State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

August 1, 2020

Mike Richardson
Covenant Health
280 Fort Sanders West Boulevard, Building 4, Suite 218
Knoxville, TN 37922

RE: Certificate of Need Application – Rehabilitation Hospital of Knox County - West - CN2007-023
For the establishment of a newly constructed 51-bed inpatient rehabilitation hospital to be located at 10150 Kingston Pike, Knoxville (Knox County) 37922. If approved, Fort Sanders Regional Medical Center (Patricia Neal Rehabilitation Center) will relinquish 51 of 73 licensed inpatient rehabilitation beds upon completion. The proposed site is 12 miles southwest from Fort Sanders Regional Medical Center. The applicant is owned by Covenant Health (50%) and Encompass Health Corporation (50%). The estimated project cost is $37,105,18.

Dear Mr. Richardson:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health, Division of Policy, Planning, and Assessment for Certificate of Need review. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project began on August 1, 2020. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be

forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 28, 2020.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

1. No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

2. All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Logan G. Grant
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Logan G. Grant
Executive Director

DATE: August 1, 2020

RE: Certificate of Need Application
Rehabilitation Hospital of Knox County - West - CN2007-023

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on August 1, 2020 and end on October 1, 2020.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Mike Richardson

LETTER OF INTENT

The Publication of Intent is to be published in the **Knoxville News Sentinel** (Name of Newspaper) which is a newspaper of general circulation in **Knox County** (County), Tennessee, on or before **July 10** (Month / day), **2020** (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Rehabilitation Hospital of Knox County ("West") (Name of Applicant) **(Not Applicable)** (Facility Type-Existing)

owned by: **Rehabilitation Hospital of Knox County, LLC** with an ownership type of **Limited Liability Company**

and to be managed by: **Encompass Health Corporation** intends to file an application for a Certificate of Need for: **the establishment of a 51-bed Inpatient Rehabilitation Facility (Rehabilitation Hospital) in a newly-constructed building to be located at a site currently addressed as 10150 Kingston Pike, Knoxville, TN 37922 (the site also includes a parcel of adjacent land). The applicant is jointly owned by a subsidiary of Covenant Health and a subsidiary of Encompass Health Corporation. The project will not result in the addition of inpatient rehabilitation beds to the market, because Fort Sanders Regional Medical Center ("Fort Sanders") will relinquish 51 of its 73 inpatient rehabilitation beds upon completion of the project. (A certificate of need application for a companion project will be filed concurrently that will result in Fort Sanders relinquishing the remaining 22 of its 73 inpatient rehabilitation beds.) This project does not seek to initiate any other service for which a certificate of need is required. The total estimated project cost is $ 37,105,128.**

The contact person for this project is **Mike Richardson** (Contact Name) **Vice President, Strategic Planning & Development** (Title)

who may be reached at: **Covenant Health** (Company Name) **280 Fort Sanders West Boulevard, Building 4, Suite 218** (Address)

Knoxville (City) **Tennessee** (State) **37922** (Zip Code) **(865) 531-5123** (Area Code / Phone Number)

(Signature) **July 10, 2020** (Date) **mdr@covhlth.com** (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Rehabilitation Hospital of Knox County, LLC
("West")

Certificate of Need Application

For

Establishment of an Inpatient Rehabilitation Facility Using Existing Licensed Beds

CON Filing Date: July 15, 2020

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

IDENTIFYING INFORMATION

1. Name of Facility, Agency, or Institution

Rehabilitation Hospital of Knox County, LLC

Name

Site currently addressed as: 10150 Kingston Pike — **Knox**
Street or Route — County

Knoxville — **Tennessee** — **37922**
City — State — Zip Code

Website address: **Not Applicable (TBA)**

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Mike Richardson — **Vice President, Strategic Planning and Development**
Name — Title

Covenant Health — **mdr@covhlth.com**
Company Name — Email address

280 Fort Sanders West Blvd., Building 4, Suite 218 — **Knoxville** — **TN** — **37922**
Street or Route — City — State — Zip Code

Employee *(of a member organization)* — **(865) 531-5123** — **(865) 531-5729**
Association with Owner — Phone Number — Fax Number

Please answer all questions on **8½" X 11" white paper, clearly typed and spaced, single sided, in order and sequentially numbered. In answering, please type the question and the response.** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable)*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response:

This CON application is for the establishment of an independently-licensed Inpatient Rehabilitation Facility ("IRF"), or Rehabilitation Hospital, utilizing existing licensed inpatient rehabilitation facility (hospital) beds in Knoxville, Tennessee (Knox County).

The proposed project will not add any new licensed beds or healthcare services to the region. Rather, the project supports an important continuation and upgrade of existing inpatient rehabilitation services at another location within Knox County. All licensed beds to be relocated and utilized for the proposed project existed prior to any outstanding or unimplemented certificates of need in the service area. Approval of the CON will result in a bed neutral project for the service area.

The proposed IRF to be independently-licensed will be created by relocating and utilizing 51 of the 73 existing licensed IRF beds that are licensed currently as part of Fort Sanders Regional Medical Center ("FSRMC"), an Acute Care Hospital that has been operating in Knox County, Tennessee since early 1920. FSRMC is a wholly-owned affiliate of Covenant Health, a non-profit health system that operates hospitals and other healthcare organizations in East Tennessee. The inpatient rehabilitation beds to be used for the proposed project have been operated by FSRMC under the well-known name "Patricia Neal Rehabilitation Center" ("PNRC") since 1978. Since its beginning, PNRC has cared for about 40,000 inpatients as a tertiary referral center for specialized rehabilitation care located in East Tennessee. Named for the late Oscar-winning actress Patricia Neal, who was a Knoxville native and 43-year stroke survivor, PNRC is nationally recognized for its treatment of stroke, spinal injuries, traumatic brain injuries, and many other conditions. PNRC is one of the largest inpatient rehabilitation centers within an acute care hospital in the country and is a six-time recipient of the Crystal Award for top performance in patient satisfaction.

The proposed project, Rehabilitation Hospital of Knox County, LLC ("West"), will be a collaborative partnership between Covenant Health (parent company of FSRMC, PNRC, and many other affiliates in East Tennessee) and Encompass Health (a well-known provider of inpatient rehabilitation services nationally and across Tennessee). The project will be completed and operated by these two organizations that each have significant experience providing high-quality inpatient rehabilitation services to many patients in Tennessee.

See Attachment, Section A-3A: Overview of Covenant Health and Encompass Health

The project represents a unique opportunity for the timely conversion and upgrade of existing healthcare resources to create a modern rehabilitation hospital (IRF) to be located on an available building site at the Fort Sanders West (FSW) medical campus established by Fort Sanders Regional Medical Center in 1985. The project involves new construction to create a state-of-the-art replacement facility for inpatient rehabilitation services that will meet or exceed all relevant requirements for a modern IRF. Moreover, CON approval will allow collaboration of Covenant Health and Encompass Health to improve patient care in East Tennessee via significant enhancements to care environments, support space, infrastructure, and clinical processes outlined throughout the CON application. The project will create all private rooms utilizing the existing licensed beds at FSRMC.

The proposed IRF will operate within approximately 54,400 square feet of facility space to be constructed if the CON project is approved. Property to be utilized for the project is controlled by Covenant Health and will be made available for the project if the CON is

approved. The proposed project site is a convenient, accessible, and well-known location for patients in the service area.

It is important to note that the other 22 licensed IRF beds of FSRMC (i.e. 73 beds – 51 beds = 22 beds) will remain at their current location in downtown Knoxville for use by patients needing inpatient rehabilitation services at the FSRMC campus. However, the applicant is seeking contemporaneous CON approval to use the remaining 22 beds at the FSRMC location to establish a separately-licensed facility using space leased from FSRMC. The companion CON ("Downtown") seeks to create a new IRF, to be independently licensed by the applicant under the proven "hospital in a hospital" ("HIH") model of IRF care. If both CONs are approved, the two new institutions will be operated by the applicant in a fully integrated and complementary manner by the applicant and associated organizations. If the two proposed CON projects are approved, FSRMC will relinquish its number of licensed inpatient rehabilitation beds commensurate with the number of beds for each companion project as it is completed; at the conclusion of the last project to be completed, FSRMC will have relinquished all of its currently licensed 73 inpatient rehabilitation beds. Together, the two related CON projects do not seek to add licensed bed capacity to the service area.

The primary goal of this project is to better serve and benefit the community with highest quality inpatient rehabilitation care while addressing evolving value-based-purchasing expectations of community stakeholders, referring providers, and payers. This project, along with its companion CON project, will allow better future use of existing FSRMC IRF beds that have not been fully accessible in the past due to space constraints, building/infrastructure requirements, stakeholder expectations, and other operational factors. Project approval will allow important care environment upgrades to occur in an optimal manner to strengthen ongoing patient care improvement efforts, enhance consumer/provider perception and satisfaction, and address all relevant regulatory, space, privacy, and accreditation requirements for a modern inpatient rehabilitation facility.

All services at the proposed IRF will be provided under the oversight of experienced clinical leaders and physicians affiliated with Covenant Health and Encompass Health. Moreover, patients to be cared for within the proposed Rehabilitation Hospital will benefit from the significant clinical performance collaboration and care management advantages created by the partnership of these organizations.

2) Ownership structure;

Response:

The proposed inpatient rehabilitation facility will be operated by Rehabilitation Hospital of Knox County, LLC – a new Limited Liability Company recently formed which is owned by Covenant Health (i.e. 50% ownership through its wholly-owned subsidiary Fortress Corporation) and Encompass Health Corporation (i.e. 50% ownership through its wholly-owned subsidiary Encompass Health Knoxville Holdings, LLC). Encompass Health Corporation will provide operational management services for the proposed Rehabilitation Hospital via agreement. Additional explanation and required documentation is provided elsewhere in the CON application and via attachments.

3) Service area;

Response:

For CON purposes, the primary service area for the proposed IRF project includes five (5) counties in East Tennessee where the majority of anticipated service recipients reside: Knox ("Home County"), Sevier, Loudon, Anderson, and Blount.

