HEALTHSOUTH CORP
Form 10-K
February 22, 2017
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

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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, 2016
Commission File Number 001-10315

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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<br>Birmingham, Alabama | 35243 |
| (Address of Principal Executive Offices) | (Zip Code) |

(205) 967-7116
(Registrant's telephone number)

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

| Title of each class | Name of each exchange on which registered |
|---|---|
| Common Stock, $0.01 par value | New York Stock Exchange |

Securities Registered Pursuant to Section 12(g) of the Act:
None

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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 whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). 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 $3.3 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 89,052,284 shares of common stock of the registrant outstanding, net of treasury shares, as of February 15, 2017.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2017 annual meeting of stockholders is incorporated by reference in Part III to the extent described therein.

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NOTE TO READERS

As used in this report, the terms "HealthSouth," "we," "us," "our," and the "Company" refer to HealthSouth Corporation and it consolidated subsidiaries, unless otherwise stated or indicated by context. This drafting style is suggested by the Securities and Exchange Commission and is not meant to imply that HealthSouth Corporation, the publicly traded parent company, owns or operates any specific asset, business, or property. The hospitals, operations, and businesses described in this filing are primarily owned and operated by subsidiaries of the parent company. 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. We use the term "Encompass," depending on the context, to refer to our consolidated subsidiary, EHHI Holdings, Inc. ("EHHI"), and its subsidiaries as well as the home health and hospice business operated through various subsidiaries of EHHI.

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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, among other things, future events, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy, our dividend and stock repurchase strategies, our financial plans, our growth plans, our future financial performance, our projected business results, or our projected capital expenditures. In some cases, the reader can identify forward-looking statements by terminology such as “may,” “will,” “should,” “could,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “predicts,” “targets,” “potential,” or “conti negative of 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, many of which are beyond our control. 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. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ, such as decreases in revenues or increases in costs or charges, materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, Risk Factors; as well as 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 in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction such as the reinstatement of the “75% Rule” or the introduction of site neutral payments with skilled nursing facilities for certain conditions, payment system reforms, and related increases in the costs of complying with such changes;
- reductions 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;
- restrictive interpretations of the regulations governing the claims that are reimbursable by Medicare;
- delays in the administrative appeals process associated with denied Medicare reimbursement claims, including from various Medicare audit programs, and our exposure to the related delay or reduction in the receipt of the reimbursement amounts for services previously provided;
- the ongoing evolution of the healthcare delivery system, including alternative payment models and value-based purchasing initiatives, which may decrease our reimbursement rate or increase costs associated with our operations;
- our ability to comply with extensive and changing healthcare regulations as well as the increased costs of regulatory compliance and compliance monitoring in the healthcare industry, including the costs of investigating and defending asserted claims, whether meritorious or not;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on our labor expenses from potential union activity and staffing recruitment and retention;
- competitive pressures in the healthcare industry, including from other providers that may be participating in integrated delivery payment arrangements in which we do not participate, and our response to those pressures;
- changes in our payor mix or the acuity of our patients affecting reimbursement rates;
- our ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with our growth strategy, including realization of anticipated revenues, cost savings, productivity improvements arising from the related operations and avoidance of unanticipated difficulties, costs or liabilities that could arise from acquisitions or integrations;
- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including the ongoing investigations initiated by the U.S. Department of Health and Human Services, Office of the Inspector General;
- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to claims;

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- potential incidents affecting the proper operation, availability, or security of our information systems;
- new or changing quality reporting requirements impacting operational costs or our Medicare reimbursement;
- the price of our common stock as it affects our willingness and ability to repurchase shares and the financial and accounting effects of any repurchases;
- our ability and willingness to continue to declare and pay dividends on our common stock;
- our ability to maintain proper local, state and federal licensing, including compliance with the Medicare conditions of participation, which is required to participate in the Medicare program;
- our ability to attract and retain key management personnel, including as a part of executive management succession planning; and
- general conditions in the economy and capital markets, including any instability or uncertainty related to governmental impasse over approval of the United States federal budget, an increase to the debt ceiling, or an international sovereign debt crisis.

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.

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PART I

Item 1. Business.

Overview of the Company

General

HealthSouth Corporation is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 35 states and Puerto Rico through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. HealthSouth was organized as a Delaware corporation in February 1984. Its principal executive offices are located at 3660 Grandview Parkway, Birmingham, Alabama 35243, and the telephone number of the principal executive offices is (205) 967-7116. Its website address is www.healthsouth.com.

In addition to the discussion here, we encourage the reader to review Item 1A, Risk Factors, Item 2, Properties, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, which highlight additional considerations about HealthSouth.

We manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. The table below provides selected operating and financial data for our inpatient rehabilitation hospitals, home health agencies, and hospice agencies. See Note 18, Segment Reporting, to the accompanying consolidated financial statements for detailed financial information for each of our segments.

| | As of or for the Year Ended December 31,[1] | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Consolidated data: | (Actual Amounts) | | |
| Inpatient rehabilitation: | | | |
| Number of hospitals [2] | 123 | 121 | 107 |
| Discharges | 165,305 | 149,161 | 134,515 |
| Outpatient visits | 640,702 | 577,507 | 579,555 |
| Number of licensed beds | 8,504 | 8,404 | 7,095 |
| | | | |
| Home health and hospice: | | | |
| Number of home health locations [3] | 188 | 186 | 25 |
| Number of hospice locations | 35 | 27 | — |
| Home health admissions | 106,712 | 74,329 | 7,545 |
| Home health episodes | 185,737 | 137,568 | 8,236 |
| Hospice admissions | 3,337 | 2,452 | — |
| | | | |
| Net operating revenues: | | (In Millions) | |
| Inpatient | $2,905.5 | $2,547.2 | $2,272.5 |
| Outpatient and other | 115.6 | 105.9 | 104.8 |
| Total inpatient rehabilitation | 3,021.1 | 2,653.1 | 2,377.3 |
| Home health | 635.2 | 478.1 | 28.6 |
| Hospice | 50.9 | 31.7 | — |
| Total home health and hospice | 686.1 | 509.8 | 28.6 |
| Net operating revenues | $3,707.2 | $3,162.9 | $2,405.9 |

(1) The column for 2014 does not include amounts for Encompass Home Health and Hospice because the acquisition took place on December 31, 2014, as discussed below.

(2) These amounts include 1 hospital as of December 31, 2016, 2015, and 2014 that operates as a joint venture, which we account for using the equity method of accounting.

(3)

These amounts include 2 locations as of December 31, 2016 and 2015, which we account for using the equity method of accounting, and 7 pediatric home health locations as of December 31, 2015, which we sold in November 2016.

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Inpatient Rehabilitation

We are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. We operate hospitals in 30 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. In addition to our hospitals, we manage five inpatient rehabilitation units through management contracts.

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across a wide array of diagnoses and deliver comprehensive, high-quality, cost-effective patient care services. As participants in the Medicare program, our hospitals must comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Inpatient Rehabilitation" section. Substantially all (92%) of the patients we serve are admitted from acute care hospitals following physician referrals for specific acute inpatient rehabilitative care. Most of those patients have experienced significant physical and cognitive disabilities or injuries due to medical conditions, such as strokes, hip fractures, and a variety of debilitating neurological conditions, that are generally nondiscretionary in nature and require rehabilitative healthcare services in an inpatient setting. Our teams of highly skilled nurses and physical, occupational, and speech therapists utilize proven technology and clinical protocols with the objective of restoring our patients' physical and cognitive abilities. Patient care is provided by nursing and therapy staff as directed by physician orders while case managers monitor each patient's progress and provide documentation and oversight of patient status, achievement of goals, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leads to a higher level of care and superior outcomes.

Home Health and Hospice

Our home health and hospice business is the nation's fourth largest provider of Medicare-certified skilled home health services in terms of revenues. We acquired EHHI Holdings, Inc. ("EHHI") and its Encompass Home Health and Hospice business ("Encompass") on December 31, 2014 and have since transitioned our previously existing HealthSouth home health operations to the Encompass platform and trade name. In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. ("Holdings"), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers were members of Encompass management, including April Anthony, the chief executive officer of Encompass. These sellers contributed a portion of their shares of common stock of EHHI in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. We view Encompass as a partnership that brings together the talent and home care experience of the Encompass team with all of the resources and post-acute care experience of HealthSouth.

Encompass operates home health and hospice agencies in 25 states, with concentrations in the Southeast, Oklahoma, and Texas. As participants in the Medicare program, the Encompass agencies must comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Home Health" and "—Hospice" sections.

Encompass home health provides a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational and speech therapy, medical social work, and home health aide services. Home health patients are frequently referred to us following a stay in an acute care or inpatient rehabilitation hospital or other facility, but many patients are referred from primary care settings and specialty physicians without a preceding inpatient stay. Our patients are typically older adults with two or more chronic conditions and significant functional limitations, and require greater than ten medications. Our team of registered nurses, licensed practical nurses, physical, speech and occupational therapists, medical social workers, and home health aides work closely with patients and their families to deliver patient-centered care plans focused on their needs and their goals.

Encompass also provides hospice services that include in-home services to terminally ill patients and their families. These services address patients' physical needs, including pain control and symptom management, and provide emotional and spiritual support. Our hospice care teams consist of physicians, nurses, social workers, chaplains, therapists, home health aides, and volunteers.

Competitive Strengths

As one of the nation’s largest providers of post-acute healthcare services and with our experience in and focus on those services, we believe we differentiate ourselves from our competitors based on, among other things, our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of technology. We also believe our competitive strengths discussed below give us the ability to adapt and succeed in a healthcare industry facing the uncertainty associated with the efforts to identify and implement workable integrated delivery

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payment models. For example, we are positioned to treat all types of post-acute patients by leveraging our operational expertise across our network of facility- and home-based assets in the event multiple or all post-acute settings (long-term acute care, inpatient rehabilitation, skilled nursing, and home health) face site neutral reimbursement for care provided in the future. Our hospitals have the physical construct (including therapy gym and training areas), clinical staffing, and operating expertise to address the full spectrum of needs for higher acuity post-acute patients needing inpatient care. Encompass can then often treat patients leaving our or other inpatient facilities who need additional post-acute care services in lieu of skilled nursing facility-based care. Additionally, Encompass can serve the lower acuity patients that do not require more intensive facility-based care.

- People. We believe our approximately 35,710 employees, in particular our highly skilled clinical staff, share a steadfast commitment to providing outstanding care to our patients. We undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality care in the most cost-effective manner. We also have hospital staff trained for all patient acuity levels faced in the post-acute setting.
- Quality. We have an extensive base of facility-based and home-based clinical experience from which we have developed best practices and protocols. We believe these clinical best practices and protocols, particularly as leveraged with industry leading technology, help ensure the delivery of consistently high-quality rehabilitative healthcare services. We have developed a program called “TeamWorks,” which is a series of operations-focused initiatives using identified best practices to reduce inefficiencies and improve performance across a wide spectrum of operational areas. We believe these initiatives have enhanced, and will continue to enhance, patient-employee interactions and coordination of care and communication among the patient, the patient’s family, the hospital’s treatment team, other care providers, and payors, which, in turn, improves outcomes and patient satisfaction. One of our primary operational initiatives in 2017 will be a TeamWorks program focused on enhancing clinical collaboration between our hospitals and home health agencies.

Our best practices and protocols have helped our hospitals consistently achieve patient outcomes, such as the rate of discharge to community and average functional improvement, that exceed industry averages. Additionally, our hospitals participate in The Joint Commission's Disease-Specific Care Certification Program. Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based, clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care. As of December 31, 2016, 101 of our hospitals hold one or more disease-specific certifications, including 99 hospitals with stroke-specific certifications.

In home health, Encompass places a significant emphasis on culture and technology for the purpose of furthering clinical excellence and consistency. Encompass has also developed institutional programs to, among other things, create physician-specific custom treatment protocols and provide care transition from inpatient facilities to home for higher acuity patients. As a result of its efforts, Encompass consistently achieves an acute care readmission rate lower than the industry average along with an average quality of patient care star rating above the industry average.

The clinical collaboration effort between our inpatient and home health services furthers our pursuit of quality. An important component of this effort has been to place Encompass care transition coordinators in our overlap market hospitals. These highly skilled professionals collaborate with clinicians and case managers in our hospitals to assess patients who may require home health services, facilitate patient choice, and prepare these patients for the care they will receive at home. The coordinators also work with patients’ families to ensure that those family members are prepared to bring their loved ones home safely.

- Efficiency and Cost Effectiveness. Our size, technology-enabled business practices, and culture help us provide facility-based and home-based healthcare services on a cost-effective basis. For example, our inpatient rehabilitation hospitals have historically received, on average, a lower per discharge payment from Medicare than the industry average payment while also treating patients with higher average acuity. Our hospitals have also historically averaged significantly less Medicare reimbursement for high cost outlier patients than other inpatient rehabilitation facility (“IRF”) providers have averaged. Specifically, we can leverage our centralized administrative functions, identify best practices, utilize proven staffing models, and take advantage of supply chain efficiencies across our extensive

platform of operations. At the location level, we also enjoy economies of scale as our hospitals are often larger (more beds) than industry average. Also, Encompass targets a certain patient density in the markets it serves which contributes to a lower cost per visit than competing publicly-held home

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health providers. In addition, our proprietary information systems, discussed below, aggregate data from our business into a comprehensive reporting package and database used by the management teams in our hospitals as well as executive management. Our information systems allow users to analyze data and trends and create custom reports on a timely basis. Likewise, Encompass utilizes Homecare Homebase[SM], an industry-leading information system originally developed by the Encompass management team, to provide home-based care with an emphasis on efficiency and cost effectiveness.

With a significant presence in both facility-based and home-based healthcare services, we have the opportunity to take advantage of the broader industry focus on reducing costs. Home health and hospice services, which typically have significantly lower cost structures than facility-based care settings, have increasingly been serving larger populations of higher acuity patients than in the past. These home-based services provide a cost-effective alternative to facility-based care where patient acuities do not require a hospital stay.

Lastly, the combination of home health and hospice with our existing inpatient rehabilitative healthcare services provides us with an increased opportunity to succeed in value-based purchasing programs and to participate in more coordinated care and integrated delivery payment models, such as accountable care organizations ("ACOs") and bundled payment arrangements. We believe enhanced clinical collaboration between our hospitals and home health agencies offers an excellent means to deliver the quality of care and the cost effectiveness that these new models require to be successful. We have focused, and will continue to focus, on increasing this collaboration. For additional discussion of our participation in these models, including the Bundled Payments for Care Improvement initiative and the Comprehensive Care for Joint Replacement payment model, see Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview."

- Strong Cash Flow Generation and Balance Sheet. We have a proven track record of generating strong cash flows from operations that have allowed us to successfully implement our growth strategy, reduce our financial leverage, and make significant shareholder distributions. As of December 31, 2016, we have a flexible balance sheet, no significant debt maturities prior to 2020, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide sufficient support for our business strategy.
- Technology-Enabled Processes. As a market leader in post-acute healthcare services, we have devoted substantial effort and expertise to leveraging technology to improve patient care and operating efficiencies. We have developed and implemented information technology, such as our rehabilitation-specific electronic clinical information system that we have branded as ACE-IT and our internally developed management reporting system described above that we have branded as BEACON, which we then leverage to enhance our clinical and business processes. For example, part of our clinical data analytics strategy has been the development of a predictive model for identifying patients at risk for acute care transfers. As of December 31, 2016, we have installed ACE-IT in 101 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. We believe ACE-IT will improve patient care and safety, streamline operating efficiencies, and enhance staff recruitment and retention, making it a key competitive differentiator.

Encompass internally developed, and is now a licensee of, Homecare Homebase, a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. The Encompass team's knowledge of Homecare Homebase as well as the thorough integration of it into the operating culture allow Encompass to maximize the system's capability to drive superior clinical, operational, and financial outcomes. Additionally, Encompass offers a number of evidence-based specialty programs, including post-operative care, fall prevention, chronic disease management and transitional care.

We believe our information systems that allow us to collect, analyze, and share information on a timely basis make us an ideal partner for other healthcare providers in a coordinated care delivery environment. Systems such as ACE-IT allow for interoperability with referral sources and health information exchanges. Encompass has a technology platform designed to manage the entire patient work flow and provide valuable data for health system, payor and ACO partners.

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Patients and Demographic Trends

Demographic trends, such as population aging, should increase long-term demand for facility-based and home-based post-acute care services. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. We believe the demand for facility-based and home-based post-acute care services will continue to increase as the U.S. population ages. We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute care services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring or opening home health and hospice agencies in that extremely fragmented industry.

Strategy

Our 2016 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals, home health agencies, and hospice agencies;
- expanding our services to more patients who require post-acute healthcare services by constructing and acquiring hospitals in new markets and acquiring and opening home health and hospice agencies in new markets;
- continuing our shareholder distributions via common stock dividends and repurchases of our common stock; and
- positioning the Company for success in the evolving healthcare delivery system. This preparation included continuing the installation of our electronic clinical information system in our hospitals which allows for interfaces with all major acute care electronic medical record systems and health information exchanges and participating in bundling projects and ACOs.

Total hospital discharges grew 10.8% from 2015 to 2016. Our same-store discharges grew 1.7% during 2016 compared to 2015. Encompass' home health agencies experienced same-store admissions growth of 13.7% in 2016 as well. We entered new inpatient rehabilitation markets and enhanced our geographic coverage in existing markets in 2016 by adding 4 new hospitals with 161 licensed beds to our portfolio. Likewise, Encompass added another 10 home health and 8 hospice locations. In addition to our new hospitals and agencies added in 2016, we integrated the significant acquisitions of the hospitals of Reliant Hospital Partners, LLC and the home care operations of CareSouth Health System, Inc. made in late 2015.

In 2016, we further positioned ourselves for the healthcare industry's movement to integrated delivery payment models, value-based purchasing, and post-acute site neutrality. We installed ACE-IT in 20 hospitals. We deployed and coordinated clinical protocols and discharge planning between our hospitals and home health agencies. We increased the clinical collaboration rate between our hospitals and our home health agencies. Within our inpatient rehabilitation segment, we initiated development of a predictive model to identify patients at risk for acute care transfer. We implemented a multidisciplinary medication reconciliation process using ACE-IT. Our hospitals and agencies also participated in bundling and ACO alternative payment models in various markets, and we developed a form of collaborator agreement to facilitate entering into arrangements with acute care hospitals participating in bundled payment projects.

Many of our quality and outcome measures remained above both inpatient rehabilitation and home health industry averages. Not only did we treat more patients and enhance outcomes, we did so in a cost-effective manner. For additional discussion of the pursuit of our 2016 strategic priorities, including operating results, growth, and shareholder value-enhancing achievements, as well as our 2017 strategy and business outlook, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview," "Results of Operations," and "Liquidity and Capital Resources."

Employees

As of December 31, 2016, we employed approximately 27,968 individuals, of whom approximately 17,187 were full-time employees, in our inpatient rehabilitation business and approximately 7,742 individuals, of whom approximately 5,698 were full-time employees, in the Encompass home health and hospice business. 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 63 employees at one hospital (about 17% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2016. Like most healthcare providers, our labor

costs are rising faster than the general inflation rate. In some markets, the lack of availability of medical personnel is a significant operating issue facing healthcare providers. To address this

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challenge, we will continue to focus on maintaining the competitiveness of our compensation and benefit programs and improving our recruitment, retention, and productivity. Shortages of nurses and other medical personnel, including therapists, may, from time to time, require us to increase utilization of more expensive temporary personnel, which we refer to as "contract labor," and other types of premium pay programs.

Competition

Inpatient Rehabilitation. The inpatient rehabilitation industry, outside our leading position, is highly fragmented. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units, many of which are within acute care hospitals, in the markets we serve. For a list of our markets by state, see the table in Item 2, Properties. There are some smaller privately held companies that compete with us primarily in select geographic markets in Texas and the West. In addition, there are two public companies that are primarily focused on other post-acute care services but also own or operate between 15 and 20 inpatient rehabilitation facilities each, one of which also manages the operations of inpatient rehabilitation facilities as part of its business model. Other providers of post-acute care services may attempt to become competitors in the future. For example, over the past few years, the number of nursing homes marketing themselves as offering certain rehabilitation services has increased even though nursing homes are not required to offer the same level of care, or be licensed, as hospitals. Also, acute care hospitals, including those owned or operated by large public companies or not-for-profits that have dominant positions in specific markets, may choose to expand their post-acute rehabilitation services. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, and the relationship and reputation with the acute care hospitals in the market. The ability to work as part of an integrated delivery payment model with other providers is likely to become an increasingly important factor in competition. See the "Regulation—Relationships with Physicians and Other Providers" section below for further discussion. Additionally, for a discussion regarding the effects of certificate of need requirements on competition in some states, see the "Regulation—Certificates of Need" section below.

Home Health and Hospice. Similarly, the home health and hospice services industry is highly competitive and fragmented. There are more than 12,300 home health agencies and approximately 4,200 hospice agencies nationwide certified to participate in Medicare. Encompass is the fourth largest provider of Medicare-certified skilled home health services in the United States. For a list of the Encompass home health markets by state, see the table in Item 2, Properties. Encompass' primary competition comes from locally owned private home health companies or acute care hospitals with adjunct home health services and typically varies from market to market. Providers of home health and hospice services include both not-for-profit and for-profit organizations. There are six public companies, including us, with significant presences in the home health industry, the largest of which operates long-term acute care hospitals, inpatient rehabilitation facilities, nursing centers and assisted living facilities. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, and the relationship and reputation with the acute care hospitals, physicians or other referral sources in the market. The ability to work as part of an integrated care delivery model with other providers is likely to become an increasingly important factor in competition. For example, Encompass is currently the exclusive preferred home health provider in an ACO serving approximately 22,000 patients. Competing companies may also offer varying home care services. Home health providers with scale, which include the other public companies, may have competitive advantages, including professional management, efficient operations, sophisticated information systems, brand recognition, and large referral bases.

Regulatory and Reimbursement Challenges

Healthcare has always been a highly regulated industry. Currently, the industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"), to identify and implement workable coordinated care and integrated delivery payment models. In January 2015, the United States Department of Health and Human Services ("HHS") announced it had set various goals with respect to tying Medicare reimbursements to alternative payment models and value-based purchasing. Specifically, HHS set a goal of tying 50 percent of traditional, or fee-for-service, Medicare payments to quality or value through integrated delivery payment models, such as ACOs or bundled payment arrangements, by the end of 2018. HHS also set a goal of tying 90 percent of traditional Medicare payments to quality or value by the end

of 2018 through programs such as those that include financial incentives for reducing acute care hospital readmissions. While we do not expect the drive toward integrated delivery payment models, value-based purchasing, and post-acute site neutrality in Medicare reimbursement to reverse, there remains significant uncertainty around the future of healthcare regulation in general.

The election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. On January 20, 2017, President Trump issued his first executive order titled “Minimizing the Economic Burden of the Patient Protection And Affordable Care Act Pending Repeal,” that directs federal regulators to begin dismantling those laws through regulatory and policy-making processes and procedures, “to the maximum extent permitted by

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law." Any changes may ultimately affect, among other things, reimbursement of healthcare providers and consumers' access to coverage of health services, including among non-Medicare aged population segments within commercial insurance markets and Medicaid enrollees. Changes may also affect the delivery of healthcare services to patients by providers and the regulatory compliance obligations associated with those services.

Successful healthcare providers are those who provide high-quality, cost-effective care and have the ability to adjust to changes in the regulatory and operating environments. We believe we have the necessary capabilities — scale, infrastructure, balance sheet, and management — to adapt to and succeed in a highly regulated industry, and we have a proven track record of doing so. For more in-depth discussion of the primary challenges and risks related to our business, particularly the changes in Medicare reimbursement (including the impact of announced alternative payment models and value-based purchasing initiatives), increased federal compliance and enforcement burdens, and changes to our operating environment resulting from healthcare reform, see "Regulation" below in this section as well as Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), managed care plans and private insurers, and, to a considerably lesser degree, state governments (under their respective Medicaid or similar programs) and directly from patients. Revenues and receivables from Medicare are significant to our operations. In addition, we receive relatively small payments for non-patient care activities from various sources.

We offer discounts from established charges to certain group purchasers of healthcare services that are included in "Managed care" in the tables below, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care plans. Medicare, through its Medicare Advantage program, offers Medicare-eligible individuals an opportunity to participate in a managed care plan. Revenues from Medicare and Medicare Advantage represent approximately 83% of total revenues.

Patients are generally not responsible for the difference between established gross charges and amounts reimbursed for such services under Medicare, Medicaid, and other private insurance plans, HMOs, or PPOs but are responsible to the extent of any exclusions, deductibles, copayments, or coinsurance features of their coverage. The amount of these exclusions, deductibles, copayments, and coinsurance has been increasing each year but is not material to our business or results of operations.

The following tables identify the sources and relative mix of our revenues for the periods stated for each of our business segments:

Inpatient Rehabilitation

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Medicare | 73.3 % | 73.2 % | 73.9 % |
| Medicare Advantage | 7.7 % | 7.9 % | 7.5 % |
| Managed care | 11.2 % | 11.1 % | 11.3 % |
| Medicaid | 3.0 % | 2.5 % | 1.8 % |
| Other third-party payors | 1.8 % | 2.0 % | 1.8 % |
| Workers' compensation | 1.0 % | 1.1 % | 1.2 % |
| Patients | 0.6 % | 0.7 % | 1.0 % |
| Other income | 1.4 % | 1.5 % | 1.5 % |
| Total | 100.0% | 100.0% | 100.0% |

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Home Health and Hospice[1]

| | For the Year Ended December 31, | |
|---|---|---|
| | 2016 | 2015 |
| Medicare | 82.9 % | 83.7 % |
| Medicare Advantage | 8.7 % | 7.7 % |
| Managed care | 3.9 % | 3.0 % |
| Medicaid | 4.3 % | 5.5 % |
| Other third-party payors | — % | — % |
| Workers' compensation | — % | — % |
| Patients | 0.1 % | 0.1 % |
| Other income | 0.1 % | — % |
| Total | 100.0% | 100.0% |

(1) We began reporting for our home health and hospice segment in the first quarter of 2015 as a result of the acquisition of Encompass on December 31, 2014. For 2014, the home health and hospice business was not material to our consolidated net operating revenues.

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. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"), the home health prospective payment system ("HH-PPS") and the hospice prospective payment system (the "Hospice-PPS"). Congress is not obligated to adopt MedPAC recommendations, and in recent years Congress has not adopted any of the recommendations on the annual market basket update to Medicare payment rates under the IRF-PPS, which updates are discussed in greater detail below. However, MedPAC's recommendations have, and could in the future, become the basis for subsequent legislative or regulatory action.

The Medicare statutes and regulations are subject to change from time to time. For example, in March 2010, President Obama signed the 2010 Healthcare Reform Laws. With respect to Medicare reimbursement, the 2010 Healthcare Reform Laws provided for specific reductions to healthcare providers' annual market basket updates, and the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 mandated a market basket update of 1.0% in 2018 for inpatient rehabilitation, home health, and hospice providers. In August 2011, President Obama signed into law the Budget Control Act of 2011 providing for an automatic 2% reduction, or "sequestration," of Medicare program payments for all healthcare providers. Sequestration took effect April 1, 2013 and will continue through 2025 unless Congress and the President take further action. As a result of the 2016 elections, the future of the 2010 Healthcare Reform Laws as well as the nature and substance of any replacement reform legislation enacted remain uncertain. Additionally, concerns held by federal policymakers about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both, in 2017 and beyond.

From time to time, Medicare reimbursement methodologies and rates can be further modified by HHS's Centers for Medicare & 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 IRF-PPS and HH-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS requires IRFs to submit data on certain quality of care measures for the IRF Quality Reporting Program. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in a

subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions for fiscal years 2015, 2016 and 2017. Similarly, home health and hospice agencies are also required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update. To date, only one of Encompass' home health and hospice agencies has incurred a reduction in its reimbursement rate.

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We cannot predict the adjustments to Medicare payment rates Congress or CMS may make in the future. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. Any additional downward adjustment to rates for the types of facilities we operate and services we provide could have a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of the risks associated with our concentration of revenues from the federal government or with potential changes to the statutes or regulations governing Medicare reimbursement, see Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

Although reductions or changes in reimbursement from governmental or third-party payors and regulatory changes affecting our business represent one of the most significant challenges to our business, our operations are also affected by other rules and regulations that indirectly affect reimbursement for our services, such as data coding rules and patient coverage rules and determinations. For example, on October 1, 2015, healthcare providers were required to begin using the updated and expanded diagnosis and procedure codes of the International Classification of Diseases 10th Edition ("ICD-10") in connection with Medicare billings. We have not experienced any significant disruptions to the billing process or Medicare payments as a result of the implementation of ICD-10.

