EBITDA, per our 2006 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) expenses 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 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements, and (5) compensation expenses recorded in accordance with FASB Statement No. 123(R).

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 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.

As noted earlier in this Item, certain previously reported financial results have been reclassified to conform to the current year presentation. Such reclassifications relate to facilities we closed or sold in 2006 that qualify under FASB Statement No. 144 to be reported as discontinued operations. These reclassifications may also impact previously reported Adjusted Consolidated EBITDA amounts. Furthermore, Adjusted Consolidated EBITDA, as presented below, was computed using the definition of Adjusted Consolidated EBITDA contained within our 2006 Credit Agreement. The definition of Adjusted Consolidated EBITDA within our 2006 Credit Agreement differs from the definition contained within the documents that governed our prior indebtedness. The facilities that were classified as discontinued operations in 2006 and changes made to our Adjusted Consolidated EBITDA calculation based on our 2006 Credit Agreement impacted Adjusted Consolidated EBITDA in 2005 and 2004 reported in our 2005 Form 10-K by approximately ($1.5) million and ($1.2) million, respectively.

Under our 2006 Credit Agreement, our Adjusted Consolidated EBITDA for the years ended December 31, 2006, 2005, and 2004 was as follows:

Reconciliation of Net Loss to Adjusted Consolidated EBITDA

	For the Year Ended December 31,		
	2006	**2005**	**2004**
	(In Millions)		
Net loss	$ (625.0)	$ (446.0)	$ (174.5)
Loss from discontinued operations	26.0	67.2	125.3
Provision for income tax expense	41.1	38.4	11.9
Loss on interest rate swap	10.5		
Loss on sale of marketable securities	0.3		
Interest income	(15.7)	(17.1)	(13.1)
Interest expense and amortization of debt discounts and fees	335.1	337.5	301.4
Loss on early extinguishment of debt	365.6		
Professional fees accounting, tax, and legal	163.6	169.8	206.2
Government, class action, and related settlements expense	38.8	215.0	
Impairment charges	15.2	43.3	36.5
Net non-cash loss on disposal of assets	6.4	16.6	10.2
Depreciation and amortization	148.2	162.6	172.2
Compensation expense under FASB Statement No. 123(R)	15.5		
Sarbanes-Oxley related costs	4.8	32.2	17.5
Restructuring activities under FASB Statement No. 146	5.1	8.1	4.0
Adjusted Consolidated EBITDA	$ 535.5	$ 627.6	$ 697.6

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

	For the year ended December 31,		
	2006	**2005**	**2004**
	(In Millions)		
Adjusted Consolidated EBITDA	$ 535.5	$ 627.6	$ 697.6
Compensation expense under FASB Statement No. 123(R)	(15.5)		
Restructuring charges under FASB Statement No. 146	(5.1)	(8.1)	(4.0)
Sarbanes-Oxley related costs	(4.8)	(32.2)	(17.5)
Provision for doubtful accounts	119.3	94.3	109.6
Net gain on disposal of assets	(10.9)	-	
Professional fees accounting, tax, and legal	(163.6)	(169.8)	(206.2)
Interest expense and amortization of debt discounts and fees	(335.1)	(337.5)	(301.4)
Interest income	15.7	17.1	13.1
Loss (gain) on sale of investments, excluding marketable securities	1.6	0.1	(4.0)
Equity in net income of nonconsolidated affiliates	(21.3)	(29.4)	(9.9)
Minority interest in earnings of consolidated affiliates	92.3	97.2	95.0
Amortization of debt issue costs, debt discounts, and fees	18.3	39.0	21.8
Amortization of restricted stock	3.4	2.0	0.6
Distributions from nonconsolidated affiliates	14.1	22.5	17.0
Stock-based compensation	12.1		(0.5)
Current portion of income tax provision	(7.9)	(21.4)	(17.3)
Change in assets and liabilities, net of acquisitions	(215.4)	(101.8)	35.6
Cash portion of 2006 government, class action, and related settlements expense	(14.9)		
Change in government, class action, and related settlements liability	(118.4)	(165.4)	(7.0)
Other operating cash used in discontinued operations	(19.6)	(36.5)	(31.9)
Other	(0.2)	(0.6)	0.2
Net Cash (Used In) Provided by Operating Activities	$ (120.4)	$ (2.9)	$ 390.8

Adjusted Consolidated EBITDA decreased in 2006 due to the declining volumes experienced by each of our operating segments and the increase to our *Provision for doubtful accounts*, as discussed above. Adjusted Consolidated EBITDA for 2006 includes the recovery of incentive bonuses from Mr. Scrushy, as discussed above. Adjusted Consolidated EBITDA for 2005 includes the net gain on lease termination associated with our former Braintree and Woburn facilities and the Meadowbrook recovery, as discussed above. Adjusted Consolidated EBITDA decreased from 2004 to 2005 due to the declining volumes experienced by each of our operating segments and increased operating expenses associated with professional service fees, as discussed above.

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

Historically, HealthSouth and its prior management and board of directors engaged in numerous relationships and transactions with related parties. However, since 2003, we have eliminated our interests in and relationships with related parties. Related party transactions are not material to our ongoing operations, and therefore, will not be 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, 2006, 2005, or 2004, information regarding the relationship or transaction(s) have been included within this Item.

For information regarding our relationships and transactions with related parties, see Note 8, *Investments in and Advances to Nonconsolidated Affiliates*, and Note 21, *Related Party Transactions*, to our accompanying consolidated financial statements.

Segment Results of Operations

Our internal financial reporting and management structure is focused on the major types of services provided by HealthSouth. We currently provide various patient care services through four operating divisions and certain other services through a fifth division, which correspond to our five reporting business segments: (1) inpatient, (2) surgery centers, (3) outpatient, (4) diagnostic, and (5) corporate and other. For additional information regarding our business segments, including a detailed description of the services we provide and financial data for each segment, please see Item 1, *Business*, and Note 26, *Segment Reporting,* to our accompanying consolidated financial statements.

As part of the continued implementation of our strategic plan, management continues to evaluate the role of each segment and the services provided within each segment. Based on this evaluation, in the second quarter of 2006, our management realigned five electro-shock wave lithotripter units from our diagnostic segment to our corporate and other segment, as the services performed by these lithotripter units are not diagnostic services. We also realigned five occupational medicine centers from our corporate and other segment into our outpatient segment, as these centers provide therapy services that are consistent with other services provided by our outpatient segment. Prior periods have been reclassified to conform to this presentation.

Future changes to this organizational structure may result in changes to the reportable segments disclosed.

Inpatient

We are the nation s largest provider of inpatient rehabilitation services. Our inpatient rehabilitation facilities 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.

Our inpatient segment operates IRFs and LTCHs and provides treatment on both an inpatient and outpatient basis. As of December 31, 2006, our inpatient segment operated 92 freestanding IRFs, 10 LTCHs, and 81 outpatient facilities located within or near our IRFs. In addition to HealthSouth facilities, our inpatient segment manages 11 inpatient rehabilitation units, 3 outpatient facilities, and 2 gamma knife radiosurgery centers through management contracts. Our inpatient facilities are located in 27 states, with a concentration of facilities in Texas, Pennsylvania, Florida, Tennessee, and Alabama. We also have a facility in Puerto Rico.

For the years ended December 31, 2006, 2005, and 2004, our inpatient segment comprised approximately 57.5%, 56.8%, and 58.1%, respectively, of consolidated *Net operating revenues*. For 2004 through 2006, this segment s operating results were as follows:

	For the year ended December 31,		
	2006	**2005**	**2004**
	(Dollars In Millions)		
Inpatient			
Net operating revenues	$ 1,724.8	$ 1,769.1	$ 1,979.5
Operating expenses*	1,365.3	1,380.4	1,545.8
Operating earnings	$ 359.5	$ 388.7	$ 433.7
Discharges (in thousands)	102.4	105.7	120.0
Outpatient visits (in thousands)	1,435.6	1,616.6	2,153.0
Full time equivalents (actual amounts)	15,780	16,555	19,294
Average length of stay	15.3 days	15.7 days	15.8 days

* Includes divisional overhead, but excludes corporate overhead allocation. See Note 26, *Segment Reporting*, to our accompanying consolidated financial statements. Includes the effect of *Minority interests in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*.

During 2006, 2005, and 2004, inpatient s *Net operating revenues* were derived from the following payor sources:

	For the year ended December 31,		
	2006	**2005**	**2004**
Medicare	69.7%	71.2%	71.3%
Medicaid	2.1%	2.4%	2.7%
Workers' compensation	2.5%	2.8%	3.4%
Managed care and other discount plans	18.2%	16.0%	15.2%
Other third-party payors	5.1%	5.1%	5.8%
Patients	0.3%	0.5%	0.0%
Other income	2.1%	2.0%	1.6%
Total	100.0%	100.0%	100.0%

Our inpatient segment s payor mix is weighted heavily towards Medicare. Our IRFs receive Medicare reimbursements under IRF-PPS. Under IRF-PPS, our IRFs receive fixed payment amounts per discharge based on certain rehabilitation impairment categories established by the Department of Health and Human Services. With IRF-PPS, our facilities retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our facilities are rewarded for being high quality, low cost providers. For additional information regarding Medicare reimbursement, please see the Sources of Revenues section of Item 1, *Business*, of this Form 10-K.

Due to the significance of Medicare payments to our inpatient facilities, the number of patient discharges is a key metric utilized by the segment to monitor and evaluate its performance. The number of outpatient visits is also tracked in order to measure the volume of outpatient activity within the segment. The segment s primary operating expenses include *Salaries and benefits* and *Supplies*. *Salaries and benefits* represent the most significant cost to the segment and include all amounts paid to full- and part-time employees, including all related costs of benefits provided to employees. It also includes amounts paid for contract labor. *Supplies* expense includes all costs associated with supplies used while providing patient care. These costs include pharmaceuticals, needles, bandages, food, and other similar items.

Significant Changes in Regulations Governing IRF Reimbursement

As discussed in Item 1, *Business*, Sources of Revenues, changes in regulations governing IRF reimbursement have combined to create a challenging operating environment for our inpatient division. One of these changes occurred on May 7, 2004, when the United States Centers for Medicare and Medicaid Services (CMS) issued a final rule stipulating revised criteria for qualifying as an IRF under Medicare. This rule, known as the 75% Rule, has created significant volume volatility in our inpatient division. We also continue to experience Medicare payment updates that have led to reduced unit pricing applicable to our IRFs.

The 75% Rule, as revised, generally provides that to be considered an IRF, and to receive reimbursement for services under the IRF-PPS methodology, 75% of a facility s total patient population must require treatment for at least one of 13 designated medical conditions. As a practical matter, this means that to maintain our current level of revenue from our IRFs we will need to reduce the number of non-qualifying patients treated at our IRFs and replace them with qualifying patients, establish other sources of revenues at our IRFs, or both. The Deficit Reduction Omnibus Reconciliation Act of 2005, signed by President Bush on February 8, 2006 as Public Law 109-171, extended the phase-in schedule for the 75% Rule by one year and delayed implementation of the 65% compliance threshold until July 1, 2007.

On August 1, 2006, CMS released a final rule that updates the IRF-PPS for the federal fiscal year 2007 (covering discharges occurring on or after October 1, 2006 and on or before September 30, 2007). Although the final rule includes an overall market basket update of 3.3%, this market basket update is offset by a 2.6% reduction in standard payment rates. We estimate that the final rule will modestly increase our inpatient segment s net Medicare revenues by approximately $5 million per quarter for federal fiscal year 2007 as compared to federal fiscal year 2006.

