Encompass Health Corp
Form 10-Q
May 02, 2018
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

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FORM 10-Q

ý QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended March 31, 2018
OR

o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
Commission File Number 001-10315

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Encompass Health 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.)
9001 Liberty Parkway Birmingham, Alabama	35242
(Address of Principal Executive Offices)	(Zip Code)

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

3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
(Former name or former address, if changed since last report)

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 ý 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 ý No o

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," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ý Accelerated filer o Smaller reporting company o
Non-Accelerated filer o (Do not check if a smaller reporting company) Emerging growth company o
If an emerging growth company, indicate by checkmark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. o

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

The registrant had 98,819,848 shares of common stock outstanding, net of treasury shares, as of April 25, 2018.

TABLE OF CONTENTS

NOTE TO READERS

As used in this report, the terms "Encompass Health," "we," "us," "our," and the "Company" refer to Encompass Health Corporation and its 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 Encompass Health 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 "Encompass Health Corporation" to refer to Encompass Health Corporation alone wherever a distinction between Encompass Health Corporation and its subsidiaries is required or aids in the understanding of this filing.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This quarterly 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, of our Annual Report on Form 10-K for the year ended December 31, 2017, as well as uncertainties and factors, if any, discussed elsewhere in this Form 10-Q, including in the “Executive Overview—Key Challenges” section of Part I, Item 2, Management’s Discussion and Analysis of Financial Condition and Results of Operations, 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 re-basing of payment systems, the introduction of site neutral payments or case-mix weightings across post-acute settings, or the home health groupings model, and other payment system reforms), affecting revenues 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. Departments of Justice and of Health and Human Services, Office of the Inspector General;

ii

- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to claims;
- potential incidents affecting the proper operation, availability, or security of our information systems, including the patient information stored there;
- our ongoing rebranding and name change initiative and the impact on our existing operations, including our ability to attract patient referrals to our hospitals as well as the associated costs of rebranding;
- 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; and
- general conditions in the economy and capital markets, including any instability or uncertainty related to armed conflict or an act of terrorism, 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.

PART I. FINANCIAL INFORMATION

Item 1. Financial Statements (Unaudited)

Encompass Health Corporation and Subsidiaries

Condensed Consolidated Statements of Operations

(Unaudited)

	Three Months Ended March 31,	
	2018	2017
	(In Millions, Except Per Share Data)	
Net operating revenues	$1,046.0	$957.1
Operating expenses:		
Salaries and benefits	570.2	530.1
Other operating expenses	141.2	127.8
Occupancy costs	18.6	17.9
Supplies	39.9	37.0
General and administrative expenses	61.1	36.5
Depreciation and amortization	45.9	45.2
Total operating expenses	876.9	794.5
Interest expense and amortization of debt discounts and fees	35.6	41.3
Other loss (income)	0.1	(1.0)
Equity in net income of nonconsolidated affiliates	(2.3)	(2.1)
Income from continuing operations before income tax expense	135.7	124.4
Provision for income tax expense	30.0	39.7
Income from continuing operations	105.7	84.7
Loss from discontinued operations, net of tax	(0.5)	(0.3)
Net income	105.2	84.4
Less: Net income attributable to noncontrolling interests	(21.4)	(17.6)
Net income attributable to Encompass Health	$83.8	$66.8
Weighted average common shares outstanding:		
Basic	97.8	88.8
Diluted	99.4	99.0
Earnings per common share:		
Basic earnings per share attributable to Encompass Health common shareholders:		
Continuing operations	$0.86	$0.75
Discontinued operations	(0.01)	—
Net income	$0.85	$0.75
Diluted earnings per share attributable to Encompass Health common shareholders:		
Continuing operations	$0.85	$0.70
Discontinued operations	(0.01)	—
Net income	$0.84	$0.70
Cash dividends per common share	$0.25	$0.24
Amounts attributable to Encompass Health common shareholders:		
Income from continuing operations	$84.3	$67.1

Loss from discontinued operations, net of tax	(0.5)	(0.3)
Net income attributable to Encompass Health	$83.8	$66.8

The accompanying notes to condensed consolidated financial statements are an integral part of these condensed statements.

Encompass Health Corporation and Subsidiaries
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

	Three Months Ended March 31,	
	2018	2017
	(In Millions)	
COMPREHENSIVE INCOME		
Net income	$105.2	$84.4
Other comprehensive income, net of tax:		
Net change in unrealized gain on available-for-sale securities:		
Unrealized net holding gain arising during the period	—	0.4
Other comprehensive income before income taxes	—	0.4
Provision for income tax expense related to other comprehensive income items	—	(0.1)
Other comprehensive income, net of tax	—	0.3
Comprehensive income	105.2	84.7
Comprehensive income attributable to noncontrolling interests	(21.4)	(17.6)
Comprehensive income attributable to Encompass Health	$83.8	$67.1

The accompanying notes to condensed consolidated financial statements are an integral part of these condensed statements.

Encompass Health Corporation and Subsidiaries
Condensed Consolidated Balance Sheets
(Unaudited)

	March 31, 2018	December 31, 2017
	(In Millions)	
Assets		
Current assets:		
Cash and cash equivalents	$86.4	$ 54.4
Restricted cash	69.4	62.4
Accounts receivable	463.1	472.1
Other current assets	89.6	113.3
Total current assets	708.5	702.2
Property and equipment, net	1,554.3	1,517.1
Goodwill	1,973.1	1,972.6
Intangible assets, net	396.1	403.1
Deferred income tax assets	68.5	63.6
Other long-term assets	239.1	235.1
Total assets[(1)]	$4,939.6	$ 4,893.7
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	$32.7	$ 32.3
Accounts payable	83.1	78.4
Accrued expenses and other current liabilities	456.2	406.8
Total current liabilities	572.0	517.5
Long-term debt, net of current portion	2,544.4	2,545.4
Other long-term liabilities	183.8	185.3
	3,300.2	3,248.2
Commitments and contingencies		
Redeemable noncontrolling interests	198.6	220.9
Shareholders' equity:		
Encompass Health shareholders' equity	1,197.0	1,181.7
Noncontrolling interests	243.8	242.9
Total shareholders' equity	1,440.8	1,424.6
Total liabilities[(1)] and shareholders' equity	$4,939.6	$ 4,893.7

(1) Our consolidated assets as of March 31, 2018 and December 31, 2017 include total assets of variable interest entities of $264.7 million and $264.1 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of March 31, 2018 and December 31, 2017 include total liabilities of the variable interest entities of $52.9 million and $52.5 million, respectively. See Note 3, Variable Interest Entities.

The accompanying notes to condensed consolidated financial statements are an integral part of these condensed statements.

Encompass Health Corporation and Subsidiaries
Condensed Consolidated Statements of Shareholders' Equity
(Unaudited)

	Three Months Ended March 31, 2018 (In Millions)							
	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Loss	Treasury Stock	Noncontrolling Interests	Total
Balance at beginning of period	98.3	$ 1.1	$2,791.4	$(1,191.0)	$ (1.3)	$(418.5)	$ 242.9	$1,424.6
Net income	—	—	—	83.8	—	—	18.6	102.4
Receipt of treasury stock	(0.2)	—	—	—	—	(8.3)	—	(8.3)
Dividends declared on common stock	—	—	(24.9)	—	—	—	—	(24.9)
Stock-based compensation	—	—	5.3	—	—	—	—	5.3
Distributions declared	—	—	—	—	—	—	(17.7)	(17.7)
Fair value adjustments to redeemable noncontrolling interests, net of tax	—	—	(40.5)	—	—	—	—	(40.5)
Other	0.7	—	0.3	(1.3)	1.3	(0.4)	—	(0.1)
Balance at end of period	98.8	$ 1.1	$2,731.6	$(1,108.5)	$ —	$(427.2)	$ 243.8	$1,440.8

	Three Months Ended March 31, 2017 (In Millions)							
	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Loss	Treasury Stock	Noncontrolling Interests	Total
Balance at beginning of period	88.9	$ 1.1	$2,799.1	$(1,448.4)	$ (1.2)	$(614.7)	$ 192.8	$928.7
Net income	—	—	—	66.8	—	—	14.5	81.3
Receipt of treasury stock	(0.2)	—	—	—	—	(6.9)	—	(6.9)
Dividends declared on common stock	—	—	(21.6)	—	—	—	—	(21.6)
Stock-based compensation	—	—	3.4	—	—	—	—	3.4
Stock options exercised	—	—	0.6	—	—	(0.4)	—	0.2
Stock warrants exercised	0.7	—	26.6	—	—	—	—	26.6
Distributions declared	—	—	—	—	—	—	(10.5)	(10.5)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	2.6	2.6
Fair value adjustments to redeemable noncontrolling interests, net of tax	—	—	(8.2)	—	—	—	—	(8.2)
Repurchases of common stock in open market	(0.5)	—	—	—	—	(18.1)	—	(18.1)

Other	0.6	—	0.2	1.2	0.3	(0.1)	—	1.6
Balance at end of period	89.5	$ 1.1	$2,800.1	$(1,380.4)	$ (0.9)	$(640.2)	$ 199.4	$979.1

The accompanying notes to condensed consolidated financial statements are an integral part of these condensed statements.

Encompass Health Corporation and Subsidiaries
Condensed Consolidated Statements of Cash Flows
(Unaudited)

	Three Months Ended March 31,	
	2018	2017
	(In Millions)	
Cash flows from operating activities:		
Net income	$105.2	$84.4
Loss from discontinued operations, net of tax	0.5	0.3
Adjustments to reconcile net income to net cash provided by operating activities—		
Depreciation and amortization	45.9	45.2
Stock-based compensation	26.1	8.0
Deferred tax (benefit) expense	(3.0)	49.0
Other, net	1.6	2.5
Change in assets and liabilities, net of acquisitions—		
Accounts receivable	8.3	(3.6)
Other assets	14.2	(16.4)
Accounts payable	1.3	(1.7)
Accrued payroll	(9.5)	(3.0)
Other liabilities	26.4	16.5
Net cash used in operating activities of discontinued operations	(0.7)	(0.4)
Total adjustments	110.6	96.1
Net cash provided by operating activities	216.3	180.8
Cash flows from investing activities:		
Purchases of property and equipment	(59.9)	(41.2)
Acquisitions of businesses, net of cash acquired	(0.6)	(16.4)
Other, net	(0.1)	8.5
Net cash used in investing activities	(60.6)	(49.1)
Cash flows from financing activities:		
Borrowings on revolving credit facility	95.0	55.0
Payments on revolving credit facility	(95.0)	(122.0)
Repurchases of common stock, including fees and expenses	—	(18.1)
Dividends paid on common stock	(25.4)	(22.2)
Purchase of equity interests in consolidated affiliates	(65.1)	—
Proceeds from exercising stock warrants	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	(15.4)	(11.5)
Other, net	(10.8)	(14.1)
Net cash used in financing activities	(116.7)	(106.3)
Increase in cash, cash equivalents, and restricted cash	39.0	25.4
Cash, cash equivalents, and restricted cash, at beginning of period	116.8	101.4
Cash, cash equivalents, and restricted cash, at end of period	$155.8	$126.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash		
Cash and cash equivalents at beginning of period	$54.4	$40.5
Restricted cash at beginning of period	62.4	60.9
Cash, cash equivalents, and restricted cash at beginning of period	$116.8	$101.4

Cash and cash equivalents at end of period	$86.4	$61.2
Restricted cash at end of period	69.4	65.6
Cash, cash equivalents, and restricted cash at end of period	$155.8	$126.8

The accompanying notes to condensed consolidated financial statements are an integral part of these condensed statements.