Likewise, 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 and necessary. For example, current CMS coverage rules require inpatient rehabilitation services to be ordered by a physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide the rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services that may be needed. For individual claims, Medicare contractors make coverage determinations regarding medical necessity which can represent more restrictive interpretations of the CMS coverage rules. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

In the ordinary course, Medicare reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors ("MACs") that act as fiscal intermediaries for all Medicare billings and insurance carriers, as well as the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG"), CMS, and state Medicaid programs. In addition to those audits conducted by existing MACs, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. Some contractors are paid a percentage of the overpayments recovered. One type of audit contractor, the Recovery Audit Contractors ("RACs"), began post-payment audit processes in late 2009 for providers in general. The RACs receive claims data directly from MACs on a monthly or quarterly basis. RAC audits of IRFs initially focused on coding errors, but CMS subsequently expanded the program to include medical necessity and billing accuracy reviews.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors are successors to the Program Safeguard Contractors and conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the HHS-OIG or the United States Department of Justice. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error.

As a matter of course, we undertake significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules. However, despite our belief that our coding and assessment of patients are accurate, audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these audit programs will affect us. For additional discussion of these audits and the risks associated with them, see Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

A basic summary of current Medicare reimbursement in our business segments follows:

Inpatient Rehabilitation. As discussed above, our hospitals receive a fixed payment reimbursement amount per discharge under IRF-PPS based on the patient's rehabilitation impairment category established by HHS and other characteristics and conditions identified by the attending clinicians. In order to qualify for reimbursement under IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, pre-admission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. For example, a physician must admit each patient and in doing so determine

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that the patient's IRF treatment is reasonable and necessary. Also, each patient admitted to an IRF must be able to tolerate a minimum of three hours of therapy per day. Once in an IRF, patients must have nursing care available 24 hours, each day of the week.

Under IRF-PPS, CMS is required to adjust the payment rates based on a market basket index. Beginning in fiscal year 2016, CMS began implementing an inpatient IRF-specific market basket. The annual market basket update is designed to reflect changes over time in the prices of a mix of goods and services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units. In setting annual market basket updates, CMS 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. 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 cost-effective providers.

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for inpatient rehabilitation providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to healthcare providers. For example, in 2004, CMS narrowed its 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 its requirements 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 Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") was signed, 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 modification of the compliance threshold in 2004 significantly reduced the total number of Medicare IRF discharges, but since setting the 60% threshold, the number of discharges has grown. In another example, 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, or a Medicare pricing "roll-back," which resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs.

On July 31, 2015, CMS released its notice of final rulemaking for the fiscal year 2016 IRF-PPS. This rule was effective for Medicare discharges between October 1, 2015 and September 30, 2016. The pricing changes in this rule included a 2.4% market basket update that was reduced by 0.2% to 2.2% under the requirements of the 2010 Healthcare Reform Laws, as well as other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. The 2010 Healthcare Reform Laws also require the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustments equal the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective October 1, 2015 decreased the market basket update by 50 basis points. Additionally, the 2016 IRF Rule required us to report six additional quality measures, the reporting of which will require additional time and expense and could affect reimbursement beginning October 1, 2017.

On July 29, 2016, CMS released its notice of final rulemaking for fiscal year 2017 IRF-PPS (the "2017 IRF Rule"). The 2017 IRF Rule will implement a net 1.65% market basket increase effective for discharges between October 1, 2016 and September 30, 2017, calculated as follows:

| | |
|---|---|
| Market basket update | 2.7% |
| Healthcare reform reduction | 75 basis points |
| Productivity adjustment reduction | 30 basis points |

The 2017 IRF Rule also includes other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index values, changes to designations between rural and urban facilities, and updates to the outlier fixed-loss threshold. The final rule also continues the freeze to the update to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, and teaching status adjustment factors. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the 2017 IRF Rule,

we believe the 2017 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2016, prior to the impact of sequestration. Additionally, the 2017 IRF Rule requires us to report five new quality measures, the reporting of which will require additional time and expense and could affect reimbursement beginning October 1, 2017.

Unlike our inpatient services, our outpatient services are primarily reimbursed under the physician fee schedule of Medicare Part B. Medicare reimbursement for outpatient services are subject to an annual outpatient therapy cap and a therapy cap exception process. On November 2, 2016, CMS released its final notice of rulemaking for the payment policies under the

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physician fee schedule and other revisions to Part B for calendar year 2017. The provisions of this rule, including the updates to the fee schedule, are not material to us.

Home Health. Medicare pays home health benefits for patients discharged from a hospital or patients otherwise suffering from chronic conditions that require ongoing but intermittent skilled care. As a condition of participation under Medicare, patients must be homebound (meaning unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, or have a continuing need for occupational therapy, and receive treatment under a plan of care established and periodically reviewed by a physician. The 2010 Healthcare Reform Laws mandate that, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she or a qualifying nurse practitioner has had a face-to-face encounter with the patient. Medicare pays home health providers under the HH-PPS for each 60-day period of care for each patient. Payments are adjusted based on each patient's condition and clinical treatment. This is referred to as the case-mix adjustment. In addition to the case-mix adjustment, payments for periods of care may be adjusted for other reasons, including unusually large (outlier) costs, low-utilization patients that require four or fewer visits, and geographic differences in wages. Payments are also made for non-routine medical supplies that are used in treatment. Home health providers typically receive either 50% or 60% of the estimated base payment for the full 60 days for each patient upon submission of the initial claim. The estimate is based on the patient's condition and treatment needs. The provider receives the remaining portion of the payment after the 60-day treatment period, subject to any applicable adjustments. If a patient remains eligible for care after that period, a new 60-day treatment period may begin. There are currently no limits to the number of home health treatment periods an eligible Medicare patient may receive.

In 2016, CMS launched a three-year pre-claim review demonstration project for home health services. The project is intended to test whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud and whether the pre-claim review helps reduce expenditures while maintaining or improving quality of care. The project covers agencies in the states of Illinois, Florida, Texas, Michigan, and Massachusetts and began in Illinois on August 3, 2016. Because of difficulties encountered in administering the project, the start date in Florida has been delayed to April 1, 2017. The start dates for the other states have not been announced. For additional discussion of this project, see Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

On October 29, 2015, CMS released its notice of final rulemaking for the calendar year 2016 HH-PPS (the "2016 HH Rule"). CMS estimated the rule would cut Medicare payments to home health agencies by 1.4% in 2016. Specifically, while the rule provided for a market basket update of 2.3%, that update was offset by a 2.4% rebasing adjustment reduction (the third year of a four-year phase-in) and a productivity adjustment reduction of 40 basis points, and a nominal case-mix coding intensity reduction of 90 basis points.

In addition, the 2016 HH Rule established a five-year Home Health Value-Based Purchasing model in nine states to test whether incentives for better care can improve outcomes in the delivery of home health services. The model, which began in 2016, applies a reduction or increase to Medicare-certified home health agency payments, depending on quality performance, made to agencies in those nine states. Performance will be assessed based on several process, outcome, and care satisfaction measures. We cannot predict what, if any, impact this model will have on our Medicare reimbursements. For additional discussion of this model, see Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

On October 31, 2016, CMS released its notice of final rulemaking for calendar year 2017 for home health agencies under the HH-PPS (the "2017 HH Rule"). Specifically, while the rule provides for a market basket update of 2.8%, that update is offset by a 2.3% rebasing adjustment reduction (the final year of a four-year phase-in), a productivity adjustment reduction of 30 basis points, and a nominal case-mix coding intensity reduction of 90 basis points. The 2017 HH Rule also includes other pricing changes, such as a reduction to the case-mix weights for certain cases and a change in the outlier payment calculation, that impact our Medicare reimbursement. Based on our analysis, we believe the 2017 HH Rule will result in a net decrease to our Medicare home health payment rates of approximately 3.6% effective for episodes ending in calendar year 2017, prior to the impact of sequestration. Additionally, the 2017 HH Rule requires us to report four new quality measures, the reporting of which will require additional time and expense

and could affect reimbursement beginning in 2018.

Hospice. Medicare pays hospice benefits for patients with life expectancies of six months or less, as documented by the patient's physician(s). Under Medicare rules, patients seeking hospice benefits must agree to forgo curative treatment for their terminal medical conditions. For each day a patient elects hospice benefits, Medicare pays an adjusted daily rate based on patient location, and payments represent a prospective per diem amount tied to one of four different categories or levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Medicare hospice reimbursements to each provider are also subject to two annual caps, one limiting total hospice payments based on the average annual payment

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per beneficiary and another limiting payments based on the number of days of inpatient care billed by the hospice provider. There are currently no limits to the number of hospice benefit periods an eligible Medicare patient may receive, and a patient may revoke the benefit at any time.

On July 29, 2016, CMS released its notice of final rulemaking for fiscal year 2017 for hospice agencies under the hospice-PPS (the "2017 Hospice Rule"). The final rule would impact hospice payments between October 1, 2016 and September 30, 2017. Specifically, the rule provides for a net market basket update of 2.1% after reductions required by the 2010 Healthcare Reform Laws and the annual productivity adjustment, and we believe that update is indicative of the change we will see in our Medicare hospice payment rates effective October 1, 2016. However, the provisions of the 2017 Hospice Rule were not material to us.

For additional discussion of matters and risks related to reimbursement, see Item 1A, Risk Factors.

Managed Care and Other Discount Plans

We offer discounts from established charges to certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms 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. In 2016, typical rate increases for our inpatient rehabilitation contracts ranged from 2-4% and for our home health and hospice contracts ranged from 0-2%. We cannot provide any assurance we will continue to receive increases in the future. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed 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. However, for the year ended December 31, 2016, Medicaid payments represented only 3.2% of our consolidated Net operating revenues. In certain states in which we operate, we are experiencing an increase in Medicaid patients, likely the result of expanded coverage consistent with the intent of the 2010 Healthcare Reform Laws. Changes to these laws and regulations implemented by Congress, the Trump Administration, or both, could impact expanded Medicaid coverage, including the number of Medicaid patients with access to our services. For additional discussion, see Item 1A, Risk Factors, "Changes in our payor mix or the acuity of our patients could adversely impact our revenues or our profitability."

Cost Reports

Because of our participation in Medicare, Medicaid, and certain Blue Cross and Blue Shield 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 inpatient hospital, home health, and hospice providers to Medicare beneficiaries and Medicaid recipients. These annual cost reports are subject to routine audits which may result in adjustments to the amounts ultimately determined to be due to us 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. Medicare also makes retroactive adjustments to payments for certain low-income patients after comparing subsequently published statistical data from CMS to the cost report data. We cannot predict what retroactive adjustments, if any, will be made, but we do not anticipate such adjustments would have a material impact on us.

Regulation

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

and controlling our growth. We are also subject to the broader federal and state regulations that prohibit fraud and abuse in the delivery of healthcare services. As a healthcare provider, we are subject to periodic audits, examinations and investigations conducted by, or at the direction of, government investigative and oversight agencies. Violations of the applicable federal and state healthcare

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regulations can result in a provider's exclusion from participation in government reimbursement programs and in substantial civil and criminal penalties.

We undertake significant effort and expense to provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as, for most facilities, 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.

We maintain a comprehensive compliance program that is designed to meet or exceed all laws and regulations and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the compliance program, we provide annual compliance training to our employees and encourage all employees to report any violations to their supervisor or through a toll-free telephone hotline.

Licensure and Certification

Healthcare facility construction and operation are subject to numerous federal, state, and local regulations relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, acquisition and dispensing of pharmaceuticals and controlled substances, infection control, maintenance of adequate records and patient privacy, fire prevention, and compliance with building codes and environmental protection laws. Our hospitals are subject to periodic inspection and other reviews 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. Certification and participation in these programs involve numerous regulatory obligations. For example, hospitals must treat at least 30 patients free-of-charge prior to certification and eligibility for Medicare reimbursement. Once certified by Medicare, hospitals undergo periodic on-site surveys and revalidations in order to maintain their certification. All of our inpatient hospitals participate in the Medicare program.

Encompass agencies are each licensed under applicable law, certified by CMS for participation in the Medicare program, and generally certified by the applicable state Medicaid agencies to participate in those programs.

Failure to comply with applicable certification requirements may make our hospitals and agencies, as the case may be, ineligible for Medicare or Medicaid reimbursement. In addition, Medicare or Medicaid may seek retroactive reimbursement from noncompliant providers or otherwise impose sanctions for noncompliance. Non-governmental payors often have the right to terminate provider contracts if the provider loses its Medicare or Medicaid certification.

The 2010 Healthcare Reform Laws added new screening requirements and associated fees for all Medicare providers. The screening must include a licensure check and may include other procedures such as fingerprinting, criminal background checks, unscheduled and unannounced site visits, database checks, and other screening procedures prescribed by CMS.

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 Medicare, Medicaid, or other regulatory authorities will not allege instances of noncompliance. A determination by a regulatory authority that a facility is not in compliance with applicable requirements could also lead to the assessment of fines or other penalties, loss of licensure, exclusion from participation in Medicare and Medicaid, and the imposition of requirements that an offending facility takes corrective action.

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities or agencies, or the introduction of new beds or inpatient, home health, and hospice services may be subject to review by and prior approval of state regulatory bodies under a "certificate of need," or "CON," law. As of December 31, 2016, approximately 51% of our licensed beds and 20% of our home health and hospice locations are located in states or U.S. territories that have CON laws. CON laws often require a reviewing agency to determine the public need for additional or expanded healthcare facilities and services. These laws also generally require approvals

for capital expenditures involving inpatient rehabilitation hospitals, if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any time a CON is required, we

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must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility, starting a new healthcare program, or opening a new home health or hospice agency.

We potentially face opposition any time we initiate a CON project or seek to acquire an existing facility, agency, or CON. This opposition may arise either from competing national or regional companies or from local hospitals, agencies, or other providers which file competing applications or oppose the proposed CON project. Opposition to our applications may delay or prevent our future addition of beds, hospitals, or agencies in given markets or increase our costs in seeking those additions. The necessity for these approvals serves as a barrier to entry and has the potential to limit competition, including in markets where we hold a CON and a competitor is seeking an approval. We have generally been successful in obtaining CONs or similar approvals when required, although there can be no assurance we will achieve similar success in the future, and the likelihood of success varies by locality and state.

False Claims

The federal False Claims Act (the "FCA") 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 approximately $22,000 per claim. Beginning no later than August 1, 2016, federal civil penalties will be adjusted to account for inflation each year. In addition, the FCA 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. The government and relators may also allege violations of the FCA for the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. This is known as a "reverse false claim." The government deems identification of the overpayment to occur when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

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, cost reporting error or disagreement over physician medical judgment could result in significant civil or criminal penalties under the FCA. Many states have also adopted similar laws relating to state government payments for healthcare services. The 2010 Healthcare Reform Laws amended the FCA to expand the definition of false claim, to make it easier for the government to initiate and conduct investigations, to enhance the monetary reward to relators where prosecutions are ultimately successful, and to extend the statute of limitations on claims by the government. The federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent FCA violations and challenging the medical judgment of independent physicians as the basis for FCA allegations. Furthermore, well-publicized enforcement actions indicate that the federal government has increasingly sought to use statistical sampling to extrapolate allegations to larger pools of claims or to infer liability without proving knowledge of fraud. For additional discussion, see Item 1A, Risk Factors, and Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

Anti-Kickback Law. Various state and federal laws regulate relationships between providers of healthcare services, including management or service contracts and investment relationships. Among the most important of these restrictions is a federal 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 (the "Anti-Kickback Law"). The 2010 Healthcare Reform Laws amended the federal Anti-Kickback Law to provide that proving violations of this law does not require proving actual knowledge or specific intent to commit a violation. Another amendment made it clear that Anti-Kickback Law violations can be the basis for claims under the FCA. These changes and those described above related to the FCA, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. In addition to standard federal criminal and civil sanctions, including imprisonment and 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. Those regulations provide for certain 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 of the Anti-Kickback Law by us or one or more of our joint ventures could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

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Some of our rehabilitation hospitals are owned through joint ventures with institutional healthcare providers that may be in a position to make or influence referrals to our hospitals. In addition, we have a number of relationships with physicians and other healthcare providers, including management or service contracts. Some of these investment relationships and contractual relationships may not fall within the protection offered by a safe harbor. Despite our compliance and monitoring efforts, there can be no assurance violations of the Anti-Kickback Law will not be asserted in the future, nor can there be any assurance our defense against any such assertion would be successful.
For example, we have entered into agreements to manage our hospitals that are owned by joint ventures. 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 comply with the Anti-Kickback Law.
Physician Self-Referral Law. 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, and home health services, to an entity in which the physician (or an immediate family member) has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing Medicare for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $15,000 for each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.
Under the 2010 Healthcare Reform Laws, the exception to the Stark law that currently permits physicians to refer patients to hospitals in which they have an investment or ownership interest has been dramatically limited by providing that only physician-owned hospitals with a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the physician ownership percentage in the hospital after March 23, 2010. Additionally, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, except when certain market and regulatory approval conditions are met. Currently, we have no hospitals that would be considered physician-owned under this law, except for one hospital acquired in 2015 which has an outside limited partner with a 0.5% equity interest.
CMS has issued several phases of final regulations implementing the Stark law. On November 16, 2015, CMS issued a new rule revising, clarifying, and adding two exceptions in order to accommodate delivery and payment system reform, reduce burdens on physicians and other providers, and promote compliance. While the changes are generally expected to help providers comply with the Stark law requirements, the complexity of the law and the associated regulations will remain a challenge for healthcare providers, who do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet one or more exceptions to the Stark law, but the regulations implementing the exceptions are detailed and complex. Accordingly, we cannot assure that every relationship complies fully with the Stark law.
Additionally, no assurances can be given that any agency charged with enforcement of the Stark law and regulations might not assert a violation under the Stark law, nor can there be any assurance our defense against any such assertion would be successful 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 or another of our providers. A violation of the Stark law by us could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

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 or Medicaid 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

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least $100 of Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties. The HHS Office of Civil Rights ("HHS-OCR") implemented a permanent HIPAA audit program for healthcare providers nationwide in 2016. As of December 31, 2016, we have not been selected for audit.

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.

With the enactment of the Health Information Technology for Economic and Clinical Health ("HITECH") Act as part of the American Recovery and Reinvestment Act of 2009, the privacy and security requirements of HIPAA have been modified and expanded. The HITECH Act applies certain of the HIPAA privacy and security requirements directly to business associates of covered entities. The modifications to existing HIPAA requirements include: expanded accounting requirements for electronic health records, tighter restrictions on marketing and fundraising, and heightened penalties and enforcement associated with noncompliance. Significantly, the HITECH Act also establishes new mandatory federal requirements for notification of breaches of security involving protected health information. HHS-OCR is responsible for enforcing the requirement that covered entities notify any individual whose protected health information has been improperly acquired, accessed, used, or disclosed. In certain cases, notice of a breach is required to be made to HHS and media outlets. The heightened penalties for noncompliance range from $100 to $50,000 per violation for most violations. In the event of violations due to willful neglect that are not corrected within 30 days, penalties start at $50,000 per violation and are not subject to a per violation statutory maximum. All penalties are subject to a $1,500,000 cap for multiple identical violations in a single calendar year. Willful neglect could include the failure to conduct a security risk assessment or adequately implement HIPAA compliance policies.

On January 17, 2013, the HHS-OCR issued a final rule, with a compliance date of September 23, 2013, to implement the HITECH Act and make other modifications to the HIPAA and HITECH regulations. This rule expanded the potential liability for a breach involving protected health information to cover some instances where a subcontractor is responsible for the breaches and that individual or entity was acting within the scope of delegated authority under the related contract or engagement. The final rule generally defines "breach" to mean the acquisition, access, use or disclosure of protected health information in a manner not permitted by the HIPAA privacy standards, which compromises the security or privacy of protected health information. Under the final rule, improper acquisition, access, use, or disclosure is presumed to be a reportable breach, unless the potentially breaching party can demonstrate a low probability that protected health information has been compromised.

In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Healthcare providers 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. HHS-OIG and other regulators have also increasingly interpreted laws and regulations in a manner as to increase exposure of healthcare providers to allegations of noncompliance. Any actual or perceived violation of privacy-related laws and regulations, including HIPAA and the HITECH Act, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Available Information

We make available through our website, www.healthsouth.com, 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 to those reports promptly after we electronically file such material with, or furnish it to, the United States Securities and Exchange Commission. In addition to the information that is available on our website, the reader may review 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. The reader 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 the reader should take such risks into account in evaluating HealthSouth or any investment decision involving HealthSouth.

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This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of certain material risk factors. More detailed information concerning other risk factors as well as those described below is contained in other sections of this annual report.

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

We derive a substantial portion of our Net operating revenues from the Medicare program. See Item 1, Business, "Sources of Revenues," for a table identifying the sources and relative payor mix of our revenues. In addition to many ordinary course reimbursement rate changes that the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"), adopts each year as part of its annual rulemaking process for various healthcare provider categories, Congress and some state legislatures have periodically proposed significant changes in laws and regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). The election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. On January 20, 2017, President Trump issued his first executive order titled "Minimizing the Economic Burden of the Patient Protection And Affordable Care Act Pending Repeal," that directs federal regulators to begin dismantling those laws through regulatory and policy-making processes and procedures, "to the maximum extent permitted by law." Any changes may ultimately impact the provisions of the 2010 Healthcare Reform Laws discussed below or other laws or regulations that either currently affect, or may in the future affect, our business.

Many provisions within the 2010 Healthcare Reform Laws have impacted or could in the future impact our business, including: (1) Medicare reimbursement reductions, such as reductions to annual market basket updates to providers and reimbursement rate rebasing adjustments; (2) the promotion of bundling initiatives for Medicare reimbursement of episodes of care; (3) implementation of accountable care organizations ("ACOs"); and (4) creation of the Independent Payment Advisory Board.

For our inpatient rehabilitation hospitals, these laws include reductions in CMS's annual adjustments to Medicare reimbursement rates by what is commonly known as a "market basket update." In accordance with Medicare laws and statutes, CMS makes market basket updates by provider type. There will be a reduction of 0.75% in the annual market basket update for our hospitals in each of the CMS fiscal years beginning October 1 of 2017 and 2019. The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 ("MACRA") eliminated the mandated annual reduction for 2018 in favor of fixing a market basket update of 1.0% in that year for inpatient rehabilitation, home health and hospice providers.

In addition, the 2010 Healthcare Reform Laws require the market basket update for our hospitals to be reduced by a productivity adjustment on an annual basis, except in 2018 because of the changes mandated by MACRA. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment in effect for fiscal year (October 1 to September 30) 2017 is a decrease to the market basket update of 30 basis points.

For home health agencies, the 2010 Healthcare Reform Laws directed CMS to improve home health payment accuracy through rebasing home health payments over four years starting in 2014. The rebasing adjustment for calendar year 2017 (the final year of the phase-in) offset the annual market basket update of 2.8% with a 2.3% reduction. CMS is also implementing a case-mix coding intensity reduction of 90 basis points in 2016. In addition, the 2010 Healthcare Reform Laws also require an annual home health productivity adjustment. For calendar year 2017, that adjustment is a decrease to the market basket update of 30 basis points.

For hospice agencies, the 2010 Healthcare Reform laws require, in addition to an annual productivity adjustment, further reduction of the annual market basket update of 30 basis points for fiscal years 2017 and 2019. The hospice productivity adjustment for the fiscal year beginning October 1, 2016 was a decrease to the market basket update of

30 basis points.

Other federal legislation can also have a significant direct impact on our Medicare reimbursement. On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2% reduction of Medicare program payments. This automatic reduction, known as “sequestration,” which began affecting payments received after April 1,

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2013, reduced the payments we receive under the inpatient rehabilitation facility prospective payment system (the "IRF-PPS") resulting in a net year-over-year decrease in our Net operating revenues of approximately $9 million in 2014. The effect of sequestration on year-over-year comparisons of Net operating revenues ceased on April 1, 2014. However, each year through 2025, the reimbursement we receive from Medicare, after first taking into account all annual payment adjustments including the market basket update, will be reduced by sequestration unless it is repealed before then.

Additionally, concerns held by federal policymakers about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. For example, on April 16, 2015, the President signed MACRA into law, which repealed the statutory mechanism providing for annual automatic adjustments to the Medicare physician fee schedule using a sustainable growth rate formula that has historically resulted in annual deep cuts to physician reimbursement rates, a consequence of which has been the so-called "doc fixes" passed by Congress annually since 2002 to override those automatic adjustments. The primary impact of this act on us is a mandated market basket update of +1.0% in 2018 for rehabilitation hospitals as well as home health and hospice agencies.

In October 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act"). The IMPACT Act was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees' solicitation of post-acute payment reform ideas and proposals. It directs the United States Department of Health and Human Services ("HHS"), in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the development of a new post-acute payment system, we believe this act will lay the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided, also referred to as "site neutral" reimbursement. It will also create additional data reporting requirements for our hospitals and home health and hospice agencies. The precise details of these new reporting requirements, including timing and content, will be developed and implemented by CMS through the regulatory process that we expect will take place over the next several years. We cannot quantify the potential effects of the IMPACT Act on us.

Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency, advises Congress on issues affecting Medicare and makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the IRF-PPS, the home health prospective payment system ("HH-PPS") and the hospice prospective payment system ("Hospice-PPS"). MedPAC also provides comments to CMS on proposed rules, including the prospective payment system rules. Congress is not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. However, MedPAC's recommendations have, and could in the future, become the basis for subsequent legislative or regulatory action.

In connection with CMS's final rulemaking for the 2016 HH-PPS, MedPAC recommended, among other things, legislative changes to make the rebasing cuts larger in size to further reduce margins and the overhaul of the HH-PPS to pay providers based on patient characteristics in lieu of the number of therapy services furnished. MedPAC also recommended that CMS not provide for a market basket update in the 2016 IRF-PPS. In March 2016, MedPAC recommended eliminating the market basket update for each of the IRF-PPS, the HH-PPS and the Hospice-PPS for 2017. In a June 2016 report mandated by the IMPACT Act, MedPAC set out its evaluation of a unified payment system for all post-acute care ("PAC-PPS") in lieu of separate systems for IRFs, skilled nursing facilities, long-term acute care hospitals, and home health agencies. MedPAC found a PAC-PPS to be feasible and desirable but also suggested many existing regulatory requirements, including the IRF 60% rule discussed below and the requirement for a minimum of three hours of therapy per day, should be waived as part of implementing a PAC-PPS. MedPAC also suggested that ultimately Medicare should move from fee-for-service reimbursement to more integrated delivery payment models. In December 2016, MedPAC suggested it would recommend a 5% reduction in both inpatient rehabilitation and home health reimbursement for 2018 and a two-year rebasing of home health reimbursement rates beginning in 2019. MedPAC also reiterated an increase to the outlier payment pool to be funded by reductions to base

Medicare payments rates under the IRF-PPS. This proposal would adversely affect us as we have a relatively low percentage of outlier patients compared to other inpatient rehabilitation providers.

We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post-acute care reforms, if any, will ultimately be enacted into law, or the timing or effect of any initiatives or reductions. Those initiatives or reductions would be in addition to many ordinary course reimbursement rate changes that CMS adopts each year as part of the market basket update rulemaking process for various provider categories. Even more significantly, the future of healthcare reform generally and the 2010 Healthcare Reform Laws specifically is uncertain given the results of the 2016 elections in the United States. While we do not expect the drive toward integrated delivery payment models, value-based purchasing, and post-acute site neutrality in Medicare reimbursement to reverse, there are well publicized efforts to repeal

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various provisions of the 2010 Healthcare Reform Laws and substitute yet to be determined healthcare reforms. We cannot predict the nature or timing of any changes to the 2010 Healthcare Reform Laws or other laws or regulations that either currently affect, or may in the future affect, our business.

There can be no assurance future governmental action will not result in substantial changes to, or material reductions in, our reimbursements. Similarly, we may experience material increases in our operating costs. In any given year, the net effect of regulatory changes may result in a decrease in our reimbursement rate, and that decrease may occur at a time when our expenses are increasing. As a result, there could be a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of how we are reimbursed by Medicare, see Item 1, Business, "Regulatory and Reimbursement Challenges" and "Sources of Revenues—Medicare Reimbursement."