On November 1, 2006, CMS issued a final rule that will update the payment methodology under the Physician Fee Schedule beginning January 1, 2007. Specifically, the rule would update the work relative value units (RVUs) based on the five-year review required under statute, implement a new payment methodology for practice expense RVUs, and apply a negative budget neutrality adjustment to the work order RVUs. These changes, combined with a 5% reduction to the payment conversion factor under the Physician Fee Schedule, will result in lower reimbursement to us for outpatient services.

On December 20, 2006, the President of the United States signed into law the Tax Relief and Healthcare Act of 2006 that reverses the 5% reduction to the payment conversion factor under the Physician Fee Schedule. We estimate that combined these changes will decrease our inpatient division s *Net operating revenue*s by approximately $0.5 million per quarter for calendar year 2007 as compared to calendar year 2006.

The combination of volume volatility created by the 75% Rule and lower unit pricing resulting from IRF-PPS and Physician Fee Schedule changes reduced our *Net operating revenues* in 2006. Thus far, we have been able to partially mitigate the impact of the 75% Rule on our inpatient division s operating earnings by implementing the mitigation strategies discussed in Item 1, *Business*, Inpatient Division.

Change in Ownership of Facilities

As noted earlier in this Item, 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 facilities and placed us as the manager, rather than the owner, of these two facilities. Accordingly, our inpatient segment s 2006 and 2005 results of operations include only the $4.0 million and $5.4 million management fee we earned for operating these facilities on behalf of the landlord during the nine months ended September 30, 2006 and the year ended December 31, 2005, respectively. In 2004, the results of operations of these two inpatient facilities were included in our inpatient segment s results of operations on a gross basis. This segment s *Net operating revenues* and operating earnings were negatively impacted by approximately $106.3 million and $3.6 million, respectively, in 2005 as a result of the change in ownership of these two facilities. In September 2006, we completed the transition of these two facilities to the landlord.

For additional information, see Note 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

Other Notable Events of 2006

During 2006, the following other notable events occurred within our inpatient segment:

- In April 2006, HealthSouth Ridge Lake Hospital, our 40-bed long term acute care hospital in Sarasota, Florida, received its license approval.
- In June 2006, we opened HealthSouth Rehabilitation Hospital of Petersburg, a 40-bed rehabilitation facility in Petersburg, Virginia.
- We broke ground on a new 40-bed IRF in Fredericksburg, Virginia.
- In October 2006, we closed a transaction to sell Cedar Court Rehabilitation Hospital in Melbourne, Australia, and related assets (Cedar Court), to Epworth Foundation and ING Management Limited. The Cedar Court assets included a 74-bed rehabilitation hospital and outpatient center, a stand alone rehabilitation facility at the Oasis Leisure Center, and an occupational medicine rehabilitation therapy business. Cedar Court is included in discontinued operations in our accompanying consolidated financial statements.
- In August 2006, we completed a business consolidation agreement with TMC HealthCare in Tucson, Arizona to provide rehabilitation services. Under the agreement, HealthSouth Rehabilitation Institute of Tucson now provides rehabilitation and therapy services historically provided at El Dorado Hospital in Tucson and select TMC outpatient therapies.
- The lease associated with Central Georgia Rehabilitation Hospital in Macon, Georgia expired on September 30, 2006 and was not extended. This facility included 58 rehabilitation beds and an outpatient rehabilitation satellite facility.
- In November 2006, we reached an agreement to close a competitor s 48-bed IRF in Wichita Falls (Texas) and consolidated its patients to our existing 63-bed IRF.

None of the above events or transactions, individually or in the aggregate, is expected to have a material impact on the results of operations, financial position, or cash flows of our inpatient segment or to HealthSouth on a consolidated basis.

Net Operating Revenues

Our inpatient segment s *Net operating revenues* for 2006 were 2.5% lower than 2005. The decrease was primarily due to a reduction of non-compliant case volumes due to the continued phase-in of the 75% Rule. In 2005, our IRFs were required to operate at a 50% minimum qualifying patient mix threshold under the 75% Rule. In 2006, the minimum qualifying patient mix threshold increased to 60% causing further reductions of non-compliant case volumes. Our inpatient segment also experienced a decrease in outpatient volumes due to the decrease in our inpatient volumes, changes in patient-program mix, shortages in therapy staffing, and continued competition from physicians offering physical therapy services within their own offices. Certain regulatory pricing changes implemented as of October 1, 2005 also negatively impacted *Net operating revenues* for the first three quarters of 2006. However, we were able to mitigate a portion of these unit price reductions by achieving an approximate 6.0% compliant case growth during 2006 compared to 2005. This compliant case growth also increased the acuity of our patients year over year.

Our inpatient segment s *Net operating revenues* declined by 10.6% from 2004 to 2005. The change in ownership of our Braintree and Woburn facilities contributed to approximately $106.3 million, or 50.5%, of the decline. The remainder of the decrease in *Net operating revenues* was due to declining volumes. Excluding the impact of the change in ownership of the Braintree and Woburn facilities, discharges were approximately 7.5% lower than 2004 due to the continued phase-in of the 75% Rule and the majority of our facilities moving to the 50% phase. Our inpatient segment also experienced a 10.5% decrease in outpatient volumes (excluding the impact of the change in ownership) due to continued competition from physicians offering physical therapy within their own offices, as well as the decrease in our inpatient volumes. Due to this continued competition from physicians and resulting decrease in outpatient visits, we evaluated our outpatient satellites sites and closed 22 sites during 2005. Declining volumes were offset slightly by favorable pricing from Medicare during the first nine months of 2005 due to the Medicare market basket adjustment of 3.1% that was received from Medicare in October 2004 for their fiscal year 2005. However, the IRF-PPS Final Rule, as discussed above, negatively impacted our fourth quarter earnings

by approximately $10.0 million. Human capital constraints in key clinical positions (therapists and nurses) at some of our hospitals also negatively impacted volumes as facilities managed volumes within these constraints.

Operating Expenses

Salaries and Benefits

Salaries and benefits comprised over 59% of inpatient s operating expenses in each year.

Salaries and benefits grew from 46.6% of *Net operating revenues* in 2005 to 48.3% of *Net operating revenues* in 2006. This increase resulted from increased labor costs during a year of declining unit pricing within our inpatient segment. As noted earlier in this Item, shortages of therapists and nurses have 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 addition, as a result of our efforts to comply with the 75% Rule, we are increasingly treating higher acuity patients, which has resulted in increased labor costs in our inpatient segment.

Salaries and benefits decreased by $116.2 million, or 12.3%, from 2004 to 2005 primarily as a result of the change in facility ownership discussed above and fewer full-time equivalents due to the decline in volumes. The change in ownership of our Braintree and Woburn facilities contributed approximately $66.1 million, or 56.9%, to the decrease. Full-time equivalents, excluding the employees of the Braintree and Woburn facilities, declined by 8.7% from 2004 to 2005 which more than offset the increase in average *Salaries and benefits* per full-time equivalent due to merit and market rate adjustments. However, excluding the impact of the change in facility ownership discussed above, *Salaries and benefits* as a percent of *Net operating revenues* remained consistent from 2004 to 2005, approximating 46.7% and 46.6%, respectively. The segment s ability to maintain this ratio while experiencing a 5.6% decline in *Net operating revenues* (excluding the impact of the change in facility ownership) is evidence of our facilities ability to adjust staffing levels to accommodate changing volumes.

Supplies

Supplies expense decreased by $1.4 million, or 1.3%, from 2005 to 2006 due to the decline in volumes. From 2004 to 2005, *Supplies* expense decreased by $13.3 million, or 11.2%. Approximately $6.2 million of the decrease was due to the change in ownership of our Braintree and Woburn facilities. The remainder was due to the decline in volumes during 2005.

As noted earlier in this Item, as a result of our efforts to comply with the 75% Rule, our inpatient segment is increasingly treating higher acuity patients, which has resulted in increased supply costs for the segment. These increased supply costs are occurring in a flat or declining unit pricing environment. As a result, our inpatient segment s *Supplies* expense is increasing as a percent of *Net operating revenues*.

Provision for Doubtful Accounts

Our *Provision for doubtful accounts* increased from 2.3% of *Net operating revenues* in 2005 to 2.9% of *Net operating revenues* in 2006. The installation and implementation of new collections software and processes within our inpatient segment negatively impacted collection activity during 2006, but we believe this distraction and negative impact will be temporary. From 2004 to 2005, the segment s *Provision for doubtful accounts* as a percent of *Net operating revenues* remained flat, approximating 2.3% in each year.

All Other Operating Expenses

From 2005 to 2006, all other operating expenses decreased by 7.7% due primarily to the reduction in volumes discussed above. All other operating expenses for 2006 included approximately $8.9 million in fees paid to a consulting firm for process standardization of billing and collection procedures and assistance with technology enhancements with installation of upgraded patient accounting systems. We do not expect to incur similar fees in 2007. All other operating expenses for 2006 also included a $0.3 million impairment charge related to long-lived assets at a facility experiencing declining cash flows from operations. We determined the fair value of the impaired long-lived assets based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals. During 2006, all other operating expenses decreased from 23.1% of *Net operating revenues* in 2005 to 21.9% of *Net operating revenues* due primarily to decreased insurance costs during 2006 based on current claims history.

From 2004 to 2005, all other operating expenses decreased by 7.1% due to the change in facility ownership and the reduction in volumes discussed above. However, all other operating expenses increased from 22.3% of *Net operating revenues* in 2004 to 23.1% of *Net operating revenues* in 2005 due primarily to a $1.3 million impairment charge recorded as a result of continued negative cash flows experienced by one of our facilities in Texas. We determined the fair value of the impaired long-lived assets based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

Operating Earnings

Operating earnings of our inpatient segment decreased during 2006 due primarily to continued volume decline, as discussed above, as well as increased labor costs without a proportionate increase in pricing. In addition, operating earnings of our inpatient segment were negatively impacted by fees paid to a consulting firm for process standardization and technology assistance (as discussed above), which also resulted in an increase in our inpatient segment s *Provision for doubtful accounts* based on current collection activities and payment trends. However, as noted above, we believe this distraction and negative impact to our *Provision for doubtful accounts* will be temporary.

Approximately $3.6 million of the decrease in operating earnings from 2004 to 2005 was due to the change in ownership of our Braintree and Woburn facilities. The remainder was due to the declining volumes experienced by the segment and the reimbursement challenges presented by the 75% Rule.

Surgery Centers

We operate one of the largest networks of ASCs in the United States. As of December 31, 2006, we provided these services through the operation of our network of 144 freestanding ASCs and 3 surgical hospitals in 35 states, with a concentration of centers in California, Texas, Florida, North Carolina, and Alabama.

Our ASCs provide the facilities and medical support staff necessary for physicians to perform nonemergency surgical procedures. For 2004 through 2006, this segment s operating results were as follows:

	For the year ended December 31,		
	2006	2005	2004
	(Dollars In Millions)		
Surgery Centers			
Net operating revenues	$ 737.0	$ 755.5	$ 794.3
Operating expenses*	643.7	670.2	706.0
Operating earnings	$ 93.3	$ 85.3	$ 88.3
Cases (in thousands)	572.4	607.1	684.1
Full time equivalents (actual amounts)	3,942	4,302	4,442

* Includes divisional overhead, but excludes corporate overhead allocation. See Note 26, *Segment Reporting*, to our accompanying consolidated financial statements. Includes the effect of *Minority interests in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*.

