HEALTHSOUTH CORP
Form 10-K
February 24, 2009

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)

OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2008

Commission File Number 001-10315

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.)**
3660 Grandview Parkway, Suite 200 Birmingham, Alabama	**35243**
(Address of Principal Executive Offices)	**(Zip Code)**

(205) 967-7116

(Registrant's telephone number)

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

Common Stock, $0.01 Par Value

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

None

Indicate by check mark if the registrant is a well-known seasoned issuer as defined in Rule 405 of the Securities Act. Yes x No o

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

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

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

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $1.5 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 88,009,707 shares of common stock of the registrant outstanding, net of treasury shares, as of February 13, 2009.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2009 Annual Meeting of Stockholders is incorporated by reference in Part III to the extent described therein.

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CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to future events, our future financial performance, or our projected business results. In some cases, you can identify forward-looking statements by terminology such as “may,” “will,” “should,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “predicts,” “targets,” “potential,” or “continue” or t these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. Any forward-looking statement is based on information current as of the date of this report and speaks only as of the date on which such statement is made. While it is impossible to identify all such factors, factors that could cause actual results to differ materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, *Risk Factors*;
- uncertainties and factors discussed elsewhere in this Form 10-K, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;
- changes or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages;
- changes in the regulations of the healthcare industry at either or both of the federal and state levels;
- competitive pressures in the healthcare industry and our response to those pressures;
- our ability to successfully access the credit markets on favorable terms; and
- general conditions in the economy and capital markets.

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

PART I

Item 1. Business
Overview of the Company

HealthSouth Corporation was organized as a Delaware corporation in February 1984. As used in this report, the terms "HealthSouth," "we," "us," "our," and the "Company" refer to HealthSouth Corporation and its consolidated subsidiaries, unless otherwise stated or indicated by context. In addition, we use the term "HealthSouth Corporation" to refer to HealthSouth Corporation alone wherever a distinction between HealthSouth Corporation and its subsidiaries is required or aids in the understanding of this filing. Our principal executive offices are located at 3660 Grandview Parkway (formerly One HealthSouth Parkway), Birmingham, Alabama 35243, and the telephone number of our principal executive offices is (205) 967-7116. In addition to the discussion here, we encourage you to read Item 1A, *Risk Factors*, and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, which highlight additional considerations about HealthSouth.

We are the nation's largest provider of inpatient rehabilitative healthcare services in terms of revenues, number of hospitals, and patients treated and discharged. We operate 93 inpatient rehabilitation hospitals (including 3 joint venture hospitals which we account for using the equity method of accounting), 6 freestanding long-term acute care hospitals, or "LTCHs," 49 outpatient rehabilitation satellites (operated by our hospitals), and 25 licensed, hospital-based home health agencies. Our consolidated *Net operating revenues* approximated $1.8 billion, $1.7 billion, and $1.7 billion for the years ended December 31, 2008, 2007, and 2006, respectively. For 2008, approximately 90% of our *Net operating revenues* came from inpatient services and approximately 10% came from outpatient services and other revenue sources (see Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*). During 2008, we treated and discharged over 107,000 patients in our rehabilitation hospitals. We had approximately 22,000 employees as of December 31, 2008.

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across a wide array of diagnoses and deliver comprehensive patient care services. The majority of patients we serve experience significant physical disabilities due to medical conditions, such as strokes, hip fractures, head injury, spinal cord injury, and neurological disorders, that are non-discretionary in nature and which require rehabilitative services in an inpatient setting. Our team of highly skilled physicians, nurses, and physical, occupational, and speech therapists utilize the latest in equipment and techniques to return patients to home and work. 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, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leads to what we believe is a higher level of care and superior outcomes.

Our outpatient rehabilitation facilities offer a range of rehabilitative healthcare services, including physical, occupational, and speech therapies treating a broad range of neurological and orthopedic conditions. LTCHs provide medical treatment to patients with chronic diseases and/or complex medical conditions. In order for a hospital to qualify as an LTCH, Medicare patients discharged from the hospital in any given cost reporting year must have an average length-of-stay in excess of 25 days.

As of December 31, 2008, our inpatient rehabilitation hospitals and LTCHs had 6,543 licensed beds. Our inpatient rehabilitation hospitals are located in 26 states and Puerto Rico, with a concentration of hospitals in Texas, Pennsylvania, Florida, Tennessee, and Alabama. In addition to HealthSouth hospitals and outpatient satellites, we manage eight inpatient rehabilitation units and one outpatient satellite through management contracts.

As the nation's largest provider of inpatient rehabilitative services and with our business focused primarily on those services, we believe we differentiate ourselves from our competitors in the following ways:

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

- *Technology*. As a market leader in inpatient rehabilitation, we have devoted substantial effort and expertise to creating and leveraging rehabilitative technology. For example, we have developed an innovative therapeutic device called the "AutoAmbulator," which can help advance the rehabilitative process for patients who experience difficulty walking. Technology instituted in our facilities allows us to effectively treat patients with a wide variety of significant physical disabilities.
- *Efficiency and Cost Effectiveness*. Our size helps us provide inpatient rehabilitative services on a cost-effective basis. Specifically, because of our large number of inpatient hospitals, we can utilize proven staffing models and take advantage of certain supply chain efficiencies. We have also developed a program called "TeamWorks," which is an operations-focused initiative using identified "best practices" to reduce inefficiencies and improve performance across a wide spectrum of operational areas.

We entered 2008 seeking disciplined growth opportunities for our inpatient rehabilitation business within the context of our primary emphasis on debt reduction and further deleveraging. During the year, we commenced or completed the following development projects:

- In June 2008, a certificate of need was approved that will enable us to establish up to a 40-bed comprehensive medical rehabilitation hospital in Marion County, Florida. The certificate of need has been contested by two competitors in the market and is progressing through the normal Florida certificate of need appeals process. The appeals process is expected to take at least one year, and there can be no assurance regarding the timing or outcome.
- In July 2008, we purchased The Rehabilitation Hospital of South Jersey, a 34-bed inpatient rehabilitation hospital in Vineland, New Jersey. This transaction added a third New Jersey rehabilitation hospital to our northeast region.
- Our certificate of need application for a new 40-bed rehabilitation hospital in Loudoun County, Virginia was approved on July 30, 2008. We expect to break ground on this site in the first half of 2009.
- In August 2008, we acquired an inpatient rehabilitation unit at the Medical Center of Arlington in Texas. The operations of this unit were relocated to, and consolidated with, HealthSouth Rehabilitation Hospital of Arlington.
- In August 2008, we acquired an inpatient rehabilitation hospital in Midland, Texas from Rehabcare Corporation. The operations of this hospital were relocated to, and consolidated with, HealthSouth Rehabilitation Hospital of Midland/Odessa.
- In October 2008, we broke ground on a new, 40-bed freestanding inpatient rehabilitation hospital in Mesa, Arizona, and we expect operations to commence in the third quarter of 2009.

As the year progressed and the general economy and credit market weakened further, we began to place even greater emphasis on debt reduction and deleveraging. We reduced our total debt outstanding by approximately $228 million in 2008. See the "Leverage and Liquidity" section below for additional discussion of our deleveraging efforts. We will continue to focus on debt reduction while enhancing the operations of our inpatient rehabilitation hospitals and growing our inpatient rehabilitation business through bed expansions and other disciplined development opportunities that require minimal initial cash outlays, such as consolidations in existing markets (through joint venturing or acquisition) and de-novo projects with third-party financing. Once we reduce our leverage and have a balance sheet capable of withstanding additional risk, we will consider growth opportunities in other post-acute services complementary to our existing services such as long-term acute care, home health, and hospice.

As of December 31, 2008, we employed approximately 22,000 individuals, of whom approximately 14,000 were full-time employees. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 70 employees at one inpatient rehabilitation hospital (about 17% of that hospital's workforce), none of our employees are represented by a labor

union. We are not aware of any current activities to organize our employees at other hospitals. We believe our relationship with our employees is good. Like most healthcare providers, our labor costs are rising faster than the general inflation rate. In some markets, the lack of availability of nurses and other medical support personnel has become a significant operating issue to healthcare providers. To address this challenge, we will continue to focus on improving our retention, recruiting, compensation programs, and productivity. The shortage of nurses and other medical support personnel, including physical therapists, may require us to increase utilization of more expensive temporary personnel.

Competition

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

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

We rely significantly on our ability to attract, develop, and retain nurses, therapists, and other clinical personnel for our hospitals. We compete for these professionals with other healthcare companies, hospitals, and potential clients and partners. In addition, physicians and others have opened inpatient rehabilitation hospitals in direct competition with us, particularly in states in which a CON is not required to build a hospital, which has made it more difficult and expensive to hire the necessary personnel for our hospitals in those markets.

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), state governments (under their respective Medicaid or similar programs), managed care plans, private insurers, and directly from patients. Revenues and receivables from government agencies are significant to our operations. In addition, we receive payment for non-patient care activities from various sources. The following table identifies the sources and relative mix of our revenues for the periods stated:

	For the Year Ended December 31,		
	2008	**2007**	**2006**
Medicare	67.2%	67.8%	68.6%
Medicaid	2.2%	2.0%	2.1%
Workers’ compensation	2.1%	2.3%	2.6%
Managed care and other discount plans	19.0%	18.5%	18.5%
Other third-party payors	7.0%	6.3%	5.0%
Patients	0.7%	0.6%	0.4%
Other income	1.8%	2.5%	2.8%
Total	100.0%	100.0%	100.0%

Our hospitals generally offer discounts from established charges to certain group purchasers of healthcare services, including Blue Cross and Blue Shield, or "BCBS," other private insurance companies, employers, health maintenance organizations, or "HMOs," preferred provider organizations, or "PPOs," and other managed care plans.