In addition, there are increasing pressures, including as a result of the 2010 Healthcare Reform Laws, 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 nongovernmental 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.

The ongoing evolution of the healthcare delivery system, including alternative payment models and value-based purchasing initiatives, in the United States may significantly affect our business and results of operations.

The healthcare industry in general is facing uncertainty associated with the efforts, primarily arising from initiatives such as payment bundling and ACOs included in the 2010 Healthcare Reform Laws, to identify and implement workable coordinated care and integrated delivery payment models. In an integrated delivery payment model, hospitals, physicians, and other care providers are reimbursed in a fashion meant to encourage the provision of coordinated healthcare on a more efficient, patient-centered basis. These providers are then paid based on the overall value and quality (as determined by outcomes) of the services they provide to a patient rather than the number of services they provide. While this is consistent with our goal and proven track record of being a high-quality, cost-effective provider, broad-based implementation of a new delivery payment model would represent a significant evolution or transformation of the healthcare industry, which may have a significant impact on our business and results of operations.

The 2010 Healthcare Reform Laws directed HHS to examine the feasibility of bundling, including conducting a voluntary, multi-year bundling pilot program to test and evaluate alternative payment methodologies. There are four project types or models: acute care only, acute/post-acute (Model 2), post-acute only (Model 3), and acute and physician services. In the initial non-risk bearing stage of the bundling program (Phase 1), pilot participants received data from CMS on care patterns and engaged in shared learning in how to improve care. The second phase (Phase 2) requires participants, pending contract finalization and completion of the standard CMS program integrity reviews, to take on financial risk for episodes of care.

Eight of our hospitals began participating in Phase 2, the "at-risk" phase, of Model 3 of CMS' voluntary Bundled Payments for Care Improvement ("BPCI") initiative in 2015. We also have several hospitals that have signed participation agreements with acute care providers participating in Model 2 of the BPCI initiative. Ten of Encompass' home health agencies began participating in Phase 2 of Model 3 in 2014. As of December 31, 2016, 38 home health agencies participate in Phase 2.

Similarly, CMS has established per the 2010 Healthcare Reform Laws several separate ACO programs, the largest of which is the Medicare Shared Savings Program ("MSSP"), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Under the MSSP, there are two different ACO tracks from which participants can choose. The first track allows ACOs to share only in the savings. The second track requires ACOs to share in any savings and losses but offers ACOs a greater share of any savings realized than the first track offers. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. According to CMS, 562 ACOs will be serving patients in 2017. We continue to evaluate, on a case-by-case basis,

appropriate ACO participation opportunities for our hospitals, home health agencies, and patients. To date, we have signed two ACO participation agreements for our hospitals. Encompass has also partnered as the exclusive preferred home health provider with Premier PHC™, an ACO serving approximately 22,000 Medicare patients.

In January 2015, HHS announced it set various goals with respect to tying Medicare reimbursements to alternative payment models and value-based purchasing. Specifically, HHS set goals of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016 and tying 50 percent of payments to those models by the end of 2018. HHS also set goals of tying 85 and 90

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percent of traditional Medicare payments to quality or value by the end of 2016 and 2018, respectively, through programs such as those that include financial incentives for reducing acute care hospital readmissions. Given the results of the 2016 elections in the United States, the future of these goals and the means by which CMS attempts to achieve them, such as continued proliferation of mandatory bundled payment models, are uncertain.

On November 16, 2015, CMS published its final rule establishing the Comprehensive Care for Joint Replacement ("CJR") payment model. This mandatory model holds acute care hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for lower extremity joint replacements (i.e., knees and hips) from surgery through recovery. During the CJR model's five-year term, healthcare providers in 67 geographic areas, in which we operate 36 IRFs, will continue to be paid under existing Medicare payment systems. However, the hospital where the joint replacement takes place will be held accountable for the quality and costs of care for the entire episode of care — from the time of the original admission through 90 days after discharge. Depending on the quality and cost performance during the entire episode, the hospital may receive an additional payment or be required to repay Medicare a portion of the episode costs. Under this model, hospitals had no repayment responsibility, or downside financial risk, for 2016. However, they do have downside risk beginning in 2017. As a result, CMS believes acute care hospitals are incented to work with physicians and post-acute care providers to ensure beneficiaries receive the coordinated care they need in an efficient manner. Acute care hospitals participating in the CJR model may enter into risk-sharing financial arrangements with post-acute providers, including IRFs and home health agencies.

On January 3, 2017, CMS published its final rule providing for the creation and testing of three new episode payment models ("EPMs") as well as modification of the CJR model. The three new Medicare EPMs are: (1) acute myocardial infarction model, (2) coronary artery bypass graft ("CABG") model, and (3) surgical hip/femur fracture treatment excluding lower extremity joint replacement ("SHFFT") model. Most relevant to us are the mandatory CABG and SHFFT models which are set to begin July 1, 2017 and continue through the end of 2021. Under these models, as with the CJR model, acute care hospitals are financially accountable for the quality and cost of an episode of care, which is intended to incentivize increased coordination of care among hospitals, physicians, and post-acute care providers. The SHFFT model covers the same 67 markets as the CJR model, and the CABG model covers 98 markets, 40 of which include at least one of our IRFs. Hospitals subject to these models will earn a composite quality of care score based on performance in comparison to that of other hospitals. Following completion of a model performance year, hospitals that achieve actual episode spending below the target cost and achieve an acceptable or better quality score will be eligible to earn an incentive payment for the difference between the target and actual cost, up to a specified limit. Hospitals will have no downside financial risk for the first year, optional downside risk in the second year, and mandatory downside risk beginning in the third year.

The bundling and ACO initiatives have served as motivating factors for regulators and healthcare industry participants to identify and implement workable coordinated care and integrated delivery payment models. Broad-based implementation of a new delivery payment model would represent a significant transformation for us and the healthcare industry generally. The nature and timing of the evolution or transformation of the current healthcare system to coordinated care delivery and integrated delivery payment models and value-based purchasing are uncertain and will likely remain so for some time. The development of new delivery and payment systems will almost certainly take significant time and expense. Many of the alternative approaches, including those discussed above and the new home health value-based purchasing model discussed below, being explored may not work or could change substantially prior to a nationwide implementation. While only a small percentage of our business currently is or is anticipated to be subject to the alternative payment models discussed above, we cannot be certain these models will not be expanded or made standard.

Additionally, as the number and types of bundling and ACO models increase, the number of Medicare beneficiaries who are treated in one of the models increases. Our willingness and ability to participate in integrated delivery payment and other alternative payment models and the referral patterns of other providers participating in those models may limit our access to Medicare patients who would benefit from treatment in inpatient rehabilitation hospitals or from the services Encompass offers. To the extent that acute care hospitals participating in those models do not perceive our quality of care or cost efficiency favorably compared to alternative post-acute providers, we may experience a decrease in volumes and Net operating revenues, which could adversely affect our financial position,

results of operations, and cash flows. For further discussion of new coordinated care and integrated delivery payment models and value-based purchasing initiatives, the associated challenges, and our efforts to respond to them, see the "Executive Overview—Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section of Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations.

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Other legislative and regulatory initiatives and changes affecting the industry could adversely affect our business and results of operations.

In addition to the legislative and regulatory actions that directly affect our reimbursement rates or further the evolution of the current healthcare delivery system, other legislative and regulatory changes, including as a result of ongoing healthcare reform, affect healthcare providers like us from time to time. The 2010 Healthcare Reform Laws establish the Independent Payment Advisory Board appointed by the President that is charged with presenting proposals to Congress to reduce Medicare expenditures upon the occurrence of Medicare expenditures exceeding a certain level. If Medicare spending is projected to exceed target levels, this board will have broad authority to develop new Medicare policies (including changes to provider reimbursement). However, due to the market basket reductions that are also part of these laws, certain healthcare providers, such as our inpatient rehabilitation hospitals and hospice agencies, will not be subject to payment reduction proposals developed by this board and presented to Congress until 2020. While most of our operations may not be subject to its payment reduction proposals for a period of time, based on the scope of this board's directive to reduce Medicare expenditures and the significance of Medicare as a payor to us, other decisions made by this board could adversely affect our results of operations, including reductions in the payment for home health services. As of December 31, 2016, the Independent Payment Advisory Board members have not been appointed. Given the results of the 2016 elections in the United States and the controversial nature of this board, its future remains uncertain.

The 2010 Healthcare Reform Laws include other provisions that could adversely affect us as well. They include the expansion of the federal Anti-Kickback Law and the False Claims Act that, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the False Claims Act, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the HHS Office of Inspector General (the "HHS-OIG") or the United States Department of Justice (the "DOJ"). Any such suspension would adversely affect our financial position, results of operations, and cash flows.

Some states in which we operate have also undertaken, or are considering, healthcare reform initiatives that address similar issues. While many of the stated goals of other federal and state reform initiatives are consistent with our own goal to provide care that is high-quality and cost-effective, legislation and regulatory proposals may lower reimbursements, increase the cost of compliance, decrease patient volumes, promote frivolous or baseless litigation, and otherwise adversely affect our business. We cannot predict what healthcare initiatives, if any, will be enacted, implemented or amended, or the effect any future legislation or regulation will have on us.

On October 29, 2015, CMS issued a proposed rule relating to requirements for discharge planning for hospitals and home health agencies as called for by the IMPACT Act. The proposed rule would revise the discharge planning requirements applicable to our inpatient rehabilitation hospitals and Encompass home health agencies. CMS proposes to require hospitals (including inpatient rehabilitation facilities ("IRFs")) to have a discharge planning process that focuses on patients' goals and preferences and on preparing them and, as appropriate, their caregivers, to be active partners in their post-discharge care. For our hospitals, the proposed rule would require standardized procedures pertaining to the development and finalization of unique discharge plans for all patients. CMS proposes that discharge instructions must be provided at the time of discharge to patients, or the patient's caregiver or both, who are discharged home or who are referred to other post-acute care services, and that any post-discharge practitioners or providers must receive the patient's discharge instructions at the time of discharge, including the patient's discharge summary within 48 hours of discharge and any test results within 24 hours of availability.

For home health agencies, the proposed rule includes several new requirements. The discharge planning process would require the regular re-evaluation of patients to identify changes requiring modification of the discharge plan. The physician responsible for a patient's plan of care would have to be involved in the ongoing establishment of the discharge plan. Home health agencies must also send certain specified medical and other information to the

post-discharge facility or health care practitioner. The proposed rule would likely require the modification of existing discharge forms and reports, and patient visits may need to be extended in order to accommodate patient education. If adopted as proposed, we would expect to incur additional one-time and recurring expenses to comply, but at this time, we cannot predict what the final requirements will be or the timing or effect of those requirements.

In accordance with requirements adopted pursuant to the IMPACT Act, CMS implemented the new Medicare spending per beneficiary measures for each inpatient rehabilitation hospital in October 2016 and each home health agency in January 2017. The intent of tracking and publishing this data is to evaluate a given provider's payment efficiency relative to the efficiency of the national median provider in that provider's post-acute segment. CMS believes this measure will encourage

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improved efficiency and coordination of care in the post-acute setting by holding providers accountable for Medicare resource use during an episode of care. However, the measures do not take into account patient outcomes. CMS has not proposed to compare payment efficiency across provider segments.

In July 2016, CMS extended and expanded a temporary moratorium on the enrollment of new home health agencies and branch locations. CMS established the moratorium in July 2013, and it now applies to the entire states of Illinois and Michigan, as well as Florida and Texas (both states where Encompass has a number of agencies). In January 2017, CMS extended the moratorium through July 2017.

In June 2016, CMS published notice detailing a new demonstration project under which it would require home health providers to seek prior authorization before submitting claims for services in Florida, Texas, Illinois, Michigan, and Massachusetts. Encompass operates in three of these states (Florida, Texas, and Massachusetts). In the pre-claim review demonstration project, CMS proposes to have Medicare contractors collect additional information from home health providers submitting claims in order to determine proper payment or if there is a suspicion of fraud. The project began in Illinois on August 3, 2016. Because of difficulties encountered in administering the project, the start date in Florida was delayed to April 1, 2017. The start dates for the other states have not been announced. Approximately 48% of Encompass' Medicare claims are submitted by agencies in these three states (primarily Texas and Florida). This pre-claim demonstration project will require us to incur additional administrative and staffing costs and may impact the timeliness of claims payment given that fiscal intermediaries in Illinois have had difficulty processing pre-claim reviews on a timely basis. Accordingly, if the roll out project is not delayed or canceled, we may experience temporary increases in the Provision for doubtful accounts and decreases in cash flow or we may incur costs associated with patient care, the Medicare claim for which is subsequently denied, each of which could have an adverse effect on our financial position, results of operations, and liquidity.

As discussed above, MedPAC makes healthcare policy recommendations to Congress and provides comments to CMS on Medicare payment related issues. Congress is not obligated to adopt MedPAC's recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt any given MedPAC recommendation. For example, in January 2016, MedPAC released materials discussing several possible changes, some of which MedPAC has advocated previously, to various post-acute payment systems. One possible change reported on was an increase to outlier payments to be funded by reductions to non-outlier payments rates under the IRF-PPS.

We cannot predict what legislative or regulatory reforms or changes, if any, will ultimately be enacted, or the timing or effect any of those changes or reforms will have on us. If enacted, they may be challenging for all providers and have the effect of limiting Medicare beneficiaries' access to healthcare services and could have a material adverse impact on our Net operating revenues, financial position, results of operations, and cash flows. For additional discussion of healthcare reform and other factors affecting reimbursement for our services, see Item 1, Business, "Regulatory and Reimbursement Challenges" and "Sources of Revenues—Medicare Reimbursement."

Quality reporting requirements may negatively affect the Medicare reimbursement we receive.

The focus on alternative payment models and value-based purchasing of healthcare services has, in turn, led to more extensive quality of care reporting requirements. In many cases, the new reporting requirements are linked to reimbursement incentives. For example, under the 2010 Healthcare Reform Laws, CMS established new quality data reporting, effective October 1, 2012, for all IRFs. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in the subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions. Similarly, home health and hospice agencies are also required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket updates. To date, none of Encompass's home health and hospice agencies have incurred a reduction in their reimbursement rates.

As noted above, the IMPACT Act mandated that CMS adopt several new quality reporting measures for the various post-acute provider types. In each of the last two years, CMS adopted additional IRF quality reporting measures, the reporting of which will require additional time and expense and could affect reimbursement in the future. In healthcare generally, the burdens associated with collecting, recording, and reporting quality data are increasing. Currently, CMS requires IRF and home health providers to track and report 17 and 56 CMS-sanctioned quality reporting measures,

respectively.

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The 2016 HH Rule established a five-year home health value-based purchasing model in nine states to test whether incentives for better care can improve outcomes in the delivery of home health services. The model, which began in 2016, applies a reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, made to agencies in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. As of December 31, 2016, Encompass has 35 agencies in those states, which account for 19% of Encompass' Medicare revenue. Performance will be assessed based on several process, outcome, and care satisfaction measures, and the payment adjustments to be applied on an annual basis are set forth in the table below:

| Performance Year | Calendar Year for Payment Adjustment | Maximum Payment Adjustment (+/-) |
|---|---|---|
| 2016 | 2018 | 3% |
| 2017 | 2019 | 5% |
| 2018 | 2020 | 6% |
| 2019 | 2021 | 7% |
| 2020 | 2022 | 8% |

There can be no assurance all of our hospitals and agencies will continue to meet quality reporting requirements in the future which may result in one or more of our hospitals or agencies seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

Compliance with the extensive laws and government regulations applicable to healthcare providers requires substantial time, effort and expense, and if we fail to comply with them, we could suffer penalties or be required to make significant changes to our operations.

Healthcare providers 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;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of 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 patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements, as well as the way in which we deliver home health and hospice services. Those changes could also affect reimbursements as well as future training and staffing costs.

In addition to specific compliance-related laws and regulations, examples of regulatory changes that can affect our business, beyond direct changes to Medicare reimbursement rates, can be found from time to time in CMS's annual rulemaking. For example, the final rule for the fiscal year 2010 IRF-PPS implemented new coverage requirements which provided in part that a patient medical record must document a reasonable expectation that, at the time of admission to an IRF, the patient

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generally required and was able to participate in the intensive rehabilitation therapy services uniquely provided at IRFs. CMS has also taken the position that a patient's medical file must appropriately document the rationale for the use of group therapies, as opposed to one-on-one therapy. Beginning on October 1, 2015, CMS instituted a new data collection requirement pursuant to which IRFs must capture the minutes and mode (individual, group, concurrent, or co-treatment) of therapy by specialty. CMS plans to use this data to potentially support future rulemaking in this area. Additionally, the final rules for the fiscal years 2014 and 2015 IRF-PPS included a reduction in the number of medical conditions that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

Of note, the HHS-OIG each year releases a work plan that identifies areas of compliance focus for the coming year. In recent years, HHS-OIG work plans for IRFs have focused on, among other items, the appropriate utilization of concurrent and group therapy and adverse and temporary harm events occurring in IRFs. The 2017 work plan indicates HHS-OIG will focus on appropriate documentation to support claims by IRFs and home health and hospice agencies. The 2017 work plan also provides HHS-OIG will conduct medical reviews of IRF patient files to determine if the patients were suited for the intensive therapy required in IRFs and will determine if hospice patients are receiving the required visits by registered nurses. In December 2016, HHS-OIG also announced that it expects to complete in 2017 a nationwide audit to assess the frequency of inpatient rehabilitation stays that do not comply with all Medicare documentation and coverage requirements. The work plan, the audit or similar future efforts could result in denials of Medicare claims for patients notwithstanding the referring physicians' judgment that treatment is appropriate.

As the recent HHS-OIG work plans demonstrate, the clarity and completeness of each patient medical file, some of which is the work product of a physician not employed by us, are essential to demonstrating our compliance with various regulatory and reimbursement requirements. For example, to support the determination that a patient's IRF treatment was reasonable and necessary, the file must contain, among other things, an admitting physician's assessment of the patient as well as a post-admission assessment by the treating physician and other information from clinicians relating to the plan of care and the therapies being provided. These physicians exercise their independent medical judgment. We and our hospital medical directors, who are independent contractors, provide training on a regular basis to the physicians we work with regarding appropriate documentation. However, we ultimately do not and cannot control the physicians' medical judgment. In connection with subsequent payment audits and investigations, there can be no assurance as to what opinion a third party may take regarding the status of patient files or the physicians' medical judgment evidenced in those files.

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. Those subpoenas also requested complete copies of medical records for 100 patients treated at each of those hospitals between September 2008 and June 2012. The investigation is being conducted by the DOJ. On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. The new subpoenas reference substantially similar investigation subject matter as the original subpoenas and request materials from the period January 2008 through December 2013. Two of the four hospitals addressed in the original set of subpoenas have received supplemental subpoenas to cover this new time period. The most recent subpoenas do not include requests for specific patient files. However, in February 2015, the DOJ requested the voluntary production of the medical records of an additional 70 patients, some of whom were treated in hospitals not subject to the subpoenas, and we provided these records. We have not received any subsequent requests for medical records from the DOJ.

All of the subpoenas are in connection with an investigation of alleged improper or fraudulent claims submitted to Medicare and Medicaid and request documents and materials relating to practices, procedures, protocols and policies, of certain pre- and post-admissions activities at these hospitals including, among other things, marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% rule," 60% or more of the patients of an inpatient rehabilitation hospital must have at least one of a specified list of medical conditions in order to be reimbursed at the inpatient rehabilitation hospital payment rates, rather than at the lower acute care hospital payment rates. We are currently unable to predict the timing or outcome of these investigations.

Although we have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, we could be required to return portions of reimbursements for discharges alleged after the fact to have not been appropriate under the applicable reimbursement rules. We could also be subjected to other 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, which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement.

Because Medicare comprises a significant portion of our Net operating revenues, it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-

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fraud requirements. As discussed above in connection with the 2010 Healthcare Reform Laws, the federal government has in the last couple of years made compliance enforcement and fighting healthcare fraud top priorities. In the past few years, the DOJ and HHS as well as federal lawmakers have significantly increased efforts to ensure strict compliance with various reimbursement related regulations as well as combat healthcare fraud. The DOJ has pursued and recovered a record amount of taxpayer dollars based on alleged healthcare fraud. The increased enforcement efforts have frequently included aggressive arguments and interpretations of laws and regulations that pose risks for all providers. For example, the federal government has increasingly asserted that incidents of erroneous billing or record keeping represent violations of the False Claims Act. Human error and oversight in record keeping and documentation, particularly where those activities are the responsibility of non-employees, are always a risk in business, and healthcare providers and independent physicians are no different. Additionally, the federal government has been willing to challenge the medical judgment of independent physicians in arguing that reimbursement claims were fraudulent.

Reductions in reimbursements, 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. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Reimbursement claims are subject to various audits from time to time and such audits may negatively affect our operations and our cash flows from operations.

We receive a substantial portion of our revenues from the Medicare program. Medicare reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors ("MACs") that act as fiscal intermediaries for all Medicare billings, auditors contracted by CMS, and insurance carriers, as well as HHS-OIG, CMS and state Medicaid programs. As noted above, the clarity and completeness of each patient medical file, some of which is the work product of a physician not employed by us, is essential to successfully challenging any payment denials. If the physicians working with our patients do not adequately document, among other things, their diagnoses and plans of care, our risks related to audits and payment denials in general are greater. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material adverse effect on our financial position, results of operation and liquidity.

In the context of our inpatient rehabilitation business, one of the prevalent grounds for denying a claim or challenging a previously paid claim in an audit is that the patient's treatment in a hospital was not medically necessary. The medical record must support that both the documentation and coverage criteria requirements are met for the hospital stay to be considered medically reasonable and necessary. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. A Medicare claim may be denied or challenged based on an opinion of the auditor that the record did not evidence a medical necessity for treatment in an IRF or lacked sufficient documentation to support the conclusion. In some cases, we believe the reviewing party is not merely challenging the sufficiency of the medical record but is substituting its judgment of medical necessity for that of the attending physician or imposing documentation or other requirements which are not set out in the regulations. We argue that doing so is inappropriate and has no basis in law. However, when the government or its contractors do reject the medical judgment of physicians or impose documentation or other requirements beyond the language of the statutes and regulations, we would expect that both patient access to inpatient rehabilitation as well as our Medicare reimbursement from the related claims will be adversely affected.

MACs, under programs known as "widespread probes," have conducted pre-payment claim reviews of our Medicare billings and in some cases denied payment for certain diagnosis codes. A majority of the denials we have encountered in these probes derive from one MAC. In connection with recent probes, this MAC has made determinations regarding medical necessity which represent its uniquely restrictive interpretations of the CMS coverage rules or impose otherwise arbitrary conditions not set out in the related rules. We continue to discuss our objections to those interpretations with both the MAC and CMS. We cannot predict what, if any, changes will result from those discussions.

CMS has developed and instituted various audit programs under which CMS contracts with private companies to conduct claims and medical record audits. These audits are in addition to those conducted by existing MACs. Some contractors are paid a percentage of the overpayments recovered. One type of audit contractor, the Recovery Audit Contractors ("RACs"), receive claims data directly from MACs on a monthly or quarterly basis and are authorized to review previously paid claims. Beginning May 15, 2015, CMS limited the recovery auditor look back period to six months from the date of service in cases where the hospital submits the claim within three months of the date of service. CMS has previously operated a demonstration project that expanded the RAC program to include prepayment review of Medicare fee-for-service claims from primarily acute care hospitals. It is unclear whether CMS intends to conduct RAC prepayment reviews in the future and if so, what providers and claims would be the focus of those reviews.

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RAC audits of IRFs initially focused on coding errors but subsequently expanded to medical necessity and billing accuracy reviews. To date, the Medicare payments subject to RAC audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2016. We have appealed substantially all RAC denials arising from these audits using the same process we follow for appealing pre-payment denials by MACs.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors are successors to the Program Safeguard Contractors and conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error.

Audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid or disallow reimbursement. In some circumstances auditors have the authority to extrapolate denial rationales to large pools of claims not actually audited, which could greatly increase the impact of the audit. Additionally, if the MAC discussed above continues to deny a significant number of our claims for certain diagnosis codes, we may experience similar difficulties. As a result, we may suffer reduced profitability, and we may have to elect not to accept patients and conditions physicians believe can benefit from inpatient rehabilitation. We cannot predict when or how these audit programs will affect us.

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations.

Delays in the administrative appeals process associated with denied Medicare reimbursement claims may delay or reduce receipt of the related reimbursement amounts for services previously provided.

Ordinary course Medicare pre-payment denials by MACs, as well as denials resulting from widespread probes and audits, are subject to appeal by providers. We have historically appealed a majority of our denials. For claims we choose to appeal to an administrative law judge, we have historically experienced a greater than 70% success rate. However, the appeals adjudication process established by CMS has encountered significant delays in recent years. For example, most of our appeals heard by an administrative law judge in 2016 related to denials received in 2011 and 2012. We believe the process for resolving individual Medicare payment claims that are denied will continue to take in excess of three years. Currently, we have appeals being heard that have been pending for up to five years. Additionally, the number of new denials far exceeds the number of appeals resolved in recent years as shown in the following summary of our inpatient rehabilitation segment activity:

| | New Denials | Collections of Previously Denied Claims | Provision for Doubtful Accounts for Denial Activity |
|---|---|---|---|
| | (In Millions) | | |
| 2016 | $74.9 | $26.2 | $20.6 |
| 2015 | 79.0 | 15.0 | 20.6 |
| 2014 | 52.5 | 14.1 | 14.0 |

We record our estimates for pre-payment denials, including those resulting from widespread probes, and for post-payment audit denials that will ultimately not be collected in the Provision for doubtful accounts. See Note 1, Summary of Significant Accounting Policies, "Net Operating Revenues," to the accompanying consolidated financial statements. Given the continuing or increasing delays along with the increasing number of denials in the backlog, we may experience increases in the Provision for doubtful accounts, decreases in cash flow as a result of increasing accounts receivable, and/or a shift in the patients and conditions we treat, any of which could have an adverse effect on our financial position, results of operations, and liquidity. Although there is legislation proposed in Congress, the goal of which is to reform and improve the Medicare audit and appeals process, we cannot predict what, if any, legislation will be adopted or what, if any, effect that legislation might have on the audit and appeals process.

In May 2014, the American Hospital Association and others filed a lawsuit seeking to compel HHS to meet the statutorily required deadlines for adjudication of denied Medicare claims. In December 2016, the presiding federal district court judge in the lawsuit ordered HHS to reduce the backlog of appeals by 30% by the end of 2017, by 60% by the end of 2018, by 90% by the end of 2019, and completely by the end of 2020. HHS has appealed the federal

district court decision. On January 17, 2017, CMS published a rule implementing procedural and administrative changes to the appeals process, but it is

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unclear what, if any, impact these changes will have on the backlog. However, these changes may limit or otherwise negatively affect provider appeal rights. This new rule may be subject to legal challenge by healthcare providers as well. We cannot predict what, if any, further action CMS will take to reduce the backlog.

Changes in our payor mix or the acuity of our patients could adversely affect our Net operating revenues or our profitability.

Many factors affect pricing of our services and, in turn, our revenues. For example, in the inpatient rehabilitation segment, these factors include, among other things, the treating facility's urban or rural status, the length of stay, the payor and its applicable rate of reimbursement, and the patient's medical condition and impairment status (acuity). In 2015, our inpatient rehabilitation segment experienced a shift in payor mix to a slightly larger percentage of Medicaid patients and a shift to a slightly lower average acuity for our patients, both of which adversely affected pricing growth. See the "Segment Results of Operations—Inpatient Rehabilitation—Net Operating Revenues" section of Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations. The expansion and growth of Medicaid and insurance exchanges resulting from provisions of the 2010 Healthcare Reform Laws have increased the number of those patients coming to us. Medicaid reimbursement rates are almost always the lowest among those of our payors, and frequently Medicaid patients come to us with other complicating conditions that make treatment more difficult and costly. Similarly, the insurance coverages offered in the exchanges typically reimburse us at rates lower than we receive under other managed care contracts. We do not anticipate that Medicaid and insurance exchanges will continue to grow at the rate they have in recent years. As previously noted, potential changes to or repeal of the provisions of the 2010 Healthcare Reform Laws targeted at Medicaid expansion may impact the number of Medicaid patients we treat. However, we cannot predict what, if any, Medicaid changes will be adopted. In 2016, the growth in our percentage of Medicaid patients slowed, but we cannot predict whether our payor mix will continue to shift to these lower reimbursement rate payors. In the future, we may experience shifts in our payor mix or the acuity of our patients that could adversely affect our pricing, Net operating revenues, or profitability.