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

1. Basis of Presentation

Encompass Health Corporation, incorporated in Delaware in 1984, including its subsidiaries, is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based patient services in 36 states and Puerto Rico through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. Effective January 1, 2018, we changed our name from HealthSouth Corporation to Encompass Health Corporation. Our operations in both business segments will transition to the Encompass Health name on a rolling basis.

The accompanying unaudited condensed consolidated financial statements of Encompass Health Corporation and Subsidiaries should be read in conjunction with the consolidated financial statements and accompanying notes contained in Encompass Health's Annual Report on Form 10-K filed with the United States Securities and Exchange Commission on February 27, 2018 (the "2017 Form 10-K"). The unaudited condensed consolidated financial statements have been prepared in accordance with the rules and regulations of the SEC applicable to interim financial information. Certain information and note disclosures included in financial statements prepared in accordance with generally accepted accounting principles in the United States of America have been omitted in these interim statements, as allowed by such SEC rules and regulations. The condensed consolidated balance sheet as of December 31, 2017 has been derived from audited financial statements, but it does not include all disclosures required by GAAP. However, we believe the disclosures are adequate to make the information presented not misleading.

The unaudited results of operations for the interim periods shown in these financial statements are not necessarily indicative of operating results for the entire year. In our opinion, the accompanying condensed consolidated financial statements recognize all adjustments of a normal recurring nature considered necessary to fairly state the financial position, results of operations, and cash flows for each interim period presented.

See also Note 11, Segment Reporting.

Net Operating Revenues—

Our Net operating revenues disaggregated by payor source and segment are as follows (in millions):

	Inpatient Rehabilitation		Home Health and Hospice		Consolidated	
	Three Months Ended March 31,		Three Months Ended March 31,		Three Months Ended March 31,	
	2018	2017	2018	2017	2018	2017
Medicare	$624.5	$573.7	$176.9	$152.3	$801.4	$726.0
Medicare Advantage	72.5	64.8	20.0	18.2	92.5	83.0
Managed care	85.0	84.9	7.6	7.1	92.6	92.0
Medicaid	24.7	21.6	0.5	1.2	25.2	22.8
Other third-party payors	12.0	11.4	—	—	12.0	11.4
Workers' compensation	7.4	7.4	0.1	0.1	7.5	7.5
Patients	4.4	4.4	0.4	0.2	4.8	4.6
Other income	9.8	9.6	0.2	0.2	10.0	9.8
Total	$840.3	$777.8	$205.7	$179.3	$1,046.0	$957.1

We record Net operating revenues on an accrual basis using our best estimate of the transaction price for the type of service provided to the patient. Our estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. Our accounting systems calculate contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Adjustments related to payment reviews by third-party payors or their agents are based on our historical experience and success rates in the claims adjudication process. Estimates for uncollectible amounts are based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors.

6

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

Management continually reviews the revenue transaction price 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. Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. In addition, laws and regulations governing the Medicare and Medicaid programs are complex, subject to interpretation, and are routinely modified for provider reimbursement. All healthcare providers participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided under each hospital, home health, and hospice provider number to program beneficiaries. Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to Encompass Health under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

The Centers for Medicare and Medicaid Services ("CMS") has been granted authority to suspend payments, in whole or in part, to Medicare providers if CMS possesses reliable information an overpayment, fraud, or willful misrepresentation exists. If CMS suspects payments are being made as the result of fraud or misrepresentation, CMS may suspend payment at any time without providing prior notice to us. The initial suspension period is limited to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG") or the United States Department of Justice. Therefore, we are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period, or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. As a matter of course, we undertake significant efforts through training and education to ensure compliance with Medicare requirements. However, audits may lead to assertions 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. In some circumstances auditors assert the authority to extrapolate denial rationales to large pools of claims not actually audited, which could increase the impact of the audit. We cannot predict when or how these audit programs will affect us.

Medicare Administrative Contractors ("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. The majority of the denials we have encountered in these probes relate to determinations regarding medical necessity and provision of therapy services. We dispute, or "appeal," most of these denials, and for claims we choose to take to administrative law judge hearings, we have historically experienced a success rate of approximately 70%. This historical success rate is a component of our estimate of transaction price as discussed above. The resolution of these disputes can take in excess of three years, and we cannot provide assurance as to our ongoing and future success of these disputes. When the amount collected related to denied claims differs from the amount previously estimated, these collection differences are recorded as an adjustment to Net operating revenues.

In August 2017, CMS announced the Targeted Probe and Educate ("TPE") initiative. Under the TPE initiative, MACs use data analysis to identify healthcare providers with high claim error rates and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE initiative includes up to three rounds of claims review with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds,

the MAC may refer the provider to CMS for further action, which may include extrapolation of error rates to a broader universe of claims or referral to a ZPIC or RAC (defined below). We cannot predict the impact of the TPE initiative on our ability to collect claims on a timely basis.

In connection with CMS approved and announced Recovery Audit Contractors ("RACs") audits related to inpatient rehabilitation facilities ("IRFs"), we received requests from 2013 to 2017 to review certain patient files for discharges occurring from 2010 to 2017. These RAC audits are focused on identifying Medicare claims that may contain improper payments. RAC

contractors must have CMS approval before conducting these focused reviews which cover issues ranging from billing documentation to medical necessity. 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.

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 as a result of ZPIC audits. We have, from time to time, received ZPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all ZPIC denials arising from these audits using the same process we follow for appealing other denials by contractors.

To date, the Medicare claims that are subject to these post-payment audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2017, and not all of these patient file requests have resulted in payment denial determinations by the audit contractor. Because we have confidence in the medical judgment of both the referring and admitting physicians who assess the treatment needs of their patients, we have appealed substantially all claim denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by MACs. Due to the delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take in excess of three years. In addition, because we have limited experience with ZPICs and RACs in the context of claims reviews of this nature, we cannot provide assurance as to the timing or outcomes of these disputes. As such, we make estimates for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs. The impact on our estimates of amounts determined to be due to Encompass Health as a result of these audits during the three months ended March 31, 2018 and 2017 was not material.

Our performance obligations relate to contracts with a duration of less than one year. Therefore, we elected to apply the optional exemption to not disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. These unsatisfied or partially unsatisfied performance obligations primarily relate to services provided at the end of the reporting period.

Inpatient Rehabilitation Revenues

Inpatient rehabilitation segment revenues are recognized over time as the services are provided to the patient. The performance obligation is the rendering of services to the patient during the term of their inpatient stay. Revenues are recognized (or measured) using the input method as therapy, nursing and auxiliary services are provided based on our estimate of the respective transaction price. Revenues recognized by our inpatient rehabilitation segment are subject to a number of elements which impact both the overall amount of revenue realized as well as the timing of the collection of the related accounts receivable. Factors considered in determining the estimated transaction price include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes.

Home Health and Hospice Revenues

Home Health

Under the Medicare home health prospective payment system, we are paid by Medicare based on episodes of care. The performance obligation is the rendering of services to the patient during the term of the episode of care. An episode of care is defined as a length of stay up to 60 days, with multiple continuous episodes allowed. A base episode payment is established by the Medicare program through federal regulation. The base episode payment can be adjusted based on each patient's health including clinical condition, functional abilities, and service needs, as well as for the applicable geographic wage index, low utilization, patient transfers, and other factors. The services covered by the episode payment include all disciplines of care in addition to medical supplies.

8

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

We bill a portion of reimbursement from each Medicare episode near the start of each episode, and the resulting cash payment is typically received before all services are rendered. As we provide home health services to our patients on a scheduled basis over the episode of care in a manner that approximates a pro rata pattern, revenue for the episode of care is recorded over an average length of treatment period using a calendar day prorating method. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the pro rata number of days in the episode which have been completed as of the period end date. As of March 31, 2018 and December 31, 2017, the difference between the cash received from Medicare for a request for anticipated payment on episodes in progress and the associated estimated revenue was not material and was recorded in Other current liabilities in our condensed consolidated balance sheets.

We are subject to certain Medicare regulations affecting outlier revenue if our patient's care was unusually costly. Regulations require a cap on all outlier revenue at 10% of total Medicare revenue received by each provider during a cost reporting year. Management has reviewed the potential cap. Adjustments to the transaction price for the outlier cap were not material as of March 31, 2018 and December 31, 2017.

For episodic-based rates that are paid by other insurance carriers, including Medicare Advantage, we recognize revenue in a similar manner as discussed above for Medicare revenues. However, these rates can vary based upon the negotiated terms. For non-episodic-based revenue, revenue is recorded on an accrual basis based upon the date of service at amounts equal to our estimated per-visit transaction price. Price concessions, including contractual allowances for the differences between our standard rates and the applicable contracted rates, as well as estimated uncollectible amounts from patients, are recorded as decreases to the transaction price.

Hospice

Medicare revenues for hospice are recognized and recorded on an accrual basis using the input method based on the number of days a patient has been on service at amounts equal to an estimated daily or hourly payment rate. The performance obligation is the rendering of services to the patient during each day that they are on hospice care. The payment rate is dependent on whether a patient is receiving routine home care, general inpatient care, continuous home care or respite care. Adjustments to Medicare revenues are recorded based on an inability to obtain appropriate billing documentation or authorizations acceptable to the payor or other reasons unrelated to credit risk. Hospice companies are subject to two specific payment limit caps under the Medicare program. One limit relates to inpatient care days that exceed 20% of the total days of hospice care provided for the year. The second limit relates to an aggregate Medicare reimbursement cap calculated by the Medicare fiscal intermediary. Adjustments to the transaction price for these caps were not material as of March 31, 2018 and December 31, 2017.

For non-Medicare hospice revenues, we record gross revenue on an accrual basis based upon the date of service at amounts equal to our estimated per day transaction price. Price concessions, including contractual adjustments for the difference between our standard rates and the amounts estimated to be realizable from patients and third parties for services provided, are recorded as decreases to the transaction price and thus reduce our Net operating revenues.

We are subject to changes in government legislation that could impact Medicare payment levels and changes in payor patterns that may impact the level and timing of payments for services rendered.

Marketable Securities—

Effective January 1, 2018, in connection with the adoption of ASU 2016-01, we record all equity securities with readily determinable fair values and for which we do not exercise significant influence at fair value and record the change in fair value for the reporting period in our condensed consolidated statements of operations.

Prior to January 1, 2018, we recorded all equity securities with readily determinable fair values and for which we did not exercise significant influence as available-for-sale securities. We carried the available-for-sale securities at fair value and reported unrealized holding gains or losses, net of income taxes, in Accumulated other comprehensive loss, which is a separate component of shareholders' equity. We recognized realized gains and losses in our consolidated statements of operations using the specific identification method. Unrealized losses were charged against earnings when a decline in fair value was determined to be other than temporary. Management reviewed several factors to determine whether a loss was other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than cost, the financial

condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

Accounts Receivable—

We report accounts receivable from services rendered at their estimated transaction price which takes into account price concessions from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable is concentrated by type of payor. The concentration of patient service accounts receivable by payor class, as a percentage of total patient service accounts receivable, is as follows:

	March 31, 2018	December 31, 2017
Medicare	73.2 %	75.1 %
Managed care and other discount plans, including Medicare Advantage	19.1 %	17.4 %
Medicaid	2.6 %	2.4 %
Other third-party payors	2.9 %	2.9 %
Workers' compensation	1.3 %	1.3 %
Patients	0.9 %	0.9 %
Total	100.0 %	100.0 %

While revenues and accounts receivable from the Medicare program are significant to our operations, we do not believe there are significant credit risks associated with this government agency. We do not believe there are any other significant concentrations of revenues from any particular payor that would subject us to any significant credit risks in the collection of our accounts receivable.

Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine all in-house efforts have been exhausted or it is a more prudent use of resources, accounts may be turned over to a collection agency.

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. While it is our policy to verify insurance prior to a patient being admitted, there are various exceptions that can occur. Such exceptions include instances where we are (1) unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid, and it takes several days, weeks, or months before qualification for such benefits is confirmed or denied, and (3) the patient is transferred to our hospital from an acute care hospital without having access to a credit card, cash, or check to pay the applicable patient responsibility amounts (i.e., deductibles and co-payments).

Our primary collection risks relate to patient responsibility amounts and claims reviews conducted by MACs or other contractors. Patient responsibility amounts include accounts for which the patient was the primary payor or the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient co-payment amounts remain outstanding. Changes in the economy, such as increased unemployment rates or periods of recession, can further exacerbate our ability to collect patient responsibility amounts.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. Changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

Recently Adopted Accounting Pronouncements—
In May 2014, the FASB issued ASU 2014-09, “Revenue from Contracts with Customers” and has subsequently issued supplemental and/or clarifying ASUs (collectively “ASC 606”). ASC 606 outlines a five-step framework that supersedes the principles for recognizing revenue and eliminate industry-specific guidance. In addition, ASC 606 revises current disclosure requirements in an effort to help financial statement users better understand the nature, amount, timing, and uncertainty of revenue that is recognized. We adopted ASC 606 on January 1, 2018 using the full retrospective model. The primary impact of adopting under ASC 606 is that all amounts we previously presented as Provision for doubtful accounts are now considered an implicit price concession in determining Net operating revenues. Such concessions reduce the transaction price and therefore Net operating revenues, as shown below. Adopting ASC 606 on January 1, 2018 using the full retrospective transition method had the following impact to our previously reported condensed consolidated statements of operations (in millions):

	For the Three Months Ended March 31, 2017		
	As Previously Reported	Adjustment for ASC 606	Restated
Net operating revenues	$974.8	$ (17.7)	$ 957.1
Provision for doubtful accounts	$16.4	$ (16.4)	$ —
Other operating expenses	$129.1	$ (1.3)	$ 127.8
Net income attributable to Encompass Health	$66.8	$ —	$ 66.8

In addition, the adoption of ASC 606 resulted in increased disclosure, including qualitative and quantitative disclosures about the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. See the "Net Operating Revenues" and "Accounts Receivable" sections of this note. Except for the adjustments discussed above, the adoption of ASC 606 did not have a material impact on our condensed consolidated financial statements.
In January 2016, the FASB issued ASU No. 2016-01, “Financial Instruments - Overall (Topic 825): Recognition and Measurement of Financial Assets and Financial Liabilities.” This standard revises the classification and measurement of investments in certain equity investments and the presentation of certain fair value changes for certain financial liabilities measured at fair value. This revised standard requires the change in fair value of many equity investments to be recognized in Net income. This revised standard requires a modified retrospective application with a cumulative effect adjustment recognized in retained earnings as of the date of adoption and was effective for our interim and annual periods beginning January 1, 2018. During the first quarter of 2018, we recognized mark-to-market gains and losses associated with our available-for-sale equity securities through Net income instead of Accumulated other comprehensive income. The adoption of this guidance resulted in an immaterial impact to our condensed consolidated financial statements. See the "Marketable Securities" section of this note.
In August 2016, the FASB issued ASU 2016-15, “Statement of Cash Flows (Topic 230), Classification of Certain Cash Receipts and Cash Payments,” to reduce diversity in practice in how certain transactions are classified in the statement of cash flows. In addition, the standard clarifies when cash receipts and cash payments have aspects of more than one class of cash flows and cannot be separated, classification will depend on the predominant source or use. The new guidance requires retrospective application and was effective for our annual reporting period beginning January 1, 2018, including interim periods within that reporting period. The adoption of this standard did not have any effect on our previously presented statement of cash flows for the three months ended March 31, 2017. The clarification that debt prepayment premiums should be classified as financing activities will result in an immaterial increase in operating cash inflows and a corresponding increase in financing cash outflows for the nine months and year ended September 30, 2017 and December 31, 2017, respectively, when presented.
In November 2016, the FASB issued ASU 2016-18, “Statement of Cash Flows (Topic 230), Restricted Cash,” to clarify how entities should present restricted cash and restricted cash equivalents in the statement of cash flows. The new guidance requires amounts generally described as restricted cash and restricted cash equivalents be included with Cash

and cash equivalents when reconciling the total beginning and ending amounts for the periods shown on the statement of cash flows. The new guidance requires retrospective application and is effective for our annual reporting period beginning January 1, 2018, including interim periods within that reporting period. The adoption of this guidance resulted in an immaterial decrease to previously reported Net cash used in investing activities for the three months ended March 31, 2017 and a corresponding increase to previously reported Increase in cash and cash equivalents (which is now captioned Increase in cash, cash

equivalents, and restricted cash, pursuant to the adoption of this guidance). In addition, as noted above, we added a reconciliation of cash, cash equivalents, and restricted cash to the condensed consolidated statements of cash flows.

Recent Accounting Pronouncements Not Yet Adopted—

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)," in order to increase transparency and comparability by recognizing lease assets and liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the new standard, lessees will recognize a right-of-use asset and a corresponding lease liability for all leases other than leases that meet the definition of a short-term lease. The liability will be equal to the present value of future minimum lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, the FASB retained a dual model, requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense while finance leases will result in an expense pattern similar to current capital leases. Classification will be based on criteria that are similar to those applied in current lease accounting. This standard will be effective for our annual reporting period beginning on January 1, 2019. Early adoption is permitted. In transition, we will be required to recognize and measure leases beginning in the earliest period presented using a modified retrospective approach; therefore, we anticipate restating our condensed consolidated financial statements for the two fiscal years prior to the year of adoption. While we are currently assessing the impact this guidance may have on our condensed consolidated financial statements, we expect that virtually all of our existing operating leases will be reflected as right-of-use assets and liabilities on our condensed consolidated balance sheets under the new standard. See Note 6, Property and Equipment, to the consolidated financial statements accompanying the 2017 Form 10-K for disclosure related to our operating leases.

In June 2016, the FASB issued ASU 2016-13, "Financial Instruments – Credit Losses (Topic 326)," which provides guidance for accounting for credit losses on financial instruments. The new guidance introduces an approach based on expected losses to estimate credit losses on certain types of financial instruments and modifies the impairment model for available-for-sale debt securities. The new guidance is effective for our annual reporting period beginning January 1, 2020, including interim periods within that reporting period. Early adoption is permitted beginning January 1, 2019. We continue to review the requirements of this standard and any potential impact it may have on our condensed consolidated financial statements.

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

2. Business Combinations

On May 1, 2018, we completed the previously announced acquisition of privately owned Camellia Healthcare and affiliated entities for a cash purchase price of approximately $135 million using cash on hand and borrowings under our revolving credit facility. Camellia Healthcare operates a portfolio of hospice, home health and private duty locations in Mississippi, Alabama, Louisiana and Tennessee. The acquisition leverages our home health and hospice operating platform across key certificate of need states and strengthens our geographic presence in the Southeastern United States. The preliminary purchase price allocation has not been provided as estimates of the fair value of the assets acquired and liabilities assumed have not been completed.

During the three months ended March 31, 2018, we completed one hospice acquisition in Oklahoma City, Oklahoma, which was immaterial to our financial position, results of operations, and cash flows. See Note 2, Business Combinations, to the consolidated financial statements accompanying the 2017 Form 10-K for information regarding acquisitions completed in 2017.

3. Variable Interest Entities

As of March 31, 2018 and December 31, 2017, we consolidated ten limited partnership-like entities that are variable interest entities ("VIEs") and of which we are the primary beneficiary. Our ownership percentages in these entities range from 6.8% to 99.5%. Through partnership and management agreements with or governing each of these entities, we manage all of these entities and handle all day-to-day operating decisions. Accordingly, we have the decision making power over the activities that most significantly impact the economic performance of our VIEs and an obligation to absorb losses or receive benefits from the VIE that could potentially be significant to the VIE. These decisions and significant activities include, but are not limited to, marketing efforts, oversight of patient admissions, medical

training, nurse and therapist scheduling, provision of

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

healthcare services, billing, collections, and creation and maintenance of medical records. The terms of the agreements governing each of our VIEs prohibit us from using the assets of each VIE to satisfy the obligations of other entities. The carrying amounts and classifications of the consolidated VIEs' assets and liabilities, which are included in our consolidated balance sheet, are as follows (in millions):

	March 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$2.0	$ 1.2
Accounts receivable	33.7	32.6
Other current assets	5.0	5.6
Total current assets	40.7	39.4
Property and equipment, net	142.4	142.8
Goodwill	73.5	73.5
Intangible assets, net	7.3	7.7
Other long-term assets	0.8	0.7
Total assets	$264.7	$ 264.1
Liabilities		
Current liabilities:		
Current portion of long-term debt	$1.8	$ 1.8
Accounts payable	7.5	6.5
Accrued expenses and other current liabilities	15.8	15.9
Total current liabilities	25.1	24.2
Long-term debt, net of current portion	27.8	28.3
Total liabilities	$52.9	$ 52.5

4. Investments in and Advances to Nonconsolidated Affiliates

As of March 31, 2018 and December 31, 2017, we had $13.0 million and $11.9 million, respectively, of investments in and advances to nonconsolidated affiliates included in Other long-term assets in our condensed consolidated balance sheets. Investments in and advances to nonconsolidated affiliates represent our investments in six partially owned subsidiaries, of which five are general or limited partnerships, limited liability companies, or joint ventures in which Encompass Health or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 1% to 60%. We account for these investments using the cost and equity methods of accounting.

The following summarizes the combined results of operations of our equity method affiliates (on a 100% basis, in millions):

	Three Months Ended March 31,	
	2018	2017
Net operating revenues	$11.0	$10.8
Operating expenses	(7.6)	(6.3)
Income from continuing operations, net of tax	3.4	4.4
Net income	3.4	4.4

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

5. Redeemable Noncontrolling Interests

The following is a summary of the activity related to our Redeemable noncontrolling interests during the three months ended March 31, 2018 and 2017 (in millions):

	Three Months Ended March 31,	
	2018	2017
Balance at beginning of period	$220.9	$138.3
Net income attributable to noncontrolling interests	2.8	3.1
Distributions declared	(2.2)	(1.9)
Purchase of redeemable noncontrolling interests	(65.1)	—
Change in fair value	42.2	13.9
Balance at end of period	$198.6	$153.4

The following table reconciles the net income attributable to nonredeemable Noncontrolling interests, as recorded in the shareholders' equity section of the condensed consolidated balance sheets, and the net income attributable to Redeemable noncontrolling interests, as recorded in the mezzanine section of the condensed consolidated balance sheets, to the Net income attributable to noncontrolling interests presented in the condensed consolidated statements of operations for the three months ended March 31, 2018 and 2017 (in millions):

	Three Months Ended March 31,	
	2018	2017
Net income attributable to nonredeemable noncontrolling interests	$18.6	$14.5
Net income attributable to redeemable noncontrolling interests	2.8	3.1
Net income attributable to noncontrolling interests	$21.4	$17.6

On December 31, 2014, we acquired 83.3% of our home health and hospice business when we purchased EHHI Holdings, Inc. ("EHHI"). In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Encompass Health Home Health Holdings, Inc. ("Holdings"), a subsidiary of Encompass Health and an indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. Those sellers were members of EHHI management, and they contributed a portion of their shares of common stock of EHHI, valued at approximately $64 million on the acquisition date, 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 has the right (but not the obligation) to have his or her shares of Holdings stock repurchased by Encompass Health for a cash purchase price per share equal to the fair value. 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, Encompass Health 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. In February 2018, each management investor exercised the right to sell one-third of his or her shares of Holdings stock to Encompass Health, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. On February 21, 2018, Encompass Health settled the acquisition of those shares upon payment of approximately $65 million in cash. As of March 31, 2018, the value of the outstanding shares of Holdings owned by management investors was approximately $170 million. See also Note 6, Fair Value Measurements.