4) Existing similar service providers;

Response:

Historically, there have been only two providers of inpatient rehabilitation services within this IRF project's five (5) county primary service area: 1) Fort Sanders Regional Medical (FSRMC has 73 licensed IRF beds related to this CON project as addressed previously) and 2) Tennova Healthcare's Physicians Regional Medical Center (which once included 30 licensed IRF beds before it closed in late 2018 – 12 of those 30 beds are currently held in "inactive status", and the remaining 18 of those 30 beds were used for part of an "approved but unimplemented" CON (CN1812-051) project to relocate the 18 beds to the former Tennova Hospice House location in north Knoxville). There is another "approved but unimplemented CON" project (CN1903-007) to consolidate all of the Tennova-affiliated rehabilitation beds in the region under one new license. That project involves 57 total licensed beds retained after the recent closure of two hospitals in late 2018: 30 licensed beds from Physicians Regional Medical Center (i.e. the 12 beds held in inactive status + the 18 beds that were used for the "approved and unimplemented" CON) + 27 licensed beds held in "inactive status" from Lakeway Medical Center in Morristown in Hamblen County, which is closed and was located northeast of the service area for the project that is the subject to this application.

5) Project cost;

Response:

The total estimated project cost is $ 37,105,128 for CON purposes. A significant portion of the estimated total project cost is related to the cost of facility construction and the valuation of property to be used for the project.

6) Funding;

Response: The project anticipates covering all expenses via operational cash flow over time. However, all initial and ongoing funding needs can be met via the sufficient cash reserves of Covenant Health and Encompass Health.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: Projected revenue and expenses for the project indicate the proposed IRF will create positive free cash flow from operations within the first two years and maintain viability over time. The project anticipates positive net income by Year 2.

8) Staffing.

Response: The projected clinical staffing pattern for direct patient care in Year 1 of the proposed project includes 35.5 FTEs (full-time equivalent employees).

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area.

Provide a brief description of how the project meets the criteria necessary for granting a CON using the data and information points provided in Section B of the application.

1) Need;

Response:

The proposed project will not add any new licensed beds or healthcare services to the region. Rather, the project supports an important continuation and modernization of existing inpatient rehabilitation resources at a different location within Knox County. Approval of the CON will result in a bed neutral project for the service area. The project meets all applicable criteria for IRF CON approval as addressed within various sections of the application.

The proposed project will address both unmet current demand for IRF services and increasing demand for inpatient rehabilitation services in the service area related to a growing and aging population as well as other factors. The project will upgrade existing healthcare resources in Knox County to better serve patients and referring providers across the service area. Additionally, the proposed IRF will complement both Covenant Health and Encompass Health care networks in Tennessee through a partnership to enhance care and access for all patients in East Tennessee.

2) Economic Feasibility;

Response:

The costs anticipated for the project are reasonable. Adequate funding is available to support the project as needed through the cash reserves of Covenant Health and Encompass Health. Projected revenue and expenses for the project indicate the IRF will create positive free cash flow within the first two years of operations, achieve positive net income by Year 2, and maintain operational viability over time.

3) Quality Standards;

Response:

The applicant is committed to ensuring high-quality care for all patients at the proposed IRF. All services at the new IRF will be provided under the oversight of experienced clinical leaders and physicians affiliated with Covenant Health and Encompass Health. The applicant will maintain compliance with all applicable quality, safety, licensure, and other regulatory standards – and will ensure that all relevant clinical standards for both patient care and patient experience performance are met or exceeded within the new facility.

The applicant will ensure that all State, Federal, CMS, and other requirements for inpatient rehabilitation care environments are met – and will seek accreditation by the Joint Commission and explore accreditation by other organizations as appropriate during the initial years of operation. Additionally, patients to be cared for within the proposed IRF will benefit from the significant clinical collaboration and care management resources available through the integrated care networks of Covenant Health and Encompass Health.

4) Orderly Development of adequate and effective health care.

Response:

The proposed project will have a positive effect on the overall health care system in the service area and will promote the orderly achievement of the Tennessee State Health Plan's core tenets. Modernization efforts planned for the project will create a state-of-the-art care environment that will be more attractive, accessible, and beneficial to inpatient rehabilitation patients through the proposed conversion of existing licensed beds and related healthcare resources. Approval of the CON will result in a bed neutral project for the service area.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response:

The applicant respectfully requests consideration for CON review as a Consent Calendar agenda item. As required, written communication regarding this Consent Calendar request is provided via an attached cover letter to the Agency's Executive Director.

The rationale for an expedited review of the CON application is summarized below:

- **Approval of the CON will result in a bed neutral project for the service area.**
  - **Although the CON project seeks to establish a new inpatient rehabilitation facility (IRF) to be independently licensed, the project does not seek to add any new licensed beds to the service area.**
  - **Rather, the project involves the conversion, upgrade, and partial relocation of existing healthcare resources at another suitable location.**
- **The proposed project does not seek to initiate any new services for which a CON is required in Tennessee.**
- **The proposed project seeks to better serve patients (in the same service area currently served by the existing IRF beds) through a collaborative partnership to modernize existing healthcare resources to address evolving needs and expectations of many stakeholders in the region.**
- **The project meets applicable criteria for IRF CON approval as addressed within various sections of the application.**
- **The project meets the general criteria for CON approval.**
- **The project supports the core tenets of the Tennessee State Health Plan.**

4. PROJECT DETAILS

A. *Owner of the Facility, Agency or Institution*

Rehabilitation Hospital of Knox County, LLC — Name

(205) 967-7116 — Phone Number

9001 Liberty Parkway — Street or Route

Jefferson — County

Birmingham — City

Alabama — State

35242 — Zip Code

B. *Type of Ownership of Control (Check One)*

1) Sole Proprietorship _____
2) Partnership _____
3) Limited Partnership _____
4) Corporation (For Profit) _____
5) Corporation (Not-for-Profit) _____
6) Government (State of TN or Political Subdivision) _____
7) Joint Venture _____
8) **Limited Liability Company** X
9) Other (Specify)_____ _____

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4AB.**

See Attachments, Section A-4A/B: Corporate Charter and Certificate of Corporate Existence

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

Response: The proposed IRF will be owned and operated by Rehabilitation Hospital of Knox County, LLC – a new Tennessee Limited Liability Company recently formed which is jointly owned by Covenant Health (50% through its wholly-owned subsidiary Fortress Corporation) and Encompass Health Corporation (50% through its wholly-owned subsidiary Encompass Health Knoxville Holdings, LLC). Encompass Health Corporation will provide management services for the new inpatient rehabilitation facility via management agreement. Additional information regarding Covenant Health (www.covenanthealth.com) and Encompass Health (www.encompasshealth.com) is available via websites of each organization.

See Attachment, Section A-4A/B: Organization Chart

5. ***Name of Management/Operating Entity (If Applicable)***

Encompass Health Corporation
Name

9001 Liberty Parkway **Jefferson (AL)**
Street or Route County

Birmingham **AL** **35242**
City State Zip Code

Website address: **www.encompasshealth.com**

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5**.

See Attachment, Section A-5: Draft Management Agreement

6A. ***Legal Interest in the Site***

(Check the appropriate line and submit the following documentation)

The legal interest described below must be valid on the date of the Agency consideration of the certificate of need application.

☐ **Ownership** (Applicant or applicant's parent company/owner)
Submit a copy of the title/deed.

☐ **Lease** (Applicant or applicant's parent company/owner)
Attach a fully executed lease that includes the terms of the lease and the actual lease expense.

☐ **Option to Purchase**
Attach a fully executed Option that includes the anticipated purchase price

☐ **Option to Lease**
Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense

X **Other** *(Documentation of Intent to Transfer Property)*

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.
Attachment Section A-6A

See Attachment, Section A-6A:
Deeds and Documentation of Intent to Transfer Property

6B. Briefly describe the following and attach the requested documentation on an 8 ½" x 11" sheet of white paper, legibly labeling all requested information.

1) Plot Plan **must include**:
   a) Size of site (***in acres***);
   b) Location of structure on the site;
   c) Location of the proposed construction/renovation; and
   d) Names of streets, roads or highway that cross or border the site.

See Attachments, Section A-6A/B: Plot Plan (Site Plan)

2) Floor Plan – If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page.

a) Patient care rooms (private or semi-private)
b) Ancillary areas
c) Equipment areas
d) Other (specify)

See Attachments, Section A-6A/B: Floor Plan

3) Public Transportation Route - Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response:

Located at the established and well-known Fort Sanders West medical campus in Knox County, the project site is on the south side of Kingston Pike (merged stretch of US 70 and US 11) and immediately west of Fort Sanders West Boulevard. Near Interstate 40 (where it overlaps with I-75 through Knoxville) and Pellissippi Parkway (I-140 and sections of SR 162), the proposed site is highly visible and easily accessible for patients in the service area. Together, these highways represent the most significant travel corridors that run through Knox County (i.e. North-South and East-West), connect many communities across service area counties, and will provide easy access to the rehabilitation hospital from where most service area patients live. The location is in close proximity to many residential areas, businesses, hospitals, physician offices, and other established medical complexes. The proposed site is accessible to residents of the service area via primary and secondary transportation routes – and to both EMS and public transportation providers (i.e. ETHRA and other community transportation resources, both public and private) operating in the region.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A.	**Hospital** ***(Inpatient Rehabilitation)***	X	H	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	I.	Outpatient Diagnostic Center	_____
C.	ASTC, Single Specialty	_____	J.	**Rehabilitation Facility**	X
D.	Home Health Agency	_____	K.	Residential Hospice	_____
E.	Hospice	_____	L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	_____
F.	Mental Health Hospital	_____			
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID	_____	M.	Other (Specify)_____ _____	

8. **Purpose of Review** ***(Check appropriate lines(s) – more than one response may apply)***

A.	**Establish New Health Care Institution** ***(Inpatient Rehabilitation Facility)***	X	G.	MRI Unit Increase	_____
B.	Change in Bed Complement	_____	H.	Satellite Emergency Department	_____
C.	Initiation of Health Care Service as Defined in TCA 68-11-1607(4) (Specify) _____	_____	I.	Addition of ASTC Specialty	_____
D.	**Relocation and/or Replacement** ***(Existing Beds)***	X	J.	Addition of Therapeutic Catheterization	_____
E.	Initiation of MRI	_____	K.	Other (Specify)_____ _____	_____
F.	Initiation of Pediatric MRI	_____			

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number *Applicant will apply for a Medicare Provider Number*

Medicaid Provider Number *Applicant will apply for a Medicaid Provider Number*

Certification Type *Inpatient Rehabilitation Facility (Hospital)*

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare X **Yes** __ No __ N/A **Medicaid/TennCare** X **Yes** __ No __ N/A

10. Bed Complement Data ***Chart provided regarding Fort Sanders Regional Medical Center***

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	317	191				317
2) Surgical	45	44				45
3) ICU/CCU	50	50				50
4) Obstetrical	32	32				32
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation *(See Note)*	73	48	0			0
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)	24	24				24
19) ICF/IID						
20) Residential Hospice						
TOTAL	541	389	0			468

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

***Note**: if this proposed CON project is approved, FSRMC will relinquish 51 inpatient rehabilitation beds available under its current license upon project completion. Likewise, the other 22 licensed IRF beds of FSRMC will be relinquished upon project completion if a contemporaneously filed CON application is approved (which would allow operation of the other 22 IRF beds at the FSRMC campus as a new and independently licensed IRF).*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

Response:

The only change in bed allocation related to this specific CON project will involve the relocation of 51 existing IRF beds to be operated by a new IRF institution – all beds needed for the project are currently operated as the Patricia Neal Rehabilitation Center (PNRC) under the acute care hospital license of Fort Sanders Regional Medical Center (FSRMC). If the CON is approved, FSRMC will relinquish the 51 inpatient rehabilitation beds available under its current license upon project completion. However, if a simultaneously filed companion CON for another new IRF (involving the other 22 beds, to be separately licensed) is approved, all

73 IRF beds under the FSRMC hospital license currently would be relinquished upon completion of the proposed projects and after patients have been discharged.