We face intense competition for patients from other healthcare providers.

We operate in a highly competitive, fragmented inpatient rehabilitation and home health and hospice industries. Although we are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals, in any particular market we may encounter competition from local or national entities with longer operating histories or other competitive advantages. For example, acute care hospitals, including those owned and operated by large public companies, may choose to expand or begin offering post-acute rehabilitation services. Given that approximately 92% of our hospitals' referrals come from acute care hospitals, that increase in competition could materially and adversely affect our admission referrals in the related markets. There are also large acute care systems that may have more resources available to compete than we have. Other providers of post-acute care services may attempt to become competitors in the future. For example, over the past few years, the number of nursing homes marketing themselves as offering certain rehabilitation services has increased even though nursing homes are not required to offer the same level of care, or be licensed, as hospitals.

In the home health and hospice services industry, our primary competition comes from locally owned private home health companies or acute care hospitals with adjunct home health services and typically varies from market to market. We compete with a variety of other companies in providing home health and hospice services, some of which, including several large public companies, may have greater financial and other resources and may be more established in their respective communities. Competing companies may offer newer or different services from those we offer or have better relationships with referring physicians and may thereby attract patients who are presently, or would be candidates for, receiving Encompass home health or hospice services. The other public companies have or may obtain significantly greater marketing and financial resources than we have or may obtain. Relatively few barriers to entry exist in most of our local markets. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing competing services, may expand their services to include home health services, hospice care, community care services, or similar services. Additionally, nursing homes compete for referrals in some instances when the patients may be suitable for home-based care.

There can be no assurance 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, from time to time,

there are efforts in states with certificate of need ("CON") laws to weaken those laws, which could potentially increase competition in those states. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, Properties.

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If we are unable to maintain or develop relationships with patient referral sources, our growth and profitability could be adversely affected.

Our success depends in large part on referrals from physicians, hospitals, case managers and other patient referral sources in the communities served. Referral sources are not contractually obligated to refer patients to us and may refer their patients to other providers. Our growth and profitability depend on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of inpatient rehabilition, home health, and hospice care by our referral sources and their patients. We cannot provide assurance that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to grow our business and operate profitably.

We may have difficulty completing investments and transactions that increase our capacity consistent with our growth strategy.

We are selectively pursuing strategic acquisitions of, and in some instances joint ventures with, other healthcare providers. We may face limitations on our ability to identify sufficient acquisition or other development targets and to complete those transactions to meet goals. In the home health industry, there is significant competition among acquirors attempting to secure the acquisition of companies that have a large number of locations. In many states, the need to obtain governmental approvals, such as a CON or an approval of a change in ownership, may represent a significant obstacle to completing transactions. Additionally, in states with CON laws, it is not unusual for third-party providers to challenge initial awards of CONs, the increase in the number of approved beds in an existing CON, or expand or change the area served, and the adjudication of those challenges and related appeals may take multiple years. These factors may increase the cost to us associated with any acquisition or prevent us from completing one or more acquisitions.

We may make investments or complete transactions that could expose us to unforeseen risks and liabilities.

Investments, acquisitions, joint ventures or other development opportunities identified and completed may involve material cash expenditures, debt incurrence, operating losses, amortization of certain intangible assets of acquired companies, issuances of equity securities, and expenses, some of which are unforeseen, that could affect our business, financial position, results of operations and liquidity. Acquisitions, investments, and joint ventures involve numerous risks, including:

- limitations, including state CONs as well as CMS and other regulatory approval requirements, on our ability to complete such acquisitions, particularly those involving not-for-profit providers, on terms, timetables, and valuations reasonable to us;
- limitations in obtaining financing for acquisitions at a cost reasonable to us;
- difficulties integrating acquired operations, personnel, and information systems, and in realizing projected revenues, efficiencies and cost savings, or returns on invested capital;
- entry into markets, businesses or services in which we may have little or no experience;
- diversion of business resources or management’s attention from ongoing business operations; and
- exposure to undisclosed or unforeseen liabilities of acquired operations, including liabilities for failure to comply with healthcare laws and anti-trust considerations in specific markets.

As part of our development activities, we intend to build new, or de novo, inpatient rehabilitation hospitals. The construction of new hospitals involves numerous risks, including the receipt of all zoning and other regulatory approvals, such as a CON where necessary, construction delays and cost over-runs and unforeseen environmental liability exposure. Once built, new hospitals must undergo the state and Medicare certification process, the duration of which may be beyond our control. We may be unable to operate newly constructed hospitals as profitably as expected, and those hospitals may involve significant additional cash expenditures and operating expenses that could, in the aggregate, have an adverse effect on our business, financial position, results of operations, and cash flows.

We may not be able to successfully integrate acquisitions or realize the anticipated benefits of any acquisitions.

We may undertake strategic acquisitions from time to time. For example, we completed the acquisitions of Encompass in 2014, the operations of Reliant Hospital Partners, LLC and affiliated entities in 2015, and the home care operations of CareSouth Health System, Inc. in 2015. Prior to consummation of any acquisition, the acquired business will have operated

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independently of us, with its own procedures, corporate culture, locations, employees and systems. We will fold those businesses into our existing business as one combined organization, for example utilizing certain common information systems, operating procedures, administrative functions, financial and internal controls and human resources practices. There may be substantial difficulties, costs and delays involved in the integration of an acquired business with our business. Additionally, an acquisition could cause disruption to our business and operations and our relationships with customers, employees and other parties. In some cases, the acquired business has itself grown through acquisitions, as was the case with Encompass, Reliant and CareSouth, and there may be legacy systems, operating policies and procedures, financial and administrative practices yet to be fully integrated. To the extent we are attempting to integrate multiple businesses at the same time, we may not be able to do so as efficiently or effectively as we would prefer. The failure to successfully integrate on a timely basis any acquired business with our existing business could have an adverse effect on our business, financial position, results of operations, and cash flows.

We anticipate our acquisitions will result in benefits including, among other things, increased revenues and an enhanced ability to provide a continuum of facility-based and home-based post-acute healthcare services. However, acquired businesses may not contribute to our revenues or earnings to the extent anticipated, and any synergies we expect may not be realized after the acquisitions have been completed. If the acquired businesses underperform and such underperformance is other than temporary, we may be required to take an impairment charge. Failure to achieve the anticipated benefits could result in the inability to meet the financial ratios and financial condition tests under our credit agreement and diversion of management's time and energy and could have an adverse effect on our business, financial position, results of operations, and cash flows.

Competition for staffing, shortages of qualified personnel, union activity or other factors may increase our labor costs and reduce profitability.

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This issue may be exacerbated if immigration is limited in the future. A shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for 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 experience reimbursement rate or pricing increases to offset these additional costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual market basket update from Medicare or we continue to experience a shift in our payor mix to lower rate payors such as Medicaid, our results of operations and cash flows will be adversely affected. Conversely, decreases in reimbursement revenues, such as with sequestration, may limit our ability to increase compensation or benefits to the extent necessary to retain key employees, in turn increasing our turnover and associated costs. Union activity is another factor that may contribute to increased labor costs. We currently have a minimal number of union employees, so an increase in labor union activity could have a significant impact on our labor costs. Our failure to recruit and retain qualified medical personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

We operate in a highly regulated industry in which healthcare providers are routinely subject to litigation. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are a defendant in a number of lawsuits. The material lawsuits and investigations, including the subpoenas received from HHS-OIG, are discussed in Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements. Substantial damages, fines, or other remedies assessed against us or agreed to in settlements could have a material adverse effect on our business, financial position, results of operations,

and cash flows. Additionally, the costs of defending litigation and investigations, even if frivolous or nonmeritorious, could be significant.

Home care services, by their very nature, are provided in an environment, the patient's place of residence, that is not in the substantial control of the healthcare provider. Accordingly, home care involves an increased level of associated risk of general and professional liability. On any given day, we have thousands of nurses, therapists and other care providers driving to and from the homes of patients where they deliver care. We cannot predict the impact any claims arising out of the travel, the home visits or the care being provided, regardless of their ultimate outcome, could have on our business or reputation or on our

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ability to attract and retain patients and employees. We also cannot predict the adequacy of any reserves for such losses or recoveries from any insurance or re-insurance policies.

We insure a substantial portion of our professional liability, general liability, and workers' compensation liability risks, which may not include risks related to regulatory fines and penalties, through our captive insurance subsidiary, as discussed further in Note 10, Self-Insured Risks, to the accompanying consolidated financial statements. Changes in the number of these liability claims and the cost to resolve them impact the reserves for these risks. A variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the reserves for these liability risks, which could have an effect on our financial position and results of operations.

The False Claims Act allows private citizens, called "relators," to institute civil proceedings alleging violations of the False Claims Act. These lawsuits, which may be initiated by "whistleblowers," can involve significant monetary damages, fines, attorneys' fees and the award of bounties to the relators who successfully bring these suits and to the government. These qui tam cases are sealed by the court at the time of filing. Prior to the lifting of the seal by the court, the only parties typically privy to the information contained in the complaint are the relator, the federal government, and the presiding court. It is possible that qui tam lawsuits have been filed against us and that those suits remain under seal or that we are unaware of such filings or prevented by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed qui tam cases brought pursuant to the False Claims Act.

The proper function, availability, and security of our information systems are critical to our business.

We are and will remain dependent on the proper function, availability and security of our and third-party information systems, including our electronic clinical information system, referred to as ACE-IT, which plays a substantial role in the operations of the hospitals in which it is installed and the information systems currently in use by Encompass. We undertake substantial measures to protect the safety and security of our information systems and the data maintained within those systems, and we periodically test the adequacy of our security and disaster recovery measures. We have implemented administrative, technical and physical controls on our systems and devices in an attempt to prevent unauthorized access to that data, which includes patient information subject to the protections of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and other sensitive information. For additional discussion of these laws, see Item 1, Business, "Regulation."

We expend significant capital to protect against the threat of security breaches, including cyber attacks, malware and ransomware. Substantial additional expenditures may be required to alleviate any problems caused by breaches, including unauthorized access to or theft of patient data and protected health information stored in our information systems and the introduction of computer malware or ransomware to our systems. We also provide our employees training and regular reminders on important measures they can take to prevent breaches. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. For example, it has been widely reported that many well-organized international interests, in certain cases with the backing of sovereign governments, are targeting the theft of patient information through the use of advance persistent threats. Similarly, in recent years, several hospitals have reported being the victim of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. We are likely to face attempted attacks in the future. Accordingly, we may be vulnerable to losses associated with the improper functioning, security breach or unavailability of our information systems as well as any systems used in acquired operations. To date, we are not aware of having experienced a material cyber breach or attack. However, given the well-publicized and increasing cyber security threats in the healthcare industry, there can be no assurance we will not experience business interruptions; data loss, ransom, misappropriation or corruption; theft or misuse of proprietary or patient information; or litigation and investigation related to any of those, any of which could have a material adverse effect on our financial position and results of operations and harm our business reputation.

A compromise of our network security measures or other controls, or of those businesses and vendors with whom we interact, which results in confidential information being accessed, obtained, damaged or used by unauthorized or improper persons or unavailability of systems necessary to the operation of our business, could impact patient care, harm our reputation, and expose us to significant remedial costs as well as regulatory actions and claims from patients, financial institutions, law enforcement agencies, and other persons, any of which could have a material adverse effect on our business, financial position, results of operations and cash flows. Moreover, a security breach, or threat thereof, could require that we expend significant resources to repair or improve our information systems and infrastructure and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber-attack, the associated expenses and losses may exceed our current insurance coverage for such events. Some adverse consequences are not insurable, such as reputational harm and third-party business interruption. Failure to maintain proper function, security, or availability of

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our information systems or protect our data against unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows.

ACE-IT is subject to a licensing, implementation, technology hosting, and support agreement with Cerner Corporation. In June 2011, we entered into an agreement with Cerner to begin a company-wide implementation of this system. As of December 31, 2016, we have installed ACE-IT in 101 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. Similarly, Encompass has an agreement to license, host, and support its comprehensive management and clinical information system, Homecare Homebase[SM]. Our inability, or the inability of software vendors, to continue to maintain and upgrade our information systems, software, and hardware could disrupt or reduce the efficiency of our operations, including affecting patient care. In addition, costs, unexpected problems, and interruptions associated with the implementation or transition to new systems or technology or with adequate support of those systems or technology across numerous hospitals and agencies could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Successful execution of our current business plan depends on our key personnel.

The success of our current business plan depends in large part upon the leadership and performance of our executive management team and key employees and our ability to retain and motivate these individuals. We rely upon their ability, expertise, experience, judgment, discretion, integrity and good faith. With respect to our home health business, we rely on the experience and expertise of Encompass' management team in that industry. In order to retain this experience and expertise, we have entered into three-year employment agreements that include noncompetition and other restrictive covenants with certain key senior management personnel of Encompass. However, there is no guarantee we will be able to retain these individuals or other members of Encompass' management team. If we are unable to retain these members of Encompass' senior management, we could face increased difficulties in operating Encompass and in expanding our presence in home health and hospice.

There can be no assurance that we will retain our key executives and employees or that we can attract or retain other highly qualified individuals in the future. If we lose key personnel, we may be unable to replace them with personnel of comparable experience in, or knowledge of, the healthcare provider industry or our specific post-acute segments. The loss of the services of any of these individuals could prevent us from successfully executing our business plan and could have a material adverse effect on our business and results of operations.

Our leverage or level of indebtedness may have negative consequences for our business, and we may incur additional indebtedness in the future.

As of December 31, 2016, we have approximately $2.7 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $279.3 million in capital leases). See Note 9, Long-term Debt, to the accompanying consolidated financial statements. Subject to specified limitations, our credit agreement and the indentures governing our debt securities permit us and our subsidiaries to incur material additional debt. If new debt is added to our current debt levels, the risks described here could intensify.

Our indebtedness could have important consequences, including:

- limiting our ability to borrow additional amounts to fund working capital, capital expenditures, acquisitions, debt service requirements, execution of our business strategy and other general corporate purposes;
- making us more vulnerable to adverse changes in general economic, industry and competitive conditions, in government regulation and in our business by limiting our flexibility in planning for, and making it more difficult for us to react quickly to, changing conditions;
- placing us at a competitive disadvantage compared with competing providers that have less debt; and
- exposing us to risks inherent in interest rate fluctuations for outstanding amounts under our credit facility, which could result in higher interest expense in the event of increases in interest rates, as discussed in Item 7A, Quantitative and Qualitative Disclosures about Market Risk.

We are subject to contingent liabilities, prevailing economic conditions, and financial, business, and other factors beyond our control. Although we expect to make scheduled interest payments and principal reductions, we cannot provide assurance 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 instruments. If we are unable to generate sufficient cash flow from operations in the future to service our debt and meet our other needs or have an unanticipated cash payment

obligation, we may have to refinance all or a portion

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of our debt, obtain additional financing or reduce expenditures or sell assets we deem necessary to our business. We cannot provide assurance these measures would be possible or any additional financing could be obtained.

The restrictive covenants in our credit agreement and the indentures governing our senior notes could affect our ability to execute aspects of our business plan successfully.

The terms of our credit agreement and the indentures governing our senior notes do, and our future debt instruments may, contain various provisions that limit our ability and the ability of certain of our subsidiaries to, among other things:

- incur or guarantee indebtedness;
- pay dividends on, or redeem or repurchase, our capital stock; or repay, redeem or repurchase our subordinated obligations;
- issue or sell certain types of preferred stock;
- make investments;
- incur obligations that restrict the ability of our subsidiaries to make dividends or other payments to us;
- sell assets;
- engage in transactions with affiliates;
- create certain liens;
- enter into sale/leaseback transactions; and
- merge, consolidate, or transfer all or substantially all of our assets.

These covenants could adversely affect our ability to finance our future operations or capital needs and pursue available business opportunities. For additional discussion of our material debt covenants, see the “Liquidity and Capital Resources” section of Item 7, Management’s Discussion and Analysis of Financial Condition and Results of Operations, and Note 9, Long-term Debt, to the accompanying consolidated financial statements.

In addition, our credit agreement requires us to maintain specified financial ratios and satisfy certain financial condition tests. See the “Liquidity and Capital Resources” section of Item 7, Management’s Discussion and Analysis of Financial Condition and Results of Operations, and Note 9, Long-term Debt, to the accompanying consolidated financial statements. Although we remained in compliance with the financial ratios and financial condition tests as of December 31, 2016, we cannot provide assurance we will continue to do so. Events beyond our control, including changes in general economic and business conditions, may affect our ability to meet those financial ratios and financial condition tests. A severe downturn in earnings, failure to realize anticipated earnings from acquisitions, or, if we have outstanding borrowings under our credit facility at the time, a rapid increase in interest rates could impair our ability to comply with those financial ratios and financial condition tests and we may need to obtain waivers from the required proportion of the lenders to avoid being in default. If we try to obtain a waiver or other relief from the required lenders, we may not be able to obtain it or such relief might have a material cost to us or be on terms less favorable than those in our existing debt. If a default occurs, the lenders could exercise their rights, including declaring all the funds borrowed (together with accrued and unpaid interest) to be immediately due and payable, terminating their commitments or instituting foreclosure proceedings against our assets, which, in turn, could cause the default and acceleration of the maturity of our other indebtedness. A breach of any other restrictive covenants contained in our credit agreement or the indentures governing our senior notes would also (after giving effect to applicable grace periods, if any) result in an event of default with the same outcome.

As of December 31, 2016, approximately 74% of our consolidated Property and equipment, net was held by HealthSouth Corporation and its guarantor subsidiaries under our credit agreement. See Note 9, Long-term Debt, and Note 20, Condensed Consolidating Financial Information, to the accompanying consolidated financial statements, and Item 2, Properties.

Uncertainty in the capital markets could adversely affect our ability to carry out our development objectives.

In recent years, the global and sovereign credit markets have experienced significant disruptions, and the debt ceiling and federal budget disputes in the United States affected capital markets. Future market shocks could negatively affect the

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availability or terms of certain types of debt and equity financing, including access to revolving lines of credit. Future business needs combined with market conditions at the time may cause us to seek alternative sources of potentially less attractive financing and may require us to adjust our business plan accordingly. For example, tight credit markets, such as might result from further turmoil in the sovereign debt markets, would likely make additional financing more expensive and difficult to obtain. The inability to obtain additional financing at attractive rates or prices could have a material adverse effect on our financial performance or our growth opportunities.

As a result of credit market uncertainty, we also face potential exposure to counterparties who may be unable to adequately service our needs, including the ability of the lenders under our credit agreement to provide liquidity when needed. We monitor the financial strength of our depositories, creditors, and insurance carriers using publicly available information, as well as qualitative inputs.

If any of our hospitals or home health or hospice agencies fail to comply with the Medicare conditions of participation, that hospital or agency could be terminated from the Medicare program.

Each of our hospitals and home health and hospice agencies must comply with extensive conditions of participation for certification in the Medicare program. If any fail to meet any of the Medicare conditions of participation, we may receive a notice of deficiency from the applicable state survey agency. If that hospital or agency then fails to institute an acceptable plan of correction and correct the deficiency within the applicable correction period, it could lose the ability to bill Medicare. For example, the conditions require that hospice agencies have a certain number of volunteers. A hospital or agency could be terminated from the Medicare benefit if it fails to address the deficiency within the applicable correction period. If CMS terminates one hospital or agency, it may increase its scrutiny of others under common control. In June 2016, CMS proposed revisions to the Medicare conditions of participation applicable to inpatient rehabilitation hospitals and intended to modernize and revise the requirements to reflect current standards of practice and support improvements in quality of care. On January 9, 2017, CMS issued a final rule, effective on July 13, 2017, revising the Medicare conditions of participation applicable to home health agencies. The new conditions of participation address administrative, clinical and informational requirements for agencies. We are still assessing the impact of the recently released conditions of participation. However, we will likely have to incur additional costs and alter or supplement some of our business practices to comply with the new requirements. We do not believe the new conditions of participation will have a material impact on our business or results from operations. Any termination of one or more of our hospitals or agencies from the Medicare program for failure to satisfy the conditions of participation could adversely affect our business, financial position, results of operations, and cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We maintain our principal executive office at 3660 Grandview Parkway, Birmingham, Alabama. We occupy those office premises under a long-term lease which expires in March 2018. On February 25, 2016, we entered into an agreement with a developer to build and lease a new corporate office building at another location in Birmingham. We expect to move to that location in the first half 2018. Our current landlord has granted us an option to extend our lease for up to 75 days in the event construction of the new building is not completed prior to the expiration of that lease.

In addition to our principal executive office, as of December 31, 2016, we leased or owned through various consolidated entities 363 locations to operate or support our business. Our hospital leases, which represent the largest portion of our rent expense, have at least two years remaining on their current terms and, generally, one or more renewal options for an additional term of at least 5 years. Some renewal options provide for shorter additional terms. Our consolidated entities associated with our leased hospitals are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses. Our home health and hospice business is based in Dallas, Texas where it leases office space for corporate and administrative functions. The remaining home health and hospice locations are in the localities served by that business and are subject to relatively small space leases, approximately 2,800 square feet on average. Those space leases are typically less than five years in term. We do not believe any one of our individual properties is material to our consolidated operations.

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The following table sets forth information regarding our hospital properties (excluding the one hospital that has 51 licensed beds and operates as a joint venture which we account for using the equity method of accounting) and our Encompass locations as of December 31, 2016:

| | | Number of Hospitals | | | | |
|---|---|---|---|---|---|---|
| State | Licensed Beds | Building and Land Owned | Building Owned and Land Leased | Building and Land Leased | Total | Encompass Locations |
| Alabama *+ | 383 | 1 | 3 | 2 | 6 | 4 |
| Arizona | 335 | 1 | 1 | 3 | 5 | 4 |
| Arkansas *+ | 360 | 3 | 1 | 1 | 5 | 5 |
| California | 184 | 2 | — | 1 | 3 | — |
| Colorado | 104 | 1 | — | 1 | 2 | 6 |
| Connecticut* | — | — | — | — | — | 1 |
| Delaware * | 34 | — | 1 | — | 1 | — |
| Florida * | 907 | 10 | — | 2 | 12 | 17 |
| Georgia *+ | 150 | 2 [1] | 1 | | 3 | 24 |
| Idaho | — | — | — | — | — | 11 |
| Illinois * | 61 | — | 1 | — | 1 | — |
| Indiana | 103 | — | — | 1 | 1 | — |
| Kansas | 242 | 1 | — | 2 | 3 | 8 |
| Kentucky * | 312 | 2 | 1 | — | 3 | 1 |
| Louisiana | 47 | 1 | — | — | 1 | — |
| Maine * | 100 | — | — | 1 | 1 | — |
| Maryland *+ | 59 | 1 | — | — | 1 | 1 |
| Massachusetts * | 560 | 2 | — | 2 | 4 | 2 |
| Missouri * | 156 | — | 2 | — | 2 | 2 |
| Nevada | 219 | 2 | — | 1 | 3 | 2 |
| New Hampshire | 50 | — | 1 | — | 1 | — |
| New Jersey * | 199 | 1 | 1 | 1 | 3 | — |
| New Mexico | 87 | 1 | — | — | 1 | 7 |
| North Carolina + | — | — | — | — | — | 6 |
| Ohio | 150 | — | — | 2 | 2 | — |
| Oklahoma | 22 | — | 1 | — | 1 | 20 |
| Oregon | — | — | — | — | — | 2 |
| Pennsylvania | 734 | 5 | — | 4 | 9 | 3 |
| Puerto Rico * | 72 | — | — | 2 | 2 | — |
| South Carolina *+ | 343 | 1 | 4 | — | 5 | 2 |
| Tennessee *+ | 445 | 5 | 3 | — | 8 | 6 |
| Texas | 1,443 | 12 | 1 | 9 | 22 | 59 |
| Utah | 84 | 1 | — | — | 1 | 15 |
| Virginia * | 291 | 2 | 1 | 3 | 6 | 13 |
| West Virginia * | 268 | 1 | 3 | — | 4 | — |
| Wyoming | — | — | — | — | — | 2 |
| | 8,504 | 58 | 26 | 38 | 122 | 223 [2] |

* Hospital certificate of need state or U.S. territory

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+ Home health certificate of need state or U.S. territory

(1) The inpatient rehabilitation hospitals in Augusta and Newnan, Georgia are parties to industrial development bond financings that reduce the ad valorem taxes payable by each hospital. In connection with each of these bond structures, title to the related property is held by the local development authority. We lease the related hospital property and hold the bonds issued by that authority, the payment on which equals the amount payable under the lease. We may terminate each bond financing and the associated lease at any time at our option without penalty, and fee title to the related hospital property will return to us.

(2) This total includes 188 locations where we provide adult home health services and 35 locations where we provide hospice services. In addition, two of the adult home health locations operate as joint ventures which we account for using the equity method of accounting.

Our principal executive office, hospitals, and other properties are suitable for their respective uses and are, in all material respects, adequate for our present needs. Information regarding the utilization of our licensed beds and other operating statistics can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations.

Item 3. Legal Proceedings

Information relating to certain legal proceedings in which we are involved is included in Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements, which is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

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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 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, 2015 through December 31, 2016:

| | High | Low |
|---|---|---|
| 2015 | | |
| First Quarter | $46.92 | $36.46 |
| Second Quarter | 48.13 | 41.37 |
| Third Quarter | 48.37 | 36.71 |
| Fourth Quarter | 39.89 | 32.55 |
| | | |
| 2016 | | |
| First Quarter | $37.84 | $30.26 |
| Second Quarter | 42.65 | 34.79 |
| Third Quarter | 43.38 | 38.00 |
| Fourth Quarter | 42.70 | 36.97 |

### Holders

As of February 15, 2017, there were 89,052,284 shares of HealthSouth common stock issued and outstanding, net of treasury shares, held by approximately 8,537 holders of record.

### Dividends

We paid quarterly cash dividends of $0.21 per share on our common stock on January 15, April 15, and July 15 of 2015. On July 16, 2015, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.23 per share that was paid on October 15, 2015, and we paid the same per share quarterly dividend through July 15, 2016. On July 21, 2016, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.24 per share that was paid on October 17, 2016, and we paid the same per share quarterly dividend on January 17, 2017. We expect quarterly dividends to continue to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board each quarter after consideration of various factors, including our capital position and alternative uses of funds.

The terms of our credit agreement allow us to declare and pay cash dividends on our common stock so long as: (1) we are not in default under our credit agreement and (2) our senior secured leverage ratio remains less than or equal to 1.75x. The terms of our senior note indenture allow us to declare and pay cash dividends on our common stock so long as (1) we are not in default, (2) the consolidated coverage ratio (as defined in the indenture) exceeds 2x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture's restricted payments covenant to declare and pay dividends. We believe we currently have adequate capacity under these covenants to pursue the dividend strategy described in this report for the foreseeable future based on the capacity as of the date of this report and anticipated restricted payments. See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

### Recent Sales of Unregistered Securities

None.

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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, "Equity Compensation Plans," and incorporated here by reference.

Purchases of Equity Securities

The following table summarizes our repurchases of equity securities during the three months ended December 31, 2016:

| Period | Total Number of Shares (or Units) Purchased[1] | Average Price Paid per Share (or Unit) ($) | Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs | Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs[2] |
|---|---|---|---|---|
| October 1 through October 31, 2016 | 439,486 | $ 39.25 | 438,650 | $120,290,930 |
| November 1 through November 30, 2016 | 715,475 | 39.66 | 616,104 | 96,058,731 |
| December 1 through December 31, 2016 | 13,598 | 41.24 | — | 96,058,731 |
| Total | 1,168,559 | $ 39.53 | 1,054,754 | |

(1) Except as noted in the following sentence, the number of shares reported in this column includes the shares purchased under the plan or program as reported in the third column of this table and the shares tendered by employees as payments of the tax liabilities incident to the vesting of previously awarded shares of restricted stock and the exercise price and tax liability incident to the net settlement of an option exercise. In October, 836 shares were purchased pursuant to our Directors' Deferred Stock Investment Plan. This plan is a nonqualified deferral plan allowing non-employee directors to make advance elections to defer a fixed percentage of their director fees. The plan administrator acquires the shares in the open market which are then held in a rabbi trust. The plan provides that dividends paid on the shares held for the accounts of the directors will be reinvested in shares of our common stock which will also be held in the trust. The directors' rights to all shares in the trust are nonforfeitable, but the shares are only released to the directors after departure from our board.

(2) On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock. On February 14, 2014, our board of directors approved an increase in this common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended.