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

Medicare Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare facilities and services, and, from time to time, these methodologies and rates can be modified by the United States Congress or the United States Centers for Medicare and Medicaid Services ("CMS"). In some instances, these modifications can have a substantial impact on existing healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems, including the inpatient rehabilitation facility prospective payment system, or "IRF-PPS," under what is commonly known as a market basket increase. In the case of the IRF-PPS, unless Congress changes the law, CMS is required to adjust the payment rates based on a market basket index, known as the rehabilitation, psychiatric, and long-term care hospital, or "RPL," market basket. The RPL is designed to reflect changes over time in the prices of an appropriate mix of goods and services included in covered services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units. The RPL uses data furnished by the Bureau of Labor Statistics for price proxy purposes, primarily in three categories: Producer Price Indexes, Consumer Price Indexes, and Employment Cost Indexes. The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") included an elimination of the IRF-PPS market basket adjustment for the period from April 1, 2008 through September 30, 2009 causing a reduction in the pricing of services eligible for Medicare reimbursement to a pricing level that existed in the third quarter of 2007, or a Medicare pricing "roll-back," which has resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs.

Each year, the Medicare Payment Advisory Commission, or "MedPAC," makes payment policy recommendations to Congress for a variety of Medicare payment systems. MedPAC is an independent Congressional agency that advises Congress on issues affecting Medicare. In January 2009, MedPAC voted to recommend to Congress that the IRF-PPS market basket for the twelve-month period beginning October 1, 2009 should not be increased. MedPAC recommended an increase to the market basket for LTCHs, with an adjustment for productivity. However, Congress is not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, we have no indication of whether Congress will adopt MedPAC's recommendations for the twelve-month period beginning October 1, 2009. We cannot predict the adjustments, if any, to Medicare payment rates that Congress or CMS may make. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings over the next several years. Any downward adjustment to rates, or continuance of the pricing roll-back, for the types of facilities we operate could have a material adverse effect on our business, financial position, results of operations, and cash flows.

On January 16, 2009, CMS approved final rules that require healthcare providers to update and supplement diagnosis and procedure codes to the International Classification of Diseases 10th Edition, effective October 1, 2013, and make related changes to the formats used for certain electronic transactions, effective January 1, 2012. At this time, we cannot predict how these changes will affect us.

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

Inpatient Rehabilitation Services. Our hospitals receive Medicare reimbursements under IRF-PPS. As discussed above, our hospitals receive fixed payment amounts per discharge under IRF-PPS based on certain rehabilitation impairment categories established by the United States Department of Health and Human Services.

With IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being high quality, low cost providers.

Over the last several years, changes in regulation governing inpatient rehabilitation reimbursement have created a challenging operating environment for inpatient rehabilitative services. Specifically, on May 7, 2004, CMS issued a final rule, known as the "75% Rule," stipulating that to qualify as an inpatient rehabilitation hospital under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any inpatient rehabilitation hospital that failed to meet the requirements of the 75% Rule would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services.

On December 29, 2007, the 2007 Medicare Act was signed, permanently setting the compliance threshold at 60% instead of 75% and allowing hospitals to continue using a patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitative care under the rule. The long-term impact of the freeze at the 60% compliance threshold is positive because it allowed patient volumes to stabilize. In 2008, increased patient volumes resulting, we believe, from both our focus on standardizing sales and marketing efforts and the fact that more patients now have access to our high quality inpatient rehabilitative services offset the negative impact of the pricing roll-back. We expect the negative impact of the pricing roll-back to continue to be offset partially by our volume increases. There can be no assurance there will be an increase in Medicare reimbursement pricing upon the expiration of the roll-back period.

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

In addition, on July 31, 2008, CMS released the fiscal year 2009 notice of final rulemaking for IRF-PPS. This rule will be effective for Medicare discharges between October 1, 2008 and September 30, 2009. Based on our analysis, we do not believe this final rule will negatively impact our *Net operating revenues*.

On December 8, 2003, The Medicare Modernization Act of 2003 authorized CMS to conduct a demonstration program known as the Medicare Recovery Audit Contractor, or "RAC," program. This demonstration was first initiated in three states (California, Florida, and New York) and authorizes CMS to contract with private companies to conduct claims and medical record audits. These audits are in addition to those conducted by existing Medicare contractors, and the contracted RACs are paid a percentage of the overpayments recovered. On December 20, 2006, the Tax Relief & Health Care Act of 2006 directed CMS to expand the RAC program to the rest of the country by 2010. The new RACs were announced on October 6, 2008 and CMS is in the process of implementing the program. Among other changes in the permanent program, the new RACs will receive claims data directly from Medicare contractors on a monthly or quarterly basis and are authorized to review claims up to three years from the date a claim was paid, beginning with claims filed on or after October 1, 2007. We cannot predict when or how this new program will affect us.

Outpatient Services. Our outpatient services are primarily reimbursed based upon the Physician Fee Schedule. On November 19, 2008, CMS issued a final rule that updated payments under the Physician Fee Schedule from January 1, 2009 through December 31, 2009. In accordance with language provided for in the Medicare Improvements for Patients and Providers Act of 2007 that superseded a previously adopted annual reduction, the rule increased the standard conversion factor by 1.1% to $36.0666. We estimate that these changes will result in modestly higher reimbursement to us for outpatient services. In the future, if Congress does not again act to set aside implementation of previously adopted reductions to the Physician Fee Schedule, the outpatient payment formula will decrease by approximately 20%. We cannot predict what, if any, action Congress will take on the Physician Fee Schedule in the future, and we cannot predict how future Congressional action or inaction on the Physician Fee Schedule will affect us.

Long-Term Acute Care Hospitals. LTCHs provide medical treatment to patients with chronic diseases and/or complex medical conditions. In order for a hospital to qualify as an LTCH, Medicare patients discharged from the hospital in any given cost reporting year must have an average length-of-stay in excess of 25 days, among other requirements. LTCHs are currently reimbursed under a prospective payment system ("LTCH-PPS") pursuant to which Medicare classifies patients into distinct Medicare Severity diagnosis-related groups ("MS-LTC-DRGs") based upon specific clinical characteristics and expected resource needs.

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

On May 9, 2008, CMS issued final regulations that updated payment rates under the LTCH-PPS for rate year 2009, which are effective for discharges occurring on or after July 1, 2008 through September 30, 2009. This rule implements various payment changes and will consolidate the timing of the rate year changes with the MS-LTC-DRG changes beginning on October 1, 2009. This final rule did not materially impact our *Net operating revenues* in 2008, nor is it expected to materially impact our 2009 *Net operating revenues*.

On August 19, 2008, CMS issued final regulations that updated the LTCH-PPS. The final rule made changes to the LTCH relative payment weights and average lengths of stay. These changes were effective beginning October 1, 2008. This final rule is not expected to have a material impact on our *Net operating revenues* during federal fiscal year 2009. In January 2009, MedPAC recommended an increase to the market basket for LTCHs for the twelve-month period beginning October 1, 2009, with an adjustment for productivity.

Medicaid Reimbursement

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

Cost Reports

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

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

Managed Care and Other Discount Plans

All of our hospitals offer discounts from established charges to certain large group purchasers of healthcare services, including managed care plans, BCBS, other private insurance companies, and third-party administrators.

Managed care contracts typically have terms of between one and three years, although we have a number of managed care contracts that automatically renew each year (with pre-defined rate increases) unless a party elects to terminate the contract. While some of our contracts provide for annual rate increases of three to five percent, we cannot provide any assurance we will continue to receive increases. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Regulation

The healthcare industry in general is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our hospitals, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth.

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

Corporate Integrity Agreement

On December 30, 2004, we entered into a Corporate Integrity Agreement, or "CIA," with the Office of Inspector General of the United States Department of Health and Human Services (the "HHS-OIG"), and we have subsequently entered into two addenda to the CIA. The CIA has an effective date of January 1, 2005 and a term of five years (same for the addenda) from that effective date. The CIA expires at the end of 2009, subject to the HHS-OIG accepting and approving our annual report for 2009 that we will submit in the first half of 2010. The CIA sets forth a comprehensive compliance program that we are required to follow. For additional information, see Note 20, *Settlements*, to the accompanying consolidated financial statements. The CIA requires us to submit annual reports to the HHS-OIG regarding our compliance with the CIA. The CIA also requires us to engage an Independent Review Organization ("IRO") to assist us in assessing and evaluating: (1) our billing, coding, and cost reporting practices with respect to our inpatient rehabilitation hospitals; (2) our billing and coding practices for outpatient items and services furnished by outpatient departments of our inpatient rehabilitation hospitals; and (3) certain other obligations pursuant to the CIA and the related settlement agreement. We engaged PricewaterhouseCoopers LLP to serve as our IRO.

We believe we have complied with the requirements of the CIA on a timely basis, and to date, there are no objections or unresolved comments from the HHS-OIG relating to our annual reports. Failure to meet our obligations under our CIA could result in stipulated financial penalties or extension of the term of the CIA. Failure to comply with material terms, however, could lead to exclusion from further participation in federal healthcare programs, including Medicare and Medicaid, which currently account for a substantial portion of our revenues.

Licensure and Certification

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

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

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

Certificates of Need

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

False Claims Act

The federal False Claims Act prohibits the knowing presentation of a false claim to the United States government, and provides for penalties equal to three times the actual amount of any overpayments plus up to $11,000 per claim. In addition, the False Claims Act allows private persons, known as "relators," to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties under the False Claims Act. Many states have also adopted similar laws relating to state government payments for healthcare services.

Relationships with Physicians and Other Providers

The Anti-Kickback Law. Various state and federal laws regulate relationships between providers of healthcare services, including employment or service contracts and investment relationships. Among the most important of these restrictions is a federal criminal law, or the "Anti-Kickback Law," prohibiting the offer, payment, solicitation, or receipt of remuneration by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs. In addition to federal criminal sanctions, including penalties of up to $50,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. In 1991, the HHS-OIG issued regulations describing compensation arrangements that are not viewed as illegal remuneration under the Anti-Kickback Law (the "1991 Safe Harbor Rules"). The 1991 Safe Harbor Rules create certain standards, or "Safe Harbors," for identified types of compensation arrangements that, if fully complied with, assure participants in the particular arrangement that the HHS-OIG will not treat that participation as a criminal offense under the Anti-Kickback Law or as the basis for an exclusion from the Medicare and Medicaid programs or the imposition of civil sanctions. Failure to fall within a Safe Harbor does not constitute a violation of the Anti-Kickback Law, but the HHS-OIG has indicated failure to fall within a Safe Harbor may subject an arrangement to increased scrutiny. A violation, or even the assertion of, a violation of the Anti-Kickback Law by us or one or more of our partnerships could have a material adverse effect upon our business, financial position, results of operations, or cash flows.