6. Fair Value Measurements

Our financial assets and liabilities that are measured at fair value on a recurring basis are as follows (in millions):

As of March 31, 2018	Fair Value Measurements at Reporting Date Using Valuation Technique [1]

	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	
Other current assets:					
Current portion of restricted marketable securities	$ 10.2	$ —	$ 10.2	$ —	M
Other long-term assets:					
Restricted marketable securities	45.9	—	45.9	—	M
Redeemable noncontrolling interests	198.6	—	—	198.6	I
As of December 31, 2017					
Other current assets:					
Current portion of restricted marketable securities	$ 17.8	$ —	$ 17.8	$ —	M
Other long-term assets:					
Restricted marketable securities	44.2	—	44.2	—	M
Redeemable noncontrolling interests	220.9	—	—	220.9	I

(1) The three valuation techniques are: market approach (M), cost approach (C), and income approach (I).

The fair values of our financial assets and liabilities are determined as follows:

- Restricted marketable securities - The fair values of our restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.
- Redeemable noncontrolling interests - The fair value of the Redeemable noncontrolling interests related to our home health segment is determined using the product of a twelve-month adjusted EBITDA measure and a specified median market price multiple based on a basket of public home health companies and transactions, after adding cash and deducting indebtedness that includes the outstanding principal balance under any intercompany notes. To determine the fair value of the Redeemable noncontrolling interests in our joint venture hospitals, we use the applicable hospitals' projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable facilities. The projected operating results use management's best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures. See also Note 5, Redeemable Noncontrolling Interests.

In addition to assets and liabilities recorded at fair value on a recurring basis, we are also required to record assets and liabilities at fair value on a nonrecurring basis. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets. During the three months ended March 31, 2018 and March 31, 2017, we did not record any gains or losses related to our nonfinancial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a nonrecurring basis as part of our continuing operations.

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

As discussed in Note 1, Summary of Significant Accounting Policies, “Fair Value Measurements,” to the consolidated financial statements accompanying the 2017 Form 10-K, the carrying value equals fair value for our financial instruments that are not included in the table below and are classified as current in our condensed consolidated balance sheets. The carrying amounts and estimated fair values for all of our other financial instruments are presented in the following table (in millions):

	As of March 31, 2018		As of December 31, 2017	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$95.0	$ 95.0	$95.0	$ 95.0
Term loan facilities	291.0	292.5	294.7	296.3
5.125% Senior Notes due 2023	296.1	304.5	295.9	306.8
5.75% Senior Notes due 2024	1,194.1	1,221.0	1,193.9	1,228.5
5.75% Senior Notes due 2025	344.6	359.2	344.4	364.9
Other notes payable	87.9	87.9	82.3	82.3
Financial commitments:				
Letters of credit	—	37.2	—	35.4

Fair values for our long-term debt and financial commitments are 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. See Note 1, Summary of Significant Accounting Policies, “Fair Value Measurements,” to the consolidated financial statements accompanying the 2017 Form 10-K.

7. Share-Based Payments

In February 2018, we issued a total of 0.5 million restricted stock awards to members of our management team and our board of directors. Approximately 0.2 million of these awards contain only a service condition, while the remainder contain both a service and a performance condition. For the awards that include a performance condition, the number of shares that will ultimately be granted to employees may vary based on the Company’s performance during the applicable two-year performance measurement period. Additionally, in February 2018, we granted 0.1 million stock options to members of our management team. The fair value of these awards and options was determined using the policies described in Note 1, Summary of Significant Accounting Policies, and Note 13, Share-Based Payments, to the consolidated financial statements accompanying the 2017 Form 10-K.

8. Income Taxes

Our Provision for income tax expense of $30.0 million and $39.7 million for the three months ended March 31, 2018 and 2017, respectively, primarily resulted from the application of our estimated effective blended federal and state income tax rate.

We have state net operating losses (“NOLs”) of $75.6 million that expire in various amounts at varying times through 2031. The $68.5 million of net deferred tax assets included in the accompanying condensed consolidated balance sheet as of March 31, 2018 reflects management’s assessment it is more likely than not we will be able to generate sufficient future taxable income to utilize those deferred tax assets based on our current estimates and assumptions. As of March 31, 2018, we maintained a valuation allowance of $36.2 million due to uncertainties regarding our ability to utilize a portion of our state NOLs and other credits before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence 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. 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 jurisdictions, or if the timing of future tax deductions differs from our expectations.

14

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

During the third quarter of 2016, we filed a non-automatic tax accounting method change related to billings denied under pre-payment claims reviews conducted by certain of our MACs. In March 2017, the IRS approved our request resulting in additional tax benefits of approximately $51.3 million through March 31, 2018. Approximately $39 million of this amount represented pre-payment claims denials received in years prior to and including the year ended December 31, 2015. These benefits are expected to reverse as pre-payment claims denials are settled and collected. This change did not have a material impact on our effective tax rate. The 2017 Tax Cuts and Jobs Act (the "Tax Act") included revisions to Internal Revenue Code §451 that may eliminate this deferral of revenue for tax purposes and require us to pay tax on such denied claims. We are currently evaluating this provision of the Tax Act and its future impact on the method change we received in March 2017.

Total remaining gross unrecognized tax benefits were $1.1 million and $0.3 million as of March 31, 2018 and December 31, 2017, respectively, all of which would affect our effective tax rate if recognized. A reconciliation of the beginning and ending liability for unrecognized tax benefits is as follows (in millions):

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
Balance at December 31, 2017	$ 0.3	$ —
Gross amount of increases in unrecognized tax benefits related to prior periods	0.8	0.1
Balance at March 31, 2018	$ 1.1	$ 0.1

Our continuing practice is to recognize interest and penalties related to income tax matters in income tax expense. Interest recorded as part of our income tax provision during the three months ended March 31, 2018 and 2017 was not material. Accrued interest income related to income taxes as of March 31, 2018 and December 31, 2017 was not material.

In December 2014, we signed an agreement with the IRS to begin participating in their Compliance Assurance Process, a program in which we and the IRS endeavor to agree on the treatment of significant tax positions prior to the filing of our federal income tax return. We renewed this agreement in December 2015 for the 2016 tax year and in December 2016 for the 2017 tax year, and in January 2018 for the 2018 tax year. As a result of these agreements, the IRS surveyed our 2013, 2012, and 2011 federal income tax returns and is currently examining 2016, 2017, and 2018 tax years. Our 2014 federal income tax return has been filed, and the IRS has not indicated its intent to examine or survey this return. In February 2017, the IRS issued a no-change Revenue Agent's Report effectively closing our 2015 tax audit. We have settled federal income tax examinations with the IRS for all tax years through 2013 as well as 2015. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are currently under audit by two states for tax years ranging from 2012 through 2015.

For the tax years that remain open under the applicable statutes of limitation, amounts related to unrecognized tax benefits have been considered by management in its estimate of our potential net recovery of prior years' income taxes. Based on discussions with taxing authorities, we anticipate that approximately $0.2 million of our unrecognized tax benefits will be released within the next 12 months.

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

9.Earnings per Common Share

The following table sets forth the computation of basic and diluted earnings per common share (in millions, except per share amounts):

	Three Months Ended March 31,	
	2018	2017
Basic:		
Numerator:		
Income from continuing operations	$105.7	$84.7
Less: Net income attributable to noncontrolling interests included in continuing operations	(21.4)	(17.6)
Less: Income allocated to participating securities	(0.3)	(0.2)
Income from continuing operations attributable to Encompass Health common shareholders	84.0	66.9
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.5)	(0.3)
Net income attributable to Encompass Health common shareholders	$83.5	$66.6
Denominator:		
Basic weighted average common shares outstanding	97.8	88.8
Basic earnings per share attributable to Encompass Health common shareholders:		
Continuing operations	$0.86	$0.75
Discontinued operations	(0.01)	—
Net income	$0.85	$0.75
Diluted:		
Numerator:		
Income from continuing operations	$105.7	$84.7
Less: Net income attributable to noncontrolling interests included in continuing operations	(21.4)	(17.6)
Add: Interest on convertible debt, net of tax	—	2.5
Income from continuing operations attributable to Encompass Health common shareholders	84.3	69.6
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.5)	(0.3)
Net income attributable to Encompass Health common shareholders	$83.8	$69.3
Denominator:		
Diluted weighted average common shares outstanding	99.4	99.0
Diluted earnings per share attributable to Encompass Health common shareholders:		
Continuing operations	$0.85	$0.70
Discontinued operations	(0.01)	—
Net income	$0.84	$0.70

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

The following table sets forth the reconciliation between basic weighted average common shares outstanding and diluted weighted average common shares outstanding (in millions):

	Three Months Ended March 31,	
	2018	2017
Basic weighted average common shares outstanding	97.8	88.8
Convertible senior subordinated notes	—	8.6
Restricted stock awards, dilutive stock options, and restricted stock units	1.6	1.6
Diluted weighted average common shares outstanding	99.4	99.0

In October 2017 and February 2018, our board of directors declared cash dividends of $0.25 per share that were paid in January and April 2018, respectively. As of March 31, 2018 and December 31, 2017, accrued common stock dividends of $25.8 million and $25.4 million, respectively, were included in Accrued expenses and other current liabilities in our condensed consolidated balance sheets. Future dividend payments are subject to declaration by our board of directors.

On September 30, 2009, we issued 5.0 million shares of common stock and 8.2 million common stock warrants in full satisfaction of our obligation to do so under the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. Under the terms of the related warrant agreement, the warrants were exercisable at a price of $41.40 per share by means of a cash or a cashless exercise at the option of the holder. The warrants were not assumed exercised for dilutive shares outstanding because they were antidilutive in the periods presented. The warrants expired on January 17, 2017.

The following table summarizes information relating to these warrants and their activity through their expiration date (number of warrants in millions):

	Number of Warrants	Weighted-Average Exercise Price
Common stock warrants outstanding as of December 31, 2016	8.2	$ 41.40
Cashless exercise	(6.5)	41.40
Cash exercise	(0.6)	41.40
Expired	(1.1)	41.40
Common stock warrants outstanding as of January 17, 2017	—	

The above exercises resulted in the issuance of 0.7 million shares of common stock. Cash exercises resulted in gross proceeds of approximately $27 million.

See Note 9, Long-term Debt and Note 16, Earnings per Common Share, to the consolidated financial statements accompanying the 2017 Form 10-K for additional information related to our convertible senior subordinated notes, common stock and common stock warrants.

10. Contingencies and Other Commitments

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims, or legal and regulatory proceedings could materially and adversely affect our financial position, results of operations, and cash flows in a given period.