The proposed project allows optimal replacement and use of existing licensed IRF beds at FSRMC to be operated under a separate license in a manner to allow modernization of patient care environments and minimize operational disruptions. The project will not have a negative impact on other existing FSRMC services. All services of the proposed CON project will be operated in a collaborative manner with existing services of FSRMC, and other Covenant Health and Encompass Health affiliates. Projected utilization for the proposed facility is based primarily upon discharges from Covenant Health hospitals.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

Response:

Not Applicable.

11. Home Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: **(Not Applicable.)**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart ("WEST")

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Main Entry & Lobby						1373	1373
Administration						3418	3418
Dietary						2537	2537
Environmental/Supply						956	956
Plant Services						1112	1112
Nursing Unit						22867	22867
Dining/Rec/Dayroom						3384	3384
Activities for Daily Living						492	492
Pharmacy						578	578
Physical Therapy						5812	5812
Psych/OT/Speech						600	600
Social Services / Case Mgt						660	660
Unit/Department GSF Sub-Total						**43,789**	**43,789**
Other GSF Total						**10,611**	**10,611**
Total GSF						**54,400**	**54,400**
*Total Cost						**$19,403,166**	**$19,403,166**
**Cost Per Square Foot						**$356.68**	**$356.68**
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)* ***Note**: Not Applicable – specific IRF Construction Cost per Square Foot Quartiles are not available via HSDA Website currently; however, qualified architectural and construction professionals have confirmed that the projected costs are appropriate for the proposed project. Additionally, the proposed Construction Costs per Square Foot for the project fall within an acceptable quartile range for Hospital "NEW" Construction.*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☒ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

Response:

The "*Square Footage and Cost Per Square Footage Chart*" has been completed as required.

The *Project Cost Chart* includes anticipated *Total Construction Cost*s (Line A.5.) and an appropriate *Contingency Fund* (Line A.6.) for the project. The estimated *Total Construction Cost* for the project is $ 19,403,166 as reflected on both the *Project Cost Chart* and the *Square Footage and Cost Per Square Footage Chart.*

Specific IRF Construction Cost per Square Foot Quartiles are not available on the HSDA Website at this time; however, qualified architectural and construction professionals have confirmed that the projected costs are appropriate for the proposed project ($ 356.68 per square foot). Additionally, the proposed *Construction Costs per Square Foot* for the project fall within an acceptable quartile range for *Hospital "New" Construction Costs per Square Foot* when compared to information currently available on the HSDA website.

All space required for the proposed IRF project will be developed by Rehabilitation Hospital of Knox County, LLC and other qualified organizations as indicated by various CON attachments. After outlined modifications, the new facility will comply with all relevant architectural, building, licensure, and current inspection requirements for a modern IRF.

See Attachment, Section 12-A: Architect and Construction Letter

A. Describe the construction and renovation associated with the proposed project. If applicable, provide a description of the existing building, including age of the building and the use of space vacated due to the proposed project.

Response:

The proposed inpatient rehabilitation facility at the West location will operate within approximately 54,400 square feet of space in a new building to be constructed on land that is owned and controlled by Covenant Health. The property to be used for the project will be made available to the applicant via an appropriate ownership transfer.

The "*Square Footage and Cost Per Square Footage Chart*" provides an overview of the building space to be constructed for the project. The new building will be designed and constructed to address all relevant Federal, State, and other regulatory requirements for a modern rehabilitation hospital.

Highlights of the proposed construction associated with the project are provided below:

- **This project involves de novo construction of a freestanding inpatient rehabilitation facility to utilize 51 of the 73 existing licensed IRF beds historically maintained by FSRMC.**
- **The project will be developed on a suitable site available to the applicant, providing space needed for the proposed construction to support the relocated IRF beds and to allow for future growth.**

- **Upon project completion, the proposed IRF will include the following:**
  - **Modern IRF patient care areas, including all private patient rooms, nursing stations, dialysis suite, rehabilitation gym, and specialized therapy space**
  - **Appropriate dining and activity space for patients**
  - **Adequate functional space for clinical, administrative, and support staff**
  - **Space to support pharmacy and storage needs**
  - **Appropriate space to support all required IRF infrastructure (HVAC; utilities; IT and telecommunications; fire alarm, sprinkler, and nurse call systems; etc.)**
  - **Access to outdoor therapy courtyard area for patients**
  - **Visitor reception and patient admissions area, including transport accessibility**
  - **Modern aesthetics including interior finishes and signage to enhance patient/visitor experience**
  - **The facility will have a covered main entrance for visitors and adequate parking adjacent to the building.**
  - **Perhaps most importantly, this project (along with its companion CON project) will create additional space required to accommodate all private rooms with private bathrooms <u>and</u> utilize the complete licensed bed capacity currently available under the FSRMC license. The project will allow significant improvements over the historical "status quo" at PNRC – marked by bed capacity limitations and other operational challenges caused by space constraints and dated clinical support infrastructure. Creation of modern facility space needed to support patient care more efficiently and effectively will greatly increase the accessibility and benefits of needed IRF resources in the service area.**

In addition to benefits highlighted for this "West" CON project that seeks to relocate 51 of FSRMC's 73 licensed IRF beds to the FSW campus, the proposed project allows major space renovations necessary to improve existing healthcare resources on the FSRMC campus in downtown Knoxville. The additional space and operational flexibility made available by, in effect, moving 51 licensed IRF beds to the west location will allow significant facility and infrastructure improvements to occur for the older building areas historically utilized by PNRC with minimal disruption to patient care.

The Patricia Neal Rehabilitation Center (IRF unit at FSRMC) will remain operational and accessible to patients throughout the proposed construction and development efforts of both companion CON projects. Design, development, and management of both projects will occur in a coordinated manner to optimize efforts, minimize service disruptions, and preserve operating flexibility. Both companion CON projects are expected to be complete in 2022.

Upon simultaneous completion of both projects, an updated 22-bed unit on the FSRMC campus will be operated (and independently licensed) as a "HIH" unit by the applicant. The 22-bed IRF operation to remain at the current PNRC location will be especially beneficial for patients who need inpatient rehabilitation care at the FSRMC campus downtown, many of whom will be linked to other FSRMC service lines. The updated 22-bed IRF unit to remain on the FSRMC campus is addressed more thoroughly within the required companion CON application.

13. MRI, PET, and/or Linear Accelerator

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or

(Not Applicable.)

2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

(Not Applicable.)

A. Complete the chart below for acquired equipment.

(Not Applicable.)

☐ Linear Accelerator	Mev _____	Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____	
	Total Cost*: _____	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____	
☐ MRI	Tesla: _____	Magnet: ☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____	
	Total Cost*: _____	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____	
☐ PET	☐ PET only ☐ PET/CT	☐ PET/MRI	
	Total Cost*: _____	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____	

* As defined by Agency Rule 0720-9-.01(4)(b)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

(Not Applicable.)

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

(Not Applicable.)

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

(Not Applicable.)

E. Identify the clinical applications to be provided that apply to the project.

(Not Applicable.)

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

(Not Applicable.)

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards provided in the State Health Plan.
Additional criteria for review are prescribed in Chapter 11 of the Agency's Rules, Tennessee Rules and Regulations 01730-11.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate.

QUESTIONS

NEED

The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.

1. Provide a response to the applicable criteria and standards for the type of institution or service requested. https://www.tn.gov/hsda/hsda-criteria-and-standards.html

Comprehensive Inpatient Rehabilitation Services

(HSDA: 05-12-2020)

The Health Services Development Agency (HSDA) may consider the following standards and criteria for applicants seeking to establish Inpatient Rehabilitation Services. Rationale statements are provided for standards to explain the Division of Health Planning's underlying reasoning. Additionally, these rationale statements may assist stakeholders in responding to these Standards and may assist the HSDA in its assessment of certificate of need (CON) applications. Existing Inpatient Rehabilitation programs are not affected by these Standards and Criteria unless they take action that requires a new CON for such services.

These Standards and Criteria are effective immediately upon approval and adoption by the Governor. However, applications to provide Inpatient Rehabilitation Services that are deemed complete by the HSDA prior to the approval and adoption of these Standards and Criteria shall be considered under the Guidelines for Growth, 2000 Edition.

The Certificate of Need Standards and Criteria serve to uphold the Five Principles for Achieving Better Health set forth by the State Health Plan. Utilizing the Five Principles for Achieving Better Health during the development of the CON Standards and Criteria ensures the protection and promotion of the health of the people of Tennessee. The State Health Plan's Five Principles for Achieving Better Health are as follows:

1. **Healthy Lives:** The purpose of the State Health Plan is to improve the health of Tennesseans.
2. **Access:** Every citizen should have reasonable access to health care.
3. **Economic Efficiencies:** The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.
4. **Quality of Care:** Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.
5. **Workforce:** The state should support the development, recruitment and retention of a sufficient and quality health care workforce.

Standards and Criteria

1. **Determination of Need:** The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of one bed per 1,000 applied to the age 65+ population in the service area of the proposal.

   The need shall be based upon the current year's population and projected four years forward. Population statistics from the Department of Health should be used for the calculation.

   In accordance with Tennessee Code Annotated 68-11-14607 (g), "no more frequently than one time every three years, a hospital, rehabilitation facility, or mental health hospital may increase its total number of licensed beds in any category by ten percent or less of its licensed capacity at any one campus over any period of one year for any services it purposes it is licensed to perform without obtaining a certificate of need. These licensed beds that were added without a certificate of need should be considered as part of the determination of need formula by the agency.