We currently operate some of our rehabilitation hospitals as general partnerships, limited partnerships, or limited liability companies with third-party investors, including other institutional healthcare providers but also including, in one case, physician investors. Some of these partners may be deemed to be in a position to make or influence referrals to our hospitals. Those entities that are providers of services under the Medicare program, and their owners, are subject to the Anti-Kickback Law. A number of the relationships we have established with

physicians and other healthcare providers do not fit within any of the Safe Harbors. While we do not believe our rehabilitation hospital partnerships engage in activities that violate the Anti-Kickback Law, there can be no assurance such violations may not be asserted in the future, nor can there be any assurance that our defense against any such assertion would be successful.

We have entered into agreements to manage many of our hospitals that are owned by partnerships. Most of these agreements incorporate a percentage-based management fee. Although there is a safe harbor for personal services and management contracts, this safe harbor requires, among other things, the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, the fee arrangement may not meet this requirement. However, we believe our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and they comply with the Anti-Kickback Law. We have implemented training and compliance programs designed to safeguard against overbilling and otherwise to achieve compliance with the Anti-Kickback Law and other laws, but there can be no assurance the HHS-OIG would find our compliance programs to be adequate.

Stark Exceptions. The federal law commonly known as the Stark law and CMS regulations promulgated under the Stark law prohibit physicians from making referrals for "designated health services" including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, or radiation therapy, to an entity in which the physician has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing for those referred services. These prohibitions apply to our financial relationships with physicians and any partnerships with physician partners. Violators of the Stark statute and regulations may be subject to recoupments, civil monetary fines, penalties and exclusion from any federal, state, or other governmental healthcare programs. We have put in place training and compliance programs and policies intended to prevent violations of the Stark statute and regulations.

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds.

HIPAA and related HHS regulations contain certain administrative simplification provisions that require the use of uniform electronic data transmission standards for certain healthcare claims and payment transactions submitted or received electronically. HIPAA regulations also regulate the use and disclosure of individually identifiable health-related information, whether communicated electronically, on paper, or orally. The regulations provide patients with significant rights related to understanding and controlling how their health information is used or disclosed and require healthcare providers to implement administrative, physical, and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically.

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

the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. Any actual or perceived violation of these privacy-related laws, including HIPAA could have a material adverse effect on our business, financial position, results of operations, and cash flows. We have put in place training and compliance programs and policies intended to prevent violations of HIPAA and related regulations.

Hospital Within Hospital Rules

CMS has enacted multiple regulations governing "hospital within hospital" arrangements for inpatient rehabilitation hospitals and LTCHs. These regulations provide, among other things, that if a long-term acute care "hospital within hospital" has Medicare admissions from its host hospital that exceed 25% (or an adjusted percentage for certain rural or Metropolitan Statistical Area dominant hospitals) of its Medicare discharges for its cost-reporting period, the LTCH will receive an adjusted payment for its Medicare patients of the lesser of (1) the otherwise full payment under the LTCH-PPS or (2) a comparable payment that Medicare would pay under the acute care inpatient prospective payment system. In determining whether an LTCH meets the 25% criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host facility would not count as part of the host hospital's allowable percentage. Cases admitted from the host hospital before the LTCH crosses the 25% threshold will be paid under the LTCH-PPS. Additionally, other excluded hospitals or units of a host hospital, such as inpatient rehabilitation facilities and/or units, must meet certain "hospital within hospital" requirements in order to maintain their excluded status and not be subject to the acute care inpatient prospective payment system.

On July 1, 2007, CMS regulations extended the 25% referral limitation applicable to "hospital within hospital" locations to freestanding, satellite, and grandfathered LTCHs. The 2007 Medicare Act modified and delayed implementation of this extension of the rule and certain other portions of the "hospital within hospital" rules applicable to LTCHs for cost report periods beginning on or after December 29, 2007 for a three-year period. These regulations did not materially impact our *Net operating revenues* in 2008, nor are they expected to materially impact our 2009 *Net operating revenues*. We cannot predict when or how these new program policies will affect us.

2008 Significant Events

The unprecedented turmoil and volatility of the equity and credit markets and the corresponding weakening of the economy during 2008, in particular the second half of 2008, led us to reassess our strategic thinking to ensure it was appropriate given the new business climate. In the third quarter of 2008, we determined that, while we are positioned to do well in a volatile economic environment and have adequate sources of liquidity, we will place greater emphasis on reducing our debt. As we reassessed the appropriateness of our strategic outlook during the current economic uncertainty, we took a critical look at our development strategy, especially as it related to de-novo projects. In recognition of changing economic conditions, we will continue to be disciplined in our approach to development opportunities, carefully evaluating these opportunities against our deleveraging priority. For the foreseeable future, reducing our long-term debt will be our primary objective. We will continue to pursue bed expansions in existing hospitals as they provide immediate earnings growth, and we will pursue acquisitions and market consolidations where we can do so with minimal initial cash outlays. For any de-novo project we decide to pursue, we will work with third parties willing to assume the majority of the financing risks associated with these projects.

During the first quarter of 2008, we sold our corporate campus for a purchase price of $43.5 million in cash and a deferred purchase price component related to a part of the campus (see Item 2, *Properties*, below and Note 5, *Property and Equipment*, to the accompanying consolidated financial statements). As part of this transaction, we entered into a long-term lease for office space within the property that was sold. The sale of this property will help us continue to reduce corporate operating expenses going forward. The net proceeds from this transaction were used to reduce our debt outstanding in April 2008 (see Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements).

On June 27, 2008, we finalized the issuance and sale of 8.8 million shares of our common stock to J.P. Morgan Securities Inc. for net proceeds of approximately $150 million. We used the net proceeds of the offering primarily for redemption and repayment of short-term and long-term borrowings. See Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements for additional information regarding use of the net proceeds.

In October 2008, we entered into an agreement, approved by the court on January 13, 2009, with UBS Securities, LLC ("UBS Securities") to settle litigation filed by the derivative plaintiffs on the Company's behalf. Under the settlement, $100.0 million in cash previously paid into escrow by UBS Securities and its insurance carriers will be released to us, and we will receive a release of all claims by UBS Securities including the release and satisfaction of an approximate $31 million judgment in favor of an affiliate of UBS Securities related to a loan guarantee.

Out of the $100.0 million cash settlement proceeds received from UBS Securities and its insurance carriers, we are obligated to pay $26.2 million in fees and expenses to the derivative plaintiffs' attorneys, and pursuant to the previously disclosed settlement agreements in the consolidated securities litigation, 25% of the net proceeds, after deducting all of our costs and expenses in connection with the derivative litigation, will be paid to plaintiffs in the consolidated securities litigation. See Note 20, *Settlements*, to the accompanying consolidated financial statements. These funds are expected to be dispersed to the applicable parties during the first quarter of 2009. We intend to use the majority of our net cash proceeds to reduce long-term debt.

In October 2008, we received a total cash refund of approximately $46.0 million (including interest) attributable to our settlement with the Internal Revenue Service (the "IRS") for tax years 2000 through 2003. We used the majority of this cash to reduce amounts outstanding under our Credit Agreement. See Note 8, *Long-term Debt*, and Note 17, *Income Taxes*, to the accompanying consolidated financial statements.

In the fourth quarter of 2008, we settled federal income tax issues outstanding with the IRS for the tax years 1995 through 1999, and the Joint Committee on Taxation reviewed and approved the associated income tax refund of approximately $42 million (including interest) due to the Company. In February 2009, we received the majority of this cash refund and used it to pay down long-term debt.

Leverage and Liquidity

Our total debt outstanding has decreased from $2.0 billion as of December 31, 2007 to $1.8 billion as of December 31, 2008. With the continued deleveraging of the Company as a priority, on June 27, 2008, we issued and sold 8.8 million shares of our common stock to J.P. Morgan Securities Inc. for net proceeds of approximately $150 million (see Note 10, *Shareholders' Deficit*, to the accompanying consolidated financial statements) and used the majority of these net proceeds to reduce our total debt outstanding. This debt reduction was in addition to the use of the net proceeds from the sale of our corporate campus (see Note 5, *Property and Equipment*, to the accompanying consolidated financial statements) in April 2008 to reduce total debt outstanding. We also used the majority of our federal income tax refund received in October 2008 (see Note 17, *Income Taxes,* to the accompanying consolidated financial statements) to reduce amounts outstanding under our Credit Agreement.

Our long-term debt (excluding notes payable to banks and others and capital lease obligations) as of December 31, 2008 and 2007 is summarized in the following table:

	As of December 31, 2008 (In Millions)	**As of December 31, 2007**
Revolving credit facility	$ 40.0	$ 75.0
Term loan facility	783.6	862.8
Bonds payable	862.1	979.7
Total long-term debt	$ 1,685.7	$ 1,917.5

As of December 31, 2008, we had approximately $32.2 million in *Cash and cash equivalents*. This amount excludes approximately $154.0 million in *Restricted cash* and $20.3 million of *Restricted marketable securities*. As of December 31, 2008, *Restricted cash* included approximately $97.9 million related to our settlement with UBS Securities (see Note 20, *Settlements*, to the accompanying consolidated financial statements). This amount was transferred to us in December 2008, with an additional $2.1 million related to this settlement transferred to us in January 2009, from UBS Securities and its insurance carriers and held in escrow pending the court's implementation of the final court order entered on January 13, 2009. These funds are expected to be dispersed to the applicable parties during the first quarter of 2009. We intend to use the majority of our net cash proceeds from this settlement

(see above discussion related to amounts owed to the derivative plaintiffs' attorneys and the plaintiffs in the consolidated securities litigation) to reduce long-term debt outstanding. The remainder of our *Restricted cash* pertains to various obligations we have under lending agreements, partnership agreements, and other arrangements primarily related to our captive insurance company.