Nichols Litigation—

We have been named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned Nichols v. HealthSouth Corp. The plaintiffs allege that we, some of our former

17

officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiffs are seeking compensatory and punitive damages. This case was stayed in the circuit court on August 8, 2005. The plaintiffs filed an amended complaint on November 9, 2010 to which we responded with a motion to dismiss filed on December 22, 2010. During a hearing on February 24, 2012, plaintiffs' counsel indicated his intent to dismiss certain claims against us. Instead, on March 9, 2012, the plaintiffs amended their complaint to include additional securities fraud claims against Encompass Health and add several former officers to the lawsuit. On September 12, 2012, the plaintiffs further amended their complaint to request certification as a class action. One of the former officers named as a defendant has repeatedly attempted to remove the case to federal district court, most recently on December 11, 2012. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. On November 25, 2014, the plaintiffs filed another amended complaint to assert new allegations relating to the time period of 1997 to 2002. On December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lack standing because their claims were derivative in nature, and the claims were time-barred by the statute of limitations. On May 26, 2016, the court granted our motion to dismiss. The plaintiffs appealed the dismissal of the case to the Supreme Court of Alabama on June 28, 2016. On March 23, 2018, the Alabama Supreme Court reversed the trial court's dismissal, holding that the plaintiffs' claims were not derivative or time-barred, and remanded the case for further proceedings. On April 6, 2018, we filed an application for rehearing with the Alabama Supreme Court.

We intend to vigorously defend ourselves in this case. Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate an amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case.

Other Litigation—

One of our hospital subsidiaries was named as a defendant in a lawsuit filed August 12, 2013 by an individual in the Circuit Court of Etowah County, Alabama, captioned Honts v. HealthSouth Rehabilitation Hospital of Gadsden, LLC. The plaintiff alleged that her mother, who died more than three months after being discharged from our hospital, received an unprescribed opiate medication at the hospital. We deny the patient received any such medication, accounted for all the opiates at the hospital and argued the plaintiff established no causal liability between the actions of our staff and her mother's death. The plaintiff sought recovery for punitive damages. On May 18, 2016, the jury in this case returned a verdict in favor of the plaintiff for $20.0 million. On June 17, 2016, we filed a renewed motion for judgment as a matter of law or, in the alternative, a motion for new trial or, in the further alternative, a motion seeking reduction of the damages awarded (collectively, the "post-judgment motions"). The trial court denied the post-judgment motions. We appealed the verdict as well as the rulings on the post-judgment motions to the Supreme Court of Alabama on October 12, 2016. On November 8, 2017, the supreme court heard the oral hearing of the appeal but has not yet rendered a decision.

We posted a bond in the amount of the judgment pending resolution of our appeal. We intend to vigorously defend ourselves in this case. Although we continue to believe in the merit of our defenses and counterarguments, we recorded a net charge of $5.7 million to Other operating expenses in our consolidated statements of operations for the year ended December 31, 2016. As of March 31, 2018, we maintained a liability of $20.1 million in Accrued expenses and other liabilities in our condensed consolidated balance sheet with a corresponding receivable of $15.5 million in Other current assets for the portion of the liability we would expect to be covered through our excess insurance coverages. The portion of this liability that would be a covered claim through our captive insurance subsidiary, HCS, Ltd. is $6.0 million.

Governmental Inquiries and Investigations—

On March 4, 2013, we received document subpoenas from an office of the United States Department of Health and Human Services Office of Inspector General ("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 United States Department of Justice (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," an inpatient rehabilitation hospital must treat 60% or more of its patients from 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 cooperating fully with the DOJ in connection with this investigation and are currently unable to predict the timing or outcome of it. We intend to vigorously defend ourselves in this matter. Based on discussions with the DOJ, review of the current facts and circumstances as we understand them, and the nature of the investigation, it is not possible to estimate an amount of loss, if any, or range of possible loss that might result from it.

Other Matters—

The False Claims Act allows private citizens, called "relators," to institute civil proceedings on behalf of the United States alleging violations of the False Claims Act. These lawsuits, also known as "whistleblower" or "qui tam" actions, can involve significant monetary damages, fines, attorneys' fees and the award of bounties to the relators who successfully prosecute or bring these suits to the government. Qui tam cases are sealed at the time of filing, which means knowledge of the information contained in the complaint typically is limited to the relator, the federal government, and the presiding court. The defendant in a qui tam action may remain unaware of the existence of a sealed complaint for years. While the complaint is under seal, the government reviews the merits of the case and may conduct a broad investigation and seek discovery from the defendant and other parties before deciding whether to intervene in the case and take the lead on litigating the claims. The court lifts the seal when the government makes its decision on whether to intervene. If the government decides not to intervene, the relator may elect to continue to pursue the lawsuit individually on behalf of the government. It is possible that qui tam lawsuits have been filed against us, which suits remain under seal, or that we are unaware of such filings or precluded 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.

It is our obligation as a participant in Medicare and other federal healthcare programs to routinely conduct audits and reviews of the accuracy of our billing systems and other regulatory compliance matters. As a result of these reviews, we have made, and will continue to make, disclosures to the HHS-OIG and CMS relating to amounts we suspect represent over-payments from these programs, whether due to inaccurate billing or otherwise. Some of these disclosures have resulted in, or may result in, Encompass Health refunding amounts to Medicare or other federal healthcare programs.

11. Segment Reporting

Our internal financial reporting and management structure is focused on the major types of services provided by Encompass Health. We manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. These reportable operating segments are consistent with information used by our chief executive officer, who is our chief operating decision maker, to assess performance and allocate resources. The following is a brief description of our reportable segments:

- Inpatient Rehabilitation - Our national network of inpatient rehabilitation hospitals stretches across 31 states and Puerto Rico, with a concentration of hospitals in the eastern half of the United States and Texas. As of March 31, 2018, we operate 127 inpatient rehabilitation hospitals, including one hospital that operates as a joint venture which we account for using the equity method of accounting. In addition, we manage four inpatient rehabilitation

19

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

units through management contracts. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. Our inpatient rehabilitation hospitals provide a higher level of rehabilitative care to patients who are recovering from conditions such as stroke and other neurological disorders, cardiac and pulmonary conditions, brain and spinal cord injuries, complex orthopedic conditions, and amputations.

- Home Health and Hospice - As of March 31, 2018, we provide home health and hospice services in 236 locations across 28 states with concentrations in the Southeast and Texas. In addition, two of these agencies operate as joint ventures which we account for using the equity method of accounting. Our home health services include 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. Our hospice services primarily include in-home services to terminally ill patients and their families to address patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support.

The accounting policies of our reportable segments are the same as those described in Note 1, Basis of Presentation, "Net Operating Revenues" and "Accounts Receivable" to these condensed consolidated financial statements and Note 1, Summary of Significant Accounting Policies, to the consolidated financial statements accompanying the 2017 Form 10-K. All revenues for our services are generated through external customers. See Note 1, Basis of Presentation, "Net Operating Revenues," for the payor composition of our revenues. No corporate overhead is allocated to either of our reportable segments. Our chief operating decision maker evaluates the performance of our segments and allocates resources to them based on adjusted earnings before interest, taxes, depreciation, and amortization ("Segment Adjusted EBITDA").

Selected financial information for our reportable segments is as follows (in millions):

	Inpatient Rehabilitation Three Months Ended March 31,		Home Health and Hospice Three Months Ended March 31,	
	2018	2017	2018	2017
Net operating revenues	$840.3	$777.8	$205.7	$179.3
Operating expenses:				
Inpatient rehabilitation:				
Salaries and benefits	424.2	398.2	—	—
Other operating expenses	122.9	111.8	—	—
Supplies	35.9	33.7	—	—
Occupancy costs	15.5	15.1	—	—
Home health and hospice:				
Cost of services sold (excluding depreciation and amortization)	—	—	98.6	87.7
Support and overhead costs	—	—	72.0	66.8
	598.5	558.8	170.6	154.5
Other income	(0.5)	(1.0)	—	—
Equity in net income of nonconsolidated affiliates	(2.0)	(1.9)	(0.3)	(0.2)
Noncontrolling interests	20.5	16.5	1.9	1.1
Segment Adjusted EBITDA	$223.8	$205.4	$33.5	$23.9
Capital expenditures	$62.2	$43.1	$1.7	$1.7

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

	Inpatient Rehabilitation	Home Health and Hospice	Encompass Health Consolidated
As of March 31, 2018			
Total assets	$ 3,827.5	$1,152.5	$ 4,939.6
Investments in and advances to nonconsolidated affiliates	10.2	2.8	13.0
As of December 31, 2017			
Total assets	$ 3,789.1	$1,150.5	$ 4,893.7
Investments in and advances to nonconsolidated affiliates	9.3	2.6	11.9

Segment reconciliations (in millions):

	Three Months Ended March 31,	
	2018	2017
Total segment Adjusted EBITDA	$257.3	$229.3
General and administrative expenses	(61.1)	(36.5)
Depreciation and amortization	(45.9)	(45.2)
(Loss) gain on disposal of assets	(0.8)	0.5
Interest expense and amortization of debt discounts and fees	(35.6)	(41.3)
Net income attributable to noncontrolling interests	21.4	17.6
SARs mark-to-market impact on noncontrolling interests	1.0	—
Change in fair market value of equity securities	(0.6)	—
Income from continuing operations before income tax expense	$135.7	$124.4

	March 31, 2018	December 31, 2017
Total assets for reportable segments	$4,980.0	$ 4,939.6
Reclassification of deferred income tax liabilities to net deferred income tax assets	(40.4)	(45.9)
Total consolidated assets	$4,939.6	$ 4,893.7

Additional detail regarding the revenues of our operating segments by service line follows (in millions):

	Three Months Ended March 31,	
	2018	2017
Inpatient rehabilitation:		
Inpatient	$817.1	$752.7
Outpatient and other	23.2	25.1
Total inpatient rehabilitation	840.3	777.8
Home health and hospice:		
Home health	185.2	163.7
Hospice	20.5	15.6
Total home health and hospice	205.7	179.3
Total net operating revenues	$1,046.0	$957.1

12. Condensed Consolidating Financial Information

The accompanying condensed consolidating financial information has been prepared and presented pursuant to SEC Regulation S-X, Rule 3-10, “Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered.” Each of the subsidiary guarantors is 100% owned by Encompass Health, and all guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. Encompass Health’s investments in its consolidated subsidiaries, as well as guarantor subsidiaries’ investments in nonguarantor subsidiaries and nonguarantor subsidiaries’ investments in guarantor subsidiaries, are presented under the equity method of

accounting with the related investment presented within the line items Intercompany receivable and investments in consolidated affiliates and Intercompany payable in the accompanying condensed consolidating balance sheets.

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 (as defined in our credit agreement) remains less than or equal to 2x. 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. See Note 9, Long-term Debt, to the consolidated financial statements accompanying the 2017 Form 10-K.

Periodically, certain wholly owned subsidiaries of Encompass Health make dividends or distributions of available cash and/or intercompany receivable balances to their parents. In addition, Encompass Health makes contributions to certain wholly owned subsidiaries. When made, these dividends, distributions, and contributions impact the Intercompany receivable and investments in consolidated affiliates, Intercompany payable, and Encompass Health shareholders' equity line items in the accompanying condensed consolidating balance sheet but have no impact on the consolidated financial statements of Encompass Health Corporation.