During the years ended December 31, 2006, 2005, and 2004, our surgery centers segment derived its *Net operating revenues* from the following payor sources:

	For the year ended December 31,		
	2006	2005	2004
Medicare	18.4%	18.1%	17.9%
Medicaid	3.3%	3.2%	2.7%
Workers' compensation	9.6%	10.6%	10.8%
Managed care and other discount plans	59.9%	58.3%	55.7%
Other third-party payors	3.2%	3.5%	0.1%
Patients	4.3%	5.0%	11.2%
Other income	1.3%	1.3%	1.6%
Total	100.0%	100.0%	100.0%

Our commercial revenues, which are included in Other third-party payors in the above chart, increased by approximately $25 million from 2004 to 2005. We believe this increase is the result of an increase in out-of-network cases that yield higher net patient revenue per case. The number of plastic surgery cases performed by our centers decreased by approximately 7% from 2004 to 2005. As a result, net patient revenues from cases where the patient has primary financial responsibility decreased from 2004 to 2005.

The number of cases performed by our ASCs is a key metric utilized by the segment to regularly evaluate its performance. The segment s primary operating expenses include *Salaries and benefits* and *Supplies*. *Salaries and benefits* represent the most significant costs to the segment and include all amounts paid to full- and part-time employees, as well as all related costs of benefits provided to employees. It also includes amounts paid for contract labor. *Supplies* expense includes all costs associated with medical supplies used while providing patient care at our ASCs. Such costs include sterile disposables, pharmaceuticals, implants, and other similar items.

Like most other ASCs, the majority of our centers are owned in partnership with surgeons and other physicians who perform procedures at the centers. As existing physician partners retire or change geographic location, it is important that the surgery centers segment periodically provide other physicians with opportunities to purchase ownership interests in our ASCs. Our ability to resyndicate our partnerships is a key success factor for our surgery centers segment.

In 2006, our focus within our surgery centers segment was on resyndication activities in existing centers, portfolio rationalization, and operational improvements. During the latter part of 2006, we began to see margin expansion through improved revenues and labor and supply cost management initiatives, including the standardization of non-physician preference items. However, this margin expansion was negatively impacted by an

increase in minority interests from our resyndication efforts. We believe, however, that our resyndication efforts helped stabilize our portfolio of surgery centers and will add value to the segment over time.

Changes in the Reimbursement Environment for ASCs

Our surgery centers segment faces a changing reimbursement environment. For example, the Deficit Reduction Act of 2005 caps payments for ASC procedures in 2007 to the lesser of the ASC or hospital outpatient prospective payment system (OPPS) payment rate. In addition, on August 8, 2006, CMS issued a proposed rule that would substantially change Medicare reimbursement for ASC procedures. The proposed rule would revise ASC payment rates to be based on 221 Ambulatory Payment Classifications currently used to categorize procedures under OPPS and would tentatively set calendar year 2008 ASC payment rates at 62% of applicable OPPS payment rates subject to a phase in period whereby payments during the first year would equal a blend of the existing and proposed rates. Beginning in 2010, the ASC conversion factor would be updated by the consumer price index for urban consumers. The proposed rule would also expand the list of ASC approved procedures beginning in 2008. CMS proposes to phase in the new payment system over two years.

On November 1, 2006, CMS released changes to the ASC approved procedure list and ASC payment rates, effective January 1, 2007. Twenty-one procedures are being added to the ASC approved procedure list. Payments for 275 procedures will be capped at the OPPS rate. We estimate that the 2007 final rule will decrease our surgery centers division s *Net operating revenues* by approximately $1.4 million in 2007. This final rule, which also includes 2007 OPPS payment rates, does not cover changes to the ASC payment system that will take effect in 2008. If the final rule relating to the 2008 ASC payment system changes results in downward adjustment to ASC reimbursement rates or limits the expansion of covered surgical procedures, it could have a material adverse effect on our business, financial position, results of operations, and cash flows.

While difficult to predict, we believe these 2008 proposed changes could have a neutral to positive impact on our *Net operating revenues* once the new system is in place, depending upon the rule s overall effect on unit pricing and our ability to realize increased case volume as the list of approved ASC procedures is expanded. However, the proposed rule has not been finalized and we cannot provide any assurance that the rule will be finalized in its current form, or that the rule, if finalized in its current form, will have the impact we predict. Moreover, we believe the proposed rule disproportionately impacts certain specialties. We are working with a coalition of ASC companies and associations to provide data to CMS supporting a number of modifications to the proposed rule.

On November 24, 2006, CMS published a final OPPS rule that indicates the Secretary of Health and Human Services may require ASCs to begin reporting certain quality information beginning in 2009. Failure to report this quality data would result in a reduction of the payment update by 2%.

Net Operating Revenues

As a result of our resyndication activities, certain surgery centers may become equity method investments rather than consolidated entities as a result of changes in control of the applicable centers. These types of changes will decrease *Net operating revenues* when the change in control occurs. During 2006, two surgery centers became equity method investments rather than consolidated entities. During 2005, five surgery centers became equity method investments rather than consolidated entities. The timing of these changes in each year effect the extent of the impact to *Net operating revenues* in each year.

Approximately $16.1 million of the decrease in *Net operating revenues* from 2005 to 2006 is due to surgery centers that became equity method investments rather than consolidated entities during these periods. An additional $9.2 million of the decrease is due to six facility closures that did not qualify as discontinued operations. During 2006, *Net operating revenues* were also negatively impacted by continued market competition and physician turnover, but these volume declines were offset by favorable pricing.

Declining volumes was the primary contributor to the decrease in *Net operating revenues* from 2004 to 2005. Although the majority of this decrease is due to the limited resyndication activities that took place from 2003 through the first half of 2005, approximately $25.6 million of the decrease is due to the change of five surgery centers that became equity method investments rather than consolidated entities during 2005. The *Net operating revenues* lost through volume declines were partially offset by a shift in case mix to ophthalmology cases which generate higher average net revenue per case. *Net operating revenues* in 2005 were also negatively impacted by a decrease in rental income associated with subleases that were terminated during the year.

Operating Expenses

Salaries and Benefits

In each year, *Salaries and benefits* represent approximately 37% of our surgery centers segment s operating expenses.

Salaries and benefits decreased from 33.0% of *Net operating revenues* in 2005 to 32.6% of *Net operating revenues* in 2006. This decrease was due to a reduction in full-time equivalents that primarily resulted from facilities that became equity method investments rather than consolidated entities and facility closures and a reduction in workers compensation premiums (before the impact of minority interest) due to lower headcount, recent claims history, and updated actuarial calculations.

Salaries and benefits decreased by 2.8% from 2004 to 2005 due primarily to a reduction in full-time equivalents year over year due to the decline in the number of cases performed by our surgery centers and the segment s focus to improve operational performance and productivity. However, efforts to reduce full-time equivalents were not made quickly enough. Therefore, declining case volumes coupled with annual merit increases and market adjustments increased *Salaries and benefits* from 32.3% of *Net operating revenues* in 2004 to 33.0% of *Net operating revenues* in 2005.

Supplies

Supplies expense represents approximately 26% of our surgery centers segment s operating expenses in each year, making it important for our ASCs to appropriately manage and monitor these costs. Supply chain operations is a focus of management to improve product standardization, compliance with those standards, and consolidating market share with vendors to maximize savings opportunities. *Supplies* expense approximated 23.2%, 23.2%, and 23.1% of *Net operating revenues* in 2006, 2005, and 2004, respectively.

Provision for Doubtful Accounts

Our surgery centers segment s *Provision for doubtful accounts* consistently remained between 1.7% and 2.0% of *Net operating revenues* in each year.

All Other Operating Expenses

From 2005 to 2006, all other operating expenses decreased by approximately 6.4%. This decrease is primarily due to the change of surgery centers from consolidated entities to equity method investments during 2006 and 2005. All other operating expenses in 2006 also include a net gain on disposal of assets of approximately $9.8 million (compared to a net loss of $1.1 million in 2005) related to various facility sales and asset disposals that occurred during the year. All other operating expenses also decreased in 2006 due to a decrease in impairment charges, year over year, as discussed below.

From 2004 to 2005, all other operating expenses decreased by approximately 8.0%. This decrease is primarily due to the change of five surgery centers from consolidated entities to equity method investments during 2005. These changes favorably impacted both *Minority interest in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*. In addition, all other operating expenses decreased due to the closure and/or sale of underperforming facilities in 2005 that did not qualify as discontinued operations. All other operating expenses in 2005 also include the recovery of equity losses from nonconsolidated affiliates.

We recorded impairment charges of $2.4 million, $3.9 million, and $2.0 million in 2006, 2005, and 2004, respectively. Facility closings and facilities experiencing negative cash flows from operations resulted in the impairment charges in each year. We determined the fair value of the impaired long-lived assets based on the assets estimated fair value using valuation techniques that included discounted cash flows and third-party appraisals.

Operating Earnings

The increase in 2006 operating earnings primarily related to the net gain on disposal of assets recorded during the year, as discussed above. The decrease in operating earnings from 2004 to 2005 was due to the volume declines discussed above.

Outpatient

We are one of the largest operators of free standing outpatient rehabilitation facilities in the United States. As of December 31, 2006, we provided outpatient rehabilitative health care services through 582 HealthSouth facilities. We have locations in 35 states and the District of Columbia, with a concentration of centers in Florida, Texas, New Jersey, and Missouri.

Our outpatient rehabilitation facilities are staffed by physical therapists, occupational therapists, and other clinicians and support personnel, depending on the services provided at a particular location, and we are open at hours designed to accommodate the needs of the patient population being served and the local demand for services. Our outpatient centers offer a range of rehabilitative health care services, including physical therapy and occupational therapy, with a particular focus on orthopedic, sports-related, work-related, hand and spine injuries, and various neurological/neuromuscular conditions.

On January 29, 2007, we announced that we have entered into a definitive agreement with Select Medical to sell our outpatient division for approximately $245 million in cash, subject to certain adjustments. The closing of this transaction is anticipated to occur on or before April 30, 2007, and is subject to customary closing conditions, including regulatory approval. As a result of the disposition of our outpatient division, we expect to record an approximate $120 million to $155 million pre-tax gain on disposal in the first half of 2007. See Note 3, *Subsequent Event Divestiture*, to our accompanying consolidated financial statements for additional information regarding this disposition.

For 2004 through 2006, this segment s operating results were as follows:

	For the year ended December 31,		
	2006	2005	2004
	(Dollars In Millions)		
Outpatient			
Net operating revenues	$ 326.6	$ 371.1	$ 431.1
Operating expenses*	299.9	339.4	392.3
Operating earnings	$ 26.7	$ 31.7	$ 38.8
Visits (in thousands)	3,183.3	3,779.5	4,345.5
Full time equivalents (actual amounts)	3,131	3,815	4,568

* Includes divisional overhead, but excludes corporate overhead allocation. See Note 26, *Segment Reporting*, to our accompanying consolidated financial statements. Includes the effect of *Minority interests in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*.