In light of the current downturn in the global economy, we have evaluated, to the extent practicable, our exposure to financial services counterparties to whom we have material exposure. We monitor the financial strength of our depositories, creditors, derivative counterparties, and insurance carriers using publicly available information, as well as qualitative inputs. During the fourth quarter of 2008, we made a $40.0 million draw on the revolving credit facility and issued letters of credit under its subfacility without incident. The draw was used for general corporate purposes. Based on our current borrowing capacity and compliance with the financial covenants under our Credit Agreement, we do not believe there is significant risk in our ability to make additional draws under our revolving credit facility, if needed. However, no such assurances can be provided.

In addition, we do not face substantial near-term refinancing risk, as our revolving credit facility does not expire until 2012, our Term Loan Facility (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) does not mature until 2013, and the majority of our bonds are not due until 2014 and 2016.

We expect our cash flow to allow us to further reduce our debt. During February 2009, we used our federal income tax refund for tax years 1995 through 1999 along with available cash to reduce our Term Loan Facility by $24.5 million and amounts outstanding under our revolving credit facility to zero. As noted above, we intend to use the majority of the net cash proceeds from the UBS Settlement to pay down long-term debt (see Note 20, *Settlements*, to the accompanying consolidated financial statements). While our focus in 2009 will be to pay down debt, we intend to direct a portion of our excess cash flow into our development activities, focusing on bed additions at our existing hospitals and transactions that require a minimal initial outlay of cash.

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

Risk Management and Insurance

We insure a substantial portion of our professional, general liability, and workers' compensation risks through a self-insured retention program underwritten by our wholly owned offshore captive insurance subsidiary, HCS Limited ("HCS"), which we fund via regularly scheduled premium payments. For 2008, HCS provided our first layer of insurance coverage for professional and general liability risks and workers' compensation claims. We maintained professional and general liability insurance and workers' compensation insurance with unrelated commercial carriers for losses in excess of amounts insured by HCS. HealthSouth and HCS maintained reserves for professional, general liability, and workers' compensation risks. Management considers such reserves, which are based on actuarially determined estimates, to be adequate for those liability risks. However, there can be no assurance the ultimate liability will not exceed management's estimates. See Note 1, *Summary of Significant Accounting Policies*, "Self-Insured Risks," to our accompanying consolidated financial statements for a description of these reserves.

We also maintain director and officer, property, and other typical insurance coverages with unrelated commercial carriers. Our director and officer liability insurance coverage for our current officers and directors includes coverage for individual directors and officers in circumstances where we are legally or financially unable to indemnify these individuals. Examples of a company's inability to indemnify would include judgments in connection with shareholder derivative lawsuits, bankruptcy/financial restraints, and claims that are against public policy. Within our coverage, we have a self-insured retention for indemnifiable loss. See Note 20, *Settlements*, "Insurance Coverage Litigation Settlements," to our accompanying consolidated financial statements for a description of various lawsuits that have been filed to contest coverage under certain directors and officers insurance policies.

Available Information

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

Item 1A. Risk Factors

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

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

We continue to make progress in improving our leverage and liquidity. As discussed in Item 1, *Business*, "Leverage and Liquidity," we reduced our long-term debt from $2.0 billion to approximately $1.8 billion during 2008. These continued reductions in our long-term debt improve our financial position, increase our liquidity, and enhance our operational flexibility.

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

Recent uncertainty in the global credit markets could adversely affect our business and financial condition by making it more challenging for us to carry out our deleveraging and development objectives.

The global credit markets experienced significant disruptions in 2008, which have caused the interest rates on prospective debt financings to increase. These circumstances have impacted liquidity in the debt markets, and in certain cases have resulted in reductions in the availability of certain types of debt financing, including access to revolving lines of credit. Where financing can be obtained, the terms for borrowers are less attractive. A prolonged downturn in the credit markets may cause us to seek alternative sources of potentially less attractive financing and may require us to adjust our business plan accordingly.

We have evaluated, to the extent practicable, our exposure to counterparties who have or may likely experience significant threats to their ability to adequately service our needs. We monitor the financial strength of our depositories, creditors, derivative counterparties, and insurance carriers using publicly available information, as well as qualitative service experience inputs. We are generally confident that we will have access to our revolving credit facility. During the fourth quarter of 2008, we made a $40.0 million draw on our revolving credit facility and issued letters of credit under its subfacility without incident. The draw was used for general corporate purposes. Based on the current borrowing capacity and leverage ratio required under our Credit Agreement, we do not believe there is significant risk in our ability to make additional draws under our revolving credit facility, if needed. In addition, we do not face substantial near-term refinancing risk, as our revolving credit facility does not expire until 2012, our Term Loan Facility (as defined in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements) does not expire until 2013, and the majority of our bonds are not due until 2014 and 2016.

Our portfolio of restricted marketable securities has performed as expected in the current economy. During the fourth quarter of 2008, we recorded impairment charges related to our marketable equity securities (see Note 3, *Cash and Marketable Securities*, to our accompanying consolidated financial statements). We continue to evaluate our portfolio allocation in relation to our investment objectives.

Our primary risks relating to current market conditions is the possibility that a rapid increase in interest rates and/or a down-turn in operating earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement and that lenders in our Credit Agreement will be unable to provide liquidity when needed. Loans under our Credit Agreement bear interest at a rate of, at our option, 1-month, 2-month, 3-month, or 6-month LIBOR or the Prime rate, plus an applicable margin that varies depending upon our leverage ratio and corporate credit rating. Our primary covenants include a leverage ratio and an interest coverage ratio, with the interest coverage ratio being a four consecutive fiscal quarters test. A default due to violation of the covenants contained within our Credit Agreement could require us to immediately repay all amounts then outstanding under the Credit Agreement. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might not be on terms as favorable to those in our existing Credit Agreement. Under such circumstances, there is also the potential our lenders would not grant relief to us which, among other things, would depend on the state of the credit markets at that time.

While our variable interest payments increase or decrease in accordance with changes in interest rates, the vast majority of the variation in these payments will be offset by net settlement payments or receipts on our interest rate swap that is not designated as a hedge. Therefore, our cash position is generally protected from such changes. Net settlement payments or receipts on this interest rate swap are included in the line entitled *Loss on interest rate swap* in our consolidated statements of operations.

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

We derive a substantial portion of our *Net operating revenues* from the Medicare and Medicaid programs. See Item 1, *Business*, “Sources of Revenues,” for a table identifying the sources and relative payor mix of our revenues. Historically, Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on and, in some cases, significant reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. For the period from April 1, 2008 through September 30, 2009, the 2007 Medicare Act reduced the Medicare reimbursement levels for inpatient rehabilitation hospitals to the levels existing in the third quarter of 2007. In 2008, increased patient volumes offset the negative impact of the pricing roll-back. If we are not able to maintain increased volumes to offset this pricing roll-back or any future pricing freeze or roll-back, our operating results could be adversely affected. Our results could be further adversely affected by other changes in laws or regulations governing the Medicare and Medicaid programs, as well as possible changes to or expansion of the audit processes conducted by Medicare contractors or Medicare recovery audit contractors. For a discussion of the factors affecting reimbursement for our services, see Item 1, *Business*, “Sources of Revenues – Medicare Reimbursement.”

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

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

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

Medicare providers also can be negatively affected by the adoption of coverage policies, either at the national or local levels, describing whether an item or service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. In the absence of a national coverage determination, local Medicare contractors may specify more restrictive criteria than otherwise would apply nationally. For instance, Cahaba Government Benefit Administrators, the Medicare contractor for many of our hospitals, has issued a local coverage determination setting forth very detailed criteria for determining the medical appropriateness of services

provided by inpatient rehabilitation hospitals. We cannot predict whether other Medicare contractors will adopt additional local coverage determinations or other policies or how these will affect us.

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

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

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

In December 2004, we entered into a Corporate Integrity Agreement, or the "CIA," with the Office of Inspector General of the United States Department of Health and Human Services (the "HHS-OIG") to promote our compliance with the requirements of Medicare, Medicaid, and all other federal healthcare programs. We have also entered into two addendums to this agreement. The CIA expires at the end of 2009, subject to the HHS-OIG accepting and approving our annual report for 2009 that we will submit in the first half of 2010. Under the agreement and addendums, we are subject to certain administrative requirements and are subject to review of certain Medicare cost reports and reimbursement claims by an Independent Review Organization (see Note 20, *Settlements*, to our accompanying consolidated financial statements). Our failure to comply with the material terms of the CIA could lead to suspension or exclusion from further participation in federal healthcare programs, including Medicare and Medicaid, which currently account for a substantial portion of our revenues. Further, if the HHS-OIG determines that we have violated the anti-kickback laws, the False Claims Act or the federal Stark statute's general prohibition on physician self-referrals, we may be subject to significant civil monetary penalties, and may be excluded from further participation in federal healthcare programs. Any of these sanctions would have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

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

- licensure, certification, and accreditation,
- coding and billing for services,
- requirements of the 75% Rule, including the 60% compliance threshold under the 2007 Medicare Act,
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws,
- quality of medical care,
- use and maintenance of medical supplies and equipment,
- maintenance and security of medical records,
- acquisition and dispensing of pharmaceuticals and controlled substances, and
- disposal of medical and hazardous waste.