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Statement of Operations

	Three Months Ended March 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Net operating revenues	$5.4	$ 587.0	$ 486.2	$ (32.6)	$ 1,046.0
Operating expenses:					
Salaries and benefits	13.2	279.2	283.2	(5.4)	570.2
Other operating expenses	8.4	83.7	61.5	(12.4)	141.2
Occupancy costs	0.5	23.7	9.2	(14.8)	18.6
Supplies	—	24.4	15.5	—	39.9
General and administrative expenses	39.4	—	21.7	—	61.1
Depreciation and amortization	2.0	26.1	17.8	—	45.9
Total operating expenses	63.5	437.1	408.9	(32.6)	876.9
Interest expense and amortization of debt discounts and fees	29.8	5.2	5.7	(5.1)	35.6
Other (income) loss	(4.7)	(0.2)	(0.1)	5.1	0.1
Equity in net income of nonconsolidated affiliates	—	(1.9)	(0.4)	—	(2.3)
Equity in net income of consolidated affiliates	(112.0)	(17.8)	—	129.8	—
Management fees	(38.4)	28.4	10.0	—	—
Income from continuing operations before income tax (benefit) expense	67.2	136.2	62.1	(129.8)	135.7
Provision for income tax (benefit) expense	(17.1)	36.7	10.4	—	30.0
Income from continuing operations	84.3	99.5	51.7	(129.8)	105.7
Loss from discontinued operations, net of tax	(0.5)	—	—	—	(0.5)
Net income	83.8	99.5	51.7	(129.8)	105.2
Less: Net income attributable to noncontrolling interests	—	—	(21.4)	—	(21.4)
Net income attributable to Encompass Health	$83.8	$ 99.5	$ 30.3	$ (129.8)	$ 83.8
Comprehensive income	$83.8	$ 99.5	$ 51.7	$ (129.8)	$ 105.2
Comprehensive income attributable to Encompass Health	$83.8	$ 99.5	$ 30.3	$ (129.8)	$ 83.8

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Statement of Operations

	Three Months Ended March 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Net operating revenues	$5.3	$ 560.7	$ 422.3	$ (31.2)	$ 957.1
Operating expenses:					
Salaries and benefits	11.2	270.3	253.9	(5.3)	530.1
Other operating expenses	8.2	76.9	54.6	(11.9)	127.8
Occupancy costs	0.5	23.3	8.1	(14.0)	17.9
Supplies	—	23.5	13.5	—	37.0
General and administrative expenses	31.6	—	4.9	—	36.5
Depreciation and amortization	2.4	25.7	17.1	—	45.2
Total operating expenses	53.9	419.7	352.1	(31.2)	794.5
Interest expense and amortization of debt discounts and fees	35.2	5.4	5.8	(5.1)	41.3
Other income	(5.4)	(0.1)	(0.6)	5.1	(1.0)
Equity in net income of nonconsolidated affiliates	—	(1.9)	(0.2)	—	(2.1)
Equity in net income of consolidated affiliates	(86.2)	(9.8)	—	96.0	—
Management fees	(35.9)	27.1	8.8	—	—
Income from continuing operations before income tax (benefit) expense	43.7	120.3	56.4	(96.0)	124.4
Provision for income tax (benefit) expense	(23.4)	48.0	15.1	—	39.7
Income from continuing operations	67.1	72.3	41.3	(96.0)	84.7
Loss from discontinued operations, net of tax	(0.3)	—	—	—	(0.3)
Net income	66.8	72.3	41.3	(96.0)	84.4
Less: Net income attributable to noncontrolling interests	—	—	(17.6)	—	(17.6)
Net income attributable to Encompass Health	$66.8	$ 72.3	$ 23.7	$ (96.0)	$ 66.8
Comprehensive income	$67.1	$ 72.3	$ 41.3	$ (96.0)	$ 84.7
Comprehensive income attributable to Encompass Health	$67.1	$ 72.3	$ 23.7	$ (96.0)	$ 67.1

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Balance Sheet

	As of March 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Assets					
Current assets:					
Cash and cash equivalents	$69.0	$ 2.8	$ 14.6	$—	$ 86.4
Restricted cash	—	—	69.4	—	69.4
Accounts receivable	—	276.9	186.2	—	463.1
Other current assets	81.7	19.5	75.5	(87.1)	89.6
Total current assets	150.7	299.2	345.7	(87.1)	708.5
Property and equipment, net	119.0	1,003.5	431.8	—	1,554.3
Goodwill	—	854.6	1,118.5	—	1,973.1
Intangible assets, net	11.7	103.8	280.6	—	396.1
Deferred income tax assets	96.9	8.4	5.4	(42.2)	68.5
Other long-term assets	49.6	97.6	91.9	—	239.1
Intercompany notes receivable	463.6	—	—	(463.6)	—
Intercompany receivable and investments in consolidated affiliates	2,860.0	413.5	—	(3,273.5)	—
Total assets	$3,751.5	$ 2,780.6	$ 2,273.9	$(3,866.4)	$ 4,939.6
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$32.8	$ 7.6	$ 9.8	$(17.5)	$ 32.7
Accounts payable	12.2	44.2	26.7	—	83.1
Accrued expenses and other current liabilities	217.4	73.4	235.0	(69.6)	456.2
Total current liabilities	262.4	125.2	271.5	(87.1)	572.0
Long-term debt, net of current portion	2,261.7	240.2	42.5	—	2,544.4
Intercompany notes payable	—	—	463.6	(463.6)	—
Other long-term liabilities	30.4	17.6	178.3	(42.5)	183.8
Intercompany payable	—	—	99.4	(99.4)	—
	2,554.5	383.0	1,055.3	(692.6)	3,300.2
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	198.6	—	198.6
Shareholders' equity:					
Encompass Health shareholders' equity	1,197.0	2,397.6	776.2	(3,173.8)	1,197.0
Noncontrolling interests	—	—	243.8	—	243.8
Total shareholders' equity	1,197.0	2,397.6	1,020.0	(3,173.8)	1,440.8
Total liabilities and shareholders' equity	$3,751.5	$ 2,780.6	$ 2,273.9	$(3,866.4)	$ 4,939.6

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Balance Sheet

	As of December 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Assets					
Current assets:					
Cash and cash equivalents	$34.3	$ 2.9	$ 17.2	$—	$ 54.4
Restricted cash	—	—	62.4	—	62.4
Accounts receivable	—	285.2	186.9	—	472.1
Other current assets	61.4	21.7	48.7	(18.5)	113.3
Total current assets	95.7	309.8	315.2	(18.5)	702.2
Property and equipment, net	101.8	991.5	423.8	—	1,517.1
Goodwill	—	854.6	1,118.0	—	1,972.6
Intangible assets, net	11.8	105.1	286.2	—	403.1
Deferred income tax assets	97.4	8.4	—	(42.2)	63.6
Other long-term assets	49.2	100.5	85.4	—	235.1
Intercompany notes receivable	486.2	—	—	(486.2)	—
Intercompany receivable and investments in consolidated affiliates	2,839.1	311.3	—	(3,150.4)	—
Total assets	$3,681.2	$ 2,681.2	$ 2,228.6	$(3,697.3)	$ 4,893.7
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$32.8	$ 7.4	$ 9.6	$(17.5)	$ 32.3
Accounts payable	10.4	43.5	24.5	—	78.4
Accrued expenses and other current liabilities	166.8	82.0	159.0	(1.0)	406.8
Total current liabilities	210.0	132.9	193.1	(18.5)	517.5
Long-term debt, net of current portion	2,258.5	242.2	44.7	—	2,545.4
Intercompany notes payable	—	—	486.2	(486.2)	—
Other long-term liabilities	31.0	17.8	178.6	(42.1)	185.3
Intercompany payable	—	—	144.8	(144.8)	—
	2,499.5	392.9	1,047.4	(691.6)	3,248.2
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	220.9	—	220.9
Shareholders' equity:					
Encompass Health shareholders' equity	1,181.7	2,288.3	717.4	(3,005.7)	1,181.7
Noncontrolling interests	—	—	242.9	—	242.9
Total shareholders' equity	1,181.7	2,288.3	960.3	(3,005.7)	1,424.6
Total liabilities and shareholders' equity	$3,681.2	$ 2,681.2	$ 2,228.6	$(3,697.3)	$ 4,893.7

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Statement of Cash Flows

	Three Months Ended March 31, 2018				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Net cash provided by operating activities	$10.5	$ 112.3	$ 93.5	$ —	$ 216.3
Cash flows from investing activities:					
Purchases of property and equipment	(12.3)	(31.4)	(16.2)	—	(59.9)
Acquisitions of businesses, net of cash acquired	—	—	(0.6)	—	(0.6)
Proceeds from repayment of intercompany note receivable	22.0	—	—	(22.0)	—
Other, net	(5.1)	(0.1)	5.1	—	(0.1)
Net cash provided by (used in) investing activities	4.6	(31.5)	(11.7)	(22.0)	(60.6)
Cash flows from financing activities:					
Principal payments on intercompany note payable	—	—	(22.0)	22.0	—
Borrowings on revolving credit facility	95.0	—	—	—	95.0
Payments on revolving credit facility	(95.0)	—	—	—	(95.0)
Dividends paid on common stock	(25.3)	—	(0.1)	—	(25.4)
Purchase of equity interests in consolidated affiliates	(65.1)	—	—	—	(65.1)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(15.4)	—	(15.4)
Other, net	(5.1)	(1.8)	(3.9)	—	(10.8)
Change in intercompany advances	115.1	(79.1)	(36.0)	—	—
Net cash provided by (used in) financing activities	19.6	(80.9)	(77.4)	22.0	(116.7)
Increase (decrease) in cash, cash equivalents, and restricted cash	34.7	(0.1)	4.4	—	39.0
Cash, cash equivalents, and restricted cash at beginning of period	34.3	2.9	79.6	—	116.8
Cash, cash equivalents, and restricted cash at end of period	$69.0	$ 2.8	$ 84.0	$ —	$ 155.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash					
Cash and cash equivalents at beginning of period	$34.3	$ 2.9	$ 17.2	$ —	$ 54.4
Restricted cash at beginning of period	—	—	62.4	—	62.4
Cash, cash equivalents, and restricted cash at beginning of period	$34.3	$ 2.9	$ 79.6	$ —	$ 116.8
Cash and cash equivalents at end of period	$69.0	$ 2.8	$ 14.6	$ —	$ 86.4
Restricted cash at end of period	—	—	69.4	—	69.4
Cash, cash equivalents, and restricted cash at end of period	$69.0	$ 2.8	$ 84.0	$ —	$ 155.8

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements
Condensed Consolidating Statement of Cash Flows