For the years ended December 31, 2006, 2005, and 2004, outpatient s *Net operating revenues* were derived from the following payor sources:

	For the year ended December 31,		
	2006	2005	2004
Medicare	12.8%	14.4%	12.6%
Medicaid	0.8%	0.8%	0.6%
Workers' compensation	23.1%	23.2%	24.7%
Managed care and other discount plans	53.0%	50.4%	49.9%
Other third-party payors	5.7%	5.9%	6.6%
Patients	0.5%	0.9%	1.2%
Other income	4.1%	4.4%	4.4%
Total	100.0%	100.0%	100.0%

The number of visits patients make to our centers is a key metric utilized by the segment to regularly evaluate its performance. Outpatient s *Net operating revenues* include revenues from patient visits, as well as revenues generated from trainers and management contracts. Outpatient has contracts with schools, municipalities, and other parties around the country to provide physical therapists and/or athletic trainers for various events. Outpatient also receives management and administrative fees for facilities it manages, but does not own. Trainer income, management fees, and administrative fees comprise the majority of the segment s other income.

The segment s most significant operating expense is *Salaries and benefits*, which includes all amounts paid to full- and part-time employees at our centers, as well as all related costs of benefits provided to employees. Due to the nature of the services provided by our outpatient centers, *Supplies* expense does not represent a significant portion of the segment s operating expenses, unlike our other business segments.

Our outpatient segment participates in a slower growing, lower margin business than our other operating segments. Due to regulatory changes, physicians that once referred business to us are now treating patients at their own facilities. Due to the relatively low barriers to entry associated with an outpatient facility, our outpatient segment continues to face increased competition from physician-owned physical therapy sites. The segment is also facing an industry-wide shortage of physical therapists. To combat the shortage, our outpatient segment implemented key incentive plans to help recruit and retain therapists. These incentive plans have begun to reduce therapist turnover rates and have increased the segment s overall clinical productivity.

In 2006, our facility rationalization and marketing initiatives within our outpatient segment began to improve the segment s operating results. However, while our current exposure to competition from physician-owned physical therapy sites is less than it was in 2005 as a result of our initiatives to diversify our referral sources, we continued to

be negatively impacted by continued competition from physician-owned physical therapy sites in 2006. We were also negatively impacted by the annual per-beneficiary limitations on Medicare outpatient therapy services.

Changes in the Reimbursement Environment for Outpatient Services

Our outpatient segment faces a changing reimbursement environment. The Balanced Budget Act of 1997 changed the reimbursement methodology for Medicare Part B therapy services from cost based to fee schedule payments. It also established two types of annual per-beneficiary limitations on outpatient therapy services provided outside of a hospital outpatient setting: (1) a $1,500 cap for all outpatient therapy services and speech language pathology services; and (2) a $1,500 cap for all outpatient occupational therapy services, as adjusted for inflation (per beneficiary per year caps are set at $1,740 for calendar year 2006 and $1,780 for calendar year 2007). These therapy caps are subject to certain exceptions relating to medically necessary services for calendar year 2006 and 2007. These therapy caps have had a negative impact on our *Net operating revenues*.

On November 1, 2006, CMS issued a final rule that will update the payment methodology under the Physician Fee Schedule beginning January 1, 2007. Specifically, the rule would update the work RVUs based on the five-year review required under statute, implement a new payment methodology for practice expense relative value units and apply a negative budget neutrality adjustment to the work relative value units. These changes, combined with a 5% reduction to the payment conversion factor under the Physician Fee Schedule, will result in lower reimbursement to us for outpatient services.

On December 20, 2006, the President of the United States signed into law the Tax Relief and Healthcare Act of 2006 that reverses the 5% reduction to the payment conversion factor, restores the therapy cap exception process for 2007 and would extend in 2007 the 1.0 geographic practice cost indices floor under the Physician Fee Schedule. We estimate that these combined changes will decrease our outpatient division s *Net operating revenues* by approximately $0.5 million per quarter for calendar year 2007 as compared to calendar year 2006.

Net Operating Revenues

From 2004 to 2006, patient visits to our outpatient facilities decreased by over 1.1 million visits. This decreased volume negatively impacted *Net operating revenues* by approximately $56.0 million and $53.7 million in 2006 and 2005, respectively. Management attributes the volume decline in each year to continued competition from physician-owned physical therapy sites, the nationwide physical therapist shortage, and closures of underperforming facilities that did not qualify as discontinued operations. In addition, the volume decrease from 2005 to 2006 is also due to the annual per-beneficiary limitations on Medicare outpatient therapy services that became effective on January 1, 2006.

During 2006, our outpatient segment was able to offset the negative revenue impact of declining volumes by achieving higher net patient revenue per visit due to its examination and elimination of managed care contracts with low reimbursement rates, an increase in manual therapy services, and the closure of underperforming facilities that did not qualify as discontinued operations.

During 2006 and 2005, non-patient revenues of our outpatient segment decreased by $2.7 million and $2.8 million, respectively, due to facility closures and contract terminations during each year.

Operating Expenses

Salaries and Benefits

Salaries and benefits represent over 61% of outpatient s operating expenses in each year.

In 2006 and 2005, *Salaries and benefits* decreased by $24.7 million, or 11.6% and $28.5 million, or 11.8%, respectively, due to the closure of facilities that did not qualify as discontinued operations and a reduction in non-clinical full-time equivalents. The resulting decrease in full-time equivalents decreased *Salaries and benefits* by approximately $38.2 million and $39.7 million in 2006 and 2005, respectively. Decreased costs associated with fewer full-time equivalents were offset by increasing costs associated with employee benefits, contract labor, and incentives to recruit and retain physical therapists.

Provision for Doubtful Accounts

From 2004 to 2006, the *Provision for doubtful accounts* of our outpatient segment consistently remained between 2.0% and 4.5% of *Net operating revenues*.

All Other Operating Expenses

All other operating expenses decreased by approximately 16.1% from 2005 to 2006. This decrease was due to the closure of underperforming facilities that did not qualify as discontinued operations and our outpatient segment s efforts to control expenses. These expenses in 2006 included approximately $1.0 million of impairment charges. Triggering events related to facility closings and facilities experiencing negative cash flow from operations resulted in the segment recognizing these intangible and long-lived assets impairments. We determined the fair value of the impaired assets at a facility primarily based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

From 2004 to 2005, all other operating expenses decreased by approximately 10.1% due primarily to the closure of underperforming facilities that did not qualify as discontinued operations and a $2.7 million decrease in impairment charges year over year. Triggering events related to facility closings and facilities experiencing negative cash flow from operations resulted in the segment recognizing a $0.8 million impairment charge to long-lived assets in 2005. We determined the fair value of the impaired assets at a facility primarily based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

Triggering events related to facility closings and facilities experiencing negative cash flow from operations resulted in the segment recognizing an impairment charge of $3.5 million related to long-lived and intangible assets in 2004. We wrote these assets down to zero, or their estimated fair value, based on expected negative operating cash flows of these facilities in future years.

Operating Earnings

Operating earnings decreased in each year due to declining volumes, as discussed above. Although management reduced total operating expenses in each year, it was not enough to offset the decline in volumes in each year.

Diagnostic

We are one of the largest operators of freestanding diagnostic imaging centers in the United States. As of December 31, 2006, we performed diagnostic services through the operation of our network of 61 diagnostic centers in 19 states and the District of Columbia, with a concentration of centers in Texas, Alabama, Florida, and the Washington D.C. area.

Our diagnostic centers provide outpatient diagnostic imaging services, including MRI, CT, X-ray, ultrasound, mammography, and nuclear medicine services, as well as fluoroscopy. We do not provide all services at all sites, although approximately 80% of our diagnostic centers are multi-modality centers offering multiple types of service. Our outpatient diagnostic procedures are performed by experienced radiological technologists. After the diagnostic procedure is completed, the images are reviewed by radiologists who have contracted with us. These radiologists prepare an interpretation which is then delivered to the referring physician.

Due to the equipment utilized when performing diagnostic services for our patients, our diagnostic segment generally has high capital costs, including costs for maintaining its equipment.

For 2004 to 2006, our diagnostic segment s operating results were as follows:

	For the year ended December 31,		
	2006	2005	2004
	(Dollars In Millions)		
Diagnostic			
Net operating revenues	$ 186.9	$ 197.5	$ 197.7
Operating expenses*	213.5	195.5	200.3
Operating (loss) earnings	$ (26.6)	$ 2.0	$ (2.6)
Scans (in thousands)	635.6	659.2	664.5
Full time equivalents (actual amounts)	972	972	1,073

* Includes divisional overhead, but excludes corporate overhead allocation. See Note 26, *Segment Reporting*, to our accompanying consolidated financial statements. Includes the effect of *Minority interests in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*.

For the years ended December 31, 2006, 2005, and 2004, diagnostic derived its *Net operating revenues* from the following payor sources:

	For the year ended December 31,		
	2006	**2005**	**2004**
Medicare	19.7%	19.5%	18.3%
Medicaid	3.2%	3.4%	3.7%
Workers' compensation	8.1%	9.6%	8.7%
Managed care and other discount plans	58.9%	60.0%	59.4%
Other third-party payors	4.6%	4.5%	6.8%
Patients	2.9%	2.2%	2.2%
Other income	2.6%	0.8%	0.9%
Total	100.0%	100.0%	100.0%

The number of scans performed is a key metric utilized by the segment to regularly evaluate its performance. The segment s primary operating expenses include *Salaries and benefits*, *Professional and medical director fees*, and *Supplies*. *Salaries and benefits* represent the most significant costs to the segment and include all amounts paid to full- and part-time employees at our centers, as well as all related costs of benefits provided to employees. *Professional and medical director fees* primarily include fees paid under contracts with radiologists and other clinical professionals to read and interpret the scans performed at our centers. Payments under these contracts are normally tied to the number of scans read by each independent contractor, associated revenues with each scan, or cash collections. *Supplies* expense includes all costs associated with supplies used while performing diagnostic services for our patients. These costs primarily consist of the film costs associated with each scan.

Our diagnostic segment has struggled over the past several years due to poor margins for the diagnostic market in general, strong competition from physician-owned diagnostic equipment, increased pricing pressure from payors, and the age of equipment in our installed base. Competition in 2006 remained strong as diagnostic equipment manufacturers continued to lower prices and offer special financing to encourage physicians to purchase equipment through their own practices, resulting in a decline in the number of procedures performed at our diagnostic centers.

During the latter part of 2006, this segment s new management team focused on increasing scan volume while reducing operating expenses. Volume initiatives included (1) the reorganization of the sales and marketing group, including the addition of a new vice president of sales, (2) the selective upgrade of equipment at a number of our high-volume sites, and (3) the continued implementation of software tools for our referring physicians and radiologists. Expense reduction initiatives included the sale or closure of underperforming facilities, the elimination of our dependence on consultants that are engaged in various aspects of our operating activities, and a standardization of our workflow and personnel costs at the facility level. In addition, the segment completed the implementation of a new enterprise software platform that provides enhanced administrative, clinical, and revenue cycle functionality. We believe the implementation of this software will assist the segment in increasing referral volume, as well as improve the segment s collection activities at a reduced cost. While these actions should result in improvement in the segment s operating results going forward, our operating performance during 2006 was negatively impacted by the nonrecurring costs associated with these changes.