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

Although we have invested substantial time, effort, and expense in implementing internal controls and procedures designed to ensure regulatory compliance, if we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs. Substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We maintain our principal executive offices at 3660 Grandview Parkway (formerly One HealthSouth Parkway), Birmingham, Alabama. We occupy those office premises under a long-term lease with Daniel Corporation ("Daniel") which expires in 2018 and includes options for us, at our discretion, to renew the lease for up to ten years in total beyond that date. On March 31, 2008, we sold, for a purchase price of $43.5 million in cash, our 103-acre corporate campus and all related buildings including the 200,000 square-foot corporate headquarters building in which our current principal executive offices are located, the Cahaba Grand Conference Center, and an incomplete 13-story building formerly called the "Digital Hospital." As part of this transaction, we entered into our long-term lease for office space within the property that was sold.

The sale agreement includes a deferred purchase price component related to the Digital Hospital. If Daniel sells, or otherwise monetizes its interest in, the Digital Hospital for cash consideration to a third party, we are entitled to 40% of the net profit, if any and as defined in the sale agreement, realized by Daniel. In September 2008, Daniel announced that it had reached an agreement with Trinity Medical Center ("Trinity") pursuant to which Trinity will acquire the Digital Hospital. The purchase price of this transaction has not been made public, and the transaction is subject to Trinity receiving approval for a certificate of need ("CON") from the applicable state board of Alabama. Currently, there is opposition to the potential approval of Trinity's CON request, and it could take months to finalize any decision by the applicable Alabama board. Therefore, no assurances can be given as to whether or when any such cash flows related to the deferred purchase price component of our agreement with Daniel will be received, if any, if Daniel is able to realize a net profit on its transaction with Trinity. See Note 5, *Property and Equipment*, to our accompanying consolidated financial statements.

In addition to our principal executive offices, as of December 31, 2008, we leased or owned through various consolidated entities 142 business locations to support our operations. Our hospital leases, which represent the largest portion of our rent expense, have average initial terms of 15 to 20 years. Most of our leases contain one or more options to extend the lease period for up to five additional years for each option. Our consolidated entities are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses, particularly in our leased hospitals. Other than our principal executive offices, none of our other properties is materially important.

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

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

Item 3. Legal Proceedings

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

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

None.

PART II

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

Market Information

Shares of our common stock trade on the New York Stock Exchange ("NYSE") under the ticker symbol "HLS." The following table sets forth the high and low sales prices per share for our common stock as reported on the NYSE from January 1, 2007 through December 31, 2008.

	Market	High	Low
2007			
First Quarter	NYSE	$ 25.89	$ 20.51
Second Quarter	NYSE	21.70	16.59
Third Quarter	NYSE	19.33	14.84
Fourth Quarter	NYSE	23.02	17.03
2008			
First Quarter	NYSE	$ 21.70	$ 15.20
Second Quarter	NYSE	20.20	16.56
Third Quarter	NYSE	19.98	15.01
Fourth Quarter	NYSE	18.36	7.20

Holders

As of February 13, 2009, there were 88,009,707 shares of HealthSouth common stock issued and outstanding, net of treasury shares, held by approximately 3,617 holders of record.

Dividends

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

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

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

Purchases of Equity Securities

None.

Company Stock Performance

Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor's 500 Index ("S&P 500"), and the Morgan Stanley Health Care Provider Index ("RXH"), an equal-dollar weighted index

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of 16 companies involved in the business of hospital management and medical/nursing services. The graph assumes $100 invested on December 31, 2003 in HealthSouth common stock and each of the indices. We did not pay dividends during that time period and do not plan to pay dividends.

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

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

Stockholder Return Comparison

	For the Year Ended December 31,					
	Base Period	Cumulative Total Return				
Company/Index Name	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
HealthSouth Corporation	100.00	136.82	106.75	98.69	91.50	47.76
Standard & Poor's 500 Index	100.00	110.74	114.26	129.79	134.55	83.79
Morgan Stanley Health Care Provider Index	100.00	108.87	124.99	126.92	121.97	80.16

Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2008, 2007, and 2006 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below for the years ended December 31, 2005 and 2004, as adjusted for discontinued operations, from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2005. You should refer to Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* and the notes to our accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations. In addition, you should note the following information regarding the selected historical consolidated financial data presented below:

- Certain previously reported financial results have been reclassified to conform to the current year presentation. Such reclassifications primarily relate to one hospital and one gamma knife radiosurgery center we identified in 2008 that qualified under Financial Accounting Standards Board ("FASB") Statement No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, to be reported as

assets held for sale and discontinued operations. We reclassified our consolidated balance sheets as of December 31, 2007, 2006, 2005, and 2004 to show the assets and liabilities of these qualifying facilities as held for sale. We also reclassified our consolidated statements of operations for the years ended December 31, 2007, 2006, 2005, and 2004 to show the results of these qualifying facilities as discontinued operations.

- On January 1, 2006, we adopted FASB Statement No. 123 (Revised 2004), *Share-Based Payment*. As a result of our adoption of this statement, our results of operations for 2008, 2007, and 2006 included approximately $5.0 million, $7.7 million and $12.1 million of compensation expense related to stock options. These costs are included in *General and administrative expenses* in our consolidated statements of operations for the years ended December 31, 2008, 2007, and 2006.
- In March 2008, we sold our corporate campus to Daniel Corporation. In accordance with FASB Statement No. 144, we accelerated the depreciation of our corporate campus so that the net book value of the corporate campus equaled the net proceeds we received from the sale. The year-over-year impact of this acceleration of depreciation approximated $10.0 million.
- Included in our *Net income (loss)* for 2008, 2007, 2006, 2005, and 2004 are long-lived assets impairment charges of $0.6 million, $15.1 million, $9.7 million, $34.7 million, and $30.2 million, respectively.

The impairment charge recorded in 2008 represented our write-down of certain long-lived assets associated with one of our hospitals to their estimated fair value based on an offer we received from a third party to acquire the assets. Prior to 2008, the majority of these charges in each year related to the Digital Hospital (as defined in Note 5, *Property and Equipment*, to our accompanying consolidated financial statements) and represented the excess of costs incurred during the construction of the Digital Hospital over the estimated fair market value of the property, including the RiverPoint facility, a 60,000 square foot office building, which shared the construction site. The impairment of the Digital Hospital in each year was determined using either its estimated fair value based on the estimated net proceeds we expected to receive in a sale transaction or using a weighted-average fair value approach that considered an alternative use appraisal and other potential scenarios. The remainder of the impairment charges in each period, excluding 2008, related to long-lived assets at various hospitals that were examined for impairment due to hospitals experiencing negative cash flow from operations. We determined the fair value of the impaired long-lived assets at a hospital primarily based on the assets' estimated fair value using valuation techniques that included discounted future cash flows and third-party appraisals.

These impairment charges are shown separately as a component of operating expenses within the consolidated statements of operations, excluding $11.8 million, $38.2 million, $10.0 million, $17.3 million, and $26.4 million of impairment charges in 2008, 2007, 2006, 2005, and 2004, respectively, related to our former surgery centers, outpatient, and diagnostic divisions and certain closed hospitals and facilities which are included in discontinued operations.

For additional information, see Note 5, *Property and Equipment*, and Note 16, *Assets Held for Sale and Results of Discontinued Operations*, to our accompanying consolidated financial statements.

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

On December 8, 2006, we entered into an agreement with the derivative plaintiffs' attorneys to resolve the amounts owed to them as a result of the award given to us under the claim for restitution of

incentive bonuses Mr. Scrushy received in previous years and the Securities Litigation Settlement (as defined and discussed in Note 20, *Settlements*, to our accompanying consolidated financial statements). Under this agreement, we agreed to pay the derivative plaintiffs' attorneys $32.5 million on an aggregate basis for both claims. We paid approximately $11.5 million of this amount in 2006, with the remainder paid in 2007, using amounts received from Mr. Scrushy in the above referenced award.

- In 2001 and 2002, we reserved approximately $38.0 million related to amounts due from Meadowbrook Healthcare, Inc. ("Meadowbrook"), an entity formed by one of our former chief financial officers related to net working capital advances made to Meadowbrook in 2001 and 2002. In August 2005, we received a payment of $37.9 million from Meadowbrook. This cash payment is included as *Recovery of amounts due from Meadowbrook* in our 2005 consolidated statement of operations. For more information regarding Meadowbrook, see Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.
- In October 2008, we entered into an agreement, approved by the court in January 2009, with UBS Securities, LLC ("UBS Securities") to settle litigation filed by the derivative plaintiffs on the Company's behalf. Under the settlement, $100.0 million in cash previously paid into escrow by UBS Securities and its insurance carriers will be released to us, and we will receive a release of all claims by UBS Securities, including the release and satisfaction of an approximate $31 million judgment in favor of an affiliate of UBS Securities related to a loan guarantee.

Out of the $100.0 million cash settlement proceeds received from UBS Securities and its insurance carriers, we are obligated to pay $26.2 million in fees and expenses to the derivative plaintiffs' attorneys and 25% of the net proceeds, after deducting all of our costs and expenses in connection with the derivative litigation, to the plaintiffs in the consolidated securities litigation.

As a result of this settlement, we recorded a $121.3 million gain in our consolidated statement of operations for the year ended December 31, 2008. This gain is comprised of the $100.0 million cash portion of the settlement plus the principal portion of the above referenced loan guarantee.

For additional information, see Note 20, *Settlements*, to our accompanying consolidated financial statements.

- As discussed in more detail in Note 20, *Settlements*, to our accompanying consolidated financial statements, we were involved in a legal dispute regarding the lease of Braintree Rehabilitation Hospital in Braintree, Massachusetts and New England Rehabilitation Hospital in Woburn, Massachusetts. In 2005, a judgment was entered against us that upheld the landlord's termination of our lease of these two hospitals and placed us as the manager, rather than the owner, of these two hospitals. Accordingly, our 2006 and 2005 results of operations include only the $4.0 million and $5.4 million management fee we earned for operating these hospitals during the nine months ended September 30, 2006 and the year ended December 31, 2005, respectively. In 2004, the results of operations of these two hospitals were included in our consolidated statements of operations on a gross basis. Our consolidated *Net operating revenues* and consolidated operating earnings were negatively impacted by approximately $106.3 million and $3.6 million, respectively, (excluding the lease termination gain described below) in 2005 as a result of the change in ownership of these two hospitals. In September 2006, we completed the transition of these two hospitals to the landlord.