	Three Months Ended March 31, 2017				
	Encompass Health Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	Encompass Health Consolidated
	(In Millions)				
Net cash provided by operating activities	$45.1	$ 72.1	$ 63.6	$ —	$ 180.8
Cash flows from investing activities:					
Purchases of property and equipment	(5.2)	(12.9)	(23.1)	—	(41.2)
Acquisitions of businesses, net of cash acquired	(10.9)	—	(5.5)	—	(16.4)
Proceeds from repayment of intercompany note receivable	7.0	—	—	(7.0)	—
Other, net	(3.8)	8.8	3.5	—	8.5
Net cash used in investing activities	(12.9)	(4.1)	(25.1)	(7.0)	(49.1)
Cash flows from financing activities:					
Principal payments on intercompany note payable	—	—	(7.0)	7.0	—
Borrowings on revolving credit facility	55.0	—	—	—	55.0
Payments on revolving credit facility	(122.0)	—	—	—	(122.0)
Repurchases of common stock, including fees and expenses	(18.1)	—	—	—	(18.1)
Dividends paid on common stock	(22.2)	—	—	—	(22.2)
Proceeds from exercising stock warrants	26.6	—	—	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(11.5)	—	(11.5)
Other, net	(12.0)	(1.6)	(0.5)	—	(14.1)
Change in intercompany advances	82.3	(65.4)	(16.9)	—	—
Net cash used in financing activities	(10.4)	(67.0)	(35.9)	7.0	(106.3)
Increase in cash, cash equivalents, and restricted cash	21.8	1.0	2.6	—	25.4
Cash, cash equivalents, and restricted cash at beginning of period	20.6	1.6	79.2	—	101.4
Cash, cash equivalents, and restricted cash at end of period	$42.4	$ 2.6	$ 81.8	$ —	$ 126.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash					
Cash and cash equivalents at beginning of period	$20.6	$ 1.6	$ 18.3	$ —	$ 40.5
Restricted cash at beginning of period	—	—	60.9	—	60.9
Cash, cash equivalents, and restricted cash at beginning of period	$20.6	$ 1.6	$ 79.2	$ —	$ 101.4
Cash and cash equivalents at end of period	$42.4	$ 2.6	$ 16.2	$ —	$ 61.2
Restricted cash at end of period	—	—	65.6	—	65.6
Cash, cash equivalents, and restricted cash at end of period	$42.4	$ 2.6	$ 81.8	$ —	$ 126.8

Item 2. 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") relates to Encompass Health Corporation and its subsidiaries and should be read in conjunction with our condensed consolidated financial statements included under Part I, Item 1, Financial Statements (Unaudited), of this report. In addition, the following MD&A should be read in conjunction with our audited consolidated financial statements for the year ended December 31, 2017, Part II, Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, Part I, Item 1, Business and Item 1A, Risk Factors included in our Annual Report on Form 10-K for the year ended December 31, 2017 filed on February 27, 2018 (collectively, the "2017 Form 10-K").

This MD&A is designed to provide the reader with information that will assist in understanding our condensed consolidated financial statements, the changes in certain key items in those financial statements from period to period, and the primary factors that accounted for those changes, as well as how certain accounting principles affect our condensed consolidated financial statements. See "Cautionary Statements Regarding Forward-Looking Statements" on page i 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, of this report and to the 2017 Form 10-K.

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 patient services in 36 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, of the 2017 Form 10-K.

Effective January 1, 2018, we changed our name from HealthSouth Corporation to Encompass Health Corporation and our NYSE ticker symbol changed from "HLS" to "EHC." Our operations in both business segments will transition to the Encompass Health branding on a rolling basis.

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 31 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. As of March 31, 2018, we operate 127 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 our hospitals, we manage four inpatient rehabilitation units through management contracts. Our inpatient rehabilitation segment represented approximately 80% of our Net operating revenues for the three months ended March 31, 2018.

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. Our home health services include 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. We also provide hospice services to terminally ill patients and their families that address patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support. As of March 31, 2018, we provide home health and hospice services in 236 locations across 28 states, with concentrations in the Southeast 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 20% of our Net operating revenues for the three months ended March 31, 2018.

2018 Overview

Our 2018 strategy focuses on the following priorities:

- providing high-quality, cost-effective care to patients in our existing markets;
-

achieving organic growth at our existing inpatient rehabilitation 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;
- making shareholder distributions via common stock dividends and repurchases of our common stock; and
- positioning the Company for success in the evolving healthcare delivery system through key operational initiatives that includes implementing the rebranding and name change, developing and implementing post-acute patient navigation tools (Post-Acute Innovation Center), enhancing clinical collaboration between our inpatient rehabilitation hospitals and home health locations, refining and expanding use of clinical data analytics to further improve patient outcomes, and increasing participation in alternative payment models.

During the three months ended March 31, 2018, Net operating revenues increased by 9.3% over the same period of 2017 due primarily to pricing and volume growth in our inpatient rehabilitation segment and volume growth in our home health and hospice segment.

Within our inpatient rehabilitation segment, discharge growth of 6.7% coupled with a 1.7% increase in net patient revenue per discharge in the first quarter of 2018 generated 8.0% growth in net operating revenue compared to the first quarter of 2017. Discharge growth included a 4.8% increase in same-store discharges. Our inpatient rehabilitation outcomes and certain quality measures, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), remained well above the average for hospitals included in the UDS database.

Within our home health and hospice segment, home health admission growth of 9.9% coupled with the impact of a 1.5% decrease in revenue per episode in the first quarter of 2018 generated 14.7% growth in home health and hospice revenue compared to the first quarter of 2017. Home health admission growth included a 7.4% increase in same-store admissions. The quality of patient care star rating for our home health agencies continued to be well above the national average, as reported by the United States Centers for Medicare and Medicaid Services ("CMS"). In addition, 30-day readmission rates at our home health agencies continued to be well below the national average, as reported by Avalere Health and the Alliance for Home Health Quality and Innovation.

Our growth efforts thus far in 2018 related to our inpatient rehabilitation segment have included the following:

- entered into an agreement with Saint Alphonsus Regional Medical Center in February 2018 to own and operate a new 40-bed inpatient rehabilitation hospital in Boise, Idaho. We expect construction of the new hospital to commence in the second quarter of 2018. The joint venture hospital is expected to begin operating in 2019 subject to customary closing conditions, including regulatory approvals;
- continued planning the operation of our 29-bed joint venture hospital with Tidelands Health in Murrells Inlet, South Carolina. The hospital is expected to begin operating in the fourth quarter of 2018;
- continued planning the construction of our 68-bed joint venture hospital with Novant Health, Inc. in Winston-Salem, North Carolina. The hospital is expected to begin operating in the fourth quarter of 2018;
- continued planning the construction of our 40-bed joint venture hospital with University Medical Center Health System in Lubbock, Texas. The hospital is expected to begin operating in 2019; and
- continued development of the following de novo hospitals:

Location	# of Beds	Actual / Expected Construction Start Date	Expected Operational Date
Shelby County, Alabama[1]	34	Q1 2017	Q2 2018
Hilton Head, South Carolina	38	Q2 2017	Q2 2018
Murrieta, California	50	Q2 2018	2019
Katy, Texas	40	Q3 2018	2019

[1] The hospital accepted its first patient in April 2018.

We also continued our growth efforts in our home health and hospice segment. On May 1, 2018, we completed the previously announced acquisition of privately owned Camellia Healthcare and affiliated entities ("Camellia") for a cash purchase price of approximately $135 million using cash on hand and borrowings under our revolving credit facility. We expect to realize a tax benefit with an estimated present value of $20 million to $25 million related to this transaction. Camellia operates a portfolio of 18 hospice, 14 home health, and 2 private duty locations in Mississippi, Alabama, Louisiana and Tennessee. The Camellia acquisition leverages our home health and hospice operating platform across key certificate of need states and strengthens our geographic presence in the Southeastern United States. With the closing of this transaction, we are positioned as a top 25 provider of hospice services.

In addition to completing the Camellia transaction, we acquired one new hospice location located in Oklahoma City, Oklahoma and began accepting patients at our new home health location in Owasso, Oklahoma.

We also continued our shareholder distributions. In October 2017 and February 2018, our board of directors declared cash dividends of $0.25 per share that were paid in January 2018 and April 2018, respectively. In February 2018, we purchased one-third of the equity interests held by members of the home health and hospice management team for approximately $65 million. For additional information on this transaction, see the "Liquidity and Capital Resources" section of this Item and Note 5, Redeemable Noncontrolling Interests, to the accompanying condensed consolidated financial statements.

Business Outlook

We believe our business outlook remains positive. Favorable demographic trends, such as population aging, should increase long-term demand for facility-based and home-based care. 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 care 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.

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 the quality of our clinical outcomes, our cost-effectiveness, our financial strength, and our extensive application of 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 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 our electronic clinical information system ("ACE-IT"). 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}, an industry leading comprehensive information platform designed to manage the entire patient work flow and allow 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. Homecare Homebase also allows providers to share valuable data with payors to promote better patient outcomes on a more cost-effective basis. All of these systems allow us to enhance our clinical and business processes. Our information systems allow us to collect, analyze, and share information on a timely basis, making us an ideal partner for other healthcare providers in a coordinated care delivery environment.

Our short-term priorities include our operational initiatives. The implementation of our rebranding and name change reflects our expanding national footprint and our strategy to deliver high-quality, cost-effective care across the

post-acute continuum. Through the Post-Acute Innovation Center, we will combine our clinical expertise with Cerner's technology in an effort to assume a leading position in the development and utilization of market-specific clinical decision support tools. We will also continue to enhance the clinical collaboration efforts between our two segments, refine and expand our predictive data analytics to further improve patient outcomes, and increase our participation in alternative payment models.

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 and implementation of new care delivery and payment systems will require significant time and resources. Furthermore, many of the alternative approaches being explored may not work as intended. However, as outlined in the 2017 Form 10-K (see Item 1, Business, "Competitive Strengths"), 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 2022. We continue to have a strong, well-capitalized balance sheet, including 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. We intend to deploy free cash flow to fund the growth opportunities in both of our business segments and augment these investments with shareholder distributions, including a regular quarterly cash dividend on our common stock.

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

Healthcare is a highly-regulated industry facing many well-publicized regulatory and reimbursement challenges. The industry also is 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. Successful healthcare providers are those able to adapt to changes in the regulatory and operating environments, build strategic relationships across the healthcare continuum, and consistently provide high-quality, cost-effective care. We believe we have the necessary capabilities — change agility, strategic relationships, quality of patient outcomes, cost effectiveness, and ability to capitalize on growth opportunities — to adapt to and succeed in a dynamic, 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, as well as other healthcare policy priorities, could result in enactment of legislation affecting portions of the Medicare program, including post-acute care services we provide. It is not clear whether Congress will pass legislation to modify or repeal the provisions of the 2010 Healthcare Reform Laws most relevant to us, nor is it clear what, if any, other Medicare-related changes may ultimately be enacted and signed into law or otherwise implemented or caused by the Trump Administration through regulatory procedures, 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 or other legislative or regulatory initiatives.

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (the "2018 Budget Act"). The 2018 Budget Act requires CMS to update the home health prospective payment system (the "HH-PPS") with a market basket update of 1.5% and eliminates the productivity adjustment for 2020. The 2018 Budget Act also mandates several significant changes to the HH-PPS, including establishing in 2020 a 30-day unit of service for home health payment purposes to replace the current 60-day episode of payment methodology. We

cannot predict the impact of these significant changes to the HH-PPS on our home health agencies and their Medicare reimbursements. For additional discussion on changes included in the 2018 Budget Act see Item 1A, Risk Factors, to the 2017 Form 10-K.

On April 27, 2018, CMS released its Notice of Proposed Rulemaking for Fiscal Year 2019 (the "2019 Proposed IRF Rule") for inpatient rehabilitation facilities under the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"). The 2019 Proposed IRF Rule would implement a net 1.35% market basket increase effective for discharges between October 1, 2018 and September 30, 2019, calculated as follows:

Market basket update	2.9%
Healthcare reform reduction	75 basis points
Productivity adjustment	80 basis points

The 2019 Proposed IRF Rule also includes other changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revision to the wage index values, updates to the case mix group relative weights and average length of stay values using fiscal year 2017 claims data and 2016 cost report data, and an increase to the outlier fixed loss threshold. CMS has estimated the 2019 Proposed IRF Rule would increase Medicare IRF payments in fiscal year 2019 by approximately 0.9%. Based on our analysis that utilizes, among other things, the acuity of our patients over the 12-month period prior to the 2019 Proposed IRF Rule's release, our experience with outlier payments over this same time frame, and other factors, we believe the 2019 Proposed IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.2% effective October 1, 2018.