Changes in the Reimbursement Environment for Diagnostic Services

Our diagnostic segment faces a changing reimbursement environment. On November 1, 2006, CMS issued a final rule that will update the payment methodology under the Physician Fee Schedule beginning January 1, 2007. Specifically, the rule would update the work RVUs based on the five-year review required under statute, implement a new payment methodology for practice expense RVUs, and apply a negative budget neutrality adjustment to the work RVUs. In addition, the final rule caps payment rates for imaging services under the Physician Fee Schedule at the hospital outpatient prospective payment system rate. The final rule also maintains at 25% the reduction on payments for the technical component of multiple imaging procedures on contiguous body parts, as opposed to increasing the reduction to 50% as set forth in the 2006 final rule. The final rule will also implement, for the first time, 14 Independent Diagnostic Testing Facilities supplier standards to remain enrolled in the Medicare program. These changes, combined with a 5% reduction to the payment conversion factor under the Physician Fee Schedule, will result in lower reimbursement to us for diagnostic services.

On December 20, 2006, the President of the United States signed into law the Tax Relief and Healthcare Act of 2006 that reverses the 5% reduction to the payment conversion factor and would extend in 2007 the 1.0 geographic practice cost indices floor under the Physician Fee Schedule. We estimate that these combined changes will decrease our diagnostic division s *Net operating revenues* by approximately $5.6 million for calendar year 2007 as compared to calendar year 2006. That estimate includes revenue declines under our managed care contracts that contain pricing provisions tied to the Medicare fee schedule but does not include the potential for additional price compression from commercial payors as a result of CMS s rulemaking.

Net Operating Revenues

The decrease in *Net operating revenues* from 2005 to 2006 is attributable to lower scan volumes and a shift in case mix to lower-paying modalities. The segment s volume declines are primarily attributable to competition from physician-owned diagnostic equipment and the closure of underperforming facilities that did not qualify as discontinued operations. During 2006, our diagnostic segment also received approximately $2.9 million of other income related to insurance recoveries from hurricane damages in prior periods.

From 2004 to 2005, the segment experienced lower scan volumes, but the impact to *Net operating revenues* attributable to lower scan volumes was offset by a shift in case mix to higher-paying modalities.

Operating Expenses

Salaries and Benefits

Salaries and benefits increased by approximately 7.4% from 2005 to 2006. Approximately 3% of this increase is attributable to annual merit increases, with the remainder attributable to additional costs associated with hiring a new divisional management team, the use of contract labor to assist with certain back office operations of the segment, and additional staffing resources related to the implementation of the software platform discussed above. While we expect the items that resulted in these increased costs to improve operating performance going forward, these changes increased *Salaries and benefits* from approximately 26% of *Net operating revenues* in 2005 to approximately 29% of *Net operating revenues* in 2006.

Salaries and benefits decreased by 1.5% from 2004 to 2005 primarily as a result of eliminating full-time positions at certain business offices by outsourcing the segment s collections processes to a third-party and the closure of underperforming facilities that did not qualify for discontinued operations. Due to these headcount

reductions at the segment s business offices and the closure of underperforming facilities. *Salaries and benefits* remained at approximately 26% of *Net operating revenues* from 2004 to 2005.

Supplies

From 2005 to 2006, *Supplies* expense decreased from 4.7% of *Net operating revenues* to 4.4% of *Net operating revenues*. From 2004 to 2005, *Supplies* expense decreased from 5.2% of *Net operating* revenues to 4.7% of *Net operating revenues.* In each year, *Supplies* expense decreased due to the decrease in scan volumes during each year, more favorable supply pricing, and improved efficiency. In 2006, *Supplies* expense also decreased as certain of our facilities began using remote picture archiving communication systems that allow for the remote reading of digital images of the diagnostic scans performed by our centers, which allowed us to reduce our film costs.

Professional and Medical Director Fees

From 2004 to 2006, *Professional and medical director fees* generally followed the same trend as our *Net operating revenues* and cash collections.

Provision for Doubtful Accounts

Our *Provision for Doubtful Accounts* was 22.7%, 16.5%, and 17.7% of *Net operating revenues* in 2006, 2005, and 2004, respectively. During 2005, our *Provision for Doubtful Accounts* decreased as a percent of *Net operating revenues* due to the outsourcing of collection activities to a third party. During 2006, the diagnostic segment increased its *Provision for doubtful accounts* based on current collection activities and payment trends. However, we believe these trends were partially caused by the distraction of the implementation of a new enterprise software platform, which has now been completed.

All Other Operating Expenses

All other operating expenses increased by 7.1% from 2005 to 2006 due primarily to approximately $4.7 million of non-capitalizable implementation charges related to a new enterprise information technology system, increased professional fees associated with the outsourcing of collection activities, and the repairs and maintenance of equipment. In addition, the assessment of closed facilities and facilities that had continuing negative cash flows from operations resulted in the segment recognizing a $1.8 million impairment charge related to long-lived assets during 2006. We determined the fair value of the impaired long-lived assets at a facility primarily based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

All other operating expenses increased by 6.3% from 2004 to 2005 due primarily to a year-over-year increase in impairment charges. Triggering events related to facility closings and facilities experiencing negative cash flow from operations resulted in the segment recognizing a $3.5 million impairment charge to long-lived assets in 2005. We determined the fair value of the impaired long-lived assets at a facility primarily based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

During 2004, triggering events related to facility closings and facilities experiencing negative cash flow from operations resulted in the segment recognizing an impairment charge of approximately $0.8 million related to long-lived assets. We wrote these assets down to zero, or their estimated fair value, based on expected negative operating cash flows of these facilities in future years.

Operating (Loss) Earnings

Operating earnings of our diagnostic segment decreased from 2005 to 2006 due to declining volumes and the increased operating expenses discussed above. In 2005, our diagnostic segment decreased its operating loss by closing underperforming facilities and decreasing its *Provision for doubtful accounts*.

We expect the segment s volume and expense reduction initiatives to improve the segment s operating results going forward.

Corporate and Other

Corporate and other includes all revenue-producing activities that do not fall within one of the four operating segments discussed above, including the operation of the conference center located at our corporate campus, our clinical research activities, and other services that are generally intended to complement our patient care activities. This segment also includes HCS, Ltd. (HCS), our wholly owned subsidiary that handles medical malpractice, workers compensation, and other claims for us.

All our corporate departments and related overhead are also contained within this segment. These departments, which include among others accounting, communications, compliance, human resources, information technology, internal audit, legal, payor strategies, reimbursement, tax, and treasury, provide support functions to our operating divisions.

For 2004 through 2006, this segment s operating results were as follows:

	For the year ended December 31,		
	2006	2005	2004
	(Dollars In Millions)		
Corporate and Other			
Net operating revenues	$ 48.4	$ 84.9	$ 94.4
Operating expenses*	361.8	612.5	405.6
Operating loss	$ (313.4)	$ (527.6)	$ (311.2)
Full time equivalents (actual amounts)	1,000	922	760

*Includes all corporate overhead. See Note 26, *Segment Reporting*, to our accompanying consolidated financial statements. Includes the effect of *Minority interests in earnings of consolidated affiliates* and *Equity in net income of nonconsolidated affiliates*. This line item also includes approximately $34.9 million and $215 million in 2006 and 2005, respectively, related to *Government, class action, and related settlements expense*.

Salaries and benefits represents one of the most significant costs to the segment and includes all amounts paid to full- and part-time employees at our corporate headquarters (excluding any divisional management allocated to each operating segment) in Birmingham, Alabama, as well as all related costs of benefits provided to these employees. All general and administrative costs related to the operation of our corporate office are included in *Other operating expenses*. The most significant general and administrative expenses relate to insurance including property and casualty, general liability, and directors and officers coverage.

During 2006, we continued to strive to control costs associated with our corporate and other segment, but this was difficult due to our continued investment in our infrastructure (both people and technology). We continued to focus on the remediation of internal controls, including the implementation of our information technology strategic plan. We continued to replace the work performed by consultants during the reconstruction period with HealthSouth employees, and we continued to add resources to provide the necessary level of support to our facilities and meet our operational needs.

Net Operating Revenues

Changes in *Net operating revenues* from year to year primarily relate to changes in earned premiums of HCS, which eliminate in consolidation. During 2006, we experienced a reduction of approximately $30.6 million in premiums from HCS due to updated actuarial calculations driven by current claims history, exit from the acute care business, and fewer full-time equivalents.

Operating Expenses

Salaries and Benefits

From 2005 to 2006, *Salaries and benefits* increased by $19.0 million, or 27.2%. Approximately $12.1 million of this increase was due to increased stock-based compensation costs associated with our adoption of FASB Statement No. 123(R) on January 1, 2006. The remainder of the increase is due to annual merit increases provided to employees, an increase in the employer matching contribution percentage related to our 401(k) plan (see Note 17, *Employee Benefit Plans*, to our accompanying consolidated financial statements), and the hiring of additional management personnel at our corporate office, which would increase the average salary per full-time equivalent.

From 2004 to 2005, *Salaries and benefits* decreased by $11.0 million, or 13.6%, primarily due to lower claims and premiums expense associated with workers compensation.

All Other Operating Expenses

In 2006, 2005, and 2004, all other operating expenses of the corporate and other segment include $8.6 million, $24.4 million, and $30.2 million, respectively, of impairment charges related to the 19-acre tract of land that includes an incomplete 13-story building formerly called the Digital Hospital. In each year, the impairment charge represents the excess of costs incurred during the construction of the Digital Hospital over the estimated fair value of the property, including the River Point facility, a 60,000 square foot office building, which shares the site and would be included with any sale of the Digital Hospital. The impairment of the Digital Hospital in each year was determined using a weighted average fair value approach that considered an alternative use appraisal and other potential scenarios.

In addition to the $8.6 million and $24.4 million impairment charges related to the Digital Hospital in 2006 and 2005, respectively, the corporate and other segment recorded $1.1 million and $9.4 million, respectively, in other long-lived asset impairment charges. We determined the fair value of the impaired long-lived asset based on the assets estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

All other operating expenses decreased by 49.7% from 2005 to 2006. The primary contributor to this decrease was the securities litigation settlement discussed in Note 24, *Securities Litigation Settlement*, to our accompanying consolidated financial statements. During 2005, we recorded a $215 million charge as *Government, class action, and*

related settlements expense under a proposed settlement with the lead plaintiffs in these consolidated cases. 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. Therefore, year over year, charges related to our securities litigation settlement decreased our corporate segment s operating expenses by $246.2 million.

Excluding the amounts recorded for the securities litigation settlement in both 2006 and 2005, all other operating expenses of our corporate and other segment would have decreased by 7.2% in 2006 due to the $47.8 million recovery from Richard M. Scrushy (as discussed earlier in this Item), the $24.1 million year over year decrease in impairment charges (as discussed above), decreased consulting fees for strategic planning and other projects, and a decrease in insurance costs. Also, as discussed in Note 8, *Investment in and Advances to Nonconsolidated Affiliates*, to our accompanying consolidated financial statements, all other operating expenses of our corporate and other segment in 2006 includes the removal of a $6.0 million liability related to Source Medical and the repayment of a $6.9 million note receivable from Source Medical.

