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).

1

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 effort