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 S&P Health Care Services Select Industry Index ("SPSIHP"), an equal-weighted index of at least 35 companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2011 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock. We have paid a quarterly cash dividend on our common stock since October 2013.

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 we specifically incorporate it by reference into such filing.

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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. Research Data Group, Inc. provided the data for the indices presented below. We assume no responsibility for the accuracy of the indices' data, but we are not aware of any reason to doubt its accuracy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among HealthSouth Corporation, the S&P 500 Index, and the S&P Health Care Services Select Industry Index

| | For the Year Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | Base Period | Cumulative Total Return | | | | |
| Company/Index Name | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
| HealthSouth | 100.00 | 119.47 | 190.58 | 224.69 | 207.85 | 252.15 |
| Standard & Poor's 500 Index | 100.00 | 116.00 | 153.58 | 174.60 | 177.01 | 198.18 |
| S&P Health Care Services Select Industry Index | 100.00 | 120.37 | 145.31 | 175.54 | 181.27 | 162.03 |

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Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2016, 2015, and 2014 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, 2013 and 2012 from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2013. Refer to Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and the notes to the 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.

| | For the Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2013 | 2012 |
| | (In Millions, Except per Share Data) | | | | |
| Statement of Operations Data: [1] | | | | | |
| Net operating revenues | $3,707.2 | $3,162.9 | $2,405.9 | $2,273.2 | $2,161.9 |
| Operating earnings [2] | 588.1 | 485.7 | 418.4 | 435.7 | 378.7 |
| Provision for income tax expense [3] | 163.9 | 141.9 | 110.7 | 12.7 | 108.6 |
| Income from continuing operations | 318.1 | 253.7 | 276.2 | 382.5 | 231.4 |
| (Loss) income from discontinued operations, net of tax | — | (0.9) | 5.5 | (1.1) | 4.5 |
| Net income | 318.1 | 252.8 | 281.7 | 381.4 | 235.9 |
| Less: Net income attributable to noncontrolling interests | (70.5) | (69.7) | (59.7) | (57.8) | (50.9) |
| Net income attributable to HealthSouth | 247.6 | 183.1 | 222.0 | 323.6 | 185.0 |
| Less: Convertible perpetual preferred stock dividends | — | (1.6) | (6.3) | (21.0) | (23.9) |
| Less: Repurchase of convertible perpetual preferred stock [4] | — | — | — | (71.6) | (0.8) |
| Net income attributable to HealthSouth common shareholders | $247.6 | $181.5 | $215.7 | $231.0 | $160.3 |
| | | | | | |
| Weighted average common shares outstanding: [5] | | | | | |
| Basic | 89.1 | 89.4 | 86.8 | 88.1 | 94.6 |
| Diluted | 99.5 | 101.0 | 100.7 | 102.1 | 108.1 |
| Earnings per common share: | | | | | |
| Basic earnings per share attributable to HealthSouth common shareholders: | | | | | |
| Continuing operations | $2.77 | $2.03 | $2.40 | $2.59 | $1.62 |
| Discontinued operations | — | (0.01) | 0.06 | (0.01) | 0.05 |
| Net income | $2.77 | $2.02 | $2.46 | $2.58 | $1.67 |
| Diluted earnings per share attributable to HealthSouth common shareholders: | | | | | |
| Continuing operations | $2.59 | $1.92 | $2.24 | $2.59 | $1.62 |
| Discontinued operations | — | (0.01) | 0.05 | (0.01) | 0.05 |
| Net income | $2.59 | $1.91 | $2.29 | $2.58 | $1.67 |
| | | | | | |
| Cash dividends per common share [6] | $0.94 | $0.88 | $0.78 | $— | $— |
| | | | | | |
| Amounts attributable to HealthSouth: | | | | | |
| Income from continuing operations | $247.6 | $184.0 | $216.5 | $324.7 | $180.5 |
| (Loss) income from discontinued operations, net of tax | — | (0.9) | 5.5 | (1.1) | 4.5 |
| Net income attributable to HealthSouth | $247.6 | $183.1 | $222.0 | $323.6 | $185.0 |

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| | As of December 31, | | | | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2013 | 2012 |
| | (In Millions) | | | | |
| Balance Sheet Data: [1] | | | | | |
| Working capital | $178.9 | $172.3 | $322.3 | $268.8 | $335.9 |
| Total assets [7] | 4,681.9 | 4,606.1 | 3,388.3 | 2,514.1 | 2,402.4 |
| Long-term debt, including current portion [4] [7] | 3,016.4 | 3,171.5 | 2,111.2 | 1,497.2 | 1,231.7 |
| Convertible perpetual preferred stock [4] | — | — | 93.2 | 93.2 | 342.2 |
| HealthSouth shareholders' equity | 735.9 | 611.4 | 473.2 | 344.6 | 291.0 |

(1) As discussed in Note 2, Business Combinations, to the accompanying consolidated financial statements, we acquired the Encompass Home Health and Hospice business ("Encompass") of EHHI Holdings, Inc. on December 31, 2014. Because the acquisition took place on December 31, 2014, our consolidated results of operations prior to 2015 do not include any results of operations from Encompass. Assets acquired, liabilities assumed, and redeemable noncontrolling interests were recorded at their estimated fair values as of the acquisition date.

(2) We define operating earnings as income from continuing operations attributable to HealthSouth before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; (4) loss on interest rate swaps; and (5) income tax expense or benefit.

(3) For information related to our Provision for income tax expense, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and Note 15, Income Taxes, to the accompanying consolidated financial statements. During the second quarter of 2013, we entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008 and recorded a net income tax benefit of approximately $115 million.

(4) During the fourth quarter of 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our then outstanding 6.50% Series A Convertible Perpetual Preferred Stock. On April 23, 2015, we exercised our rights to force conversion of all remaining outstanding shares of our Convertible perpetual preferred stock into common stock. See Note 9, Long-term Debt and Note 16, Earnings per Common Share, to the accompanying consolidated financial statements.

(5) During 2016, we repurchased 1.7 million shares of our common stock in the open market for $65.6 million. During 2015, we repurchased 1.3 million shares of our common stock in the open market for $45.3 million. During 2014, we repurchased 1.3 million shares of our common stock in the open market for $43.1 million. In the first quarter of 2013, we completed a tender offer for our common stock whereby we repurchased approximately 9.1 million shares. See Note 16, Earnings per Common Share, to the accompanying consolidated financial statements.

(6) During the third quarter of 2013, our board of directors approved the initiation of a quarterly cash dividend on our common stock of $0.18 per share. In July 2014, our board of directors approved an increase in our quarterly cash dividend to $0.21 per share. In July 2015, our board of directors approved an increase in our quarterly cash dividend of $0.23 per share. In July 2016, our board of directors approved an increase in our quarterly cash dividend of $0.24 per share. See Note 16, Earnings per Common Share, to the accompanying consolidated financial statements.

(7) On December 31, 2014, we acquired Encompass. The total cash consideration delivered at closing was $695.5 million. We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. On October 1, 2015, we acquired Reliant Hospital Partners, LLC and affiliated entities. The total cash consideration delivered at closing was approximately $730 million. We funded the cash purchase price in the acquisition with proceeds from our August and September 2015 senior notes issuances and borrowings under our senior secured credit facility. On November 2, 2015, we acquired the home health agency operations of CareSouth Health System, Inc. The total cash consideration delivered at closing was approximately $170 million. We funded the cash purchase price with our term loan facility capacity and cash on hand. See Note 2, Business Combinations, and Note 9, Long-term Debt, to the accompanying consolidated financial statements.

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## 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") should be read in conjunction with the accompanying consolidated financial statements and related notes. This 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. 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 one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 35 states and Puerto Rico through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As discussed in this Item, "Segment Results of Operations," we manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. For additional information about our business, see Item 1, Business.

#### Inpatient Rehabilitation

We are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. We operate hospitals in 30 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. As of December 31, 2016, we operate 123 inpatient rehabilitation hospitals, including one hospital that operates as a joint venture which we account for using the equity method of accounting. In addition to HealthSouth hospitals, we manage five inpatient rehabilitation units through management contracts. Our inpatient rehabilitation segment represented approximately 81% of our Net operating revenues for the year ended December 31, 2016.

#### Home Health and Hospice

Our home health and hospice business is the nation's fourth largest provider of Medicare-certified skilled home health services in terms of revenues. We acquired EHHI Holdings, Inc. ("EHHI") and its Encompass Home Health and Hospice business ("Encompass") on December 31, 2014 and have since transitioned our previously existing HealthSouth home health operations to the Encompass platform and trade name. In the acquisition, we acquired, for cash, all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. ("Holdings"), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers were members of Encompass management, including April Anthony, the chief executive officer of Encompass. These sellers contributed a portion of their shares of common stock of EHHI in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. The total cash consideration delivered at closing was $695.5 million.

As of December 31, 2016, Encompass provides home health and hospice services in 223 locations across 25 states, with concentrations in the Southeast, Oklahoma, and Texas. In addition, two of these home health locations operate as joint ventures which we account for using the equity method of accounting. Our home health and hospice segment represented approximately 19% of our Net operating revenues for the year ended December 31, 2016.

See Item 1, Business, and Item 1A, Risk Factors, of this report, Note 2, Business Combinations, Note 9, Long-term Debt, and Note 18, Segment Reporting, to the accompanying consolidated financial statements, and the "Results of Operations" and "Liquidity and Capital Resources" sections of this Item.

#### 2016 Overview

Our 2016 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals, home health agencies, and hospice agencies;

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- expanding our services to more patients who require post-acute healthcare services by constructing and acquiring hospitals in new markets and acquiring home health and hospice agencies in new markets;
- continuing our shareholder distributions via common stock dividends and repurchases of our common stock; and
- positioning the Company for success in the evolving healthcare delivery system. This preparation includes continuing the installation of our electronic clinical information system ("ACE-IT") in our hospitals which allows for interfaces with all major acute care electronic medical record systems and health information exchanges and participating in bundling projects and Accountable Care Organizations ("ACOs").

During 2016, Net operating revenues increased by 17.2% over 2015 due primarily to our acquisitions of the operations of Reliant Hospital Partners, LLC and affiliated entities ("Reliant") on October 1, 2015 and CareSouth Health System, Inc. ("CareSouth") on November 2, 2015 (see Note 2, Business Combinations, to the accompanying consolidated financial statements).

Within our inpatient rehabilitation segment, discharge growth of 10.8% coupled with a 2.9% increase in net patient revenue per discharge in 2016 generated 13.9% growth in net patient revenue from our hospitals compared to 2015. Discharge growth included a 1.7% increase in same-store discharges. Within our home health and hospice segment, home health admission growth of 43.6% coupled with the impact of a 1.3% decrease in revenue per episode in 2016 generated 34.6% growth in home health and hospice revenue compared to 2015. Home health admission growth included a 13.7% increase in same-store admissions.

In 2016, we further positioned ourselves for the healthcare industry's movement to integrated delivery payment models, value-based purchasing, and post-acute site neutrality. We deployed and coordinated clinical protocols and discharge planning between our hospitals and home health agencies. We increased the clinical collaboration rate between our hospitals and our home health agencies. Within our inpatient rehabilitation segment, we initiated development of a predictive model to identify patients at risk for acute care transfer. We implemented a multidisciplinary medication reconciliation process using ACE-IT. Our hospitals and agencies also participated in bundling and ACO alternative payment models in various markets, and we developed a form of collaborator agreement to facilitate entering into arrangements with acute care hospitals participating in bundled payment projects. Many of our quality and outcome measures remained above both inpatient rehabilitation and home health industry averages, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), the United States Centers for Medicare and Medicaid Services ("CMS"), and Avalere Health and the Alliance for Home Health Quality and Innovation. Not only did we treat more patients and enhance outcomes, we did so in a cost-effective manner.

Likewise, our growth efforts continued to yield positive results in 2016. In our inpatient rehabilitation hospital segment, we:

- began operating the 27-bed inpatient rehabilitation hospital at CHI St. Vincent Hot Springs, a Catholic Health Initiatives' hospital, in Hot Springs, Arkansas with our joint venture partner, St. Vincent Community Health Services, Inc, in February 2016. The joint venture completed construction of a 40-bed hospital and transferred its operations on July 1, 2016;
- entered into an agreement, in July 2016, with Novant Health, Inc. to file a certificate of need ("CON") application to build a new 68-bed inpatient rehabilitation hospital in Winston-Salem, North Carolina. We were awarded a CON in November 2016 and expect construction of the new hospital to commence in the summer of 2017. The rehabilitation unit currently located at the Novant Health Rehabilitation Center in Winston-Salem will be relocated to the newly constructed hospital that is expected to be completed in the fourth quarter of 2018;
- entered into an agreement, in July 2016, with BJC HealthCare to file a CON application to build a 35-bed inpatient rehabilitation hospital on the third floor of BJC's Barnes-Jewish St. Peters Hospital located in St. Peters, Missouri. We were awarded a CON in September 2016 and construction of the new hospital commenced in October 2016. Construction is expected to be completed in the summer of 2017. The hospital will serve as a satellite location of the Rehabilitation Institute of St. Louis, an existing inpatient rehabilitation hospital we operate jointly with BJC HealthCare;
- began operating the 22-bed inpatient rehabilitation hospital at the Bernsen Rehabilitation Center at St. John, in Broken Arrow, Oklahoma with our joint venture partner, St. John Health System, in August 2016. The joint

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venture began construction of a 40-bed hospital in August 2016. We expect construction to be completed and operations to be transferred in the third quarter of 2017;

- began operating the new 49-bed inpatient rehabilitation hospital at CHI St. Joseph Health Rehabilitation Hospital in Bryan, Texas with our joint venture partner, St. Joseph's Health System, in August 2016;
- entered into an agreement, in August 2016, with Tidelands Health to jointly own and operate the existing 29-bed inpatient rehabilitation hospital currently located on the campus of Tidelands Waccamaw Community Hospital in Murrells Inlet, South Carolina. The joint venture's operation of this hospital is expected to begin in 2018 and is subject to customary closing conditions, including regulatory approvals. In addition, the joint venture will build, own, and operate a second, 46-bed inpatient rehabilitation hospital in Little River, South Carolina. Construction of the new hospital is expected to begin in 2017, subject to CON approval;
- began accepting patients at our new, 50-bed inpatient rehabilitation hospital in Modesto, California in October 2016;
- formed a joint venture, in December 2016, with Memorial Hospital at Gulfport to own and operate a 33-bed inpatient rehabilitation hospital in Gulfport, Mississippi. The joint venture's operation of the hospital is expected to begin in the second quarter of 2017, and is subject to customary closing conditions, including regulatory approvals;
- continued construction of our 60-bed joint venture hospital with Mount Carmel Health System in Westerville, Ohio. The joint venture's operation of the hospital is expected to begin in the second quarter of 2017;
- continued construction of our 48-bed joint venture hospital with West Tennessee Healthcare in Jackson, Tennessee. The joint venture's operation of the hospital is expected to begin in the third quarter of 2017;
- continued our capacity expansions by adding 83 new beds to existing hospitals; and
- continued development of the following de novo hospitals:

| Location | # of Beds | Actual / Expected Construction Start Date | Expected Operational Date |
|---|---|---|---|
| Pearland, Texas[1] | 40 | Q4 2016 | Q4 2017 |
| Shelby County, Alabama[2] | 34 | Q1 2017 | Q2 2018 |
| Hilton Head, South Carolina[3] | 38 | Q2 2017 | Q2 2018 |
| Murrieta, California[4] | 50 | First half of 2017 | Q4 2018 |

[1] In March 2016, we secured land and began the design and permitting process.
[2] In June 2016, we were awarded a CON, acquired land, and began the design and permitting process.
[3] In August 2016, we were awarded a CON, acquired land, and began the zoning, design, and permitting process.
[4] In August 2014, we acquired land and began the design and permitting process.

We also continued our growth efforts in our home health and hospice segment. During 2016, we:

- acquired, in May 2016, Home Health Agency of Georgia, LLC., a home health and hospice provider with two home health locations and two hospice locations in the Greater Atlanta area;
- began accepting patients at our new home health locations in Lee's Summit, Missouri in February 2016 and New Port Richey, Florida in May 2016;
- acquired, in July 2016, Advantage Health Inc., a home health provider with one location in Yuma, Arizona;
- acquired, in September 2016, three hospice agencies from Sotto International, Inc. located in Texarkana, Arkansas, Magnolia, Arkansas, and Texarkana, Texas;

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- began accepting patients at our new hospice location in Lee's Summit, Missouri in July 2016;
- acquired, in October 2016, two home health agencies from Summit Home Health Care, Inc. located in Cheyenne, Wyoming and Laramie, Wyoming;
- acquired, in October 2016, LightHouse Health Care, Inc., a home health provider with one location in Springfield, Virginia;
- acquired, in November 2016, Gulf City Home Care, Inc., a home health provider with one location in Sarasota, Florida;
- acquired, in November 2016, Honor Hospice, LLC, a hospice provider with one location in Wheat Ridge, Colorado; and
- began accepting patients at our new home health location in Georgetown, Texas and our new hospice location in Nashville, Tennessee in November 2016.

To support our growth efforts, we continued taking steps to further increase the strength and flexibility of our balance sheet. Specifically, we redeemed the outstanding principal balance of $176 million of the 7.75% Senior Notes due 2022 in March, May, and September of 2016. For additional information regarding these actions, see Note 9, Long-term Debt, to the accompanying consolidated financial statements and the "Liquidity and Capital Resources" section of this Item.

We also continued our shareholder distributions by repurchasing 1.7 million shares of our common stock in the open market for approximately $64 million during 2016. In addition, we continued paying a quarterly cash dividend of $0.23 per share on our common stock in the first three quarters of 2016. On July 21, 2016, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.24 per share that was paid on October 17, 2016, and we paid the same per share quarterly dividend on January 17, 2017. See the "Liquidity and Capital Resources" section of this Item.

Business Outlook

We believe our business outlook remains positive for two primary reasons. First, demographic trends, such as population aging, should increase long-term demand for facility-based and home-based post-acute services. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. We believe the demand for facility-based and home-based post-acute services will continue to increase as the U.S. population ages and life expectancies increase.

Second, we are an industry leader in the growing post-acute sector. As the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals, we believe we differentiate ourselves from our competitors based on our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, and the application of rehabilitative technology. As the fourth largest provider of Medicare-certified skilled home health services in terms of revenues, we believe we differentiate ourselves from our competitors by virtue of our scale and density in the markets we serve, the application of a highly integrated technology platform, our ability to manage a variety of care pathways, and a proven track record of consummating and integrating acquisitions.

We have invested considerable resources into clinical and management systems and protocols that have allowed us to consistently produce high-quality outcomes for our patients while continuing to contain cost growth. Our proprietary hospital management reporting system aggregates data from each of our key business systems into a comprehensive reporting package used by the management teams in our hospitals, as well as executive management, and allows them to analyze data and trends and create custom reports on a timely basis. Our commitment to technology also includes the on-going implementation of ACE-IT. As of December 31, 2016, we had installed this system in 101 of our 123 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. We believe this system will improve patient care and safety, enhance staff recruitment and retention, and set the stage for connectivity with other providers and health information exchanges. Our home health and hospice segment also uses information technology to enhance patient care and manage the business by utilizing Homecare Homebase$^{SM}$, a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. This allows our home health segment to manage the entire patient work flow and provide valuable data for health systems,

payors, and ACO partners. We are currently the home health provider to one ACO serving approximately 22,000 patients and are exploring several other participation opportunities.

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We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring home health and hospice agencies in that highly fragmented industry.

Longer-term, the nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain and will likely remain so for some time, as the development of new delivery and payment systems will almost certainly require significant time and resources. Furthermore, many of the alternative approaches being explored may not work as intended. However, as outlined in the "Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section below, our goal is to position the Company in a prudent manner to be responsive to industry shifts. We have invested in our core business and created an infrastructure that enables us to provide high-quality care on a cost-effective basis. We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2020. Our balance sheet remains strong and includes a substantial portfolio of owned real estate. We have significant availability under our revolving credit facility, and we continue to generate strong cash flows from operations. Importantly, we have flexibility with how we choose to deploy our cash and create value for shareholders, including bed expansions at existing inpatient rehabilitation hospital and de novos, acquisition and de novo construction of inpatient rehabilitation hospitals, home health agencies, and hospice agencies, repayments of long-term debt, common stock dividends, and repurchases of our common stock. While our financial leverage increased as a result of the acquisions in Note 2, Business Combinations, to the accompanying consolidated financial statements, we anticipate in the longer term reducing our financial leverage based on growth of Adjusted EBITDA and an allocation of a portion of our free cash flow to debt reduction. For these and other reasons, we believe we will be able to adapt to changes in reimbursement, sustain our business model, and grow through acquisition and consolidation opportunities as they arise.

Key Challenges

The healthcare industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the 2010 Healthcare Reform Laws (as defined in Item 1, Business, "Regulatory and Reimbursement Challenges") to identify and implement workable coordinated care and integrated delivery payment models. Successful healthcare providers are those who provide high-quality, cost-effective care and have the ability to adjust to changes in the regulatory and operating environments. We believe we have the necessary capabilities — scale, infrastructure, balance sheet, and management — to adapt to changes and continue to succeed in a highly regulated industry, and we have a proven track record of doing so.

As we continue to execute our business plan, the following are some of the challenges we face.

- Operating in a Highly Regulated Industry. We are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These rules and regulations have affected, or could in the future affect, our business activities by having an impact on the reimbursement we receive for services provided or the costs of compliance, mandating new documentation standards, requiring additional licensure or certification, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and limiting our ability to enter new markets or add new capacity to existing hospitals and agencies. Ensuring continuous compliance with extensive laws and regulations is an operating requirement for all healthcare providers.

We have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, and we are committed to continued adherence to these guidelines. More specifically, because Medicare comprises a significant portion of our Net operating revenues, it is particularly important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. If we were unable to remain compliant with these regulations, our financial position, results of operations, and cash flows could be materially, adversely impacted.

Concerns held by federal policymakers about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both, in 2017 and beyond. Additionally, many legislators in the United States House of Representatives and the United States

Senate continue to express the policy objective of modifying or repealing the 2010 Healthcare Reform Laws. The election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. At this time, it is unclear what, if any, of

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the Medicare-related changes may ultimately be enacted and signed into law by the President, but it is possible that any reductions in Medicare spending will have a material impact on reimbursements for healthcare providers generally and post-acute providers specifically. We cannot predict what, if any, changes in Medicare spending or modifications to the healthcare laws and regulations will result from future budget and other legislative initiatives.

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act, which repealed the statutory mechanism providing for annual automatic adjustments to the Medicare physician fee schedule using a sustainable growth rate formula that had historically resulted in annual deep cuts to physician reimbursement rates, a consequence of which has been the so-called "doc fixes" passed by Congress annually since 2002 to override those automatic adjustments. The primary impact of this act on post-acute care providers is a mandated market basket update of +1.0% in 2018 for rehabilitation hospitals as well as home health and hospice agencies.

Another challenge relates to reduced Medicare reimbursement, which is also discussed in Item 1A, Risk Factors. Unless the United States Congress acts to change or eliminate it, sequestration, which began affecting payments received after April 1, 2013, will continue to result in a 2% decrease to reimbursements otherwise due from Medicare, after taking into consideration other changes to reimbursement rates such as market basket updates.

The Medicare Payment Advisory Commission ("MedPAC") is an independent agency that advises Congress on issues affecting Medicare and makes payment policy recommendations to Congress and CMS for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"), the home health prospective payment system (the "HH-PPS") and the hospice prospective payment system (the "Hospice-PPS"). Congress and CMS are not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance those recommendations will be adopted. However, MedPAC's recommendations have, and may in the future, become the basis for subsequent legislative or regulatory action.

In March 2016, MedPAC released recommendations to eliminate the market basket update for each of the IRF-PPS, the HH-PPS, and the Hospice-PPS for 2017. In another recommendation affecting IRFs, MedPAC suggested increasing the IRF-PPS outlier payment pool. The final rule for the IRF-PPS discussed below did not follow MedPAC's recommendations to eliminate the market basket update or to increase the outlier pool. In a June 2016 report mandated by the IMPACT Act, MedPAC set out its evaluation of a unified payment system for all post-acute care ("PAC-PPS") in lieu of separate systems for IRFs, skilled nursing facilities, long-term acute care hospitals, and home health agencies. MedPAC found a PAC-PPS to be feasible and desireable but also suggested many existing regulatory requirements, including the IRF 60% rule (as defined in Item 1A, Risk Factors) and the requirement for a minimum of three hours of therapy per day, should be waived as part of implementing a PAC-PPS. MedPAC also suggested that ultimately Medicare should move from fee-for-service reimbursement to more integrated delivery payment models. In December 2016, MedPAC recommended a 5% reduction in both inpatient rehabilitation and home health reimbursement for 2018 and a two-year rebasing of home health reimbursement rates beginning in 2019. MedPAC also reiterated an increase to the outlier payment pool to be funded by reductions to base Medicare payments rates under the IRF-PPS. This proposal would adversely affect us as we have a relatively low percentage of outlier payments compared to other inpatient rehabilitation providers.

On July 29, 2016, CMS released its notice of final rulemaking for fiscal year 2017 for IRFs under the IRF-PPS (the "2017 IRF Rule"). The final rule will implement a net 1.65% market basket increase effective for discharges between October 1, 2016 and September 30, 2017, calculated as follows:

| | |
|---|---|
| Market basket update | 2.7% |
| Healthcare reform reduction | 75 basis points |
| Productivity adjustment | 30 basis points |

The final rule also includes other changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index values, changes to designations between rural and urban facilities, and updates to the outlier fixed loss threshold. The final rule also continues the freeze to the update to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, and teaching status adjustment factors. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period

prior to the final rule’s release and incorporates other adjustments included in

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the final rule, we believe the 2017 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2016, prior to the impact of sequestration.

Additionally, the 2017 IRF Rule contains changes that could affect us in future years. For example, CMS adopted five additional quality reporting measures, the reporting of which may require additional time and expense and could affect reimbursement beginning October 1, 2017.

Reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors ("MACs"), fiscal intermediaries and carriers, as well as the Office of Inspector General, CMS, and state Medicaid programs. Under programs designated as "widespread probes," certain of our MACs have conducted pre-payment claim reviews of our billings and denied payment for certain diagnosis codes. We dispute, or "appeal," most of these denials, and for claims we choose to take to administrative law judge hearings, we have historically experienced an approximate 70% success rate. The appeals process established by CMS has encountered significant delays in recent years. The resolution of these disputes can take in excess of three years. Currently, we have appeals being heard that have been pending for up to five years. The majority of the denials we have encountered in these probes derive from one MAC. In connection with recent probes, this MAC has made determinations regarding medical necessity which represent its uniquely restrictive interpretations of the CMS coverage rules. We continue to discuss our objections to those interpretations with both the MAC and CMS. We cannot predict what, if any, changes will result from those discussions. If the MAC continues to deny a significant number of claims for certain diagnosis codes, we may experience increases in the Provision for doubtful accounts, decreases in cash flow as a result of increasing accounts receivable, and/or a shift in the patients and conditions we treat, any of which could have an adverse effect on our financial position, results of operations, and liquidity. In December 2016, the presiding federal district court judge in the lawsuit ordered HHS to reduce the backlog of appeals by 30% by the end of 2017, by 60% by the end of 2018, by 90% by the end of 2019, and completely by the end of 2020. HHS has appealed the federal district court decision. On January 17, 2017, CMS published a rule implementing procedural and administrative changes to the appeals process, but it is unclear what, if any, impact these changes will have on the backlog. This new rule may be subject to legal challenge by healthcare providers as well. We cannot predict what, if any, further action CMS will take to reduce the backlog.

On November 16, 2015, CMS published its final rule establishing the Comprehensive Care for Joint Replacement ("CJR") bundled payment model. This mandatory model holds acute care hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for lower extremity joint replacements (i.e., knees and hips) from surgery through recovery. During the CJR model's five-year term, which began on April 1, 2016, healthcare providers in 67 geographic areas ("MSAs") will continue to be paid under existing Medicare payment systems. However, the hospital where the joint replacement takes place will be held accountable for the quality and costs of care for the entire episode of care — from the time of the original admission through 90 days after discharge. Depending on the quality and cost performance during the entire episode, the hospital may receive an additional payment or be required to repay Medicare for a portion of the episode costs. Under this model, hospitals had no repayment responsibility, or downside financial risk, for 2016. However, they do have downside risk beginning in 2017. As a result, CMS believes acute care hospitals would be incented to work with physicians and post-acute care providers to ensure beneficiaries receive the coordinated care they need in an efficient manner. Acute care hospitals participating in the CJR model may enter into risk-sharing financial arrangements with post-acute providers, including IRFs and home health agencies. We believe its impact will be positive for HealthSouth as it should favor high-quality, low-cost providers like us who have made significant commitments to information systems that enable and enhance connectivity. We also believe the rule further validates our movement into home health via the acquisition of Encompass. Currently, lower extremity joint replacement patients represent less than 8% of our total annual discharges due to our required compliance with the 60% rule. Given the 67 MSAs included in the CJR model, our patients potentially subject to this model represent approximately 2.1% of our annual Medicare discharges. The lower extremity joint replacement patients we do treat are generally higher acuity and possess significant comorbidities. In these cases and in any risk-bearing bundling initiative, quality of outcomes is critical to achieving targeted financial results.