   Response:

   Not Applicable. This CON application is for the establishment of a new freestanding Inpatient Rehabilitation Facility ("IRF"), or Rehabilitation Hospital, using only existing licensed inpatient rehabilitation facility (hospital) beds in Knoxville, Tennessee (Knox County). The proposed project will not add any new licensed beds or healthcare services to the region. All licensed beds to be relocated and utilized for the proposed project existed prior to any outstanding or unimplemented certificates of need in the service area. Approval of the CON will result in a bed neutral project for the service area.

   The proposed IRF to be independently licensed will be created by relocating and utilizing 51 of the 73 existing licensed IRF beds that are licensed currently as part of Fort Sanders Regional Medical Center ("FSRMC"), an Acute Care Hospital that has been operating in Knox County, Tennessee since early 1920. The inpatient rehabilitation beds to be used for the proposed project have been operated by FSRMC under the well-known name "Patricia Neal

Rehabilitation Center" ("PNRC") since 1978. Since its beginning, PNRC has cared for about 40,000 inpatients as a tertiary referral center for specialized rehabilitation care located in East Tennessee. Named for the late Oscar-winning actress Patricia Neal, who was a Knoxville native and 43-year stroke survivor, PNRC is nationally recognized for its treatment of stroke, spinal injuries, traumatic brain injuries, and other conditions.

However, for informational purposes, it is worth noting that the Tennessee Department of Health's new *Determination of Need* guideline for comprehensive inpatient rehabilitation beds in a service area is met for this proposed project (i.e. the recently revised *Guidelines for Growth* formula that is currently applicable):

Current Determination of Need Guideline

"The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of one bed per 1,000 applied to the age 65+ population in the service area of the proposal." "The need shall be based upon the current year's population and projected four years forward. Population statistics from the Department of Health should be used for the calculation."

Age 65+ population in the service area of the proposal

65+ Population Estimate for 2020: 159,832 *(current year)*
65+ Population Estimate for 2024: 177,285 *(projected four years forward)*

See Attachment, Section B-Need-4A/B
Service Area Population, Demographics, and TennCare

Bed Need Calculation for 2020 and 2024

2020: 159,832 / 1,000 = 159.8 *(Estimated Bed Need in Service Area)*
2024: 177,285 / 1,000 = 177.3 *(Estimated Bed Need in Service Area)*

Inpatient Rehabilitation Facility Beds Approved in Service Area

Fort Sanders Regional Medical Center:	***73 existing licensed IRF beds*** *(51 for this CON)*
+ Knoxville Rehabilitation Hospital, LLC:	***57 IRF beds approved for relocation*** *(CN1903-007)*
= Combined Service Area Total IRF Beds:	***130 Total Existing Licensed/Approved IRF Beds***

Conclusion: Service Area Supports Existing IRF Bed Need for both 2020 and 2024

2020: 159.8 IRF Beds Needed per New Guideline = 29.8 More than 130 Existing/Approved
2024: 177.3 IRF Beds Needed per New Guideline = 47.3 More than 130 Existing/Approved

This CON project does not seek to add more licensed IRF beds to the service area. Additional IRF bed need shown by the current *Guidelines for Growth* could be addressed by approved providers in the service area incrementally without requiring a CON per applicable statute if additional licensed bed capacity is required in the future.

2. **Establishment of Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant.

Response:

The proposed Rehabilitation Hospital will be created by relocating 51 of the 73 existing licensed inpatient rehabilitation facility beds that are licensed currently as part of Fort Sanders Regional Medical Center ("FSRMC"), an Acute Care Hospital that has been operating in Knox County, Tennessee since 1920. The inpatient rehabilitation beds to be used for the proposed project have been operated by FSRMC under the well-known name "Patricia Neal Rehabilitation Center" ("PNRC") since 1978.

The primary service area for the proposed IRF project includes five (5) counties in East Tennessee where the majority of anticipated service recipients reside: Knox ("Home County"), Sevier, Loudon, Anderson, and Blount. The project service area is reasonable since it is based upon recent *Patient County of Origin* data for the Patricia Neal Rehabilitation Center at FSRMC (2017-2019). The project service area is addressed in more detail in other sections of the CON application as required.

See Attachment: Service Area Map

The geographical service area for the CON project is based on an optimal balance between population density and service proximity of the applicant. Specifically, the geographical service area for the project is based upon the historical primary service area of PNRC in recent years – which includes communities with significant population density and others with less population density in outlying areas. The vast majority of all patients expected to receive care at the proposed inpatient rehabilitation facility will live less that one hour travel time from the proposed site, which is reasonable for referrals to a tertiary care center – and many patients will live less than 30 minutes from the site.

Some patients are expected from beyond the project's primary service area (representing secondary and tertiary areas of patient origin); however, patients from any other individual county of patient origin are expected to be less than 5.0% of the annual total IRF discharges during initial years of operations after project completion. Many of the patients from other counties live in areas marked by more dispersed populations with limited access to inpatient rehabilitation services – this is consistent with the experience of PNRC across many years. The project will be accessible to all patients in the region who may consider seeking inpatient rehabilitation services at the IRF.

As required, service area population estimates are projected four (4) years into the future using available population estimates and projections from the Tennessee Department of Health (see Service Area section of CON Application). Moreover, population and other demographic factors outlined within the CON application were considered as anticipated volume projections were developed for the project (*see Utilization Methodology section of CON Application*).

3. **Minimum Bed Requirements:**

Inpatient rehabilitation units should have a minimum size of 20 beds.

Response:

Not Applicable. However, the proposed IRF will exceed 20 beds.

Freestanding rehabilitation hospitals should have a minimum size of 50 beds.

Response:

The proposed 51-bed freestanding rehabilitation hospital will meet the 50 bed minimum requirement for a new freestanding rehabilitation hospital.

This CON application is for the establishment of a new IRF using existing licensed beds in Knoxville, Tennessee (Knox County). The proposed project will not add any new licensed beds or healthcare services to the region. Rather, the project supports an important continuation and upgrade of existing inpatient rehabilitation services at a different location within Knox County.

The proposed IRF will be created by relocating 51 of the 73 existing licensed inpatient rehabilitation facility beds that are licensed currently as part of Fort Sanders Regional Medical Center ("FSRMC"), an Acute Care Hospital that has been operating in Knox County, Tennessee since 1920. FSRMC is a wholly-owned affiliate of Covenant Health, a non-profit health system that operates hospitals and other healthcare organizations across East Tennessee. The inpatient rehabilitation beds to be used for the proposed project have been operated by FSRMC under the well-known name "Patricia Neal Rehabilitation Center" ("PNRC") since 1978.

4. **Relationship to Existing Similar Services in the Area:** The proposal shall discuss what similar services are available in the service area and the latest reported three-year trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed increase in rehabilitation beds on existing providers in the proposed service area and shall include how the applicant's services may differ from these existing services. The agency should consider if the approval of additional beds in the service area will result in unnecessary, costly duplication of services.

   Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA unless all existing units or facilities in the proposed service area are utilized at the following levels:

   10-30 bed unit ~ 75%
   31-50 bed unit/facility ~ 80%
   51 bed plus unit/facility ~ 85%

   Response:

   Not Applicable. The proposed project will not create additional licensed beds or add new healthcare services to the region. Rather, the project supports an important continuation and modernization of existing inpatient rehabilitation services utilizing existing licensed beds at another location within Knox County to better serve patients.

   This proposed project, along with the project addressed in a companion CON application filed concurrently, represents a partnership between Covenant Health and Encompass Health to better serve patients in the region. The collaborative and fully-integrated projects create an optimal solution to improve access and utilization of existing licensed IRF beds needed in the service area, as two experienced organizations combine resources and expertise to form an efficient, patient-focused partnership to improve patient care environments utilizing available properties.

   All other existing inpatient rehabilitation beds in the community (i.e. 57 beds associated with Tennova that were once operated as part of hospitals which closed in late 2018) will be consolidated, relocated, and operated within a new facility as well upon completion of another CON project that was approved in 2019 (CN1903-007). The CON application for that project projected 82.5% occupancy of their 57 licensed IRF beds by Year 2 (2022). The projected utilization of that project is based on discharges from Tennova hospitals in the area and the University of Tennessee Medical Center.

   The proposed project will not have a negative impact upon other providers since the project does not seek to increase the licensed beds available in the service area or add new services to the region. Projected utilization of the facility is based primarily on discharges from Covenant Health hospitals, although it will be open to referrals from any hospital or other providers.

5. **Quality Considerations:** Applicants should use the Centers for Medicare & Medicaid Services (CMS) required measures for inpatient rehabilitation facilities. As of fall 2019, these measures are as follows:

    a. Pressure ulcers,

    b. Catheter associated urinary tract infection (CAUTI),

    c. Healthcare worker influenza vaccinations,

    d. 30-day post-discharge readmissions,

    e. Clostridium difficile (C. diff),

    f. Falls with injury, and

    g. Functional outcome measures – mobility, self-care.

Applicants should use the following table to demonstrate the quality of care provided at the existing unit or units.

Measure	**National Average**	**Unit**
Pressure ulcers		
Catheter associated urinary tract infection (CAUTI),		
Healthcare worker influenza vaccinations		
30-day post-discharge readmissions		
Clostridium difficile (C. diff)		
Falls with injury		
Functional outcome measures – mobility, self-care		

Data Source: Inpatient Rehabilitation Facility Compare
https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Because these measures change over time, applicants should use the measures that are in place at the time of the application. Applicants should provide data from the most recent four quarters from existing facilities operated by the applicant.

For applicants with no existing facility or service line, quality data from the most recent four quarters would be unavailable and not required for the application.

Response:

The applicant represents a new institution, so no historical data is available to report.

However, the proposed project represents an important continuation and improvement of existing healthcare resources in the region through the relocation and use of some IRF beds currently operated by FSRMC – so requested quality data is provided via attachment to demonstrate the quality of care provided at the existing PNRC IRF unit that is operated currently under the hospital license of FSRMC.

See Attachment: Section B-Need-IRF Criteria 5: Quality Considerations

6. **Licensure and Quality Considerations**: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of TDH. Additionally, the applicant shall demonstrate certification by CMS for existing facilities.

Response:

All Covenant Health and Encompass Health affiliates maintain compliance with the appropriate rules of TDH and CMS. The proposed IRF project will seek, maintain, and demonstrate certification by CMS and other regulatory agencies as appropriate.

7. **Adequate Staffing:** The applicant must document the availability of adequate professional staff, as per licensing and Centers for Medicare & Medicaid Services (CMS) requirements, to deliver all designated services in the proposal.