These decreased costs in 2006 were offset by a $37.9 million recovery related to Meadowbrook and a $30.5 million net gain resulting from the lease termination associated with the Braintree and Woburn facilities, as recorded in 2005 and discussed earlier in this Item. Excluding the securities litigation settlement, the corporate and other segment also recorded $66.1 million in charges classified as *Government, class action, and related settlements expense* in 2006. Amounts recorded as *Government, class action, and related settlements expense* include approximately $44.0 million related to ongoing settlement negotiations with our subsidiary partnerships, $1.0 million related to our ERISA litigation, $4.0 million 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, $1.9 million related to the Goodreau litigation, $3.0 million related to the non-prosecution agreement reached with the DOJ, $5.7 million to settle disputes related to our former Braintree and Woburn facilities, and $6.5 million for settlements and other ongoing settlement negotiations. For additional information regarding these settlements, ongoing discussions, and litigation, see Note 24, *Securities Litigation Settlement*, and Note 25, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

All other operating expenses increased by 67.2% from 2004 to 2005. The primary contributor to this increase is the $215.0 million settlement associated with our securities litigation, as discussed above. Excluding the amount recorded for the securities litigation settlement, all other operating expenses in the corporate and other segment would have increased by less than 1.0% in 2005 due to increased expenses associated with accounting, legal, and consulting professional fees. We incurred these fees in 2005 as a result of Sarbanes-Oxley costs and strategic agenda consulting. These increased costs were offset by the $37.9 million recovery related to Meadowbrook (discussed earlier in this Item) and a $38.6 million decrease in *Professional fees accounting, tax, and legal* resulting from the decreased use of consultants as our new management team was in place.

Operating Loss

The change in our operating loss in each year was due primarily to the $215.0 million securities litigation settlement recorded in 2005.

As noted above, we continue to strive to control costs associated with our corporate and other segment. While we made progress in this area in 2006 by reducing the amounts paid to consultants for strategic planning, accounting assistance, and other projects, we made additional payments to tax consultants, attorneys, and investment bankers. During 2006, professional fees paid for tax services increased by approximately $9.5 million due primarily to tax projects associated with our filing of amended income tax returns for 1996 through 2003. As a result of our recovery of incentive bonuses from Richard M. Scrushy and our securities litigation settlement, we recorded a charge of approximately $32.5 million during 2006 for amounts owed to the derivatives attorneys in these cases. As part of our strategic repositioning and efforts to divest our surgery centers, outpatient, and diagnostic divisions, we incurred professional fees of approximately $7.7 million during 2006 associated with transaction support services and audit fees related to carveout financial statements for these divisions.

Because of the professional fees incurred for strategic planning and our repositioning, accounting assistance, litigation defense, tax services, and other special projects in each year and because we do not allocate corporate overhead associated with each operating segment to the applicable segment, we do not believe our historic run rate

for operating expenses in our corporate and other segment is indicative of the run rate that can be expected going forward after the divestiture of certain of our operating segments.

Results of Discontinued Operations

In our continuing effort to streamline operations, we identified 10 entities in our inpatient segment, 272 outpatient rehabilitation facilities, 30 surgery centers, 40 diagnostic centers, and 14 other facilities during 2006, 2005, and 2004 that met the requirements of FASB Statement No. 144 to report as discontinued operations. For the facilities identified during 2006 that met the requirements of FASB Statement No. 144 to report as discontinued operations, we reclassified our consolidated balance sheet for the year ended December 31, 2005 and our consolidated statements of operations and consolidated statements of cash flows for the years ended December 31, 2005 and 2004 to show the results of those facilities as discontinued operations.

When determining if a closed facility qualifies for discontinued operations under FASB Statement No. 144, we consider the proximity of the facility to other HealthSouth facilities offering similar services as well as other facilities within the same regional cost center that remain open. If we believe HealthSouth will retain patients by transferring the services to another HealthSouth facility, we will not treat the closed facility as a discontinued operation. We do not account for facilities that were closed or sold as discontinued operations until we have exited the specific market.

The operating results of discontinued operations, by operating segment and in total, are as follows:

	For the year ended December 31,		
	2006	2005	2004
	(In Millions)		
Inpatient:			
Net operating revenues	$ 29.2	$ 41.4	$ 45.6
Costs and expenses	30.7	37.0	44.2
Impairments	1.8	0.5	
(Loss) income from discontinued operations	(3.3)	3.9	1.4
(Loss) gain on disposal of assets of discontinued operations	(0.8)	0.4	(0.6)
Income tax expense	(0.2)	(1.4)	
(Loss) income from discontinued operations	$ (4.3)	$ 2.9	$ 0.8
Surgery Centers:			
Net operating revenues	$ 12.9	$ 36.8	$ 67.5
Costs and expenses	19.6	52.0	82.3
Impairments		0.5	2.5
Loss from discontinued operations	(6.7)	(15.7)	(17.3)
Gain on disposal of assets of discontinued operations	7.5	6.3	1.8
Income tax expense			
Income (loss) from discontinued operations	$ 0.8	$ (9.4)	$ (15.5)
Outpatient:			
Net operating revenues	$ 4.9	$ 22.3	$ 60.1
Costs and expenses	6.8	27.0	64.0
Impairments			0.8
Loss from discontinued operations	(1.9)	(4.7)	(4.7)
Gain (loss) on disposal of assets of discontinued operations	0.1	0.1	(1.2)
Income tax expense			
Loss from discontinued operations	$ (1.8)	$ (4.6)	$ (5.9)
Diagnostic:			
Net operating revenues	$ 11.2	$ 23.2	$ 38.0
Costs and expenses	20.9	32.3	50.6
Impairments	2.7	1.1	0.1
Loss from discontinued operations	(12.4)	(10.2)	(12.7)
Gain on disposal of assets of discontinued operations	5.0	2.0	3.1
Income tax expense			
Loss from discontinued operations	$ (7.4)	$ (8.2)	$ (9.6)
Corporate and Other:			
Net operating revenues	$ 18.3	$ 76.7	$ 153.7
Costs and expenses	25.5	118.3	232.3
Impairments		6.6	16.7
Loss from discontinued operations	(7.2)	(48.2)	(95.3)
(Loss) gain on disposal of assets of discontinued operations	(6.1)	0.3	0.2
Income tax expense			
Loss from discontinued operations	$ (13.3)	$ (47.9)	$ (95.1)
Total:			
Net operating revenues	$ 76.5	$ 200.4	$ 364.9
Costs and expenses	103.5	266.6	473.4
Impairments	4.5	8.7	20.1
Loss from discontinued operations	(31.5)	(74.9)	(128.6)
Gain on disposal of assets of discontinued operations	5.7	9.1	3.3
Income tax expense	(0.2)	(1.4)	
Loss from discontinued operations	$ (26.0)	$ (67.2)	$ (125.3)

Inpatient. As noted earlier in this Item, Segment Results of Operations Inpatient, in October 2006, we closed a transaction to sell Cedar Court. Also as discussed earlier in this Item, the lease associated with Central Georgia Rehabilitation Hospital expired on September 30, 2006 and was not extended. We also made a decision in 2006 to sell the license associated with our Pendleton LTCH in New Orleans, Louisiana. Our Pendleton LTCH has not been operational since Hurricane Katrina hit New Orleans in 2005. All three of these facilities are included in discontinued operations and are the primary sources of the net operating revenues and costs and expenses in each year. The timing of the sale or closure of these facilities drove the change in net operating revenues and costs and expenses in each year. The income tax expense in 2006 relates to the Cedar Court transaction.

Surgery Centers. Both the decline in net operating revenues and the decline in costs and expenses in each year were due to the timing of the sale or closure of the surgery centers identified as discontinued operations. The net gain on asset disposals in 2006 primarily resulted from an approximate $5.4 million gain recorded on the sale of three facilities located in Tennessee and Florida during the first quarter of 2006. The net gain on asset disposals in 2005 primarily resulted from gains recorded on the sale of assets at certain surgery centers in New Jersey, Arizona, and Florida.

Outpatient. The timing of the closure of the outpatient rehabilitation facilities identified as discontinued operations drove the change in net operating revenues and costs and expenses in each year.

Diagnostic. Both the decline in net operating revenues and the decline in costs and expenses in each year were due to the timing of the sale or closure of the diagnostic facilities identified as discontinued operations.

Corporate and Other. 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. We have transferred the hospital and associated real and personal property, including the transfer of our interest in the gamma knife partnership. The transaction also required that we acquire and convey title to the University of Alabama or its affiliate for certain professional office buildings that we leased. Both the certificate of need under which the hospital operated and the licensed beds operated by us at the hospital were transferred as part of the sale of the hospital under the amended and restated agreement.

From 2005 to 2006, the decrease in net operating revenues related primarily to the performance and eventual sale of the Birmingham Medical Center. From 2004 to 2005, the decrease in net operating revenues was due to the closure of Metro West hospital in September 2004 and the continued poor performance of the Birmingham Medical Center. The change in costs and expenses in each year follow these same trends.

The impairment charge in 2004 primarily related to a $14.8 million impairment charge associated with the Birmingham Medical Center. Due to continuing negative cash flows from operations of this facility, we had the Birmingham Medical Center appraised as of December 31, 2004. The impairment charge represents the difference between the appraised value and the net book value of the long-lived assets associated with the Birmingham Medical Center.

The net loss on disposal of assets in 2006 was the result of our sale of the Birmingham Medical Center and lease termination fees associated with certain properties adjacent to the Birmingham Medical Center offset by the gain on the sale of Metro West hospital. See Note 18, *Discontinued Operations*, to our accompanying consolidated financial statements for additional information related to our sale of the Birmingham Medical Center.

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 9, *Long-term Debt*, to our accompanying consolidated financial statements).

We are highly leveraged. As of December 31, 2006, we had approximately $3.4 billion of long-term debt outstanding. Although we are highly leveraged, we believe the recapitalization transactions (as discussed in this Item and in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements) improved our financial position by reducing our refinancing risk, improving our operational flexibility, increasing our liquidity, and improving our credit profile.

As of December 31, 2006, approximately $170 million was drawn under our $400 million revolving credit facility (excluding approximately $32.3 million utilized under the revolving letter of credit subfacility) due to seasonal borrowing needs, the timing of interest payments, and government settlement payments (as discussed in Note 22, *Medicare Program Settlement*, and Note 23, *SEC Settlement*, to our accompanying consolidated financial statements). Based on our current borrowing capacity and leverage ratio required under our Credit Agreement (presented later in this Item), we do not believe there is significant risk in our ability to make additional draws under our revolving credit facility, if needed.

The biggest risk relating to our high leverage is the possibility that a substantial down-turn in earnings could jeopardize our ability to service our debt payment obligations. 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.

In 2007, we will make the final settlement payments related to our Medicare Program Settlement and SEC Settlement (see Note 22, *Medicare Program Settlement*, and Note 23, *SEC Settlement*, to our accompanying consolidated financial statements). Until we make these final settlement payments and are able to redirect our operating cash elsewhere in the company, we will have a challenging cash management and liquidity environment. Our goal in 2007 is to deleverage the company through the use of anticipated proceeds from the divestiture of our surgery centers, outpatient, and diagnostic divisions. During 2007 or 2008, we also expect to deleverage the company through receipt of income tax refunds from amended and restated tax returns from prior years. As we receive these proceeds and refunds, and once we are no longer making payments under our Medicare Program Settlement and SEC Settlement, we expect our liquidity to improve. However, no such assurances can be given as to whether or when such proceeds will be received.

We are now in Phase 2, or the operational and growth focus portion, of our strategic plan. During this phase, we will use operating cash flows and other sources of liquidity to take advantage of selected development opportunities in our inpatient division. Specifically, we plan to explore consolidation opportunities as they arise and build new IRFs. In order to do this, we may need to borrow on our revolving credit facility and/or enter into new financing agreements until we receive the anticipated proceeds from any divestitures and the anticipated refunds related to prior year income tax returns.