On January 3, 2017, CMS published its final rule providing for the creation and testing of three new episode payment models ("EPMs") as well as modification of the CJR model. The three new Medicare EPMs are: (1) acute myocardial infarction model, (2) coronary artery bypass graft ("CABG") model, and (3) surgical hip/femur fracture treatment excluding lower extremity joint replacement ("SHFFT") model. Most relevant to us are the mandatory CABG and SHFFT models which are set to begin July 1, 2017 and continue through the end of

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2021. Under these models, as with the CJR model, acute care hospitals are financially accountable for the quality and cost of an episode of care, which is intended to incentivize increased coordination of care among hospitals, physicians, and post-acute care providers. The SHFFT model covers the same 67 MSAs as the CJR model (HealthSouth is located in 36 of these MSAs), and the CABG model covers 98 MSAs (HealthSouth is located in 40 of these MSAs). Our patients potentially subject to the CABG model represent approximately 0.7% of our annual Medicare discharges. Our patients potentially subject to the SHFFT model represent approximately 1.2% of our annual Medicare discharges incremental to the above CJR program.

On October 31, 2016, CMS released its notice of final rulemaking for calendar year 2017 for home health agencies under the HH-PPS (the "2017 HH Rule"). Specifically, while the final rule provides for a market basket update of 2.8%, that update is offset by a 2.3% rebasing adjustment reduction (the last year of a four-year phase-in), a productivity adjustment reduction of 30 basis points, an outlier fixed dollar loss adjustment of 0.1%, and a coding intensity reduction of 0.9% (the second year of a three-year phase-in). We believe the 2017 HH Rule will result in a net decrease to Encompass' Medicare payment rates of approximately 3.6% effective for episodes ending in calendar year 2017. The net decrease to Encompass' Medicare payment rates is primarily due to a 0.9% case mix re-weighting and 2.0% for the change in the outlier calculation methodology. The 2017 HH Rule had an approximate $1.5 million negative impact on revenues in the fourth quarter of 2016 applicable to episodes that began in 2016 and ended in 2017. Additionally, the 2017 HH Rule requires us to report four new quality measures, the reporting of which will require additional time and expense and could affect reimbursement beginning in 2018.

On June 8, 2016, CMS implemented a new pre-claim review demonstration of home health services in five states for a period of three years. Encompass operates in three of these states (Florida, Texas, and Massachusetts). In the pre-claim review demonstration project, CMS proposes to have Medicare contractors collect additional information from home health providers submitting claims in order to determine proper payment or if there is a suspicion of fraud. The project began in Illinois on August 3, 2016. Because of difficulties encountered in administering the project, the start date in Florida was delayed to April 1, 2017. The start dates for the other states have not been announced. Approximately 48% of Encompass' Medicare claims are submitted by agencies in these three states (primarily Texas and Florida). This pre-claim demonstration project will require us to incur additional administrative and staffing costs and may impact the timeliness of claims payment given that fiscal intermediaries in Illinois have had difficulty processing pre-claim reviews on a timely basis. Accordingly, if the roll out project is not delayed or canceled, we may experience temporary increases in the Provision for doubtful accounts and decreases in cash flow or we may incur costs associated with patient care, the Medicare claim for which is subsequently denied, each of which could have an adverse effect on our financial position, results of operations, and liquidity.

See also Item 1, Business, "Sources of Revenues" and "Regulation," and Item 1A, Risk Factors, to this report and Note 17, Contingencies and Other Commitments, "Governmental Inquiries and Investigations," to the accompanying consolidated financial statements.

Changes to Our Operating Environment Resulting from Healthcare Reform. Our challenges related to healthcare reform are discussed in Item 1, Business, "Sources of Revenues," and Item 1A, Risk Factors. Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notably for us are

- the reductions to our hospitals' annual market basket updates, including productivity adjustments, mandated reductions to home health and hospice Medicare reimbursements, and future payment reforms such as ACOs and bundled payments.

While the change in administrations has added to regulatory uncertainty, the healthcare industry in general has been facing uncertainty associated with the efforts to identify and implement workable coordinated care and integrated delivery payment models. In these models, hospitals, physicians, and other care providers work together to provide coordinated healthcare on a more efficient, patient-centered basis. These providers are then paid based on the overall value and quality of the services they provide to a patient rather than the number of services they provide. While this is consistent with our goal and proven track record of being a high-quality, cost-effective provider, broad-based implementation of a new delivery model would represent a significant transformation for the healthcare industry. As the industry and its regulators explore this transformation, we are positioning the Company in preparation for whatever changes are ultimately made to the delivery system.

- We have a track record of successful partnerships with acute care providers. Thirty-seven of our hospitals already operate as joint ventures with acute care hospitals, and we continue to pursue joint ventures as one of

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our growth initiatives. These joint ventures create an immediate link to an acute care system and position us to quickly and efficiently integrate our services in a coordinated care model.

- Our commitment to coordinated care is demonstrated and enhanced by the utilization of technology. Our hospital electronic clinical information system is capable of interfaces with all major acute care electronic medical record systems and health information exchanges making communication easier across the continuum of healthcare providers. Our home health and hospice clinical information system utilizes a leading home care technology that manages the entire patient work flow. Importantly, we have the ability to use data from both systems to develop clinical protocol best practices.
- Our balance sheet is strong, and we have consistently strong free cash flows. We have no significant debt maturities prior to 2020, and we have significant liquidity under our revolving credit facility. In addition, we own the real estate associated with approximately 69% of our hospitals.
- We have a proven track record of being a high-quality, cost-effective provider. The FIM® Gains (a tool based on an 18-point assessment used to measure functional independence from admission to discharge) at our inpatient rehabilitation hospitals consistently exceed industry results, and the 30-day readmission rates at our home health agencies are lower than the national average. In addition, we have the scale and operating leverage to generate a low cost per discharge/visit.
- The combination of home health and hospice with our existing inpatient rehabilitative healthcare services provides us with an increased opportunity to succeed in value-based purchasing programs and to participate in more coordinated care and integrated delivery payment models, such as ACOs and bundled payment arrangements. We believe enhanced clinical collaboration between our hospitals and home health agencies offers an excellent means to deliver the quality of care and the cost effectiveness that these new models require to be successful. Since partnering with Encompass, we have focused, and will continue to focus, on increasing this collaboration. We are currently participating in several coordinated care delivery model initiatives and are exploring ACO participation in several others. Eight of our IRFs began participating in Phase 2, the "at-risk" phase, of Model 3 of CMS' Bundled Payments for Care Improvement ("BPCI") initiative in 2015. We also have several IRFs that have signed participation agreements with acute care providers participating in Model 2 of the BPCI initiative. Ten of our home health agencies began participating in Phase 2 of Model 3 of the BPCI initiative in 2014. As of December 31, 2016, 38 home health agencies participate in Phase 2. In addition, we have partnered as the home health provider with Premier PHC™, an ACO serving approximately 22,000 Medicare patients.

Given the complexity and the number of changes in the 2010 Healthcare Reform Laws and other pending regulatory initiatives, we cannot predict their ultimate impact. Furthermore, the election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. Therefore, the ultimate nature and timing of the transformation of the healthcare delivery system is uncertain, and will likely remain so for some time. We will continue to evaluate these laws and position the Company for this industry shift. Based on our track record, we believe we can adapt to these regulatory and industry changes. Further, we have engaged, and will continue to engage, actively in discussions with key legislators and regulators to attempt to ensure any healthcare laws or regulations adopted or amended promote our goal of high-quality, cost-effective care.

Additionally, in October 2014, President Obama signed into law the IMPACT Act. The IMPACT Act was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees' solicitation of post-acute payment reform ideas and proposals. It directs the United States Department of Health and Human Services ("HHS"), in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the development of a new post-acute payment system, we believe this act will lay the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided, also referred to as "site neutral" reimbursement. It will also create additional data reporting requirements for our hospitals and home health agencies, and we expect to fully comply with these requirements. The precise details of

these new reporting requirements, including timing and content, will be developed and implemented by CMS through the regulatory process that we expect will take place over the next several years. While we cannot quantify the potential financial effects of the IMPACT Act on HealthSouth, we believe any post-acute payment system that is data-driven and focuses on the needs and

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underlying medical conditions of post-acute patients ultimately will be a net positive for providers who offer high-quality, cost-effective care. However, it will likely take years for the related quality measures to be established, quality data to be gathered, standardized patient assessment data to be assembled and disseminated, and potential payment policies to be developed, tested, and promulgated. As the nation's largest owner and operator of inpatient rehabilitation hospitals and fourth largest provider of Medicare-certified skilled home health services, we will work with HHS, MedPAC, and other healthcare stakeholders on these initiatives.

- Maintaining Strong Volume Growth. Various factors, including competition and increasing regulatory and administrative burdens, may impact our ability to maintain and grow our hospital, home health, and hospice volumes. In any particular market, we may encounter competition from local or national entities with longer operating histories or other competitive advantages, such as acute care hospitals who provide post-acute services similar to ours or other post-acute providers with relationships with referring acute care hospitals or physicians. Aggressive payment review practices by Medicare contractors, aggressive enforcement of regulatory policies by government agencies, and restrictive or burdensome rules, regulations or statutes governing admissions practices may lead us to not accept patients who would be appropriate for and would benefit from the services we provide. In addition, from time to time, we must get regulatory approval to expand our services and locations in states with certificate of need laws. This approval may be withheld or take longer than expected. In the case of new-store volume growth, the addition of hospitals, home health agencies, and hospice agencies to our portfolio also may be difficult and take longer than expected.
- Recruiting and Retaining High-Quality Personnel. See Item 1A, Risk Factors, for a discussion of competition for staffing, shortages of qualified personnel, and other factors that may increase our labor costs. Recruiting and retaining qualified personnel for our inpatient hospitals and home health and hospice agencies remain a high priority for us. We attempt to maintain a comprehensive compensation and benefits package that allows us to remain competitive in this challenging staffing environment while remaining consistent with our goal of being a high-quality, cost-effective provider of inpatient rehabilitative services.

See also Item 1, Business, and Item 1A, Risk Factors.

These key challenges notwithstanding, we believe we have a strong business model, a strong balance sheet, and a proven track record of achieving strong financial and operational results. We are attempting to position the Company to respond to changes in the healthcare delivery system and believe we will be in a position to take advantage of any opportunities that arise as the industry moves to this new stage. We believe we are positioned to continue to grow, adapt to external events, and create value for our shareholders in 2017 and beyond.

Results of Operations

Payor Mix

During 2016, 2015, and 2014, we derived consolidated Net operating revenues from the following payor sources:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Medicare | 75.2 % | 74.9 % | 74.1 % |
| Medicare Advantage | 7.9 % | 7.9 % | 7.4 % |
| Managed care | 9.8 % | 9.8 % | 11.2 % |
| Medicaid | 3.2 % | 3.0 % | 1.8 % |
| Other third-party payors | 1.4 % | 1.7 % | 1.8 % |
| Workers' compensation | 0.8 % | 0.9 % | 1.2 % |
| Patients | 0.5 % | 0.6 % | 1.0 % |
| Other income | 1.2 % | 1.2 % | 1.5 % |
| Total | 100.0% | 100.0% | 100.0% |

Our payor mix is weighted heavily towards Medicare. We receive Medicare reimbursements under the IRF-PPS, the HH-PPS, and the Hospice-PPS. For additional information regarding Medicare reimbursement, see the "Sources of Revenues" section of Item 1, Business.

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As part of the Balanced Budget Act of 1997, Congress created a program of private, managed healthcare coverage for Medicare beneficiaries. This program has been referred to as Medicare Part C, or "Medicare Advantage." The program offers beneficiaries a range of Medicare coverage options by providing a choice between the traditional fee-for-service program (under Medicare Parts A and B) or enrollment in a health maintenance organization, preferred provider organization, point-of-service plan, provider sponsor organization, or an insurance plan operated in conjunction with a medical savings account.

Our consolidated Net operating revenues consist primarily of revenues derived from patient care services and home health and hospice services. Net operating revenues also include other revenues generated from management and administrative fees and other nonpatient care services. These other revenues are included in "other income" in the above table.

Our Results

From 2014 through 2016, our consolidated results of operations were as follows:

| | For the Year Ended December 31, | | | Percentage Change | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2016 vs. 2015 | 2015 vs. 2014 |
| | (In Millions) | | | | |
| Net operating revenues | $3,707.2 | $3,162.9 | $2,405.9 | 17.2 % | 31.5 % |
| Less: Provision for doubtful accounts | (61.2) | (47.2) | (31.6) | 29.7 % | 49.4 % |
| Net operating revenues less provision for doubtful accounts | 3,646.0 | 3,115.7 | 2,374.3 | 17.0 % | 31.2 % |
| Operating expenses: | | | | | |
| Salaries and benefits | 1,985.9 | 1,670.8 | 1,161.7 | 18.9 % | 43.8 % |
| Other operating expenses | 492.1 | 432.1 | 351.6 | 13.9 % | 22.9 % |
| Occupancy costs | 71.3 | 53.9 | 41.6 | 32.3 % | 29.6 % |
| Supplies | 140.0 | 128.7 | 111.9 | 8.8 % | 15.0 % |
| General and administrative expenses | 133.4 | 133.3 | 124.8 | 0.1 % | 6.8 % |
| Depreciation and amortization | 172.6 | 139.7 | 107.7 | 23.6 % | 29.7 % |
| Government, class action, and related settlements | — | 7.5 | (1.7) | (100.0)% | (541.2)% |
| Professional fees—accounting, tax, and legal | 1.9 | 3.0 | 9.3 | (36.7)% | (67.7)% |
| Total operating expenses | 2,997.2 | 2,569.0 | 1,906.9 | 16.7 % | 34.7 % |
| Loss on early extinguishment of debt | 7.4 | 22.4 | 13.2 | (67.0)% | 69.7 % |
| Interest expense and amortization of debt discounts and fees | 172.1 | 142.9 | 109.2 | 20.4 % | 30.9 % |
| Other income | (2.9) | (5.5) | (31.2) | (47.3)% | (82.4)% |
| Equity in net income of nonconsolidated affiliates | (9.8) | (8.7) | (10.7) | 12.6 % | (18.7)% |
| Income from continuing operations before income tax expense | 482.0 | 395.6 | 386.9 | 21.8 % | 2.2 % |
| Provision for income tax expense | 163.9 | 141.9 | 110.7 | 15.5 % | 28.2 % |
| Income from continuing operations | 318.1 | 253.7 | 276.2 | 25.4 % | (8.1)% |
| (Loss) income from discontinued operations, net of tax | — | (0.9) | 5.5 | (100.0)% | (116.4)% |
| Net income | 318.1 | 252.8 | 281.7 | 25.8 % | (10.3)% |
| Less: Net income attributable to noncontrolling interests | (70.5) | (69.7) | (59.7) | 1.1 % | 16.8 % |
| Net income attributable to HealthSouth | $247.6 | $183.1 | $222.0 | 35.2 % | (17.5)% |

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Provision for Doubtful Accounts and Operating Expenses as a % of Net Operating Revenues

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Provision for doubtful accounts | 1.7 % | 1.5 % | 1.3 % |
| Operating expenses: | | | |
| Salaries and benefits | 53.6% | 52.8% | 48.3 % |
| Other operating expenses | 13.3% | 13.7% | 14.6 % |
| Occupancy costs | 1.9 % | 1.7 % | 1.7 % |
| Supplies | 3.8 % | 4.1 % | 4.7 % |
| General and administrative expenses | 3.6 % | 4.2 % | 5.2 % |
| Depreciation and amortization | 4.7 % | 4.4 % | 4.5 % |
| Government, class action, and related settlements | — % | 0.2 % | (0.1 )% |
| Professional fees—accounting, tax, and legal | 0.1 % | 0.1 % | 0.4 % |
| Total operating expenses | 80.8% | 81.2% | 79.3 % |

In the discussion that follows, we use “same-store” comparisons to explain the changes in certain performance metrics and line items within our financial statements. We calculate same-store comparisons based on hospitals open throughout both the full current period and prior periods presented. These comparisons include the financial results of market consolidation transactions in existing markets, as it is difficult to determine, with precision, the incremental impact of these transactions on our results of operations.

2016 Compared to 2015

Net Operating Revenues

Our consolidated Net operating revenues increased in 2016 compared to 2015 primarily from strong volume growth in both of our operating segments and included the effect of our acquisitions of Reliant on October 1, 2015 and CareSouth on November 2, 2015. See additional discussion in the “Segment Results of Operations” section of this Item.

Provision for Doubtful Accounts

The change in our Provision for doubtful accounts as a percent of Net operating revenues in 2016 compared to 2015 was primarily due to aging-based reserves resulting from continued administrative payment delays at our largest MAC. For additional information, see Item 1, Business, “Sources of Revenues—Medicare Reimbursement,” of this report.

Salaries and Benefits

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

Salaries and benefits increased in 2016 compared to 2015 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2015 development activities, the acquisitions of Reliant and CareSouth, a salary increase given to all eligible nonmanagement hospital employees effective in October of each year, and an increase in benefit costs.

Salaries and benefits as a percent of Net operating revenues increased during 2016 compared to 2015 primarily as a result of salary and benefit cost increases, Medicare home health reimbursement rate cuts, and the ramping up of new hospitals in Franklin, Tennessee, Hot Springs, Arkansas, Bryan, Texas, Broken Arrow, Oklahoma, and Modesto, California.

We provided a 2.75% salary increase to our nonmanagement hospital employees effective October 1, 2016.

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Other Operating Expenses

Other operating expenses include costs associated with managing and maintaining our hospitals and home health and hospice agencies. These expenses include such items as contract services, utilities, non-income related taxes, insurance, professional fees, and repairs and maintenance.

Other operating expenses increased during 2016 compared to 2015 primarily due to the acquisitions of Reliant and CareSouth and increased patient volumes at our hospitals offset by a $3.3 million gain from the divestiture of our home health pediatric services in November 2016. See Note 18, Segment Reporting, to the accompanying consolidated financial statements. Other operating expenses during 2015 included the settlement of an employee sexual harassment matter that was not covered by insurance.

As a percent of Net operating revenues, Other operating expenses decreased during 2016 compared to 2015 due to our increasing revenues, primarily as a result of the acquisitions of Reliant and CareSouth, and to the aforementioned divestiture and settlement.

Occupancy costs

Occupancy costs include amounts paid for rent associated with leased hospitals, outpatient rehabilitation satellite clinics, and home health and hospice agencies, including common area maintenance and similar charges. Occupancy costs increased during 2016 compared to 2015 in terms of dollars and as a percent of Net operating revenues due to the acquisition of Reliant, which leased all of its hospitals.

Supplies

Supplies expense includes all costs associated with supplies used while providing patient care. Specifically, these costs include pharmaceuticals, food, needles, bandages, and other similar items. Supplies increased during 2016 compared to 2015 due primarily to increased patient volumes. Supplies decreased as a percent of Net operating revenues during 2016 compared to 2015 primarily due to supply chain efficiencies including the continued transition of brand name drugs to generic.

General and Administrative Expenses

General and administrative expenses primarily include administrative expenses such as information technology services, human resources, corporate accounting, legal services, and internal audit and controls that are managed from our home office in Birmingham, Alabama. These expenses also include stock-based compensation expenses and transaction costs associated with our acquisitions of Reliant and CareSouth in 2015.

General and administrative expenses increased in 2016 compared to 2015 due primarily to increased corporate full time equivalents, benefit costs, and stock compensation expenses offset by transaction costs related to the acquisitions of Reliant and CareSouth. General and administrative expenses decreased as a percent of Net operating revenues in 2016 compared to 2015 primarily due to our increasing revenues, primarily as a result of the acquisitions of Reliant and CareSouth.

Depreciation and Amortization

Depreciation and amortization increased during 2016 compared to 2015 due to our acquisitions and capital expenditures throughout 2015 and 2016. We expect Depreciation and amortization to increase going forward as a result of our recent and ongoing capital investments.

Government, Class Action, and Related Settlements

The loss included in Government, Class Action, and Related Settlements in 2015 resulted from a settlement discussed in Note 17, Contingencies and Other Commitments, to the consolidated financial statements accompanying our Annual Report on Form 10-K for the year ended December 31, 2015 (the “2015 Form 10 K”).

Professional Fees — Accounting, Tax, and Legal

Professional fees—accounting, tax, and legal for 2016 and 2015 related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements, and Note 17, Contingencies and Other Commitments, to the consolidated financial statements accompanying the 2015 Form 10-K.

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Loss on Early Extinguishment of Debt

The Loss on early extinguishment of debt during 2016 resulted from the redemptions of our 7.75% Senior Notes due 2022 in March, May, and September of 2016.

In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount and used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility. As a result of the term loan prepayment, we recorded a $1.2 million Loss on early extinguishment of debt in the first quarter of 2015.

In April 2015, we used the net proceeds from the offering of 5.125% Senior Notes due 2023 along with cash on hand to execute the redemption of our 8.125% Senior Notes due 2020. As a result of this redemption, we recorded an $18.8 million Loss on early extinguishment of debt in the second quarter of 2015.

In November 2015, we used borrowings under our senior secured credit facility to execute the redemption of $50 million of the outstanding principal amount of our existing 7.75% Senior Notes due 2022. As a result of this redemption, we recorded an $2.4 million Loss on early extinguishment of debt in the fourth quarter of 2015.

See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in Interest expense and amortization of debt discounts and fees in 2016 compared to 2015 resulted from an increase in average borrowings due to our use of debt to fund the acquisitions of Reliant and CareSouth. Our average cash interest rate remained relatively flat during 2016 compared to 2015. Cash paid for interest approximated $164 million and $121 million in 2016 and 2015, respectively.

See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Other Income

Other income for 2015 included a $1.2 million realized gain from the sale of all the common stock of Surgical Care Affiliates (“SCA”), our former surgery centers division and a $2.0 million gain related to the increase in fair value of our option to purchase up to a 5% equity interest in SCA from April 1, 2015 (the date it became exercisable) to April 13, 2015 (the date we exercised the option). See Note 12, Fair Value Measurements, to the consolidated financial statements accompanying the 2015 Form 10 K.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations in 2016 increased compared to 2015 due to increased Net operating revenues primarily as a result of the acquisitions of Reliant and CareSouth.

Provision for Income Tax Expense

Due to our federal and state net operating losses (“NOLs”), our cash income taxes approximated $31.9 million, net of refunds, in 2016. These payments resulted from state income tax expense of subsidiaries which have separate state filing requirements and federal income taxes based upon alternative minimum taxes, tax planning opportunities, the utilization of the remaining federal NOL balance, and the availability of other federal tax credits. In 2017, we estimate we will pay approximately $120 million to $175 million of cash income taxes, net of refunds. In 2016 and 2015, current income tax expense was $31.0 million and $14.8 million, respectively.

Our effective income tax rate for 2016 was 34.0%. The Provision for income tax expense in 2016 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests offset by (2) state and other income tax expense. See Note 1, Summary of Significant Accounting Policies, “Income Taxes,” for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion.

Our effective income tax rate for 2015 was 35.9%. Our Provision for income tax expense in 2015 was greater than the federal statutory rate of 35% primarily due to: (1) state and other income tax expense and (2) an increase in our valuation allowance offset by (3) the impact of noncontrolling interests. The increase in our valuation allowance in 2015 related primarily to changes to our state apportionment percentages resulting from the acquisitions of Encompass, Reliant, and CareSouth and changes to our current forecast of earnings in each jurisdiction.

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During the third quarter of 2016, we filed an automatic tax accounting method change related to the deductibility of bad debts pursuant to the non-accrual experience method which resulted in a tax benefit of approximately $7 million. This change did not have a material impact on our effective tax rate. We also filed a non-automatic tax accounting method change related to billings denied under pre-payment claims reviews conducted by certain of our MACs. If our request for the non-automatic tax accounting change is accepted as filed, we estimate realization of additional tax benefits of approximately $53 million through December 31, 2016. Approximately $44 million of this amount represents pre-payment claims denials received in years prior to and including the year ended December 31, 2015. This change, if approved, is not expected to have a material impact on our effective tax rate, but will impact the payment of cash income taxes in 2017.

In certain state jurisdictions, we do not expect to generate sufficient income to use all of the available NOLs prior to their expiration. This determination is based on our evaluation of all available evidence in these jurisdictions including results of operations during the preceding three years, our forecast of future earnings, and prudent tax planning strategies. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdiction, or if the timing of future tax deductions differs from our expectations.

We recognize the financial statement effects of uncertain tax positions when it is more likely than not, based on the technical merits, a position will be sustained upon examination by and resolution with the taxing authorities. Total remaining gross unrecognized tax benefits were $2.8 million and $2.9 million as of December 31, 2016 and 2015, respectively.

See Note 15, Income Taxes, to the accompanying consolidated financial statements and the “Critical Accounting Estimates” section of this Item.

2015 Compared to 2014

Net Operating Revenues

Our consolidated Net operating revenues increased in 2015 compared to 2014 primarily from strong volume growth in both of our operating segments and included the effect of our acquisitions of Encompass, Reliant, and CareSouth. See additional discussion in the “Segment Results of Operations” section of this Item.

Provision for Doubtful Accounts

The change in our Provision for doubtful accounts as a percent of Net operating revenues in 2015 compared to 2014 primarily resulted from an increase in pre-payment claims denials by MACs, and continued substantial delays (exceeding three years) in the adjudication process at the administrative law judge hearing level.

Salaries and Benefits

Salaries and benefits increased in 2015 compared to 2014 primarily due to increased patient volumes, a 2.25% salary increase given to all eligible nonmanagement hospital employees effective October 1, 2014, and an increase in benefit costs. Increased patient volumes included an increase in the number of full-time equivalents as a result of our hospital development activities and the acquisitions of Encompass, Reliant, and CareSouth. Full-time equivalents also increased due to hospital staffing additions to ensure compliance with new Medicare quality reporting requirements and the creation of a new medical services department.

Salaries and benefits as a percent of Net operating revenues increased during 2015 compared to 2014 primarily as a result of the acquisition of Encompass, the pricing impact of proportionally higher discharge growth from payors where our reimbursement is lower (as discussed in this Item, “Segment Results of Operations—Inpatient Rehabilitation—Net Operating Revenues”), an increase in benefit costs, ramp-up costs associated with our de novo hospitals that opened in the fourth quarter of 2014, and the additional staff associated with Medicare quality reporting and the medical services department. In addition, 2015 also included the pricing impact of updated Supplemental Security Income (“SSI”) ratios (as discussed in this Item, “Segment Results of Operations—Inpatient Rehabilitation—Net Operating Revenues”).

We provided a 2.5% merit increase to our nonmanagement hospital employees effective October 1, 2015.

Other Operating Expenses

Other operating expenses increased during 2015 compared to 2014 primarily due to the acquisition of Encompass, increased patient volumes at our hospitals, and the ongoing implementation of our clinical information system. As a

percent of

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Net operating revenues, Other operating expenses decreased during 2015 compared to 2014 due to increased revenues, primarily as a result of the acquisition of Encompass.

Occupancy costs

Occupancy costs remained flat as a percent of Net operating revenues in 2015 compared to 2014 due to our increasing revenue, primarily as a result of the acquisition of Encompass.

Supplies

Supplies expense decreased as a percent of Net operating revenues in 2015 compared to 2014 primarily due to our increasing revenue, primarily as a result of the acquisition of Encompass.

General and Administrative Expenses

General and administrative expenses increased in 2015 compared to 2014 due primarily to increased expenses associated with stock-based compensation and higher transaction costs. General and administrative expenses decreased as a percent of Net operating revenues in 2015 compared to 2014 primarily due to our increasing revenue, primarily as a result of the acquisition of Encompass.