Response:

Many of the employees needed to support the proposed IRF during the first few years of the project are already employed by Covenant Health and are working currently at the existing PNRC unit located at FSRMC or at other affiliate facilities. Additionally, both Covenant Health and Encompass Health have a proven track record of finding, hiring, and developing excellent clinical leadership and professional staff consistent with CMS requirements and all relevant licensing and accreditation requirements.

8. **Services to High-Need and Underserved Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including uninsured, low-income, and underserved geographic regions, as well as other underserved population groups.

Response:

The proposed project will fulfill unique needs for inpatient rehabilitation services for high-need populations, including the growing number of elderly patients (65+) in the service area and many low-income individuals. The IRF (and involved physicians) will seek contracts with all TennCare MCOs operating in the service area and will implement appropriate charity care policies to benefit economically challenged patients. As addressed elsewhere in the CON application, the proposed IRF will be accessible to all patients in the service area, which represents a growing, aging, and increasingly diverse population.

9. **Access to Services in the Proposed Service Area:** The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is a limited access in the proposed service area. Factors influencing access to services in the proposed service area may include drive time to obtain care.

Response:

The applicant will be able and willing to serve equally all of the service area in which it seeks certification. The vast majority of all patients expected to receive care at the proposed inpatient rehabilitation facility will live less that one hour travel time from the proposed site, which is reasonable for referrals to a tertiary care center – and many patients will live less than 30 minutes from the site. Other patients will also have full access to the proposed IRF, including a much smaller number of patients from a broader tertiary referral area marked by more dispersed populations with limited access to inpatient rehabilitation services – this is consistent with the experience of PNRC across many years.

10. **Data Requirements:** Applicants shall agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response:

The applicant agrees to provide relevant information, statistics, and data related to the operation and provision of services as required by the Tennessee Department of Health (TDH), the Health Services and Development Agency (HSDA), and other regulatory agencies.

Construction, Renovation, Expansion, and Replacement of Healthcare Institutions

(HSDA: 05-12-2020)

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Response:

Not Applicable.

Although the CON project seeks to establish a new inpatient rehabilitation facility (IRF) to be independently licensed, the project does not seek to add new licensed beds to the service area. Approval of the CON will result in a bed neutral project for the region.

Additionally, the proposed project does not seek to initiate any new services for which a CON is required in Tennessee.

However, the project meets the all applicable current criteria for IRF CON approval as addressed within other sections of the application.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Response:

This "West" CON application project involves the partial relocation of existing IRF resources utilizing 51 (of the 73) existing licensed IRF beds currently operated by FSRMC. A companion CON has been filed concurrently, which seeks to utilize the remaining 22 of FSRMC's 73 existing licensed IRF beds to create a modern IRF in downtown Knoxville. The companion Downtown CON project will be operated under the "HIH IRF" model of care by the applicant and affiliated organizations. Each CON project will create a newly licensed IRF, which together will utilize all of the IRF beds currently licensed as part of FSRMC. All existing FSRMC IRF beds will be surrendered upon completion of the two integrated replacement projects.

Provided below is a brief summary of considerations related to the strengths, weaknesses, and potential costs associated with options for improving care environments and accessibility for the existing IRF beds needed in the service area.

First, the option to retain and staff all 73 licensed IRF beds at the FSRMC campus is not possible due to facility space and infrastructure limitations of the existing areas utilized by PNRC. The current space cannot be modified practically, even via extensive and costly renovations, to accommodate all applicable requirements and expectations for a modern IRF unit to support all 73 licensed IRF beds. Moreover, even if adequate space were available to make this option possible, experienced experts from Covenant Health and

Encompass have confirmed that the significant costs of such an effort, including capital cost for modernization and the cost of operational disruption, would not be prudent or acceptable compared to the projects set forth in this application and its companion.

The scenario of moving all 73 licensed IRF beds to the FSW campus might be possible due to potential construction and operational efficiencies of a "green field" or "de novo" project, when compared to the renovation and modernization of an IRF unit operating at a downtown hospital where space is limited and needed to support other service lines. However, moving all 73 licensed beds would eliminate onsite access to important IRF services at the downtown Knoxville location of FSRMC, where continuation of IRF services is important to support major service lines and patients who are discharged from FSRMC.

After careful evaluation by Encompass Health, Covenant Health, and experienced architectural and construction professionals, the applicant has created an optimal solution involving an appropriate division of the 73 existing licensed beds between two locations. This approach allows utilization of all 73 licensed IRF beds at two suitable, accessible, and complementary sites within the service area. It is important to note that this selected option creates all community benefits of a modern, freestanding IRF (including at least 50 beds per current TDH freestanding IRF guidelines), while retaining at least 20 IRF beds within the "HIH" model (consistent with current TDH IRF unit guidelines). All parties involved concur that this is the most efficient and cost-effective approach to modernizing the existing IRF resources and improving access when all factors are considered.

To fully understand the merits of approach by the companion CON projects, it is important to note that the existing physical plant utilized by the Patricia Neal Rehabilitation Center at FSRMC is within an older building that does not allow use of the full licensed bed complement considering all current facility regulations for an IRF, even if a major renovation efforts occurred. Moreover, any expansion at the downtown hospital campus would be suboptimal compared to the decision to create a freestanding IRF at a new location to avoid operational disruption, construction inefficiencies, and significant unnecessary costs. The companion CON projects will allow the existing physical plant at FSRMC to be used throughout project development stages – even as renovations and infrastructure improvements are underway to use the downtown hospital location for the 22 licensed beds that will remain at that location.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response:

Even as space constraints have limited the number of licensed IRF beds that can be staffed at FSRMC, volumes to support viable operations currently exist at PNRC. Additionally, such the capacity constraints at PNRC have resulted in unmet demand for IRF services in the region – representing individuals who might qualify for IRF admission but have rather experienced longer stays within acute care hospital settings. This is implicitly recognized by the State Health Plan need methodology, which indicates a current need for additional beds in the 5-county service area (i.e. beyond the 57 beds affiliated with Tennova hospitals and the 73 beds at PNRC). Approval of the proposed project will significantly improve access to IRF services for all patients in the region. Existing and projected demand for IRF services in the region are addressed in more detail elsewhere in the CON application.

As required, service area population estimates are projected four (4) years into the future using available population estimates and projections from the Tennessee Department of Health (*see Service Area section of CON Application*). Population and other demographic factors outlined within the CON application were considered as anticipated volume projections were developed for the project *(see utilization and projection methodology section of CON Application).*

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   Response:

   Not Applicable. This CON application does not involve the renovation of an existing licensed healthcare institution or expansion via additional licensed beds. However, the required CON guideline questions regarding "*relocation or replacement of an existing licensed health care institution*" were addressed as appropriate in a previous section of the application.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

   Response:

   Not Applicable. This CON application does not involve the renovation of an existing licensed healthcare institution or expansion via additional licensed beds. However, the required CON guideline questions regarding "*relocation or replacement of an existing licensed health care institution*" were addressed in a previous section, including consideration of the existing physical plant at the Downtown location that warrants significant renovations to create a modern IRF care setting utilizing fewer licensed beds that will be operated under a collaborative "HIH" model.

2. Describe how this project relates to existing facilities or services operated by the applicant including previously approved Certificate of Need projects and future long-range development plans.

Response:

The proposed project supports the aligned missions, goals, and long-range plans of both Covenant Health and Encompass Health as they work together to improve healthcare for many patients and communities in East Tennessee. As an important part of ongoing planning efforts and partnership considerations, both organizations involved with this proposed project regularly evaluate evolving community needs, industry trends, and consumer preferences for healthcare services. This project represents a continuation of such efforts to improve inpatient rehabilitation facility (IRF) resources in the service area – and to make them more accessible and attractive to patients, patient families, consumers, referring providers, and payers. The project seeks to provide high quality, safe, efficient, and effective inpatient rehabilitation care that will be accessible to all people who reside within the primary service area, as well as to other individuals needing IRF services who live in a broader geography with more dispersed population densities. The proposed IRF will improve access to rehabilitation services in the region by creating a modern care setting that enhances consumer choice while improving operational efficiencies, care coordination, and both patient and physician satisfaction.

3. Identify the proposed service area and provide justification for its reasonableness. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked and shaded to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment Section B - Need-3.**

Response:

The primary service area for the proposed IRF project includes five (5) counties in East Tennessee where a majority of anticipated service recipients reside: Knox ("Home County"), Sevier, Loudon, Anderson, and Blount. Combined, these five counties include the patient county of origin for most IRF inpatient discharges at PNRC/FSRMC in recent years *(i.e. 62-66% in 2017-2019).*

Additionally, some patients are expected from beyond the project's primary service area (representing secondary and tertiary areas of patient origin); however, the percent of total patients from any other individual county of patient origin is expected to be less than 5.0% of annual total IRF discharges during initial years of operations after project completion. Many of the patients from other counties live in areas marked by more dispersed populations with limited access to inpatient rehabilitation services – this is consistent with the experience of PNRC over many years. The project will be accessible to all patients in the region who may need inpatient rehabilitation services.

See Attachment, Section B-Need-3: Service Area Maps

It is expected that at least 35% of the patients who will receive care at the proposed IRF will be from Knox County (the county within the region that has the highest current and projected population) during the initial years of the project – and approximately 5-10% from each of the remaining counties in the primary service area (i.e. Sevier, Loudon, Anderson, and Blount). This is consistent with the recent experience of the hospital-based IRF unit located at FSRMC (PNRC).

As required, service area population estimates are projected four (4) years into the future using available population estimates and projections from the Tennessee Department of Health. Population and other demographic factors outlined within the CON application were considered as anticipated volume projections were developed for the project (see Utilization Methodology section of CON Application).

Complete the following utilization tables for each county in the service area, if applicable:

Service Area Counties	**Historical Utilization-County Residents – Most Recent Year (YEAR = _____)**	**% of total ☐ procedures ☐ cases ☐ patients ☐Other _____.**
Knox		
Etc.		
Total		100%

Service Area Counties	**Projected Utilization-County Residents-Year 1 (YEAR = _____)**	**% of total ☐ procedures ☐ cases ☐ patients ☐Other _____.**
County #1		
County #2		
County #3		
County #4		
Etc.		
Total		100%

RESPONSE:

The project seeks to establish a new IRF so there is no Historical Utilization to report.

However, the Historical Utilization for the Patricia Neal Rehabilitation Center (PNRC) located at FSRMC is provided for informational purposes (i.e. for each county in the project's primary service area). All licensed beds to be utilized for the proposed project exist currently under the FSRMC license.