Also, as a result of the lease termination associated with the Braintree and Woburn hospitals, we recorded a $30.5 million net gain on lease termination during 2005. This net gain is included in *Occupancy costs* in our 2005 consolidated statement of operations.

- *Government, class action, and related settlements expense* included amounts related to litigation, settlements, and ongoing settlement negotiations with various entities and individuals. In 2008, 2007, and 2006, these amounts are net of an $85.2 million, $24.0 million, and $31.2 million, respectively, reduction to the $215.0 million charge we recorded in 2005 as a result of the final court approval of our settlement in the federal securities class actions and the derivative litigation. These reductions are attributable to the value of our common stock and the associated common stock warrants underlying

the settlement as of December 31 of each year. The remainder of the amounts recorded in 2008, 2007, and 2006 related to other settlements, ongoing discussions, and litigation, as discussed in more detail in Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 20, *Settlements*, and Note 21, *Contingencies and Other Commitments*, to our accompanying consolidated financial statements.

In 2005, our *Net loss* included 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 then-proposed settlement with the lead plaintiffs in the federal securities class actions and the derivative litigation, as well as with our insurance carriers, to settle claims filed against us, certain of our former directors and officers, and certain other parties. This settlement was finalized in January 2007, and, as noted above, adjustments were recorded to this liability in 2008, 2007, and 2006. For additional information, see Note 20, *Settlements*, to our accompanying consolidated financial statements.

- Significant changes have occurred at HealthSouth since the financial fraud perpetrated by certain members of our prior management team was uncovered. The steps taken to stabilize our business and operations, provide vital management assistance, and coordinate our legal strategy came at significant financial cost. Our *Net income (loss)* in each year included professional fees associated with professional services to support the preparation of our periodic reports filed with the SEC (excluding 2008), tax preparation and consulting fees for various tax projects, and legal fees for litigation defense and support matters. For years prior to 2006, these fees included costs associated with the reconstruction and restatement of our previously filed consolidated financial statements for the years ended December 31, 2001 and 2000. These fees are included in our statements of operations as *Professional fees—accounting, tax, and legal* and approximated $44.4 million, $51.6 million, $161.4 million, $169.1 million, and $206.2 million in 2008, 2007, 2006, 2005, and 2004, respectively. See Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements for additional information.
- During 2008, we used the net proceeds from the sale of our corporate campus, the net proceeds from our equity offering, and our federal income tax refund for tax years 2000 through 2003 to reduce our total debt outstanding. As a result of these debt reductions, we allocated a portion of the debt discounts and fees associated with our debt to the debt that was extinguished and expensed debt discounts and fees totaling approximately $3.6 million to *Loss on early extinguishment of debt* during the year ended December 31, 2008. Our *Loss on early extinguishment of debt* during 2008 also included $2.3 million of net premiums associated with the redemption of certain bonds. For additional information, see Note 5, *Property and Equipment*, Note 8, *Long-term Debt*, Note 10, *Shareholders' Deficit*, and Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

During 2007, we used the net proceeds from the divestitures of our surgery centers, outpatient, and diagnostic divisions, as well as the majority of our federal income tax refund for tax years 1996 through 1999 to pay down obligations outstanding under our Credit Agreement. Also during 2007, we used a combination of cash on hand and borrowings under our revolving credit facility to redeem approximately $59.1 million of our 10.75% Senior Notes due 2016. As a result of these debt reductions, we allocated a portion of the debt discounts and fees associated with these agreements to the debt that was extinguished and wrote off debt discounts and fees totaling approximately $25.9 million to *Loss on early extinguishment of debt* during 2007. The remainder of the amount recorded to *Loss on early extinguishment of debt* during 2007 related to the premiums associated with the redemption of the 10.75% Senior Notes due 2016 discussed above. For additional information, see Note 8, *Long-term Debt*, Note 16, *Assets Held for Sale and Results of Discontinued Operations*, and Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

During 2006, we recorded an approximate $365.6 million net loss on early extinguishment of debt due to the completion of a private offering of senior notes in June 2006 and a series of recapitalization transactions during the first quarter of 2006. For more information regarding these transactions, see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements.

- As discussed in more detail in Note 8, *Long-term Debt*, to our accompanying consolidated financial statements, we entered into an interest rate swap in March 2006 to effectively convert a portion of our variable rate debt to a fixed interest rate. During 2008, 2007, and 2006, we recorded a net loss of approximately $55.7 million, $30.4, million and $10.5 million, respectively, related to the fair value adjustments, quarterly settlements, and accrued interest recorded for the swap.
- Our *Provision for income tax benefit* in 2008 primarily resulted from our settlement with the Internal Revenue Service (the "IRS") for an additional tax claim related to the tax years 1995 through 1999, state income tax refunds received, or expected to be received, and changes in the amount of unrecognized tax benefits, as discussed in Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

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

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

	For the Year Ended December 31,				
	2008	**2007**	**2006**	**2005**	**2004**
	(In Millions, Except Per Share Data)				
Income Statement Data:					
Net operating revenues	$ 1,842.4	$ 1,737.5	$ 1,695.5	$ 1,733.7	$ 1,920.5
Salaries and benefits	934.7	863.6	818.6	807.0	904.6
Other operating expenses	268.3	243.8	223.0	255.6	231.1
General and administrative expenses	105.5	127.9	141.3	164.3	82.4
Supplies	108.9	100.3	100.4	102.2	117.8
Depreciation and amortization	83.8	76.2	84.7	88.5	98.6
Impairment of long-lived assets	0.6	15.1	9.7	34.7	30.2
Recovery of amounts due from Richard M. Scrushy	–	–	(47.8)	–	–
Recovery of amounts due from Meadowbrook	–	–	–	(37.9)	–
Gain on UBS Settlement	(121.3)	–	–	–	–
Occupancy costs	49.8	52.4	54.5	11.7	67.0
Provision for doubtful accounts	27.8	33.6	45.3	31.6	38.9
Loss on disposal of assets	2.0	5.9	6.4	11.6	3.3
Government, class action, and related settlements expense	(67.2)	(2.8)	(4.8)	215.0	–
Professional fees—accounting, tax, and legal	44.4	51.6	161.4	169.1	206.2
Loss on early extinguishment of debt	5.9	28.2	365.6	–	–
Interest expense and amortization of debt discounts and fees	159.7	229.8	234.7	234.8	202.6
Other income	(0.1)	(15.5)	(9.4)	(16.5)	(11.9)
Loss on interest rate swap	55.7	30.4	10.5	–	–
Equity in net income of nonconsolidated affiliates	(10.6)	(10.3)	(8.7)	(12.3)	(12.1)
Minority interests in earnings of consolidated affiliates	29.8	31.4	26.3	41.7	31.3
	1,677.7	1,861.6	2,211.7	2,101.1	1,990.0
Income (loss) from continuing operations before income tax (benefit) expense	164.7	(124.1)	(516.2)	(367.4)	(69.5)
Provision for income tax (benefit) expense	(70.1)	(322.4)	22.4	19.6	(4.5)
Income (loss) from discontinued operations, net of income tax benefit (expense)	17.6	455.1	(86.4)	(59.0)	(109.5)
Net income (loss)	252.4	653.4	(625.0)	(446.0)	(174.5)
Convertible perpetual preferred stock dividends	(26.0)	(26.0)	(22.2)	–	–
Net income (loss) available to common shareholders	$ 226.4	$ 627.4	$ (647.2)	$ (446.0)	$ (174.5)
Weighted average common shares outstanding:					
Basic	83.0	78.7	79.5	79.3	79.3
Diluted	96.4	92.0	90.3	79.6	79.5
Earnings (loss) per common share:					
Basic:					
Income (loss) from continuing operations available to common shareholders	$ 2.52	$ 2.19	$ (7.05)	$ (4.88)	$ (0.82)
Income (loss) from discontinued operations, net of tax	0.21	5.78	(1.09)	(0.74)	(1.38)
Net income (loss) per share available to common shareholders	$ 2.73	$ 7.97	$ (8.14)	$ (5.62)	$ (2.20)
Diluted:					
Income (loss) from continuing operations available to common shareholders	$ 2.44	$ 2.16	$ (7.05)	$ (4.88)	$ (0.82)
Income (loss) from discontinued operations,					

net of tax	0.18	4.94	(1.09)	(0.74)	(1.38)
Net income (loss) per share available to common shareholders	$ 2.62	$ 7.10	$ (8.14)	$ (5.62)	$ (2.20)

	As of December 31,				
	2008	2007	2006	2005	2004
	(In Millions)				
Balance Sheet Data:					
Cash, cash equivalents, and marketable securities	$ 32.4	$ 19.8	$ 27.2	$ 190.2	$ 425.0
Restricted cash	154.0	63.6	60.3	179.4	190.2
Restricted marketable securities	20.3	28.9	71.1	–	–
Working capital deficit	(63.5)	(333.1)	(381.3)	(235.5)	(3.8)
Total assets	1,998.2	2,050.6	3,360.8	3,595.3	4,084.8
Long-term debt, including current portion	1,814.4	2,042.7	3,376.7	3,360.6	3,428.5
Convertible perpetual preferred stock	387.4	387.4	387.4	–	–
Shareholders' deficit	(1,169.4)	(1,554.5)	(2,184.6)	(1,540.7)	(1,109.4)

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

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

Forward Looking Information

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

Executive Overview

Our Business –

We are the nation's largest provider of inpatient rehabilitative healthcare services in terms of revenues, number of hospitals, and patients treated and discharged. Our inpatient rehabilitation hospitals offer specialized rehabilitative care across a wide array of diagnoses and deliver comprehensive patient care services. The majority of patients we serve experience significant physical disabilities due to medical conditions, such as strokes, hip fractures, head injury, spinal cord injury, and neurological disorders, that are non-discretionary in nature and which require rehabilitative services in an inpatient setting. Our team of highly skilled physicians, nurses, and physical, occupational, and speech therapists utilize the latest in equipment and techniques to return patients to home and work. 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, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leads to what we believe is a higher level of care and superior outcomes.