The 2019 Proposed IRF Rule would also modify certain IRF coverage requirements, remove two quality reporting measures, and eliminate the FIM™ instrument and associated function modifiers from the IRF Patient Assessment Instrument. The FIM™ elimination would require changes to the underlying IRF-PPS case mix groupings beginning in fiscal year 2020. We are in the process of evaluating the impact these changes would have on Medicare payments beginning October 1, 2019. CMS will accept comments on the 2019 Proposed IRF Rule through June 26, 2018.

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. These audits as well as the ordinary course claim reviews of our billings result in payment denials. Healthcare providers can challenge any denials through an administrative appeals process that can be extremely lengthy, taking up to eight years or longer. For additional details of these claim reviews, See Item 1A, Risk Factors, to the 2017 Form 10-K.

For additional discussion of our regulatory environment, see Item 1, Business, "Sources of Revenues" and "Regulation," Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges," to the 2017 Form 10-K and Note 10, Contingencies and Other Commitments, "Governmental Inquiries and Investigations," to the condensed consolidated financial statements included in Part I, Item 1, Financial Statements (Unaudited), of this report.

- Changes to Our Operating Environment Resulting from Healthcare Reform. Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notable for us are Medicare reimbursement reductions, such as reductions to annual market basket updates to providers and reimbursement rate rebasing adjustments, and promotion of alternative payment models, such as accountable care organizations ("ACOs") and bundled payment initiatives such as the Bundled Payment for Care Improvement Initiative ("BPCI"), the Comprehensive Care for Joint Replacement ("CJR") program, and the BPCI-Advanced program. Our challenges related to healthcare reform are discussed in Item 1, Business, "Sources of Revenues," and Item 1A, Risk Factors to the 2017 Form 10-K.

While the change in administration 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 efficiency and overall value and quality of the services they provide to a patient. 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 care delivery and payment model would represent a significant transformation for the healthcare industry. As the industry and its regulators explore this transformation, we are attempting to position the Company in preparation for whatever changes are ultimately made to the delivery system as discussed in Item 1, Business, “Competitive Strengths” to the 2017 Form 10-K.

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. As noted above, it is not clear whether Congress will pass legislation to modify or repeal the 2010 Healthcare Laws, nor can we predict whether other legislation affecting Medicare and post-acute care providers will be enacted, or what actions the Trump Administration may take or cause through the regulatory process that may result in modifications to the 2010 Healthcare Laws or the Medicare program. 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 regulations 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. For additional details on the IMPACT Act, see Item 1A, Risk Factors to the 2017 Form 10-K.

- 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, to the 2017 Form 10-K 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 post-acute services.

See also Item 1, Business, Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges," to the 2017 Form 10 K.

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 2018 and beyond.

Results of Operations

Payor Mix

We derived consolidated Net operating revenues from the following payor sources:

	Three Months Ended March 31,			
	2018		2017	
Medicare	76.6	%	75.8	%
Medicare Advantage	8.8	%	8.7	%
Managed care	8.9	%	9.6	%
Medicaid	2.4	%	2.4	%
Other third-party payors	1.1	%	1.2	%
Workers' compensation	0.7	%	0.8	%
Patients	0.5	%	0.5	%
Other income	1.0	%	1.0	%
Total	100.0	%	100.0	%

For additional information regarding our payors, see the "Sources of Revenues" section of Item 1, Business, of the 2017 Form 10-K.

Our Results

For the three months ended March 31, 2018 and 2017, our consolidated results of operations were as follows:

	Three Months Ended March 31,		Percentage Change 2018 vs. 2017
	2018	2017	
	(In Millions, Except Percentage Change)		
Net operating revenues	$1,046.0	$957.1	9.3 %
Operating expenses:			
Salaries and benefits	570.2	530.1	7.6 %
Other operating expenses	141.2	127.8	10.5 %
Occupancy costs	18.6	17.9	3.9 %
Supplies	39.9	37.0	7.8 %
General and administrative expenses	61.1	36.5	67.4 %
Depreciation and amortization	45.9	45.2	1.5 %
Total operating expenses	876.9	794.5	10.4 %
Interest expense and amortization of debt discounts and fees	35.6	41.3	(13.8)%
Other loss (income)	0.1	(1.0)	(110.0)%
Equity in net income of nonconsolidated affiliates	(2.3)	(2.1)	9.5 %
Income from continuing operations before income tax expense	135.7	124.4	9.1 %
Provision for income tax expense	30.0	39.7	(24.4)%
Income from continuing operations	105.7	84.7	24.8 %
Loss from discontinued operations, net of tax	(0.5)	(0.3)	66.7 %
Net income	105.2	84.4	24.6 %
Less: Net income attributable to noncontrolling interests	(21.4)	(17.6)	21.6 %
Net income attributable to Encompass Health	$83.8	$66.8	25.4 %

Operating Expenses as a % of Net Operating Revenues

	Three Months Ended March 31,	
	2018	2017
Operating expenses:		
Salaries and benefits	54.5%	55.4%
Other operating expenses	13.5%	13.4%
Occupancy costs	1.8 %	1.9 %
Supplies	3.8 %	3.9 %
General and administrative expenses	5.8 %	3.8 %
Depreciation and amortization	4.4 %	4.7 %
Total operating expenses	83.8%	83.0%

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 and agencies open throughout both the full current periods 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.

Net Operating Revenues

Our consolidated Net operating revenues increased in the three months ended March 31, 2018 over the same period of 2017 due primarily to volume and pricing growth in our inpatient rehabilitation segment and volume growth in our home health and hospice segment. The three months ended March 31, 2018 benefited from a year-over-year reduction in bad debt, which is now a component of revenues as a result of the new revenue recognition accounting guidance discussed in Note 1, Basis of Presentation, “Recent Accounting Pronouncements,” in the condensed consolidated financial statements of this report.

Salaries and Benefits

Salaries and benefits increased in the three months ended March 31, 2018 compared to the same period of 2017 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2017 development activities, salary increases for our employees, and an increase in benefit costs.

Salaries and benefits as a percent of Net operating revenues decreased during the three months ended March 31, 2018 compared to the same period of 2017 primarily from labor management and higher volumes which contributed to lower employees per occupied bed, as defined in “Segment Results” of this Item. In addition, Salaries and benefits as a percent of Net operating revenues during the three months ended March 31, 2018 benefited from the aforementioned reduction in bad debt.

Other Operating Expenses

Other operating expenses increased during the three months ended March 31, 2018 compared to the same period of 2017 primarily due to increased patient volumes. As a percent of Net operating revenues, Other operating expenses increased during the three months ended March 31, 2018 compared to the same period of 2017 primarily due to increases in contract services.

Supplies

Supplies increased during the three months ended March 31, 2018 compared to the same period of 2017 due primarily to increased patient volumes.

General and Administrative Expenses

General and administrative expenses increased during the three months ended March 31, 2018 compared to the same period of 2017 in terms of dollars and as a percent of Net operating revenues due primarily to increased salary and benefit costs, including expenses associated with stock appreciation rights, and costs associated with our rebranding and name change. The 2018 rebranding investment is estimated to be approximately $16 million to $19 million, of which $3.6 million was spent during the three months ended March 31, 2018. For additional information on stock appreciation rights, see Note 13, Share-Based Payments, to the consolidated financial statements accompanying the 2017 Form 10-K, and on the rebranding and name change, see the “Executive Overview” section of this Item.

Depreciation and Amortization

Depreciation and amortization increased during the three months ended March 31, 2018 compared to the same period of 2017 due to our capital expenditures and development activities throughout 2017.

Interest Expense and Amortization of Debt Discounts and Fees

The decrease in Interest expense and amortization of debt discounts and fees during the three months ended March 31, 2018 compared to the same period of 2017 primarily resulted from the redemption of the 2.0% Convertible Senior Subordinated Notes due 2043 in June 2017. See Note 9, Long-term Debt, to the consolidated financial statements accompanying the 2017 Form 10-K.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations increased during the three months ended March 31, 2018 compared to the same period of 2017 primarily due to increased Net operating revenues as discussed above.

Provision for Income Tax Expense

Our Provision for income tax expense of $30.0 million and $39.7 million for the three months ended March 31, 2018 and 2017, respectively, primarily resulted from the application of our estimated effective blended federal and state income tax

36

rate. Our Provision for income tax expense declined during the three months ended March 31, 2018 compared to the same period of 2017 due to the impact of the Tax Cuts and Jobs Act (the "Tax Act").

We currently estimate our cash payments for taxes to be approximately $105 million to $135 million, net of refunds, for 2018. These payments are expected to result from federal and state income tax expenses based on estimates of taxable income for 2018. As discussed in Note 8, Income Taxes, to the condensed consolidated financial statements included in Part I, Item 1, Financial Statements (Unaudited), of this report, the Tax Act included revisions to Internal Revenue Code §451 that may eliminate the deferral of revenue associated with pre-payment claims denials and require us to pay tax on such denied claims. We are currently evaluating this provision of the Tax Act and its impact on the tax deferral associated with pre-payment claims denials we received in 2017. The upper end of our estimate of 2018 cash taxes considers 100% of the deferred revenue will be reversed.

In certain jurisdictions, we do not expect to generate sufficient income to use all of the available state NOLs and other credits 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 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 unrecognized tax benefits were $1.1 million and $0.3 million as of March 31, 2018 and December 31, 2017, respectively.

See Note 8, Income Taxes, to the condensed consolidated financial statements included in Part I, Item 1, Financial Statements (Unaudited), of this report and Note 15, Income Taxes, to the consolidated financial statements accompanying the 2017 Form 10-K.

Net Income Attributable to Noncontrolling Interests

The increase in Net Income Attributable to Noncontrolling Interests during the three months ended March 31, 2018 compared to the same period of 2017 primarily resulted from our new joint ventures in 2017 and increased profitability of our existing joint ventures.

Segment Results of Operations

Our internal financial reporting and management structure is focused on the major types of services provided by Encompass Health. 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 11, Segment Reporting, to the condensed consolidated financial statements included in Part I, Item 1, Financial Statements (Unaudited), of this report.

Inpatient Rehabilitation

Our inpatient rehabilitation segment derived its Net operating revenues from the following payor sources:

	Three Months Ended March 31,			
	2018		2017	
Medicare	74.4	%	73.7	%
Medicare Advantage	8.6	%	8.3	%
Managed care	10.1	%	10.9	%
Medicaid	2.9	%	2.8	%
Other third-party payors	1.4	%	1.5	%
Workers' compensation	0.9	%	1.0	%
Patients	0.5	%	0.6	%
Other income	1.2	%	1.2	%
Total	100.0	%	100.0	%

Additional information regarding our inpatient rehabilitation segment's operating results for the three months ended March 31, 2018 and 2017 is as follows:

	Three Months Ended March 31,		Percentage Change
	2018	2017	2018 vs. 2017
	(In Millions, Except Percentage Change)		
Net operating revenues:			
Inpatient	$817.1	$752.7	8.6 %
Outpatient and other	23.2	25.1	(7.6)%
Inpatient rehabilitation segment revenues	840.3	777.8	8.0 %
Operating expenses:			
Salaries and benefits	424.2	398.2	6.5 %
Other operating expenses	122.9	111.8	