Sources and Uses of Cash

Our primary sources of funding are cash flows from operations, borrowings under long-term debt agreements, and sales of limited partnership interests. 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 chart shows the cash flows provided by or used in operating, investing, and financing activities for 2006, 2005, and 2004, as well as the effect of exchange rates for those same years:

	For the year ended December 31,		
	2006	**2005**	**2004**
	(In Millions)		
Net cash (used in) provided by operating activities	$ (120.4)	$ (2.9)	$ 390.8
Net cash provided by (used in) investing activities	59.3	(101.8)	(185.9)
Net cash used in financing activities	(75.3)	(172.0)	(224.7)
Effect of exchange rate changes on cash and cash equivalents	0.1	(1.2)	1.3
Decrease in cash and cash equivalents	$ (136.3)	$ (277.9)	$ (18.5)

2006 Compared to 2005

Operating activities. *Net cash used in operating activities* increased from 2005 to 2006 due to volume declines in each of our operating segments, as discussed above. *Net cash used in operating activities* in 2006 and 2005 includes approximately $118.4 million and $165.4 million, respectively, in amounts 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, including the disposal of assets for facilities that qualify as 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 partnerships cash with other corporate cash accounts. During 2006, we were able to eliminate many of these restrictions through continuing discussions and negotiations with our external partners. As a result of the elimination of these restrictions, our restricted affiliate cash accounts decreased by $19.7 million during 2006.

Within investing activities, it is also important to note that restricted cash held at HCS, Ltd. that was committed to pay for claims incurred was invested in restricted marketable securities. During 2006, restricted cash held by HCS, Ltd. decreased by approximately $117.9 million. However, we purchased approximately $77.5 million of restricted marketable securities.

Financing activities. The decrease in *Net cash used in financing activities* for 2006 compared to 2005 was due to the recapitalization transactions and private offering of senior notes discussed below. As a result of these transactions, net payments on debt, including capital lease obligations, increased by approximately $173.8 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*, as discussed below. We also paid approximately $15.7 million in dividends on our *Convertible perpetual preferred stock* during 2006.

2005 Compared to 2004

Operating activities. *Net cash provided by operating activities* decreased from 2004 to 2005 as a result of lower *Net operating revenues* in 2005, cash payments for government, class action, and related settlements, and a return to normal payment terms with many of our vendors. As discussed earlier in this Item, our *Net operating revenues* decreased in 2005 due to declining volumes experienced by our operating segments. In addition, we paid approximately $155.0 million, excluding interest, to the United States related to our Medicare Program Settlement, and we paid $12.5 million to the SEC under a settlement agreement. These settlements are discussed in Note 22, *Medicare Program Settlement*, and Note 23, *SEC Settlement*, to our accompanying consolidated financial statements. With our revolving line of credit frozen throughout 2004, we added approximately two weeks to most payment terms of our vendors as part of our cash management and conservation process. After we amended and restated our credit agreement in March 2005 (see Note 9, *Long-term Debt*, to our accompanying consolidated financial statements), we were able to return to more normal payment terms with our vendors. This decreased our net cash provided by operating activities year over year.

Investing activities. *Net cash used in investing activities* decreased from 2004 to 2005 primarily due to a reduction in capital expenditures. During 2005, we decreased capital expenditure budgets and postponed development projects to conserve cash and restructure our business.

Financing activities. *Net cash used in financing activities* decreased from 2004 to 2005 due primarily to $73.4 million less in debt issuance costs and consent fees paid in 2005 offset by $21.6 million more in net debt payments, including capital lease obligations. See Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

Current Liquidity and Capital Resources

As of December 31, 2006, we had approximately $40.6 million in cash and cash equivalents. This amount excludes approximately $99.6 million in restricted cash and $71.1 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, 2005,

we had approximately $174.5 million in cash and cash equivalents, $237.4 million in restricted cash, and $23.8 million of non-restricted marketable securities.

On March 10, 2006, we completed the last of a series of recapitalization transactions (the Recapitalization Transactions) enabling us to prepay substantially all of our prior indebtedness and replace it with approximately $3 billion of new long-term debt. Although we remain highly leveraged, we believe these Recapitalization Transactions have eliminated significant uncertainty regarding our capital structure and have improved our financial condition in several important ways:

Reduced refinancing risk The terms governing our prior indebtedness would have required us to refinance approximately $2.7 billion between 2006 and 2009, assuming all noteholders holding options to require us to repurchase their notes in 2007 and 2009 were to exercise those options. Under the terms governing our new indebtedness, we have minimal maturities until 2013 when our new term loans come due. The extension of our debt maturities has substantially reduced the risk and uncertainty associated with our near-term refinancing obligations under our prior debt.

Improved operational flexibility We have negotiated new loan covenants with higher leverage ratios and lower interest coverage ratios. In addition, our new loan agreements increase our ability to enter into certain transactions (e.g., acquisitions and sale-leaseback transactions).

Increased liquidity As a result of the Recapitalization Transactions, our revolving line of credit increased by approximately $150 million. In addition, the increased flexibility provided by the covenants governing our new indebtedness will allow us greater access to our revolving credit facility than we had under our prior indebtedness.

Improved credit profile By issuing $400 million in convertible perpetual preferred stock and using the net proceeds from that offering to repay a portion of our outstanding indebtedness and to pay fees and expenses related to such prepayment, we were able to reduce the amount we ultimately borrowed under the interim loan agreement. In addition, by increasing the ratio of our secured debt to unsecured debt, our capital structure is now closer to industry norms. Further, a substantial amount of our new indebtedness is prepayable without penalty, which will enable us to reduce debt and interest expense as operating and non-operating cash flows allow without the substantial cost associated with the prepayment of our prior public indebtedness.

The Recapitalization Transactions included (1) entering into credit facilities that provide for extensions of credit of up to $2.55 billion of senior secured financing, (2) entering into an interim loan agreement that provided us with $1.0 billion of senior unsecured financing, (3) completing a $400 million offering of convertible perpetual preferred stock, (4) completing cash tender offers to purchase $2.03 billion of our previously outstanding senior notes and $319 million of our previously outstanding senior subordinated notes and consent solicitations with respect to proposed amendments to the indentures governing each outstanding series of notes, and (5) prepaying and terminating our Senior Subordinated Credit Agreement, our Amended and Restated Credit Agreement, and our Term Loan Agreement. In order to complete the Recapitalization Transactions, we also entered into amendments, waivers, and consents to our prior senior secured credit facility, $200 million senior unsecured term loan agreement, and $355 million senior subordinated credit agreement. Detailed descriptions of each of the above transactions are contained in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

We used a portion of the proceeds of the loans under the new senior secured credit facilities, the proceeds of the interim loans, and the proceeds of the $400 million offering of convertible perpetual preferred stock, along with cash on hand, to prepay substantially all of our prior indebtedness and to pay fees and expenses related to such prepayment and the Recapitalization Transactions. The remainder of the proceeds and availability under the senior secured credit facilities are being used for general corporate purposes. In addition, the letters of credit issued under the revolving letter of credit subfacility and the synthetic letter of credit facility will be used in the ordinary course of business to secure workers compensation and other insurance coverages and for general corporate purposes.

In June 2006, we repaid our Interim Loan Agreement using cash on hand and the proceeds from a private offering of $1.0 billion aggregate principal amount of senior notes, which included $375 million in aggregate principal amount of floating rate senior notes due 2014 (the Floating Rate Notes) at par and $625 million aggregate principal amount of 10.750% senior notes due 2016 at 98.505% of par. The Floating Rate Notes bear

interest at a per annum rate equal to LIBOR plus 6.0%. For additional information regarding this transaction, see Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

The face value of our long-term debt (excluding notes payable to banks and others, noncompete agreements, and capital lease obligations) before and after the transactions described above is summarized in the following table:

	As of December 31, 2006	**As of December 31, 2005**
	(In Millions)	
Revolving credit facility	$ 170.0	$
Term loans	2,039.8	513.4
Bonds payable	1,046.5	2,720.9
	$ 3,256.3	$ 3,234.3

The following charts show our scheduled payments on long-term debt (excluding notes payable to banks and others, noncompete agreements, and capital lease obligations) as of December 31, 2005 (before the Recapitalization Transactions and private offering of senior notes) and as of December 31, 2006 (after the Recapitalization Transactions and private offering of senior notes) for the next five years and thereafter. The charts also exclude the *Convertible perpetual preferred stock*.

* Excludes $185.2 million of maturities that would have occurred in 2006.

As noted above, we have negotiated new debt covenants as part of the Recapitalization Transactions. These covenants include higher leverage ratios and lower interest coverage ratios. As of December 31, 2006, per our new senior credit facility, our required minimum interest coverage ratio was 1.65 to 1.00, and our required maximum leverage ratio was 7.50 to 1.00.

On February 20, 2007, we announced that we are seeking certain amendments to our existing Credit Agreement (as defined in Note 9, *Long-term Debt*, to our accompanying consolidated financial statements). The amendments sought include a reduction in the margin over LIBOR that we currently pay and approval for our divestiture activities.

Funding Commitments

After the above Recapitalization Transactions and private offering of senior notes, we have scheduled payments of $37.6 million and $83.4 million in 2007 and 2008, respectively, related to long-term debt obligations (including notes payable to banks and others, noncompete agreements, and capital lease obligations). For additional information about our long-term debt obligations, see Note 9, *Long-term Debt*, to our accompanying consolidated financial statements.

We also have funding commitments related to legal settlements. As a result of the Medicare Program Settlement discussed in Note 22, *Medicare Program Settlement*, to our accompanying consolidated financial statements, we made aggregate principal payments of approximately $83.3 million and $155.0 million to the United States during 2006 and 2005, respectively. The remaining principal balance of $86.7 million will be paid in quarterly installments in 2007. These amounts are exclusive of interest from November 4, 2004 at an annual rate of 4.125%. In addition to the Medicare Program Settlement, we reached an agreement with the SEC to resolve claims brought by the SEC against us in March 2003. As a result of the SEC Settlement, we made aggregate payments of $37.5 million and $12.5 million to the SEC in 2006 and 2005, respectively. We will make aggregate payments of $50.0 million in 2007.

During 2006, we made capital expenditures of approximately $99.2 million. Total amounts budgeted for capital expenditures for 2007 approximate $140 million. These expenditures include IT initiatives, new business opportunities, and equipment upgrades and purchases. Approximately $50 million of this budgeted amount is discretionary and could be revised, if necessary.

For a discussion of risk factors related to our business and our industry, please see Item 1A, *Risk Factors*, of this Form 10-K 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 our company.

We are secondarily liable for certain lease obligations associated with sold facilities. As of December 31, 2006, we had entered into eight such lease guarantee arrangements. The remaining terms of these leases range from 7 months to 150 months. If we were required to perform under all such guarantees, the maximum amount we would be required to pay approximates $22.6 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. In the event we are required to perform under these guarantees, we could potentially have recourse against the purchaser of the applicable sold facility for recovery of any amounts paid. For additional information regarding these guarantees, see Note 6, *Property and Equipment*, to our accompanying consolidated financial statements.

As of December 31, 2006, we do not have any retained or contingent interest in assets as defined above.

As of December 31, 2006, 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 new Credit Agreement, as discussed in Note 9, *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, 2006 and 2005, we are not involved in any unconsolidated SPE transactions.