We operate inpatient rehabilitation hospitals and long-term acute care hospitals ("LTCHs") and provide treatment on both an inpatient and outpatient basis. As of December 31, 2008, we operated 93 inpatient rehabilitation hospitals (including 3 joint venture hospitals which we account for using the equity method of accounting), 6 freestanding LTCHs, 49 outpatient rehabilitation satellites (operated by our hospitals), and 25 licensed, hospital-based home health agencies. In addition to HealthSouth hospitals, we manage eight inpatient rehabilitation units and one outpatient satellite through management contracts. Our inpatient hospitals are located in

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26 states, with a concentration of hospitals in Texas, Pennsylvania, Florida, Tennessee, and Alabama. As of December 31, 2008, we also had two hospitals in Puerto Rico.

As of December 31, 2007, we operated 94 inpatient rehabilitation hospitals. In the second quarter of 2008, we consolidated our Odessa, Texas inpatient rehabilitation facility into our Midland, Texas inpatient rehabilitation hospital. In the third quarter of 2008, we acquired The Rehabilitation Hospital of South Jersey, as discussed below and in Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements. During the third quarter of 2008, management made the decision to close our hospital in Dallas, Texas, effective October 31, 2008.

Net patient revenue from our hospitals increased 7.5% from 2007 to 2008. Inpatient discharges increased 7.0% from 2007 to 2008. Same store discharges experienced growth of 6.1% from 2007 to 2008. Our results for the year ended December 31, 2008 included an increase in our Medicare reimbursement that was effective October 1, 2007. However, this pricing increase was removed effective April 1, 2008 as part of the pricing roll-back of the 2007 Medicare Act, as discussed in Item 1, *Business*, and below in this Item. Operating earnings (as defined in Note 22, *Quarterly Data (Unaudited)*, to our accompanying consolidated financial statements) for 2008 and 2007 were $385.9 million and $148.8 million, respectively. This improvement resulted from our increased revenues year over year. Operating earnings for the year ended December 31, 2008 included gains of $188.5 million associated with *Government, class action, and related settlements*, including the *Gain on UBS Settlement* (see Note 20, *Settlements*, to our accompanying consolidated financial statements).

As discussed in the “Business Outlook” section below and throughout this report, our primary emphasis remains on debt reduction and further deleveraging, especially during this period of global economic uncertainty. In total during 2008, we used approximately $254 million of cash to reduce our total debt outstanding (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). In addition, during February 2009, we used our federal income tax refund for tax years 1995 through 1999 (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements) along with available cash to reduce our Term Loan Facility by $24.5 million and amounts outstanding under our revolving credit facility to zero. We also intend to use the majority of the net cash proceeds from the UBS Settlement (as described in Note 20, *Settlements*, to our accompanying consolidated financial statements) to pay down long-term debt.

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

2008 Development Activities

We entered 2008 seeking disciplined growth opportunities for our inpatient rehabilitation business in the context of our primary emphasis on debt reduction and further deleveraging. During the year, we completed the following acquisitions (see Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements):

- In July 2008, we purchased The Rehabilitation Hospital of South Jersey, a 34-bed inpatient rehabilitation hospital in Vineland, New Jersey. This transaction added a third New Jersey rehabilitation hospital to our northeast region.
- In August 2008, we acquired an inpatient rehabilitation unit at the Medical Center of Arlington in Texas. The operations of this unit were relocated to, and consolidated with, HealthSouth Rehabilitation Hospital of Arlington.
- In August 2008, we acquired an inpatient rehabilitation hospital in Midland, Texas from Rehabcare Corporation. The operations of this hospital were relocated to, and consolidated with, HealthSouth Rehabilitation Hospital of Midland/Odessa.

In addition to these acquisitions that are included in our 2008 results of operations, we also commenced the following development projects during the year:

- In June 2008, a certificate of need was approved that will enable us to establish up to a 40-bed comprehensive medical rehabilitation hospital in Marion County, Florida. The certificate of need has been contested by two competitors in the market and is progressing through the normal Florida certificate of need appeals process. The appeals process is expected to take at least one year, and there can be no assurance regarding the timing or outcome.
- Our certificate of need application for a new 40-bed rehabilitation hospital in Loudoun County, Virginia was approved on July 30, 2008. We expect to break ground on this site in the first half of 2009.
- In October 2008, we broke ground on a new, 40-bed freestanding inpatient rehabilitation hospital in Mesa, Arizona, and we expect operations to commence in the third quarter of 2009.

2008 Significant Events

During the first quarter of 2008, we finalized the sale of our corporate campus (see Note 5, *Property and Equipment*, to our accompanying consolidated financial statements). As part of this transaction, we entered into a lease for office space within the property that was sold. The sale of this property will help us continue to reduce corporate operating expenses going forward. The net proceeds from this transaction were used to reduce amounts outstanding on our revolving credit facility in April 2008 (see Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to our accompanying consolidated financial statements).

On June 27, 2008, HealthSouth finalized the issuance and sale of 8.8 million shares of its common stock to J.P. Morgan Securities Inc. for net proceeds of approximately $150 million. The Company used the net proceeds of the offering primarily for redemption and repayment of short-term and long-term borrowings. See Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to our accompanying consolidated financial statements for additional information regarding use of the net proceeds.

In October 2008, we entered into an agreement, approved by the court on January 13, 2009, with UBS Securities, LLC (“UBS Securities”) to settle litigation filed by the derivative plaintiffs on the Company’s behalf. Under the settlement, $100.0 million in cash previously paid into escrow by UBS Securities and its insurance carriers will be released to us, and we will receive a release of all claims by UBS Securities, including the release and satisfaction of an approximate $31 million judgment in favor of an affiliate of UBS Securities related to a loan guarantee.

Out of the $100.0 million cash settlement proceeds received from UBS Securities and its insurance carriers, we are obligated to pay $26.2 million in fees and expenses to the derivative plaintiffs’ attorneys, and pursuant to the previously disclosed settlement agreements in the consolidated securities litigation, 25% of the net proceeds, after deducting all of our costs and expenses in connection with the derivative litigation, will be paid to plaintiffs in the consolidated securities litigation. See Note 20, *Settlements*, to our accompanying consolidated financial statements. These funds are expected to be dispersed to the applicable parties during the first quarter of 2009. We intend to use the majority of our net cash proceeds to reduce long-term debt.

In October 2008, we received a total cash refund of approximately $46 million (including interest) attributable to our settlement with the Internal Revenue Service (the “IRS”) for tax years 2000 through 2003. We used the majority of this cash to reduce amounts outstanding under our Credit Agreement. See Note 8, *Long-term Debt*, and Note 17, *Income Taxes*, to our accompanying consolidated financial statements.

In the fourth quarter of 2008, we settled federal income tax issues outstanding with the IRS for the tax years 1995 through 1999, and the Joint Committee on Taxation reviewed and approved the associated income tax refund of approximately $42 million (including interest) due to the Company. In February 2009, we received the majority of this cash and used it to pay down long-term debt.

Regulatory Challenges to the Inpatient Rehabilitation Industry –

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

The compliance threshold of the 75% Rule was in the process of being phased-in over time, and was already at 60% or higher for all of our hospitals at the end of 2007. However, on December 29, 2007, The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") was signed, permanently setting the compliance threshold at 60% instead of 75%, and allowing hospitals to continue using a patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitation care under the rule.

An additional element to the 2007 Medicare Act was a reduction in the pricing of services eligible for Medicare reimbursement to a pricing level that existed in the third quarter of 2007, or a Medicare pricing "roll-back," which has resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs. The roll-back is effective from April 1, 2008 until September 30, 2009.

The long-term impact of the freeze at the 60% compliance threshold was positive because it allowed patient volumes to stabilize. In 2008, increased patient volumes from both our focus on standardized sales and marketing efforts and the fact that more patients now have access to our high quality inpatient rehabilitative services offset the negative impact of the pricing roll-back (see this Item, "Results of Operations – Net Operating Revenues"). We expect the negative impact of the pricing roll-back to continue to be offset partially by our volume increases (see this Item, "Business Outlook").

Key Challenges –

While we met our operational goals in 2008, we continue to face challenges, including:

- Leverage and Liquidity. Our leverage remains higher than we would like, and it increases our cost of borrowing and decreases our *Net income*. However, we have made reducing debt a primary strategic focus, and our leverage and liquidity are improving.

During 2008, we used approximately $254 million of cash to reduce our total debt outstanding (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). In addition, during February 2009, we used our federal income tax refund for tax years 1995 through 1999 (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements) along with available cash to reduce our Term Loan Facility by $24.5 million and amounts outstanding under our revolving credit facility to zero. We also intend to use the majority of the net cash proceeds from the UBS Settlement (as described in Note 20, *Settlements*, to our accompanying consolidated financial statements) to pay down long-term debt.

Our primary sources of funding are cash flows from operations and borrowings under our revolving credit facility. As of December 31, 2008, we had approximately $32.2 million in *Cash and cash equivalents*, excluding amounts that are restricted due to various obligations we have under lending agreements, partnership agreements, and other arrangements (see Note 1, *Summary of Significant Accounting Policies*, and Note 3, *Cash and Marketable Securities*, to our accompanying consolidated financial statements). In addition, as of December 31, 2008, we had approximately $307.3 million available under our revolving credit facility, net of amounts utilized under our revolving letter of credit subfacility. An additional $33.6 million (which represents the letter of credit issued in lieu of a bond in the New York Action, as discussed in Note 20, *Settlements*, to our accompanying consolidated

financial statements) will become available in connection with the court's implementation of the order approving the final UBS Settlement, which we expect to be completed in the first quarter of 2009.