Patricia Neal Rehabilitation Center (at Fort Sanders Regional Medical Center)

Service Area Counties	Historical Utilization-County Residents Most Recent Year (YEAR = 2019)	% of total ☐ procedures ☐ cases ☐ patients X Other IRF IP Discharges.
Knox	246	35.6 %
Sevier	52	7.5 %
Loudon	42	6.1 %
Blount	53	7.7 %
Anderson	32	4.6%
Service Area Subtotal	*425*	*61.5%*
All Others*	266	38.5%
Total	691	100%

** Any "Other" individual TN County provided less than 5.0 % of Total Patients – and most commonly less than 1.0 %. Any Non-TN County provided less than 0.25 % of Total Patients.*

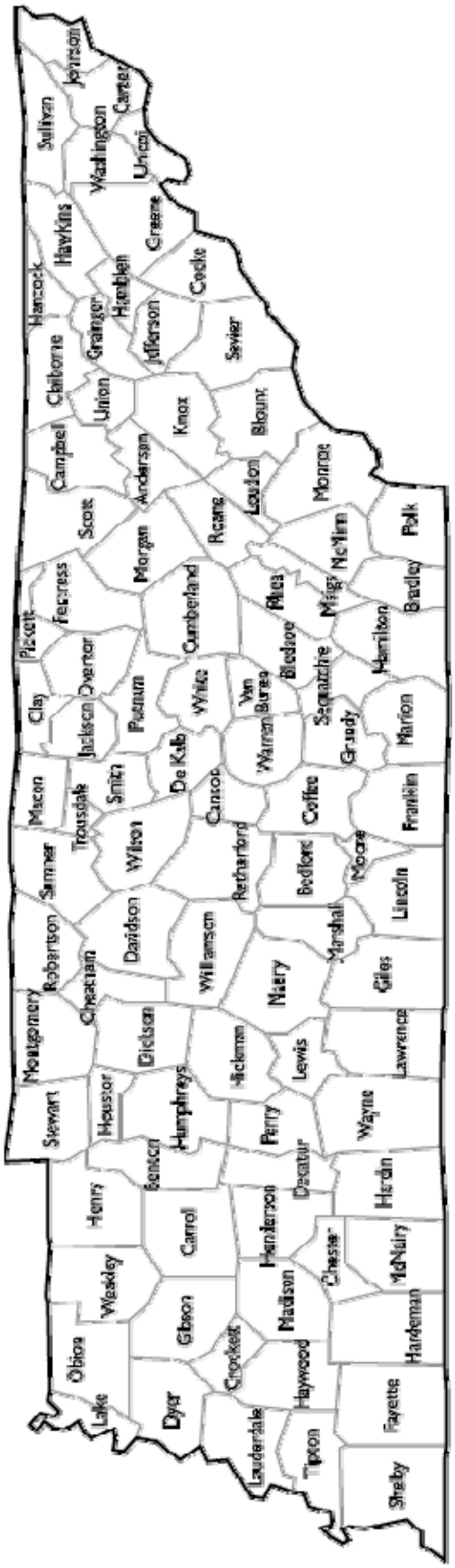
Additionally, the Projected Annual Utilization anticipated for the first year of the project is provided for each primary county of patient origin in the chart below (i.e. for each county in the project's primary service area).

Rehabilitation Hospital of Knox County, LLC ("WEST")

Service Area Counties	Projected Utilization-County Residents Year 1 (YEAR 1 = 2022)	% of total ☐ procedures ☐ cases ☐ patients X Other IRF IP Discharges.
Knox	240	36 %
Sevier	54	8 %
Loudon	46	7 %
Blount	46	7 %
Anderson	46	7 %
Service Area Subtotal	*432*	*65 %*
All Others*	233	35 %
Total	665	100%

** Any "Other" individual TN County is expected to provide less than 5.0% of Total Patients – and more commonly less than 1.0% of Total Patients. Any Non-TN County is expected to provide less than 0.25 % of Total Patients.*

County Level Map



See Attachment, Section B-Need-3: Service Area Maps

4. A. 1) Describe the demographics of the population to be served by the proposal.

Response:

The primary service area for the proposed IRF project includes five (5) counties in East Tennessee where the majority of anticipated service recipients reside: Knox ("Home County"), Sevier, Loudon, Anderson, and Blount.

This service area has a large, growing, and aging population marked by increasing diversity. As the population continues to grow and age at significant rates, it is anticipated that an increasing number of individuals who reside in the service area will need care within an inpatient rehabilitation facility.

Demographic highlights include the following:

- **The Total Population of the primary service area is estimated to be 840,529 in 2020 and is expected to grow by 3.5% to 869,598 by 2024, which is a greater percentage of total population growth than expected for the State of Tennessee as a whole (3.1%).**
- **The proposed IRF will serve adult patients exclusively, and the Target Population for the project will be elderly individuals who are Age 65+ years. There is a significant and growing number of elderly residents in the service area:**
  - **The Elderly Adult Population (i.e. 65+ years) within the service area is currently estimated to be 159,832 in 2020 (19.0% of Total Estimated Population) and is expected to grow by 10.9% to 177,285 by 2024 (20.4% of Total Projected Population).**
  - **The target Age 65+ Population for each county in the project service area is expected to grow by between 8.5% and 12.7% during the next four (4) years. As a combined result, the target Age 65+ Population Projection as a percentage of Total Projected Population in 2024 for the service area (20.4%) will be greater than projected for Tennessee (18.6%).**
  - **Moreover, the target Age 65+ Population Projection as a percentage of Total Projected Population in 2024 for each county in the primary service area, with the exception of one county (Knox: 17.8%), is significantly greater than the projected 18.6% for Tennessee (i.e. Sevier: 22.1%; Loudon: 29.4%; Anderson: 23.1%; Blount: 23.0%).**
  - **These elderly adult individuals typically need, seek, and utilize healthcare resources more frequently than other age cohorts included in the Total Population, and that is particularly true for inpatient rehabilitation care – which is recognized by the recently updated and current CON guidelines and criteria for comprehensive rehabilitation facilities.**
  - **The Median Age for the service area (42.8) is greater than for Tennessee (38.9).**
- **Although the project service area has a Median Household Income ($51,995) which is only slightly higher than the current average for Tennessee as a whole ($50,972), the service area has a significant and growing number of low-income residents (i.e. 107,568 individuals below the Poverty Level, or 12.8% of the Total Population in 2020) and TennCare enrollees (i.e. 143,878 enrollees, or 17.1% of the Total Population in 2020) who will be seeking accessible high quality and affordable healthcare in upcoming years.**
- **Additionally, like most areas of Tennessee and across the U.S., there are a number of key community health concerns and individual health and accident risk factors that are expected to increase demand for, and utilization of, healthcare services in general across**

the project's primary service area – especially for elderly individuals. Such issues support the significant and growing need for effective, efficient, accessible, and updated inpatient rehabilitation resources within the region.

Key Source Notes:

- Projected Population Data: HSDA Staff & TDH, Division of Health Planning *(Most Recent Data Available, June 2020)*
- Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml *(Most Recent Data Available, June 2020)*
- TennCare Enrollment Data: https://www.tn.gov/tenncare/information-statistics/enrollment-data.html *(Data Available June 2020)*

See Attachment, Section B-Need-4A/B
Service Area Population, Demographics, and TennCare

4. A. 2) Provide the following data for each county in the service area using current and projected population data from the Department of Health (https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/con.html), the most recent enrollee data from the Division of TennCare (https://www.tn.gov/tenncare/information-statistics/enrollment-data.html), and US Census Bureau demographic information (: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml),

- TennCare Enrollment Data: https://www.tn.gov/tenncare/information-statistics/enrollment-data.html
- Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year ___	Total Population-Projected Year ___	Total Population-% Change	*Target Population-Current Year ___	Target Population-Project Year ___	Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
County A													
County B, etc.													
Service Area Total													
State of TN Total													

- ** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-17. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2019, then default Projected Year is 2023.*
- ***Be sure to identify the target population, e.g., Age 65+, the current year and projected year being used.***

Response:

The requested data for the project service area is provided via attachment. Although the project will also be available to other adult patients, the Target Population for the IRF project is elderly adult patients (Age 65+). The most recent TDH population data has been used (2020-2024).

See Attachment, Section B-Need-4A/B
Service Area Population, Demographics, and TennCare

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response:

The proposed project plans to serve all patients in the service area regardless of race, gender, age, or income level. The IRF will be located and operated within a conveniently located building at a long-established and well-known medical campus that has ample parking. Historically, affiliates of both Covenant Health and Encompass Health have been providers of medical services to Medicare enrollees, TennCare enrollees, and uninsured (or underinsured) individuals. The proposed IRF will serve each of these populations.

Additionally, all counties within the project service area contain "rural" and/or "non-rural" areas (or populations) that have been designated "*Medically Underserved*" in at least one medical category historically by the United States Health Resources and Services Administration (HRSA). *(Source: https://data.hrsa.gov/tools/shortage-area/mua-find).*

The planned project will improve access to state-of-the-art inpatient rehabilitation services for all citizens in the service area, including patients with special needs, health disparities, and population cohorts including the elderly, women, racial and ethnic minorities, and low-income groups. The project will also improve access to similar patients across a broader geography, including patients with special needs that live in areas marked by more dispersed populations with limited access to inpatient rehabilitation services.

See Attachment, Section B-Need-4A/B
Service Area Population, Demographics, and TennCare

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response:

Not Applicable. Along with a companion CON application simultaneously filed, this project seeks to improve existing IRF resources and replace an existing IRF service – and only involves the use of existing licensed IRF beds.

However, requested data is provided below for informational purposes.

Historically, there have been only two providers of inpatient rehabilitation services within this IRF project's five (5) county primary service area: 1) Fort Sanders Regional Medical (FSRMC has 73 licensed IRF beds related to this CON project as addressed previously) and 2) Tennova Healthcare's Physicians Regional Medical Center (which once included 30 licensed IRF beds before it closed in late 2018 – 12 of those 30 beds are currently held in "inactive status", and the remaining 18 of those 30 beds were used for part of an "approved but unimplemented" CON (CN1812-051) project to relocate the 18 beds to the former Tennova Hospice House location in north Knoxville). There is another "approved but unimplemented CON" project (CN1903-007) to consolidate all of the Tennova-affiliated rehabilitation beds in the region under one new license. That project involves 57 total licensed beds retained after the recent closure of two hospitals in late 2018: 30 licensed beds from Physicians Regional Medical Center (i.e. the 12 beds held in inactive status + the 18 beds that were used for the "approved and unimplemented" CON) + 27 licensed beds held in "inactive status" from Lakeway Medical Center in Morristown in Hamblen County, which is closed and was located northeast of the service area for the project that is the subject to this application.