Contractual Obligations

Achieving optimal returns on cash often involves making long-term commitments. SEC regulations require that we present our contractual obligations, and we have done so in the table that follows. However, our future cash flow prospects cannot reasonably be assessed based on such obligations, as the most significant factor affecting our future cash flows is our ability to earn and collect cash from our third-party payors and patients. Future cash outflows, whether they are contractual obligations or not, will vary based on our future needs. While some such outflows are completely fixed (for example, commitments to repay principal and interest on fixed-rate borrowings), most will depend on future events (for example, a facility has a lease for property that includes a base rent amount and an additional amount expressed as a percentage of *Net operating revenues*). Further, normal operations involve significant expenditures that are not based on commitments (for example, amounts paid for income taxes).

Our consolidated contractual obligations as of December 31, 2006, are as follows:

	Total (In Millions)	2007	2008 - 2009	2010 - 2011	2012 and Thereafter
Long-term debt obligations:					
Long-term debt, excluding revolving credit facility and capital lease obligations[a]	$ 3,082.8	$ 20.9	$ 87.3	$ 42.8	$ 2,931.8
Revolving credit facility	170.0				170.0
Interest on long-term debt[b]	2,094.0	304.6	597.6	587.2	604.6
Capital lease obligations[c]	207.1	26.9	51.8	44.3	84.1
Operating lease obligations[d][e][f]	473.7	101.5	152.2	89.2	130.8
Purchase obligations[f][g]	93.5	43.2	25.1	3.3	21.9
Other long-term liabilities:					
Government settlements, including interest when applicable	139.0	139.0			
Other liabilities[h]	4.4	0.7	0.7	0.4	2.6

(a) Included in long-term debt are amounts owed on our bonds payable, notes payable to banks and others, and noncompete agreements. These borrowings are further explained in Note 9, *Long-term Debt,* of the notes 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, 2006. Interest related to capital lease obligations is excluded from this line. Amounts exclude amortization of debt discounts, amortization of loans 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 facilities as well as other property and equipment under operating leases in the normal course of business. Some of our facility 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 6, *Property and Equipment,* of the notes to our accompanying consolidated financial statements.

(e) Lease obligations for facility closures are included in operating leases.

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

(g) 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.

(h) 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 19, *Income Taxes,* and Note 25, *Contingencies and Other Commitments,* of the notes to our accompanying consolidated financial statements.

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, 2006, an estimate of these legal fees is included in *Other current liabilities* in our consolidated balance sheet.

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 that 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. 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.

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

Self-Insured Risks

We are self-insured for certain losses related to professional and comprehensive general liability risks, workers compensation, and certain construction 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 that 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 1,200 individual claims as of December 31, 2006 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 that 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 that 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 $15.0 million during the year ended December 31, 2006. 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, noncompete agreements, and management agreements. We amortize these assets over periods ranging from five to thirty years. As of December 31, 2006, 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 units 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, 2006, using the methodology described herein, and determined no goodwill impairment existed in any of our segments. 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, 2006 approximated $896.9 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 fair value. 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. 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. 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 cancellations.

If actual results are not consistent with our assumptions and estimates, we may be exposed to gains or losses 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.

Contingent tax liabilities must be accounted for separately from deferred tax assets and liabilities. FASB Statement No. 5, *Accounting for Contingencies*, is the governing standard for contingent liabilities. It must be probable that a contingent tax benefit will be sustained before the contingent benefit is recognized for financial reporting purposes.

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, 2006 aggregating $1.2 billion against such assets based on our current assessment of future operating results and other factors.

We believe that we have previously overpaid federal and state income taxes during the reconstruction period. The estimate of this overpayment amount is recorded as *Income tax refund receivable*. In determining taxes receivable, we evaluated the potential exposures associated with various filing positions and our documentation requirements. We computed reserves for probable exposures. Such positions and substantiation matters may come under review during the audit and/or amended return process. We are currently in the appeals process for certain proposed adjustments related to the audit of our federal consolidated income tax returns for years 1996 through 1998. We fully expect to have all open restatement years under audit by the Internal Revenue Service in the near future.

We will prepare amended federal and state income tax returns, making all appropriate restatement adjustments, in order to obtain refunds for overpaid income taxes. Upon filing amended federal and state income tax returns, the tax authorities will conduct a detailed review of the adjustments. 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 that the estimates and judgments discussed herein are reasonable, actual results could differ, and we may be exposed to gains or losses that could be material.

As of December 31, 2006, our estimated *Income tax refund receivable* was approximately $218.8 million. This receivable is net of approximately $92.9 million in tentative refunds previously received by us through 2006 and includes our estimate of applicable interest and penalties. To the extent that either the federal or state taxing authorities disagree with our presentation of amended taxable income during the reconstruction period, this receivable may be overstated resulting in additional current tax expense and/or the requirement that some or all of the previous refunds be repaid.

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 that it is probable that 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 June 2006, the FASB issued FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*. FASB Interpretation No. 48 clarifies the accounting for uncertainty in income taxes recognized in a company s financial statements in accordance with FASB Statement No. 109, *Accounting for Income Taxes*. FASB Statement No. 109 does not prescribe a recognition threshold or measurement attribute for the financial statement recognition and measurement of a tax position taken in a tax return. FASB Interpretation No. 48 clarifies the application of FASB Statement No. 109 by defining a criterion that an individual tax position must meet for any part of the benefit of that position to be recognized in a company s financial statements. Additionally, FASB Interpretation No. 48 provides guidance on measurement, derecognition, classification, interest and penalties, accounting in interim periods, disclosure, and transition.

FASB Interpretation No. 48 is effective for fiscal years beginning after December 15, 2006. We will adopt FASB Interpretation No. 48 on January 1, 2007. We are currently evaluating the impact of adopting FASB Interpretation No. 48 on our consolidated financial statements. The cumulative effect of applying FASB Interpretation No. 48, when determined, will be recorded as an adjustment to *Accumulated deficit* as of January 1, 2007.

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. We are currently evaluating the potential impact of FASB Statement No. 157 on our financial position, results of operations, and cash flows, as well as evaluating the necessary disclosures that will need to be made within our financial statements for interim and annual periods after adoption.

In September 2006, the SEC staff issued Staff Accounting Bulletin (SAB) No. 108, *Financial Statements Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements*, to address diversity in practice regarding the quantification of financial statement misstatements under the two methods most commonly used by companies and auditors the rollover and iron curtain methods. The rollover method focuses primarily on the impact of a misstatement on the income statement including the reversing effect of prior year misstatements but its use can lead to the accumulation of misstatements in the balance sheet. The iron curtain method focuses primarily on the effect of correcting the period-end balance sheet with less emphasis on the reversing effects of prior year errors on the income statement. SAB No. 108 requires registrants to quantify and analyze misstatements using both approaches.

The guidance in SAB No. 108 must be followed by registrants in their annual financial statements covering the first fiscal year ending after November 15, 2006. We have applied the provisions of SAB No. 108 to our consolidated financial statements as of and for the year ended December 31, 2006. Such application did not have an impact on our 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 accounts standards, including requirements for disclosures about fair value measurements included in FASB Statements No. 157 and FASB Statement No. 107, *Disclosures about Fair Value of Financial Instruments*.

FASB Statement No. 159 is effective as of the beginning of an entity s first fiscal year that begins after November 15, 2007. Early adoption is permitted as of the beginning of the previous fiscal year provided that the entity makes that choice in the first 120 days of that fiscal year and also elects to apply the provisions of FASB Statement No. 157. We have not begun evaluating the potential impact, if any, the adoption of FASB Statement No. 159 could have on our consolidated financial position, results of operations, and cash flows.

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 accounting pronouncements, please see Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements.

Business Outlook

Although we have been forced to devote a significant portion of our time and attention over the past several years to matters primarily outside the ordinary course of business, 2006 marked the end of many of the legal, financial, and operational rocks in the road we have faced since March 2003 and the beginning of our repositioning as a pure play provider of post-acute care services with an immediate focus on inpatient rehabilitative care. Still, we expect to continue to experience volume volatility, payor pressure, and increased competition in our markets, as well as operational uncertainty relating to the marketing, disposition, and ultimate transition of our surgery centers, outpatient, and diagnostic divisions. Our business outlook for our operating divisions is as follows:

Inpatient. We anticipate increasing volumes in many of our inpatient facilities through the first three quarters of 2007 because most of our IRFs currently operate at, and have maintained since 2006, the 60% minimum qualifying patient mix threshold under the 75% Rule. In the fourth quarter of 2007, as most of our IRFs approach a new cost reporting year, we anticipate declining volumes as we work to achieve compliance with the 65% threshold. We plan to continue to aggressively attempt to mitigate the impact of the 75% Rule by managing our expenses, focusing our marketing efforts on compliant cases, and developing new post-acute services and other services that are complementary to our IRFs. Furthermore, we believe the continued implementation of the 75% Rule will pose a challenge for our competitors and create consolidation opportunities for us. We also continue to identify new market opportunities. We plan to take advantage of industry instability and market opportunities by completing five to eight development projects in 2007.

Corporate and Other. In 2007, we will attempt to manage corporate expenses while we implement our repositioning and deleveraging plan, including providing transition services to the divested divisions. Because we do not allocate corporate overhead by division, the corporate and other division s results will reflect overhead costs associated with managing and providing shared services to our surgery centers, outpatient, and diagnostic divisions even after those divisions qualify as discontinued operations. Until we are able to rationalize our corporate overhead in relation to the size of our operations post-repositioning, this division s results will reflect unusually high costs. In addition, we plan to implement an upgrade to our PeopleSoft accounting system, the cost of which will primarily be incurred in 2007.

Surgery Centers, Outpatient, and Diagnostic. In accordance with our repositioning and deleveraging plan, we anticipate that our surgery centers, outpatient, and diagnostic divisions will qualify as discontinued operations at some point in 2007. Until the actual dispositions are concluded, we will continue to run each division in the ordinary course of business. For our surgery centers division, we plan to focus on continued volume growth and labor and supply cost management, which we believe will yield improved operating results in 2007. For our outpatient division, we will focus on closing the previously discussed sale to Select Medical and ensuring a smooth transition. For our diagnostic division, we will continue to focus on reducing bad debt and collection expense, as well as attempting to mitigate new restrictions imposed by payors in response to increased utilization of diagnostic imaging services. In each division, we will focus on maintaining key employees throughout the transition period, as well as maintaining volume.

While we expect our 2007 operating results will be consistent with the fact that HealthSouth is emerging from a turnaround period and repositioning its business, we are optimistic about the long-term positioning of HealthSouth. We continue to offer high quality services. We believe inpatient rehabilitation is a growing market with considerable consolidation opportunities, and we believe that by implementing our deleveraging and repositioning plan we will

be able to take advantage of development and consolidation opportunities in that market. Whatever market conditions we face, we will continue to seek opportunities to improve operations, stabilize our finances, and develop new facilities and post-acute services, with the ultimate goal of providing sustainable growth and return for our stockholders.

PART IV

Item 15. Exhibits and Financial Statement Schedules

Exhibits

(a)(3) The exhibits to this Form 10-K/A are set forth in the Exhibit Index on page 56 of this filing.
(b) Exhibits
See Item 15(a)(3) above.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, hereunto duly authorized.

HEALTHSOUTH CORPORATION

By: /s/ Jay Grinney
Name: Jay Grinney
Title: President and Chief Executive Officer

Dated: March 22, 2007

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EXHIBIT INDEX

Exhibit Number	Description
12	Computation of Ratios.
31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.