We have scheduled principal payments of $24.8 million and $22.1 million in 2009 and 2010, respectively, related to long-term debt obligations (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). Our earliest refinancing risk is 2012, when our revolving credit facility expires, and 2013, when our Term Loan Facility matures. The majority of our bonds are not due until 2014 and 2016.

As with any company carrying significant debt, our primary risk relating to our leverage is the possibility that a rapid increase in interest rates and/or a down-turn in operating earnings could impair our ability to comply with the financial covenants contained within our Credit Agreement. Loans under our Credit Agreement bear interest at a rate of, at our option, 1-month, 2-month, 3-month, or 6-month LIBOR or the Prime rate, plus an applicable margin that varies depending upon our leverage ratio and corporate credit rating. Our primary covenants include a leverage ratio and an interest coverage ratio, with the interest coverage ratio being a four consecutive fiscal quarters test. As of December 31, 2008, we were in compliance with the covenants under our Credit Agreement, and we do not envision any violation of these covenants in 2009.

For additional information regarding our leverage and liquidity, see Item 1, *Business*, the "Liquidity and Capital Resources" section of this Item, and Note 2, *Liquidity*, and Note 8, *Long-term Debt*, to our accompanying consolidated financial statements. See also Item 1A, *Risk Factors*, and Note 1, *Summary of Significant Accounting Policies*, to our accompanying consolidated financial statements for a discussion of risks and uncertainties facing us. As with most companies, changes in our business or other factors may occur that might have a material adverse impact on our financial position, results of operations, and cash flows.

- Reimbursement. Historically, Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on and, in some cases, significant reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. For example, and as discussed above, while the freeze at the 60% compliance threshold under the 2007 Medicare Act is a long-term positive for us, the pricing roll-back is a short-term negative in 2008 and a portion of 2009. In addition, and as discussed in Item 1, *Business*, there can be no assurance there will be an increase in Medicare reimbursement pricing upon the expiration of the roll-back period.

Because Medicare comprised approximately 67.2% of our *Net operating revenues* for the year ended December 31, 2008, single-payor exposure and any potential legislative changes present risks to us. Because we receive a significant percentage of our revenues from Medicare, our inability to achieve continued compliance with the 60% threshold under the 2007 Medicare Act could have a material adverse effect on our financial position, results of operations, and cash flows.

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

- Staffing. Our operations are dependent on the efforts, abilities, and experience of our professional medical personnel, such as physical therapists, nurses, and other healthcare professionals, and our management. If we are unable to recruit and retain qualified physical therapists, nurses, other medical support personnel, or management, or to control our labor costs, our financial position, results of operations, and cash flows could be adversely impacted.

During 2008, we maintained competitive salary structures while making an investment, in the form of enhanced benefits programs, in our employees in an effort to reduce turnover at our hospitals and attract qualified healthcare professionals to our business. Recruiting and retaining qualified personnel

for our hospitals will remain a high priority for the Company on a go-forward basis. However, we must balance our ability to maintain a competitive total compensation package with our goal of being a high quality, low cost provider of inpatient rehabilitation services. See the "Results of Operations – Salaries and Benefits" section of this Item for additional information.

Business Outlook –

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

Strategic Outlook

Our largest referral source is acute care hospitals, and it is not uncommon for acute care volumes, some of which are discretionary in nature, to decrease during periods of economic uncertainty. The majority of patients we serve have medical conditions, such as strokes, hip fractures, and neurological disorders, that are non-discretionary in nature and which require rehabilitative services in an inpatient setting. In addition, our revenue and accounts receivable balances are heavily weighted toward Medicare, and we do not believe there is significant credit risk associated with this government payor. Consequently, we believe we are well positioned to weather such economic periods. As a result, we expect the current economic uncertainty will only minimally impact our *Provision for doubtful accounts*. The area of our business at the most risk for decreases in discretionary spending is our outpatient services. However, this area of our business represents less than 10% of our consolidated *Net operating revenues*, so we anticipate minimal impact to our overall results.

We believe the above assessment of our ability to manage through these difficult economic times is evidenced by our continued volume growth in the latter half of 2008 when our consolidated portfolio yielded same store growth in discharges of approximately 8.1% and 9.7% for the third and fourth quarters of 2008 compared to the same quarters of 2007, respectively. In addition, our *Provision for doubtful accounts* remained within our stated range of 1.5% to 1.8% of *Net operating revenues*. Further, we believe we have adequate sources of liquidity due to our *Cash and cash equivalents* and the availability of our revolving credit facility. Our earliest refinancing risk is 2012, when our revolving credit facility expires, and 2013, when our Term Loan Facility matures. The majority of our bonds are not due until 2014 and 2016.

In total during 2008, we used approximately $254 million of cash to reduce our total debt outstanding (see Note 8, *Long-term Debt*, to our accompanying consolidated financial statements). In addition, during February 2009, we used our federal income tax refund for tax years 1995 through 1999 (see Note 17, *Income Taxes*, to our accompanying consolidated financial statements) along with available cash to reduce our Term Loan Facility by $24.5 million and amounts outstanding under our revolving credit facility to zero. We also intend to use the majority of the net cash proceeds from the UBS Settlement (as described in Note 20, *Settlements*, to our accompanying consolidated financial statements) to pay down long-term debt.

As we reassessed the appropriateness of our strategic outlook during the current economic uncertainty, we took a critical look at our development strategy, especially as it related to de-novo projects. In recognition of changing economic conditions, we will continue to be disciplined in our approach to development opportunities, carefully evaluating these opportunities against our deleveraging priority. For the foreseeable future, reducing our long-term debt will be a key objective. We will continue to pursue bed expansions in existing hospitals as they provide immediate earnings growth, and we will pursue acquisitions and market consolidations where we can do so with minimal initial cash outlays. For any de-novo project we decide to pursue, we will work with third parties willing to assume the majority of the financing risks associated with these projects.

Operating Outlook

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

- Sales and Marketing. Increasing the number of patients we serve is critical to maintaining and improving our profitability, particularly in light of the high percentage of fixed costs at our hospitals and the Medicare pricing roll-back discussed earlier.
- Non-Clinical Support Costs. Over the past few years, we have focused on managing the non-clinical expenses of our hospitals due to the regulatory uncertainty that was caused by the 75% Rule and rising labor costs resulting from shortages of therapists and nurses. Although we have generally reduced most categories of expenses, there is a high degree of variability from hospital to hospital. As a result, the non-clinical support costs initiative was chosen in order to further standardize our best practices in this area.

As a result of our TeamWorks initiative, we experienced an increase in patient discharges from 2007 to 2008. Over the years, we have developed clinical programs, such as those focusing on stroke and other neurological disorders, and have invested in technology to meet the needs of patients requiring inpatient rehabilitative care. Our sales and marketing efforts implemented as part of the TeamWorks initiative have focused on these programs, which benefit higher acuity patients. Typically, these conditions provide higher net patient revenue per discharge because of the higher level of services and resources required.

During the third quarter of 2008, we completed the implementation of the above two phases of TeamWorks at all of our hospitals. As we finalize our plans for the next phase of TeamWorks, we are also implementing a sustainability module to ensure the operational initiatives from the start-up phase of the project remain embedded at our hospitals. We remain optimistic about the project's ability to drive market share based on the results we have seen thus far.

Our *Salaries and benefits* grew as a percent of *Net operating revenues* during 2008 due to various factors, including the increase in the cost of certain benefits provided to our employees. We are actively managing the productive portion of our *Salaries and benefits*, and we have taken steps to address the non-productive component of these expenses (see this Item, "Results of Operations – Salaries and Benefits"). We expect to see a meaningful improvement in the non-productive component of *Salaries and benefits* during 2009, as we transitioned into a new benefit year effective January 1, 2009. We continue to monitor the labor market and will make any necessary adjustments to remain competitive in this challenging environment while also being consistent with our goal of being a high quality, low cost provider of inpatient rehabilitative services.

In addition to the specific challenges we face with staffing levels and costs, we are not immune to the impact the current global economic situation is having on the operating costs of most companies. Specifically, we are experiencing increased utility costs and increased pricing related to supplies, especially pharmaceutical costs. Because our payor mix is weighted heavily towards Medicare, we will be challenged in managing these rising costs as a percent of revenue given the Medicare pricing roll-back that became effective April 1, 2008 and remains effective through September 30, 2009. However, we will be implementing strategies to address these rising costs.

Quarter-over-quarter comparisons for the first quarter of 2009 will not be on an equal basis to the prior year due to the Medicare pricing roll-back. The first quarter of 2008 contained a Medicare pricing increase that became effective October 1, 2007 but was "rolled-back" from our Medicare reimbursement on April 1, 2008. In addition, our 2008 year-over-year and quarter-over-quarter comparisons to 2007 were positively impacted by the freeze at the 60% compliance threshold under the 2007 Medicare Act. Prior to the signing of the 2007 Medicare Act on December 29, 2007, many of our hospitals were limiting admissions due to phase-in requirements under the 75% Rule (see Item 1, *Business*). We believe we can sustain discharge growth of at least 4% annually. See this Item, "Results of Operations – Net Operating Revenues," for additional information.

In summary, we believe we are well positioned to weather the current economic environment. We do not believe our volumes or bad debt expense will be materially adversely impacted. We plan to continue to use the

majority of our excess cash flow to reduce debt. On a go-forward basis, we anticipate we will be able to generate cash flows to fund additional debt reduction and disciplined, opportunistic development activities, which we believe will bring long-term, sustainable growth and returns to our stockholders.

Results of Operations

During 2008, 2007, and 2006, we derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2008	**2007**	**2006**
Medicare	67.2%	67.8%	68.6%
Medicaid	2.2%	2.0%	2.1%
Workers' compensation	2.1%	2.3%	2.6%
Managed care and other discount plans	19.0%	18.5%	18.5%
Other third-party payors	7.0%	6.3%	5.0%
Patients	0.7%	0.6%	0.4%
Other income	1.8%	2.5%	2.8%
Total	100.0%		