See Attachment, Section B-Need-5:
IRF Healthcare Providers in Service Area

6. Provide applicable utilization and/or occupancy statistics for your institution services for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response:

This CON project seeks to establish a new IRF so there is no historical utilization to report.

The CON application is for the establishment of a new IRF using 51 of FSRMC's 73 existing licensed inpatient rehabilitation facility (hospital) beds. While the project will result in a new, separately licensed facility, it will not add new licensed IRF beds or healthcare services to the region. Rather, the project supports an important continuation and upgrade of existing inpatient rehabilitation services at another location within Knox County. Approval of the CON will result in a bed neutral project for the service area.

However, applicable utilization and occupancy statistics for the Patricia Neal Rehabilitation Center (PNRC) located at FSRMC are provided below for informational purposes, since this CON project (along with a companion CON filed simultaneously) represents an appropriate modernization of PNRC resources that have benefitted individuals within the region for many years.

Patricia Neal Rehabilitation Center (at Fort Sanders Regional Medical Center)

	2017	2018	2019
ALOS	16.2	16.5	15.5
Total IRF IP Bed Days	11,319	10,010	10,841
Occupancy % (*) *Based on 48 Staffed Beds*	65%	57%	62%
Occupancy % (*) *Based on 73 Licensed Beds*	42%	38%	41%
Discharges	698	600	691

Source: FSRMC internal records for PNRC
(*) Occupancy %: (Total Number Inpatient Days for Period x 100) / (Available Beds x Number of Days in Period)

The chart below provides a summary of projected annual utilization for the first two full years of operations following project completion – as well as projected annual utilization for the first two full years of operations following completion of the companion CON application that was filed simultaneously.

Proposed IRF Site	Year 1 *(IRF Discharges)*	Year 2 *(IRF Discharges)*
West (51 IRF beds)	665	997
Downtown (22 IRF beds)	544	574
Total (73 combined IRF beds)	1,209	1,571

Projected utilization for the project is primarily based upon a few interrelated factors:

- **The current Tennessee Department of Health *Guidelines for Growth* regarding IRF services confirm that all of the existing licensed beds in the service area are needed – and that additional licensed beds will likely be needed to address growing patient needs for IRF services in the future. However, the project does not seek to add licensed beds – representing a bed neutral project in the service area for CON consideration.**

- **Anticipated IRF discharge volume increases over historical baseline volumes at PNRC are based on unmet need for, and utilization of, the existing licensed IRF bed capacity in the project's primary service area. PNRC beds have historically been underutilized due to space, operational, and other admission constraints addressed elsewhere in the CON application.**

- **The projected volumes for the project, and its companion CON project, primarily represent patients discharged from Covenant Health hospitals who are eligible for IRF services. Historically, many of these patients, who otherwise could have benefited from admission to PNRC, stayed in an acute care hospital setting due to limited accessibility to PNRC because of capacity and intersystem referral processes across major service lines (i.e. orthopedic, neuroscience, rehabilitation, cardiac, surgery, pulmonary, ICU, and others). With the planned modernization of PNRC bed capacity, these IRF-qualified patients will benefit from improved accessibility to focused multidisciplinary IRF services that will prepare a broader spectrum of patients for optimal functionality post discharge. In addition to being fully integrated with the acute care hospitals and inpatient service lines of Covenant Health, the project will be closely aligned with outpatient rehabilitation, homecare, skilled nursing, and physician services – both within the Covenant Health network and with other providers across the region. The project will be accessible to all consumers – and to other referring providers across the region.**

- **It is expected that significant growth of both the total population and the elderly (65+) population across the project's primary service area, as well as across secondary and tertiary areas, will further increase utilization of all IRF services in the region over time.**

Additional notes to clarify utilization projection methodology assumptions and calculations, as well as primary referral sources, is provided via attachment.

See Attachment, Section B-Need-6:
Projected Annual Utilization: IRF Discharges

ECONOMIC FEASIBILITY

The responses to this section of the application will help determine whether the project can be economically accomplished and maintained.

1. Project Cost Chart Instructions

A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee) (See Application Instructions for Filing Fee)

Response: The total anticipated cost of the project is $ 37,105,128 for CON purposes, including a CON filing fee of $ 95,000. A check to cover the appropriate CON filing fee amount has been submitted with the original CON application packet.

B. The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response:

Covenant Health, through its wholly-owned subsidiary Fortress Corporation, currently owns and has full control of the site to be used for the project. The site includes two contiguous parcels of land owned and controlled by Covenant Health.

Covenant Health will contribute the land needed for development of the proposed freestanding IRF project (and transfer ownership of the same to Rehabilitation Hospital of Knox County, LLC) if the CON is approved. The FMV for the total 8.10 acre site, including the two contiguous parcels, is $ 3,700,000 per a current FMV appraisal provided recently by a credible third party. The value of the land to be contributed represents a portion of the initial capital outlay for the proposed project that will be provided by Covenant Health as part of its initial contribution as a 50% partner in the joint venture. All transactions related to the project will be subject to appropriate regulatory approvals.

The modern building to be utilized for the IRF project will be created via new construction – and will be funded entirely through the sufficient cash reserves of the two member organizations of the applicant: Rehabilitation Hospital of Knox County, LLC.

Line B.3. of the *Project Cost Chart* reflects this land acquisition by contribution. Line A.5. of the *Project Cost Chart* reflects the *Total Construction Cost* anticipated for the new IRF building. All other anticipated project expenses are included on the *Project Cost Chart* as well.

See Attachment, Economic Feasibility-Project Cost Chart:

Deeds; Documentation of Intent to Transfer Property; FMV Letter; Architect & Construction Letter

C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response: The total estimated equipment costs for the project are included in the project cost chart as required. There are no individual moveable equipment items to be acquired for the project that will exceed $ 50,000.

D. The Total Construction Cost reported on line 5 should equal the Total Cost reported on the Square Footage Chart.

Response: The *Total Construction Cost* on line A.5. equals the *Total Cost* reported on the "*Square Footage and Cost Per Square Footage Chart*".

E. For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

1) A general description of the project;
2) An estimate of the cost to construct the project;
3) A description of the status of the site's suitability for the proposed project; and
4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or comparable document in current use by the licensing authority.

Response:

Requested documentation regarding a general description of the IRF project; the total estimated cost of construction for the new building; and attestation that the physical environment for the proposed IRF will conform to all applicable standards and requirements has been included via attachment and has been addressed elsewhere in the CON application as required.

See Attachment, Economic Feasibility-Project Cost Chart:

Architect & Construction Letter

PROJECT COST CHART ("West")

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$1,674,967
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$766,788
	3.	Acquisition of Site	
	4.	Preparation of Site	$3,956,421
	5.	Total Construction Costs	$19,403,166
	6.	Contingency Fund	$1,751,969
	7.	Fixed Equipment (Not included in Construction Contract)	$1,694,631
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$3,571,586
	9.	Other *(pre-opening expenses)*	$490,600
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only *(via contribution)*	$3,700,000
	4.	Equipment (Specify)_____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$37,010,128
E.	CON Filing Fee		$95,000
F.	Total Estimated Project Cost (D+E)	**TOTAL**	**$37,105,128**

Response:

Moveable Equipment – The total estimated equipment costs for the project are included in the project cost chart as required. There are no individual moveable equipment items to be acquired for the project that will exceed $ 50,000.

Note – summary explanations and documentation related to information in the Project Cost Chart is provided as required at the beginning of this section (with the Project Cost Chart Instructions) and via attachments as appropriate.

2. Identify the funding source(s) for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-2.)***

__ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ D. Grants – Notification of intent form for grant application or notice of grant award;

X E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ F. Other – Identify and document funding from all other sources.

RESPONSE:

Anticipated cash flow from operations will support the finance needs of the proposed IRF project. The project anticipates covering ongoing expenses via operational cash flow. However, all initial and ongoing funding needs for the project can be met via the cash reserves of the partner organizations, Covenant Health and Encompass Health.

See Attachments, Economic Feasibility: Project Funding Sources

Covenant Health and Encompass Health

3. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart(s) provide revenue and expense information for the last *three (3)* years for which complete data is available. The "Project Only Chart" provides information for the services being presented in the proposed project while the "Total Facility Chart" provides information for the entire facility. Complete both, if applicable.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response:

Not applicable, since the project will create a new IRF institution. However, a Historical Data Chart regarding the PNRC IRF unit at FSRMC is provided for informational purposes since the proposed project represents a continuation and modernization of that existing healthcare service, and utilization of those existing licensed IRF beds, which have benefited communities in the region for many years.

HISTORICAL DATA CHART

Patricia Neal Rehabilitation Center (PNRC)

IRF Unit and Department of FSRMC

X Project Only

□ Total Facility

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in **January** (Month).