Depreciation and Amortization

Depreciation and amortization increased during 2015 compared to 2014 due to our acquisitions and capital expenditures throughout 2014 and 2015.

Government, Class Action, and Related Settlements

The loss included in Government, Class Action, and Related Settlements in 2015 resulted from a settlement discussed in Note 17, Contingencies and Other Commitments, to the consolidated financial statements accompanying the 2015 Form 10 K.

Professional Fees — Accounting, Tax, and Legal

Professional fees—accounting, tax, and legal for 2015 and 2014 related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 17, Contingencies and Other Commitments, to the consolidated financial statements accompanying the 2015 Form 10 K.

Loss on Early Extinguishment of Debt

In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount and used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility. As a result of the term loan prepayment, we recorded a $1.2 million Loss on early extinguishment of debt in the first quarter of 2015.

In April 2015, we used the net proceeds from the offering of 5.125% Senior Notes due 2023 along with cash on hand to execute the redemption of our 8.125% Senior Notes due 2020. As a result of this redemption, we recorded an $18.8 million Loss on early extinguishment of debt in the second quarter of 2015.

In November 2015, we used borrowings under our senior secured credit facility to execute the redemption of $50 million of the outstanding principal amount of our existing 7.75% Senior Notes due 2022. As a result of this redemption, we recorded an $2.4 million Loss on early extinguishment of debt in the fourth quarter of 2015.

The Loss on early extinguishment of debt in 2014 resulted from the redemption of our 7.25% Senior Notes due 2018 and the redemption of 10% of the outstanding principal amount of our 7.75% Senior Notes due 2022 in the fourth quarter of 2014.

See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in Interest expense and amortization of debt discounts and fees in 2015 compared to 2014 resulted from an increase in average borrowings offset by a lower average cash interest rate. Average borrowings increased due to our use of

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debt to fund the acquisitions of Encompass, Reliant, and CareSouth. Our average cash interest rate decreased from 6.3% in 2014 to 5.3% in 2015 due to the redemption of our 7.25% Senior Notes due 2018 in October 2014, the redemption of approximately $25 million of our 7.75% Senior Notes due 2022 in December 2014, and the redemption of our 8.125% Senior Notes due 2020 in April 2015. Cash paid for interest approximated $121 million and $101 million in 2015 and 2014, respectively. See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Other Income

Other income for 2015 included a $1.2 million realized gain from the sale of all the common stock of SCA, our former surgery centers division and a $2.0 million gain related to the increase in fair value of our option to purchase up to a 5% equity interest in SCA from April 1, 2015 (the date it became exercisable) to April 13, 2015 (the date we exercised the option). See Note 12, Fair Value Measurements, to the accompanying consolidated financial statements.

Other income for 2014 included a $27.2 million gain related to the acquisition of an additional 30% equity interest in Fairlawn. See Note 2, Business Combinations, to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations in 2015 increased compared to 2014 due to increased Net operating revenues primarily as a result of the acquisitions of Encompass, Reliant, and CareSouth. Our pre-tax income from continuing operations for 2014 included the $27.2 million gain on the consolidation of Fairlawn.

Provision for Income Tax Expense

As discussed above, our effective income tax rate for 2015 was 35.9%. Our Provision for income tax expense in 2015 was greater than the federal statutory rate of 35% primarily due to: (1) state and other income tax expense and (2) an increase in our valuation allowance offset by (3) the impact of noncontrolling interests.

Our effective income tax rate for 2014 was 28.6%. Our Provision for income tax expense in 2014 was less than the federal statutory rate of 35% primarily due to: (1) the impact of noncontrolling interests, (2) the nontaxable gain discussed in Note 2, Business Combinations, related to our acquisition of an additional 30% equity interest in Fairlawn, and (3) a decrease in our valuation allowance offset by (4) state and other income tax expense. As a result of the Fairlawn transaction, we released the deferred tax liability associated with the outside tax basis of our investment in Fairlawn because we possessed sufficient ownership to allow for the historical outside tax basis difference to be resolved through a tax-free transaction in the future. The decrease in our valuation allowance in 2014 related primarily to the expiration of state NOLs in certain jurisdictions, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws.

Total remaining gross unrecognized tax benefits were $2.9 million and $0.9 million as of December 31, 2015 and 2014, respectively. See Note 15, Income Taxes, to the accompanying consolidated financial statements and the “Critical Accounting Estimates” section of this Item.

Net Income Attributable to Noncontrolling Interests

The increase in Net Income Attributable to Noncontrolling Interests in 2015 compared to 2014 primarily resulted from our acquisition of Encompass on December 31, 2014.

Impact of Inflation

The impact of inflation on the Company will be primarily in the area of labor costs. The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. There can be no guarantee we will not experience increases in the cost of labor, as the need for clinical healthcare professionals is expected to grow. In addition, increases in healthcare costs are typically higher than inflation and impact our costs under our employee benefit plans. Managing these costs remains a significant challenge and priority for us.

Suppliers pass along rising costs to us in the form of higher prices. Our supply chain efforts and our continual focus on monitoring and actively managing pharmaceutical costs has enabled us to accommodate increased pricing related to supplies and other operating expenses over the past few years. However, we cannot predict our ability to cover future cost increases.

It should be noted that we have little or no ability to pass on these increased costs associated with providing services to Medicare and Medicaid patients due to federal and state laws that establish fixed reimbursement rates.

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Relationships and Transactions with Related Parties

Related party transactions were not material to our operations in 2016, 2015, or 2014, and therefore, are not presented as a separate discussion within this Item.

Segment Results of Operations

Our internal financial reporting and management structure is focused on the major types of services provided by HealthSouth. Beginning in the first quarter of 2015, we manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. For additional information regarding our business segments, including a detailed description of the services we provide, financial data for each segment, and a reconciliation of total segment Adjusted EBITDA to income from continuing operations before income tax expense, see Note 18, Segment Reporting, to the accompanying consolidated financial statements.

Inpatient Rehabilitation

During the years ended December 31, 2016, 2015 and 2014, our inpatient rehabilitation segment derived its Net operating revenues from the following payor sources:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Medicare | 73.3 % | 73.2 % | 73.9 % |
| Medicare Advantage | 7.7 % | 7.9 % | 7.5 % |
| Managed care | 11.2 % | 11.1 % | 11.3 % |
| Medicaid | 3.0 % | 2.5 % | 1.8 % |
| Other third-party payors | 1.8 % | 2.0 % | 1.8 % |
| Workers' compensation | 1.0 % | 1.1 % | 1.2 % |
| Patients | 0.6 % | 0.7 % | 1.0 % |
| Other income | 1.4 % | 1.5 % | 1.5 % |
| Total | 100.0% | 100.0% | 100.0% |

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Additional information regarding our inpatient rehabilitation segment's operating results for the years ended December 31, 2016, 2015 and 2014, is as follows:

| | For the Year Ended December 31, | | | Percentage Change | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2016 vs. 2015 | 2015 vs. 2014 |
| | (In Millions, Except Percentage Change) | | | | |
| Net operating revenues: | | | | | |
| Inpatient | $2,905.5 | $2,547.2 | $2,272.5 | 14.1 % | 12.1 % |
| Outpatient and other | 115.6 | 105.9 | 104.8 | 9.2 % | 1.0 % |
| Inpatient rehabilitation segment revenues | 3,021.1 | 2,653.1 | 2,377.3 | 13.9 % | 11.6 % |
| Less: Provision for doubtful accounts | (57.0) | (44.7) | (31.2) | 27.5 % | 43.3 % |
| Net operating revenues less provision for doubtful accounts | 2,964.1 | 2,608.4 | 2,346.1 | 13.6 % | 11.2 % |
| Operating expenses: | | | | | |
| Salaries and benefits | 1,493.4 | 1,310.6 | 1,141.0 | 13.9 % | 14.9 % |
| Other operating expenses | 431.5 | 387.7 | 342.5 | 11.3 % | 13.2 % |
| Supplies | 128.8 | 120.9 | 111.5 | 6.5 % | 8.4 % |
| Occupancy costs | 61.2 | 46.2 | 41.2 | 32.5 % | 12.1 % |
| Other income | (2.9) | (2.3) | (4.0) | 26.1 % | (42.5)% |
| Equity in net income of nonconsolidated affiliates | (9.1) | (8.6) | (10.7) | 5.8 % | (19.6)% |
| Noncontrolling interests | 64.0 | 62.9 | 59.3 | 1.7 % | 6.1 % |
| Segment Adjusted EBITDA | $797.2 | $691.0 | $665.3 | 15.4 % | 3.9 % |
| | (Actual Amounts) | | | | |
| Discharges | 165,305 | 149,161 | 134,515 | 10.8 % | 10.9 % |
| Net patient revenue per discharge | $17,577 | $17,077 | $16,894 | 2.9 % | 1.1 % |
| Outpatient visits | 640,702 | 577,507 | 579,555 | 10.9 % | (0.4)% |
| Average length of stay (days) | 12.8 | 12.9 | 13.2 | (0.8)% | (2.3)% |
| Occupancy % | 67.8 % | 62.8 % | 68.4 % | 8.0 % | (8.2)% |
| # of licensed beds | 8,504 | 8,404 | 7,095 | 1.2 % | 18.4 % |
| Full-time equivalents* | 19,612 | 17,880 | 16,405 | 9.7 % | 9.0 % |
| Employees per occupied bed | 3.44 | 3.41 | 3.40 | 0.9 % | 0.3 % |

* Excludes approximately 420 full-time equivalents in 2016 and approximately 400 in 2015 and 2014 who are considered part of corporate overhead with their salaries and benefits included in General and administrative expenses in our consolidated statements of operations. Full-time equivalents included in the above table represent HealthSouth employees who participate in or support the operations of our hospitals and exclude an estimate of full-time equivalents related to contract labor.

We actively manage the productive portion of our Salaries and benefits utilizing certain metrics, including employees per occupied bed, or "EPOB." This metric is determined by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by our occupancy percentage.

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2016 Compared to 2015

Net Operating Revenues

Net operating revenues were 13.9% higher for 2016 compared to 2015. This increase included a 10.8% increase in patient discharges and a 2.9% increase in net patient revenue per discharge. Discharge growth included a 1.7% increase in same-store discharges. Discharge growth from new stores resulted from our joint ventures in Hot Springs, Arkansas (February 2016), Bryan, Texas (August 2016), and Broken Arrow, Oklahoma (August 2016), our wholly owned hospitals that opened in Franklin, Tennessee (December 2015) and Modesto California (October 2016), and our acquisitions of Reliant (October 2015) and Cardinal Hill in Lexington, Kentucky (May 2015). Growth in net patient revenue per discharge resulted primarily from patient mix (higher percentage of stroke patients and the integration of the Reliant hospitals) and an approximate $4 million Indirect Medical Education (“IME”) adjustment associated with the former Reliant hospital in Woburn, Massachusetts. Medicare provides that hospitals with residents in an approved graduate medical education program receive an additional payment for a Medicare discharge to reflect higher patient care costs of teaching hospitals relative to non-teaching hospitals. Our revenues in 2016 were positively impacted by this adjustment to our third-party payor estimates for 2014, 2015, and the year-to-date period through July 2016. In addition, net patient revenue per discharge growth in 2016 benefited from an approximate $5 million SSI adjustment that negatively impacted revenue in 2015. CMS periodically retroactively updates SSI ratios that are used to determine adjustments to Medicare payment rates for low-income patients. In the second quarter of 2015, CMS updated the ratios for fiscal year 2013, which resulted in adjustments to our third-party payor estimates for 2013, 2014, and year-to-date period through July 2015.

Outpatient revenues increased during 2016 compared to 2015 due to the acquisition of Reliant.

See Note 2, Business Combinations, to the accompanying consolidated financial statements of this report for information regarding our joint ventures and acquisitions discussed above.

Adjusted EBITDA

The increase in Adjusted EBITDA in 2016 compared to 2015 primarily resulted from revenue growth, as discussed above. All operating expenses as a percent of net operating revenues benefited in 2016 by the aforementioned IME adjustment. Salaries and benefits in 2016 included a year-over-year decline in group medical costs. Other operating expenses decreased as a percent of revenue due primarily to the 2015 settlement discussed below. Occupancy costs increased as a percent of net operating revenues due to the acquisition of Reliant. Supplies expense decreased as a percent of revenue due to continued supply chain efficiencies including the continued transition of brand name drugs to generic. Bad debt expense as a percent of net operating revenues increased from 1.7% in 2015 to 1.9% in 2016 due to aging-based reserves resulting from continued administrative payment delays at the Company's largest MAC.

2015 Compared to 2014

Net Operating Revenues

Net operating revenues were 11.6% higher for 2015 compared to 2014. This increase included a 10.9% increase in patient discharges and a 1.1% increase in net patient revenue per discharge. Discharge growth included a 3.2% increase in same-store discharges. Discharge growth from new stores resulted from three de novo hospitals that opened in the fourth quarter of 2014 (Altamonte Springs, Florida; Newnan, Georgia; and Middletown, Delaware) and one de novo hospital that opened in December 2015 (Franklin, Tennessee), our acquisitions of Reliant (October 2015), Quillen Rehabilitation Hospital (“Quillen”) in Johnson City, Tennessee (November 2014) and Cardinal Hill in Lexington, Kentucky (May 2015), and our joint venture with Memorial Health in Savannah, Georgia (April 2015). While we experienced pricing growth from Medicare and managed care payors, the pricing adjustments were negatively impacted by proportionally higher discharge growth in Medicaid and managed care payors where our reimbursement is lower. In addition, our net patient revenue per discharge was negatively impacted in 2015 by approximately $5 million for updated SSI ratios published by CMS for fiscal year 2013.

See Note 2, Business Combinations, to the accompanying consolidated financial statements of this report for information regarding our acquisitions and joint ventures discussed above.

Adjusted EBITDA

The increase in Adjusted EBITDA in 2015 compared to 2014 primarily resulted from revenue growth, as discussed above. Adjusted EBITDA in 2015 was also impacted by (1) an increase in salaries and benefits as a percent of revenue

due to increases in group medical costs, an increase in our licensed skills mix, and an increase in volume-related "premium" pay, (2) increased bad debt expense from continued pre-payment claims denials predominately by one of our MACs, (3) SSI ratio

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adjustments, as discussed above (4) a settlement of an employee sexual harassment matter that was not covered by insurance, and (5) incremental investments in our operating platform, including a contractual increase in costs associated with the ongoing implementation of our electronic clinical information system, the addition of staff at our hospitals to ensure compliance with new CMS quality reporting requirements, the creation of a new medical services department, and costs associated with our participation in CMS' Model 3 bundling pilot initiative. Increases in group medical costs resulted from an increase in the number and size of large claims (claims greater than $100,000) and an increase in the cost and use of specialty pharmaceuticals.

Home Health and Hospice

During the years ended December 31, 2016, 2015 and 2014, our home health and hospice segment derived its Net operating revenues from the following payor sources:

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Medicare | 82.9 % | 83.7 % | 96.9 % |
| Medicare Advantage | 8.7 % | 7.7 % | 0.7 % |
| Managed care | 3.9 % | 3.0 % | 1.1 % |
| Medicaid | 4.3 % | 5.5 % | — % |
| Other third-party payors | — % | — % | 1.0 % |
| Workers' compensation | — % | — % | 0.3 % |
| Patients | 0.1 % | 0.1 % | — % |
| Other income | 0.1 % | — % | — % |
| Total | 100.0% | 100.0% | 100.0% |

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Additional information regarding our home health and hospice segment's operating results for the years ended December 31, 2016, 2015 and 2014, is as follows:

| | For the Year Ended December 31, | | | Percentage Change | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2016 vs. 2015 | 2015 vs. 2014 |
| | (In Millions, Except Percentage Change) | | | | |
| Net operating revenues: | | | | | |
| Home health | $635.2 | $ 478.1 | $28.6 | 32.9 % | NMF |
| Hospice | 50.9 | 31.7 | — | 60.6 % | N/A |
| Home health and hospice segment revenues | 686.1 | 509.8 | 28.6 | 34.6 % | NMF |
| Less: Provision for doubtful accounts | (4.2) | (2.5) | (0.4) | 68.0 % | NMF |
| Net operating revenues less provision for doubtful accounts | 681.9 | 507.3 | 28.2 | 34.4 % | NMF |
| Operating expenses: | | | | | |
| Cost of services sold (excluding depreciation and amortization) | 336.5 | 244.8 | 17.0 | 37.5 % | NMF |
| Support and overhead costs | 237.2 | 172.7 | 6.9 | 37.3 % | NMF |
| Equity in net income of nonconsolidated affiliates | (0.7) | (0.1) | — | 600.0 % | NMF |
| Noncontrolling interests | 6.5 | 6.8 | 0.4 | (4.4)% | NMF |
| Segment Adjusted EBITDA | $102.4 | $ 83.1 | $3.9 | 23.2 % | NMF |
| | (Actual Amounts) | | | | |
| Home health: | | | | | |
| Admissions | 106,712 | 74,329 | 7,545 | 43.6 % | NMF |
| Recertifications | 82,195 | 65,039 | 1,030 | 26.4 % | NMF |
| Episodes | 185,737 | 137,568 | 8,236 | 35.0 % | NMF |
| Average revenue per episode | $3,031 | $ 3,072 | $3,364 | (1.3)% | (8.7)% |
| Episodic visits per episode | 18.8 | 19.1 | 18.8 | (1.6)% | 1.6 % |
| Total visits | 3,940,295 | 2,889,373 | 159,672 | 36.4 % | NMF |
| Cost per visit | $74 | $ 72 | $108 | 2.8 % | (33.3)% |
| Hospice: | | | | | |
| Admissions | 3,337 | 2,452 | — | 36.1 % | N/A |
| Patient days | 322,519 | 204,898 | — | 57.4 % | N/A |
| Revenue per day | $158 | $ 155 | $— | 1.9 % | N/A |

2016 Compared to 2015

Net Operating Revenues

Home health and hospice revenue was 34.6% higher during 2016 compared to 2015. This increase included a 43.6% increase in home health admissions and was impacted by a 1.3% decrease in average revenue per episode. Home health admission growth included a 13.7% increase in same-store admissions. Home health admission growth from new stores resulted primarily from the acquisition of CareSouth in November 2015. Average revenue per episode was impacted by the Medicare home health reimbursement rate cuts that became effective January 1, 2016 and lower revenue per episode at CareSouth due to patient mix.

See Note 2, Business Combinations, to the accompanying consolidated financial statements of this report regarding CareSouth and Encompass' other acquisitions throughout 2015.

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Adjusted EBITDA

The increase in Adjusted EBITDA during 2016 compared to 2015 primarily resulted from revenue growth. Adjusted EBITDA for the segment during 2016 was impacted by Medicare reimbursment rate cuts, higher cost per visit (driven by an increased percentage of therapy patients), salary and benefit costs increases, a $3.3 million gain from the divestiture of our home health pediatric assets, and expenses related to the integration of CareSouth.

2015 Compared to 2014

The increase in Net operating revenues and Adjusted EBITDA during 2015 compared to 2014 was due to our acquisition of Encompass on December 31, 2014 (see Note 2, Business Combinations, to the accompanying consolidated financial statements). Because of this acquisition, certain variances in the above table are considered to be not meaningful figures and are labeled as “NMF.”

Liquidity and Capital Resources

Our primary sources of liquidity are cash on hand, cash flows from operations, and borrowings under our revolving credit facility.

The objectives of our capital structure strategy are to ensure we maintain adequate liquidity and flexibility. Pursuing and achieving those objectives allows us to support the execution of our operating and strategic plans and weather temporary disruptions in the capital markets and general business environment. Maintaining adequate liquidity is a function of our unrestricted Cash and cash equivalents and our available borrowing capacity. Maintaining flexibility in our capital structure is a function of, among other things, the amount of debt maturities in any given year, the options for debt prepayments without onerous penalties, and limiting restrictive terms and maintenance covenants in our debt agreements.

Consistent with these objectives, in both March and May of 2016, we redeemed $50.0 million of the outstanding principal amount of the 7.75% Senior Notes due 2022 using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of these notes, we completed these optional redemptions at a price of 103.875%, which resulted in a total cash outlay of approximately $104 million. As a result of these redemptions, we recorded a $2.4 million Loss on early extinguishment of debt in both the first and second quarter of 2016.

In September 2016, we redeemed the remaining outstanding principal balance of $76.0 million of the 7.75% Senior Notes due 2022 using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of these notes, this optional redemption was made at a price of 102.583%, which resulted in a total cash outlay of approximately $78 million. As a result of this redemption, we recorded a $2.6 million Loss on early extinguishment of debt in the third quarter of 2016.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2020. Our balance sheet remains strong, and we have significant availability under our credit agreement. We continue to generate strong cash flows from operations, and we have significant flexibility with how we choose to invest our cash and return capital to shareholders. While our financial leverage increased as a result of the Reliant and CareSouth transactions, we anticipate in the longer term reducing our financial leverage based on growth of Adjusted EBITDA and an allocation of a portion of our free cash flow to debt reduction.

See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Current Liquidity

As of December 31, 2016, we had $40.5 million in Cash and cash equivalents. This amount excludes $60.9 million in Restricted cash and $57.7 million of restricted marketable securities ($33.5 million of restricted marketable securities are included in Other long-term assets in our consolidated balance sheet). Our restricted assets pertain primarily to obligations associated with our captive insurance company, as well as obligations we have under agreements with joint venture partners. See Note 4, Cash and Marketable Securities, to the accompanying consolidated financial statements.

In addition to Cash and cash equivalents, as of December 31, 2016, we had approximately $415 million available to us under our revolving credit facility. Our credit agreement governs the substantial majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $75 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. In calculating the leverage ratio under our credit agreement, we are

permitted to use pro forma Adjusted EBITDA, the calculation of which includes historical income statement items and pro forma adjustments resulting from (1) the dispositions and repayments or incurrence of debt and (2) the investments, acquisitions, mergers, amalgamations,

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consolidations and operational changes from acquisitions to the extent such items or effects are not yet reflected in our trailing four-quarter financial statements. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2016, the maximum leverage ratio requirement per our credit agreement was 4.50x and the minimum interest coverage ratio requirement was 3.0x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2016 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2016, if we had drawn on the first day and maintained the maximum amount of outstanding draws under our revolving credit facility for the entire year, we would still be in compliance with the maximum leverage ratio and minimum interest coverage ratio requirements.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2020, and our bonds all mature in 2023 and beyond. See the "Contractual Obligations" section below for information related to our contractual obligations as of December 31, 2016.

As part of the Encompass acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Holdings, a subsidiary of HealthSouth and a indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers were members of Encompass management. These sellers contributed a portion of their shares of common stock of EHHI in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. At any time after December 31, 2017, each management investor will have the right (but not the obligation) to have his or her shares of Holdings stock repurchased by HealthSouth for a cash purchase price per share equal to the fair value. The fair value is determined using the product of the trailing 12-month specified performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies. Specifically, up to one-third of each management investor's shares of Holdings stock may be sold prior to December 31, 2018; two-thirds of each management investor's shares of Holdings stock may be sold prior to December 31, 2019; and all of each management investor's shares of Holdings stock may be sold thereafter. At any time after December 31, 2019, HealthSouth will have the right (but not the obligation) to repurchase all or any portion of the shares of Holdings stock owned by one or more management investors for a cash purchase price per share equal to the fair value. As of December 31, 2016, the value of those outstanding shares of Holdings was approximately $116 million. See Note 11, Redeemable Noncontrolling Interests, to the accompanying consolidated financial statements.

We anticipate we will continue to generate strong cash flows from operations that, together with availability under our revolving credit facility, will allow us to invest in growth opportunities and continue to improve our existing business. We also will continue to consider additional shareholder value-enhancing strategies such as repurchases of our common stock and distribution of common stock dividends, including the potential growth of the quarterly cash dividend on our common stock, recognizing that these actions may increase our leverage ratio. See also the "Authorizations for Returning Capital to Stakeholders" section of this Item.

See Item 1A, Risk Factors, for a discussion of risks and uncertainties facing us.

Sources and Uses of Cash

The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2016, 2015, and 2014 (in millions):

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Net cash provided by operating activities | $605.5 | $484.8 | $444.9 |
| Net cash used in investing activities | (245.0) | (1,129.8) | (876.9) |
| Net cash (used in) provided by financing activities | (381.6) | 639.9 | 434.2 |
| (Decrease) increase in cash and cash equivalents | $(21.1) | $(5.1) | $2.2 |

2016 Compared to 2015

Operating activities. The increase in Net cash provided by operating activities during 2016 compared to 2015 primarily resulted from revenue growth, as described above, and changes to payroll-related liabilities.

Investing activities. The decrease in Net cash used in investing activities during 2016 compared to 2015 resulted primarily from the decrease in cash used in the acquisition of businesses offset by the proceeds received from the divestiture of

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our home health pediatric assets in 2016. Cash outflows were significantly higher in 2015 due to the acquisitions of Reliant and CareSouth described in Note 2, Business Combinations, to the accompanying consolidated financial statements.

Financing activities. The decrease in Net cash provided by financing activities during 2016 compared to 2015 primarily resulted from the 2015 debt transactions, including the public offering of the 2023 Notes, the additional offering of the 2024 Notes, and the private offering of the 2025 Notes to fund the acquisitions of Reliant and CareSouth as discussed and defined in Note 9, Long-term Debt, to the accompanying consolidated financial statements.

2015 Compared to 2014

Operating activities. The increase in Net cash provided by operating activities during 2015 compared to 2014 primarily resulted from revenue growth. Cash flows provided by operating activities in 2015 were also impacted by increased cash interest expense and higher working capital. Higher working capital resulted from growth in accounts receivable due to additional claims denials and continued delays at the administrative law judge hearing level.

Investing activities. The increase in Net cash used in investing activities during 2015 compared to 2014 resulted primarily from the acquisitions of Reliant and CareSouth described in Note 2, Business Combinations, to the accompanying consolidated financial statements.

Financing activities. The increase in Net cash provided by financing activities during 2015 compared to 2014 primarily resulted from the public offering of the 2023 Notes, the additional offering of the 2024 Notes, and the private offering of the 2025 Notes to fund the acquisitions of Reliant and CareSouth as discussed in Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2016 are as follows (in millions):

| | Total | 2017 | 2018-2019 | 2020-2021 | 2022 and thereafter |
|---|---|---|---|---|---|
| Long-term debt obligations: | | | | | |
| Long-term debt, excluding revolving credit facility and capital lease obligations [a] | $2,585.1 | $23.5 | $ 52.2 | $ 630.6 | $ 1,878.8 |
| Revolving credit facility | 152.0 | — | — | 152.0 | — |
| Interest on long-term debt [b] | 964.4 | 129.3 | 264.3 | 236.7 | 334.1 |
| Capital lease obligations [c] | 513.3 | 34.7 | 65.9 | 56.2 | 356.5 |
| Operating lease obligations [d][e] | 420.0 | 62.5 | 108.3 | 75.4 | 173.8 |
| Purchase obligations [e][f] | 92.9 | 34.2 | 38.9 | 19.0 | 0.8 |
| Other long-term liabilities [g][h] | 3.6 | 0.3 | 0.4 | 0.4 | 2.5 |
| Total | $4,731.3 | $284.5 | $ 530.0 | $ 1,170.3 | $ 2,746.5 |

[a] Included in long-term debt are amounts owed on our bonds payable and other notes payable. These borrowings are further explained in Note 9, Long-term Debt, to the accompanying consolidated financial statements.

[b] Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2016. Interest related to capital lease obligations is excluded from this line. Future minimum payments, which are accounted for as interest, related to sale/leaseback transactions involving real estate accounted for as financings are included in this line (see Note 6, Property and Equipment, and Note 9, Long-term Debt, to the accompanying consolidated financial statements). Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of operations.

[c] Amounts include interest portion of future minimum capital lease payments.

[d] Our inpatient rehabilitation segment leases approximately 16% of its hospitals as well as other property and equipment under operating leases in the normal course of business. Our home health and hospice segment leases relatively small office spaces in the localities it serves, space for its corporate office, and other equipment under operating leases in the normal course of business. Some of our hospital leases contain escalation clauses based on changes in the Consumer

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Price Index while others have fixed escalation terms. The minimum lease payments do not include contingent rental expense. Some lease agreements provide us with the option to renew the lease or purchase the leased property. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. For more information, see Note 6, Property and Equipment, to the accompanying consolidated financial statements.

(e) Future operating lease obligations and purchase obligations are not recognized in our consolidated balance sheet. Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on HealthSouth and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed,

(f) minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support.

Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: general liability, professional liability, and workers' compensation risks, noncurrent amounts related to

(g) third-party billing audits, Encompass' stock appreciation rights, and deferred income taxes. Also, as of December 31, 2016, we had $2.8 million of total gross unrecognized tax benefits. For more information, see Note 10, Self-Insured Risks, Note 13, Share-Based Payments, Note 15, Income Taxes, and Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements.

The table above does not include Redeemable noncontrolling interests of $138.3 million because of the uncertainty

(h) surrounding the timing and amounts of any related cash outflows. See Note 11, Redeemable Noncontrolling Interests, to the accompanying consolidated financial statements.

Our capital expenditures include costs associated with our hospital refresh program, de novo projects, capacity expansions, technology initiatives, and building and equipment upgrades and purchases. During the year ended December 31, 2016, we made capital expenditures of approximately $203 million for property and equipment and capitalized software. These expenditures in 2016 are exclusive of approximately $48 million in net cash related to our acquisition activity. During 2017, we expect to spend approximately $305 million to $415 million for capital expenditures. Approximately $130 million to $150 million of this budgeted amount is considered nondiscretionary expenditures, which we may refer to in other filings as "maintenance" expenditures. The expected increase in 2017 is due to growth in the Company, an enhanced hospital maintenance program, and leasehold improvements and furnishings associated with the build-out of our new home office location. Actual amounts spent will be dependent upon the timing of construction projects and acquisition opportunities for our home health and hospice business.

Authorizations for Returning Capital to Stakeholders

In October 2015, February 2016, and May 2016, our board of directors declared cash dividends of $0.23 per share that were paid in January 2016, April 2016, and July 2016, respectively. On July 21, 2016, our board of directors approved an

increase in our quarterly dividend and declared a cash dividend of $0.24 per share, payable on October 17, 2016 to stockholders

of record on October 3, 2016. On October 20, 2016, our board of directors declared a cash dividend of $0.24 per share, payable

on January 17, 2017 to stockholders of record on January 3, 2017. We expect quarterly dividends to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board of directors after consideration of various factors, including our capital position and alternative uses of funds. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our credit agreement. The payment of cash dividends on our common stock triggers antidilution adjustments, except in instances when such adjustments are deemed de minimis, under our convertible notes. See Note 9, Long-term Debt, to the accompanying consolidated financial statements.

On February 14, 2014, our board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million. As of December 31, 2016, approximately $96 million remained under this authorization. The repurchase authorization does not require the repurchase of a specific number of shares,

has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. During 2016, we repurchased 1.7 million shares of our common stock in the open market for $64.1 million under this repurchase authorization

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using cash on hand. Future repurchases under this authorization generally are expected to be funded using a combination of cash on hand and availability under our $600 million revolving credit facility.

Adjusted EBITDA

Management believes Adjusted EBITDA as defined in our credit agreement is a measure of our ability to service our debt and our ability to make capital expenditures. We reconcile Adjusted EBITDA to Net income and to Net cash provided by operating activities.

We use Adjusted EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our credit agreement, which is discussed in more detail in Note 9, Long-term Debt, to the accompanying consolidated financial statements. These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under our credit agreement — our interest coverage ratio and our leverage ratio — could result in our lenders requiring us to immediately repay all amounts borrowed. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might be on terms less favorable to us than those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, therein referred to as “Adjusted Consolidated EBITDA,” allows us to add back to consolidated Net income interest expense, income taxes, and depreciation and amortization and then add back to consolidated Net income (1) all unusual or nonrecurring items reducing consolidated Net income (of which only up to $10 million in a year may be cash expenditures), (2) any losses from discontinued operations and closed locations, (3) costs and expenses, including legal fees and expert witness fees, incurred with respect to litigation associated with stockholder derivative litigation, and (4) share-based compensation expense. We also subtract from consolidated Net income all unusual or nonrecurring items to the extent increasing consolidated Net income.

The calculation of Adjusted EBITDA under the credit agreement does not require us to deduct net income attributable to noncontrolling interests or gains on disposal of assets and development activities. It also does not allow us to add back professional fees unrelated to the stockholder derivative litigation, losses on disposal of assets, unusual or nonrecurring cash expenditures in excess of $10 million, and charges resulting from debt transactions and development activities. These items and amounts, in addition to the items falling within the credit agreement’s “unusual or nonrecurring” classification, may occur in future periods, but can vary significantly from period to period and may not directly relate to our ongoing operations. Accordingly, these items may not be indicative of our ongoing performance, so the Adjusted EBITDA calculation presented here includes adjustments for them.

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

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Our Adjusted EBITDA for the years ended December 31, 2016, 2015, and 2014 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Net income | $318.1 | $252.8 | $281.7 |
| Loss (income) from discontinued operations, net of tax, attributable to HealthSouth | — | 0.9 | (5.5) |
| Provision for income tax expense | 163.9 | 141.9 | 110.7 |
| Interest expense and amortization of debt discounts and fees | 172.1 | 142.9 | 109.2 |
| Loss on early extinguishment of debt | 7.4 | 22.4 | 13.2 |
| Professional fees—accounting, tax, and legal | 1.9 | 3.0 | 9.3 |
| Government, class action, and related settlements | — | 7.5 | (1.7) |
| Net noncash loss on disposal or impairment of assets | 0.7 | 2.6 | 6.7 |
| Depreciation and amortization | 172.6 | 139.7 | 107.7 |
| Stock-based compensation expense | 27.4 | 26.2 | 23.9 |
| Net income attributable to noncontrolling interests | (70.5) | (69.7) | (59.7) |
| Gain on consolidation of former equity method hospital | — | — | (27.2) |
| Transaction costs | — | 12.3 | 9.3 |
| Adjusted EBITDA | $793.6 | $682.5 | $577.6 |

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Net cash provided by operating activities | $605.5 | $484.8 | $444.9 |
| Provision for doubtful accounts | (61.2) | (47.2) | (31.6) |
| Professional fees—accounting, tax, and legal | 1.9 | 3.0 | 9.3 |
| Interest expense and amortization of debt discounts and fees | 172.1 | 142.9 | 109.2 |
| Equity in net income of nonconsolidated affiliates | 9.8 | 8.7 | 10.7 |
| Net income attributable to noncontrolling interests in continuing operations | (70.5) | (69.7) | (59.7) |
| Amortization of debt-related items | (13.8) | (14.3) | (12.7) |
| Distributions from nonconsolidated affiliates | (8.5) | (7.7) | (12.6) |
| Current portion of income tax expense | 31.0 | 14.8 | 13.3 |
| Change in assets and liabilities | 102.9 | 147.1 | 90.1 |
| Net premium paid on bond transactions | 5.8 | 3.9 | 4.3 |
| Windfall tax benefits from share-based compensation | 17.3 | — | — |
| Operating cash used in discontinued operations | 0.7 | 0.7 | 1.2 |
| Transaction costs | — | 12.3 | 9.3 |
| Other | 0.6 | 3.2 | 1.9 |
| Adjusted EBITDA | $793.6 | $682.5 | $577.6 |

Growth in Adjusted EBTIDA from 2015 to 2016 resulted primarily from revenue growth in both operating segments due to the acquisitions of Reliant and CareSouth. Growth in Adjusted EBITDA from 2014 to 2015 resulted primarily from revenue growth due to the acquisition of Encompass. For additional information see the “Results of Operations” and “Segment Results of Operations” sections of this Item.

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Off-Balance Sheet Arrangements

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

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

As of December 31, 2016, we do not have any material off-balance sheet arrangements.

As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities ("SPEs"), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2016, we are not involved in any unconsolidated SPE transactions.

Critical Accounting Estimates

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

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

Revenue Recognition

We recognize net patient revenue in the reporting period in which we perform the service based on our current billing rates (i.e., gross charges) less actual adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicare Advantage, Medicaid, and other third-party payors. See Note 1, Summary of Significant Accounting Policies, "Net Operating Revenues," to the accompanying consolidated financial statements for a complete discussion of our revenue recognition policies.

Our patient accounting systems calculate contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Certain other factors that are considered and could influence the level of our reserves are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors.

Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. In addition, laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation and review, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. However, we continually

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review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective.

Allowance for Doubtful Accounts

The collection of outstanding receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. See Note 1, Summary of Significant Accounting Policies, “Accounts Receivable and the Allowance for Doubtful Accounts,” and Note 5, Accounts Receivable, to the accompanying consolidated financial statements for a complete discussion of our policies related to the allowance for doubtful accounts.

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. Changes in general economic conditions (such as increased unemployment rates or periods of recession), business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable. Our collection risks include patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding and pre-payment claim reviews by our respective MACs. In addition, reimbursement claims made by health care providers are subject to audit from time to time by governmental payors and their agents. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. See Note 1, Summary of Significant Accounting Policies, “Accounts Receivable and the Allowance for Doubtful Accounts,” to the accompanying consolidated financial statements.

As of December 31, 2016 and 2015, $172.0 million and $126.1 million, or 26.0% and 22.1%, respectively, of our patient accounts receivable represented denials by MACs that were in the pre-payment medical necessity review process. During the years ended December 31, 2016, 2015, and 2014, we wrote off $3.5 million, $2.6 million, and $1.4 million, respectively, of previously denied claims while we collected $9.2 million, $7.4 million, and $7.1 million, respectively, of previously denied claims.

The table below shows a summary of our net accounts receivable balances as of December 31, 2016 and 2015. Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, Summary of Significant Accounting Policies, “Accounts Receivable and the Allowance for Doubtful Accounts,” to the accompanying consolidated financial statements.

| | As of December 31, | |
|---|---|---|
| | 2016 | 2015 |
| | (In Millions) | |
| Current: | | |
| 0 - 30 Days | $328.4 | $300.3 |
| 31 - 60 Days | 43.1 | 39.0 |
| 61 - 90 Days | 20.8 | 24.5 |
| 91 - 120 Days | 12.6 | 9.9 |
| 120 + Days | 27.1 | 29.6 |
| Patients accounts receivable, net | 432.0 | 403.3 |
| Other accounts receivable | 11.8 | 7.2 |
| | 443.8 | 410.5 |
| Noncurrent patient accounts receivable, net | 125.9 | 96.6 |
| Accounts receivable, net | $569.7 | $507.1 |

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers’ compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers’ compensation risks are insured through a wholly owned

insurance

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subsidiary. See Note 10, Self-Insured Risks, to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

Our self-insured liabilities contain uncertainties because management must make assumptions and apply judgment to estimate the ultimate cost of reported claims and claims incurred but not reported as of the balance sheet date. Our reserves and provisions for professional liability, general liability, and workers' compensation risks are based largely upon semi-annual actuarial calculations prepared by third-party actuaries.

Periodically, we review our assumptions and the valuations provided by third-party actuaries to determine the adequacy of our self-insurance reserves. The following are certain of the key assumptions and other factors that significantly influence our estimate of self-insurance reserves:

- historical claims experience;
- trending of loss development factors;
- trends in the frequency and severity of claims;
- coverage limits of third-party insurance;
- demographic information;
- statistical confidence levels;
- medical cost inflation;
- payroll dollars; and
- hospital patient census.

The time period to resolve claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. In addition, if current and future claims differ from historical trends, our estimated reserves for self-insured claims may be significantly affected. Our self-insurance reserves are not discounted.

Given the number of factors used to establish our self-insurance reserves, we believe there is limited benefit to isolating any individual assumption or parameter from the detailed computational process and calculating the impact of changing that single item. Instead, we believe the sensitivity in our reserve estimates is best illustrated by changes in the statistical confidence level used in the computations. Using a higher statistical confidence level increases the estimated self-insurance reserves. The following table shows the sensitivity of our recorded self-insurance reserves to the statistical confidence level (in millions):

| Net self-insurance reserves as of December 31, 2016: | |
|---|---|
| As reported, with 50% statistical confidence level | 130.0 |
| With 70% statistical confidence level | 139.0 |

We believe our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. See Note 10, Self-Insured Risks, to the accompanying consolidated financial statements for additional information.

We believe our self-insurance reserves are adequate to cover projected costs. Due to the considerable variability that is inherent in such estimates, there can be no assurance the ultimate liability will not exceed management's estimates. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Goodwill

Absent any impairment indicators, we evaluate goodwill for impairment as of October 1st of each year. We test goodwill for impairment at the reporting unit level and are required to make certain subjective and complex judgments on a number of matters, including assumptions and estimates used to determine the fair value of our inpatient rehabilitation and home health and hospice reporting units. We assess qualitative factors in each reporting unit to determine whether it is

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necessary to perform the first step of the two-step quantitative goodwill impairment test. The quantitative impairment test is required only if we conclude it is more likely than not a reporting unit's fair value is less than its carrying amount.

If, based on our qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of the applicable reporting unit using generally accepted valuation techniques including the income approach and the market approach. We would validate our estimates under the income approach by reconciling the estimated fair value of the reporting units determined under the income approach to our market capitalization and estimated fair value determined under the market approach. Values from the income approach and market approach would then be evaluated and weighted to arrive at the estimated aggregate fair value of the reporting units.

The income approach includes the use of each reporting unit's projected operating results and cash flows that are discounted using a weighted-average cost of capital that reflects market participant assumptions. The projected operating results use management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. Other significant estimates and assumptions include cost-saving synergies and tax benefits that would accrue to a market participant under a fair value methodology. The market approach estimates fair value through the use of observable inputs, including the Company's stock price.

See Note 1, Summary of Significant Accounting Policies, "Goodwill and Other Intangibles," and Note 7, Goodwill and Other Intangible Assets, to the accompanying consolidated financial statements for additional information.

The following events and circumstances are certain of the qualitative factors we consider in evaluating whether it is more likely than not the fair value of a reporting unit is less than its carrying amount:

- Macroeconomic conditions, such as deterioration in general economic conditions, limitations on accessing capital, or other developments in equity and credit markets;
- Industry and market considerations and changes in healthcare regulations, including reimbursement and compliance requirements under the Medicare and Medicaid programs;
- Cost factors, such as an increase in labor, supply, or other costs;
- Overall financial performance, such as negative or declining cash flows or a decline in actual or forecasted revenue or earnings;
- Other relevant company-specific events, such as material changes in management or key personnel or outstanding litigation;
- Material events, such as a change in the composition or carrying amount of each reporting unit's net assets, including acquisitions and dispositions; and
- Consideration of the relationship of our market capitalization to our book value, as well as a sustained decrease in our share price.

In the fourth quarter of 2016, we performed our annual evaluation of goodwill and determined no adjustment to impair goodwill was necessary. If actual results are not consistent with our assumptions and estimates, we may be exposed to goodwill impairment charges. However, at this time, we continue to believe our inpatient rehabilitation and home health and hospice reporting units are not at risk for any impairment charges.

Income Taxes

We provide for income taxes using the asset and liability method. We also evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. See Note 1, Summary of Significant Accounting Policies, "Income Taxes," and Note 15, Income Taxes, to the accompanying consolidated financial statements for a more complete discussion of income taxes and our policies related to income taxes.

The application of income tax law is inherently complex. Laws and regulations in this area are voluminous and are often ambiguous. We are required to make many subjective assumptions and judgments regarding our income tax exposures. Interpretations of and guidance surrounding income tax laws and regulations change over time. As such, changes in our subjective assumptions and judgments can materially affect amounts recognized in our consolidated financial statements.

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The ultimate recovery of certain of our deferred tax assets is dependent on the amount and timing of taxable income we will ultimately generate in the future, as well as other factors. A high degree of judgment is required to determine the extent a valuation allowance should be provided against deferred tax assets. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our operating performance in recent years, the scheduled reversal of temporary differences, our forecast of taxable income in future periods in each applicable tax jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment. Our forecast of future earnings includes assumptions about patient volumes, payor reimbursement, labor costs, hospital operating expenses, and interest expense. Based on the weight of available evidence, we determine if it is more likely than not our deferred tax assets will be realized in the future.

Our liability for unrecognized tax benefits contains uncertainties because management is required to make assumptions and to apply judgment to estimate the exposures associated with our various filing positions which are periodically audited by tax authorities. In addition, our effective income tax rate is affected by changes in tax law, the tax jurisdictions in which we operate, and the results of income tax audits.

During the year ended December 31, 2016, we increased our valuation allowance by $0.3 million. As of December 31, 2016, we had a remaining valuation allowance of $27.9 million which primarily related to state NOLs. At the state jurisdiction level, we determined it was necessary to maintain a valuation allowance due to uncertainties related to our ability to utilize a portion of the NOLs before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence, as described above, including management’s estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable.

While management believes the assumptions included in its forecast of future earnings are reasonable and it is more likely than not the net deferred tax asset balance as of December 31, 2016 will be realized, no such assurances can be provided. If management’s expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to increase our valuation allowance, or reverse amounts recorded currently in the valuation allowance, for all or a portion of our deferred tax assets. Similarly, future adjustments to our valuation allowance may be necessary if the timing of future tax deductions is different than currently expected. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. See Note 1, Summary of Significant Accounting Policies, “Litigation Reserves,” and Note 17, Contingencies and Other Commitments, to the accompanying consolidated financial statements for additional information.

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

Recent Accounting Pronouncements

For information regarding recent accounting pronouncements, see Note 1, Summary of Significant Accounting Policies, to the accompanying consolidated financial statements.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use sensitivity analysis models to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2016, our primary variable rate debt outstanding related to $152.0 million in advances under our revolving credit

facility and $421.2 million outstanding under our term loan facilities. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $5.1 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $4.1 million over the next 12 months, assuming floating rate indices are floored at 0%.

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The fair value of our fixed rate debt is determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or Level 2 inputs within the fair value hierarchy, and is summarized as follows (in millions):

| | December 31, 2016 | | December 31, 2015 | |
|---|---|---|---|---|
| Financial Instrument: | Book Value | Market Value | Book Value | Market Value |
| 7.75% Senior Notes due 2022 | | | | |
| Carrying Value | — | — | 174.3 | — |
| Unamortized debt premium and fees | — | — | 1.6 | — |
| Principal amount | — | — | 175.9 | 183.7 |
| 5.125% Senior Notes due 2023 | | | | |
| Carrying Value | 295.3 | — | 294.6 | — |
| Unamortized debt discount and fees | 4.7 | — | 5.4 | — |
| Principal amount | 300.0 | 297.8 | 300.0 | 288.0 |
| 5.75% Senior Notes due 2024 | | | | |
| Carrying Value | 1,193.2 | — | 1,192.6 | — |
| Unamortized debt discount and fees | 6.8 | — | 7.4 | — |
| Principal amount | 1,200.0 | 1,216.6 | 1,200.0 | 1,146.0 |
| 5.75% Senior Notes due 2025 | | | | |
| Carrying Value | 343.9 | — | 343.4 | — |
| Unamortized debt discount and fees | 6.1 | — | 6.6 | — |
| Principal amount | 350.0 | 349.6 | 350.0 | 332.5 |
| 2.00% Convertible Senior Subordinated Notes due 2043 | | | | |
| Carrying Value | 275.7 | — | 265.9 | — |
| Unamortized debt discount and fees | 44.3 | — | 54.1 | — |
| Principal amount | 320.0 | 382.6 | 320.0 | 345.0 |

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

See also Note 9, Long-term Debt, to the accompanying consolidated financial statements.

Item 8. Financial Statements and Supplementary Data

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

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, an evaluation was carried out by our management, including our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”). Our disclosure controls and procedures are designed to ensure that information required to be disclosed in reports we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2016, our disclosure controls and procedures were effective.

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Management's Report on Internal Control Over Financial Reporting

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

Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2016. In making this assessment, management used the criteria set forth in Internal Control-Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, the COSO framework. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2016, our internal control over financial reporting was effective.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2016 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears herein.

Changes in Internal Control Over Financial Reporting

There were no changes in the Company's internal controls over financial reporting that occurred during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

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PART III

We expect to file a definitive proxy statement relating to our 2017 Annual Meeting of Stockholders (the "2017 Proxy Statement") with the United States Securities and Exchange Commission, pursuant to Regulation 14A, not later than 120 days after the end of our most recent fiscal year. Accordingly, certain information required by Part III has been omitted under General Instruction G(3) to Form 10-K. Only the information from the 2017 Proxy Statement that specifically addresses disclosure requirements of Items 10-14 below is incorporated by reference.

Item 10. Directors and Executive Officers of the Registrant

The information required by Item 10 is hereby incorporated by reference from our 2017 Proxy Statement under the captions "Items of Business Requiring Your Vote—Proposal 1—Election of Directors," "Corporate Governance and Board Structure—Code of Ethics," "Corporate Governance and Board Structure—Proposals for Director Nominees by Stockholders," "Corporate Governance and Board Structure—Audit Committee," "Section 16(a) Beneficial Ownership Reporting Compliance," and "Executive Officers."

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2017 Proxy Statement under the captions "Corporate Governance and Board Structure—Compensation of Directors," "Compensation Committee Matters," and "Executive Compensation."

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

Equity Compensation Plans

The following table sets forth, as of December 31, 2016, information concerning compensation plans under which our securities are authorized for issuance. The table does not reflect grants, awards, exercises, terminations, or expirations since that date. All share amounts and exercise prices have been adjusted to reflect stock splits that occurred after the date on which any particular underlying plan was adopted, to the extent applicable.

| | Securities to be Issued Upon Exercise | Weighted Average Price[1] | Securities Available for Future Issuance |
|---|---|---|---|
| Plans approved by stockholders | 3,120,218[2] | $ 22.25 | 13,861,862[3] |
| Plans not approved by stockholders | 330,920 [4] | 17.07 | — |
| Total | 3,451,138 | 20.90 | 13,861,862 |

(1) This calculation does not take into account awards of restricted stock, restricted stock units, or performance share units.

(2) This amount assumes maximum performance by performance-based awards for which the performance has not yet been determined.

(3) This amount represents the number of shares available for future equity grants under the 2016 Omnibus Performance Incentive Plan approved by our stockholders in May 2016.

(4) This amount includes (a) 244,090 shares issuable upon exercise of stock options outstanding under the 2005 Equity Incentive Plan and (b) 86,830 restricted stock units issued under the 2004 Amended and Restated Director Incentive Plan.

2004 Amended and Restated Director Incentive Plan

The 2004 Amended and Restated Director Incentive Plan (the "2004 Plan") provided for the grant of common stock, awards of restricted common stock, and the right to receive awards of common stock, which we refer to as "restricted stock units," to our non-employee directors. The 2004 Plan expired in March 2008 and was replaced by the 2008 Equity Incentive Plan. Some awards remain outstanding. Awards granted under the 2004 Plan at the time of its termination will continue in effect in accordance with their terms. Awards of restricted stock units were fully vested when awarded and will be settled in shares of common stock on the earlier of the six-month anniversary of the date on

which the director ceases to serve on the board of directors or certain change in control events. The restricted stock units generally cannot be transferred. Awards are

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generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

2005 Equity Incentive Plan

The 2005 Equity Incentive Plan (the "2005 Plan") provided for the grant of stock options, restricted stock, stock appreciation rights, deferred stock, and other stock-based awards to our directors, executives, and other key employees as determined by the board of directors or the compensation committee in accordance with the terms of the 2005 Plan and evidenced by an award agreement with each participant. The 2005 Plan expired in November 2008 and was replaced by the 2008 Equity Incentive Plan. Some option awards remain outstanding and are fully vested. Awards granted under the 2005 Plan at the time of its termination will continue in effect in accordance with their terms. The outstanding options have an exercise price not less than the fair market value of such shares of common stock on the date of grant and an expiration date that is ten years after the grant date. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

Security Ownership of Certain Beneficial Owners and Management

The other information required by Item 12 is hereby incorporated by reference from our 2017 Proxy Statement under the caption "Security Ownership of Certain Beneficial Owners and Management."

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by Item 13 is hereby incorporated by reference from our 2017 Proxy Statement under the captions "Corporate Governance and Board Structure—Director Independence" and "Certain Relationships and Related Transactions."

Item 14. Principal Accountant Fees and Services

The information required by Item 14 is hereby incorporated by reference from our 2017 Proxy Statement under the caption "Items of Business Requiring Your Vote—Proposal 2—Ratification of Appointment of Independent Registered Public Accounting Firm."

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PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

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

Financial Statement Schedules

None.

Exhibits

See Exhibit Index immediately following page F-79 of this report.

Item 16. Form 10-K Summary

Not applicable.

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SIGNATURES

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

HEALTHSOUTH CORPORATION

By: /s/ MARK J. TARR
Mark J. Tarr
President and Chief Executive Officer

Date: February 22, 2017

[Signatures continue on the following page]

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POWER OF ATTORNEY

Each person whose signature appears below hereby constitutes and appoints Patrick Darby his true and lawful attorney-in-fact and agent with full power of substitution and re-substitution, for him in his name, place and stead, in any and all capacities, to sign any and all amendments to this Report and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, and hereby grants to such attorney-in-fact and agent, full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agent or his substitute or substitutes may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

| Signature | Capacity | Date |
|---|---|---|
| /s/ MARK J. TARR<br>Mark J. Tarr | President and Chief Executive Officer and Director | February 22, 2017 |
| /s/ DOUGLAS E. COLTHARP<br>Douglas E. Coltharp | Executive Vice President and Chief Financial Officer | February 22, 2017 |
| /s/ ANDREW L. PRICE<br>Andrew L. Price | Chief Accounting Officer | February 22, 2017 |
| /s/ LEO I. HIGDON, JR.<br>Leo I. Higdon, Jr. | Chairman of the Board of Directors | February 22, 2017 |
| /s/ JOHN W. CHIDSEY<br>John W. Chidsey | Director | February 22, 2017 |
| /s/ DONALD L. CORRELL<br>Donald L. Correll | Director | February 22, 2017 |
| /s/ YVONNE M. CURL<br>Yvonne M. Curl | Director | February 22, 2017 |
| /s/ CHARLES M. ELSON<br>Charles M. Elson | Director | February 22, 2017 |
| /s/ JOAN E. HERMAN<br>Joan E. Herman | Director | February 22, 2017 |
| /s/ LESLYE G. KATZ<br>Leslye G. Katz | Director | February 22, 2017 |
| /s/ JOHN E. MAUPIN, JR.<br>John E. Maupin, Jr. | Director | February 22, 2017 |
| /s/ L. EDWARD SHAW, JR.<br>L. Edward Shaw, Jr. | Director | February 22, 2017 |

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Item 15. Financial Statements

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Report of Independent Registered Public Accounting Firm
To the Board of Directors and Shareholders of HealthSouth Corporation:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows present fairly, in all material respects, the financial position of HealthSouth Corporation and its subsidiaries (the "Company") at December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 22, 2017

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Consolidated Statements of Operations

| | For the Year Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| | (In Millions, Except Per Share Data) | | |
| Net operating revenues | $3,707.2 | $3,162.9 | $2,405.9 |
| Less: Provision for doubtful accounts | (61.2) | (47.2) | (31.6) |
| Net operating revenues less provision for doubtful accounts | 3,646.0 | 3,115.7 | 2,374.3 |
| Operating expenses: | | | |
| Salaries and benefits | 1,985.9 | 1,670.8 | 1,161.7 |
| Other operating expenses | 492.1 | 432.1 | 351.6 |
| Occupancy costs | 71.3 | 53.9 | 41.6 |
| Supplies | 140.0 | 128.7 | 111.9 |
| General and administrative expenses | 133.4 | 133.3 | 124.8 |
| Depreciation and amortization | 172.6 | 139.7 | 107.7 |
| Government, class action, and related settlements | — | 7.5 | (1.7) |
| Professional fees—accounting, tax, and legal | 1.9 | 3.0 | 9.3 |
| Total operating expenses | 2,997.2 | 2,569.0 | 1,906.9 |
| Loss on early extinguishment of debt | 7.4 | 22.4 | 13.2 |
| Interest expense and amortization of debt discounts and fees | 172.1 | 142.9 | 109.2 |
| Other income | (2.9) | (5.5) | (31.2) |
| Equity in net income of nonconsolidated affiliates | (9.8) | (8.7) | (10.7) |
| Income from continuing operations before income tax expense | 482.0 | 395.6 | 386.9 |
| Provision for income tax expense | 163.9 | 141.9 | 110.7 |
| Income from continuing operations | 318.1 | 253.7 | 276.2 |
| (Loss) income from discontinued operations, net of tax | — | (0.9) | 5.5 |
| Net income | 318.1 | 252.8 | 281.7 |
| Less: Net income attributable to noncontrolling interests | (70.5) | (69.7) | (59.7) |
| Net income attributable to HealthSouth | 247.6 | 183.1 | 222.0 |
| Less: Convertible perpetual preferred stock dividends | — | | |