	Year 2017	Year 2018	Year 2019
A. Utilization Data			
Specify Unit of Measure IRF Discharges	698	600	691
B. Revenue from Services to Patients			
1. Inpatient Services	$28,973,482	$25,159,495	$26,522,117
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify)			
Gross Operating Revenue	$28,973,482	$25,159,495	$26,522,117
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$15,593,315	$13,782,454	$14,452,098
2. Provision for Charity Care	682,804	700,029	722,302
3. Provisions for Bad Debt	338,912	174,276	149,880
Total Deductions	$16,615,031	$14,656,759	$15,324,280
NET OPERATING REVENUE	$12,358,451	$ 10,502,736	$11,197,837
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	5,520,527	4,880,400	5,667,169
b. Non-Patient Care	1,000,557	1,033,410	1,077,154
2. Physician's Salaries and Wages	296,976	291,510	289,180
3. Supplies	341,268	341,290	355,008
4. Rent			
a. Paid to Affiliates			
b. Paid to Non-Affiliates			
5. Management Fees:			
a. Paid to Affiliates	1,235,845	1,050,274	1,119,784
b. Paid to Non-Affiliates			
6. Other Operating Expenses (D6)	342,211	199,147	603,062
Total Operating Expenses	$ 8,737,384	$ 7,796,031	$ 9,111,357
E. **Earnings Before Interest, Taxes and Depreciation**	$ 3,621,067	$ 2,706,705	$ 2,086,480
F. Non-Operating Expenses			
1. Taxes	$	$	$
2. Depreciation	207,590	207,590	200,390
3. Interest			
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	$ 207,590	$ 207,590	$ 200,390
NET INCOME (LOSS)	$3,413,477	$ 2,499,115	$ 1,886,090

Chart Continues Onto Next Page

NET INCOME (LOSS)	$3,413,477	$ 2,499,115	$ 1,886,090
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure	16,814	3,119	11,885
Total Other Deductions	$ 16,814	$ 3,119	$ 11,885
NET BALANCE	$ 3,396,663	$ 2,495,996	$ 1,874,205
DEPRECIATION	$ 207,590	$ 207,590	$ 200,390
FREE CASH FLOW (Net Balance + Depreciation)	$ 3,604,253	$ 2,703,586	$ 2,074,595

X Project Only
□ Total Facility

HISTORICAL DATA CHART-OTHER EXPENSES

Patricia Neal Rehabilitation Center (PNRC)
IRF Unit and Department of FSRMC

OTHER OPERATING EXPENSES CATEGORIES (D6)	**Year 2017**	**Year 2018**	***Year* 2019**
1. Purchased Services	$ 110,499	$ 93,092	$ 97,091
2. Physician Sponsorship	69,461	20,255	373,506
3. Other Expenses	162,251	85,800	132,465
4.			
5.			
6.			
7.			
***Total Other Expenses**	**$ 342,211**	**$ 199,147**	**$ 603,062**

**Total other expenses should equal Line D.6. In the Historical Data Chart*

4. Complete **Projected Data Charts** on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

Projected Data Chart(s) provide information for the two years following the completion of the project. The "Project Only Chart" should reflect revenue and expense projections for the project (*i.e*., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The "Total Facility Chart" should reflect information for the total facility. Complete both, if applicable.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

□ Project Only
X Total Facility

PROJECTED DATA CHART ("WEST")

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **July** for CON purposes.

		Year 2022	Year 2023
A.	Utilization Data		
	Specify Unit of Measure **IRF Discharges**	**665**	**997**
B.	Revenue from Services to Patients		
	1. Inpatient Services	$16,333,000	$26,131,000
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$ 16,333,000**	**$ 26,131,000**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$5,566,000	$8,905,000
	2. Provision for Charity Care	$430,000	$687,000
	3. Provisions for Bad Debt	$136,000	$217,000
	Total Deductions	**$ 6,132,000**	**$ 9,809,000**
NET OPERATING REVENUE		**$ 10,201,000**	**$ 16,322,000**
D.	Operating Expenses		
	1. Salaries and Wages	$7,412,000	$9,585,000
	a. Direct Patient Care		
	b. Non-Patient Care		
	2. Physician's Salaries and Wages		
	3. Supplies	$486,000	$744,000
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	5. Management Fees:		
	a. Paid to Affiliates	$510,000	$816,000
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses (D6)	$2,573,000	$2,951,000
	Total Operating Expenses	$ 10,981,000	$ 14,096,000
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ (780,000)**	**$ 2,225,000**
F.	Non-Operating Expenses		
	1. Taxes	$(592,000)	$188,000
	2. Depreciation	$1,495,000	$1,502,000
	3. Interest		
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	$ 903,000	$ 1,690,000
NET INCOME (LOSS)		**$ (1,683,000)**	**$ 535,000**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$ (1,683,000)**	**$ 535,000**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ _____	$ _____
2. Annual Capital Expenditure	$51,000	$102,000
Total Other Deductions	$51,000	$102,000
NET BALANCE	**$ (1,734,000)**	**$ 433,000**
DEPRECIATION	$ 1,495,000	$ 1,502,000
FREE CASH FLOW (Net Balance + Depreciation)	**$ (239,000)**	**$ 1,935,000**

□ Project Only
X Total Facility

PROJECTED DATA CHART-OTHER EXPENSES

OTHER OPERATING EXPENSES CATEGORIES (D6)	**Year 2022**	**Year 2023**
1. Equipment Rental & Maintenance	$366,000	$409,000
2. Utilities/Telephone	$296,000	$302,000
3. Contract Services	$451,000	$691,000
4. Insurance/Bonding	$378,000	$386,000
5. Other	$1,082,000	$1,163,000
6. _____	_____	_____
7. _____	_____	_____
***Total Other Expenses**	**$ 2,573,000**	**$ 2,951,000**

**Total other expenses should equal Line D.6. In the Projected Data Chart*

5. A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Charts for Year 1 and Year 2 of the proposed project. Complete Project Only Chart and Total Facility Chart, if applicable.

Project Only Chart

	Previous Year to Most Recent Year Year ____	Most Recent Year Year____	Year One Year___	Year Two Year_____	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*					
Deduction from Revenue *(Total Deductions/Utilization Data)*					
Average Net Charge *(Net Operating Revenue/Utilization Data)*					

Total Facility Chart

	Previous Year to Most Recent Year Year ____	Most Recent Year Year____	Year One Year___	Year Two Year_____	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*					
Deduction from Revenue *(Total Deductions/Utilization Data)*					
Average Net Charge *(Net Operating Revenue/Utilization Data)*					

Response:

The requested information for the new IRF project is provided in the chart below.

Total Facility Chart ("West": 51 IRF Beds)

	Previous Year to Most Recent Year Year ____	Most Recent Year Year____	**Year One 2022**	**Year Two 2023**	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	N/A	N/A	**$ 24,560**	**$ 26,210**	N/A
Deduction from Revenue *(Total Deductions/Utilization Data)*	N/A	N/A	**$ 9,221**	**$ 9,839**	N/A
Average Net Charge *(Net Operating Revenue/Utilization Data)*	N/A	N/A	**$ 15,340**	**$ 16,371**	N/A

The proposed project is for a new IRF facility so there are no recent patient charges for comparison. However, the 2019 patient charges from Patricia Neal Rehabilitation Center (IRF unit at FSRMC) are provided in the response to the question immediately below (5. B).

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response:

The average projected gross charge, average projected deduction from operating revenue, and average projected net charge for Year 1 of the proposed IRF project is presented below:

West: Average Projected "Gross Charge" = $ 24,560 *(per IRF IP Discharge)*

West: Average Estimated "Deduction" = $ 9,221 *(per IRF IP Discharge)*

West: Average Projected "Net Charge" = $ 15,340 *(per IRF IP Discharge)*

Additionally, similar information regarding the companion CON project ("Downtown") is provided below for comparison purposes:

Downtown: Average Projected "Gross Charge" = $ 24,301 *(per IRF IP Discharge)*

Downtown: Average Estimated "Deduction" = $ 9,123 *(per IRF IP Discharge)*

Downtown: Average Projected "Net Charge" = $ 15,178 *(per IRF IP Discharge)*

The proposed project is for a new IRF facility so there are no existing patient charges for comparison or adjustment. However, the 2019 patient charges from Patricia Neal Rehabilitation Center (IRF unit at FSRMC) are provided below:

PNRC: Average "Gross Charge" = $ 38,382 *(per IRF IP Discharge)*

PNRC: Average "Deduction" = $ 22,177 *(per IRF IP Discharge)*

PNRC: Average "Net Charge" = $ 16,205 *(per IRF IP Discharge)*

C. Compare the proposed charges to those of similar facilities/services in the service area/adjoining service areas, or to proposed charges of recently approved Certificates of Need. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response:

The Average Gross Charge for the project is expected to be $ 24,560 for Year 1 (2022).

The following chart shows the most recently available Average Gross Charge estimates for some other IRFs operating (or approved) in Tennessee.

IRF	2018 IRF Reported Inpatients *(Discharges or Admissions)*	2018 Average Gross Charge *(Inpatients Only)*
Vanderbilt Stallworth Rehabilitation Hospital	**1,343**	*$ 43,202,066 Total Charges* **$ 32,168 Average IP Charge**
HealthSouth Rehabilitation Hospital (Kingsport)	**878**	*$ 28,768,119 Total Charges* **$ 32,766 Average IP Charge**
Quillen Rehabilitation Hospital	**677**	*$ 18,988,255 Total Charges* **$ 28,028 Average IP Charge**
Cane Creek Rehabilitation Hospital	**783**	*$ 16,993,852 Total Charges* **$ 21,704 Average IP Charge**
Knoxville Rehabilitation Hospital, LLC *(CN1903-007, Approved June 2019)*	**747**	$ 39,350,834 Total Charges **$ 52,678 Average IP Charge**

Source: TN JARs *or CON* *****AVERAGE GROSS CHARGE = $ 33,266**

****** Notes: AVERAGE GROSS CHARGE (per Discharge or Admission) = $ 33,266.***

- *Represents Average Gross Charge per Discharge or Admission calculation across all IRFs listed in Chart.*
- *Calculation = "Sum of All Total Gross Inpatient Charges / Sum of All Inpatients (Discharges or Admissions)"*
- *Sources: 1) 2018 FINAL Tennessee Hospital JARs; and 2) Year 1 information from CN1903-007: Final CON Application Packet sent to HSDA members – CON was approved by HSDA in June 2019.*

The proposed Average Gross Charge for the new IRF project is reasonable considering the Average Gross Charges for other existing (or approved) IRFs in Tennessee.

Additionally, CPT codes are not an appropriate measure for inpatient rehabilitation charge comparisons. Medicare pays inpatient rehabilitation facilities through the IRF prospective payment system (PPS). IRFs receive a pre-determined payment for goods and services furnished during each Medicare patient's stay in the IRF.

6. A. Discuss how projected utilization rates will be sufficient to support financial performance.

1) Noting when the project's financial breakeven is expected, and

2) Demonstrating the availability of sufficient cash flow until financial viability is achieved.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-6A**

Response:

Anticipated utilization rates are sufficient to produce positive Free Cash Flow for the IRF project by Year 2 of operations – and will be sufficient to maintain operations over time.

Projected Annual Utilization	**Year 1**	**Year 2**
IRF Discharges	**665**	**997**
Financial Feasibility	**Year 1**	**Year 2**
Net Operating Revenue	**$ 10,201,000**	**$ 16,322,000**
Earnings Before Interest, Taxes, & Depreciation	**($ 780,000)**	**$ 2,225,000**
Net Income (Loss)	**($ 1,683,000)**	**$ 535,000**
Free Cash Flow ***(Net Balance + Depreciation)***	**($ 239,000)**	**$ 1,935,000**

Beyond initial projections for Year 1 and Year 2, it is expected that the proposed IRF's utilization will grow modestly over time due to demographic factors and increasing demand.

The project is for a new IRF, thus financial statements for the proposed facility are not available at this time. However, relevant information to document adequate funding to support the project, which is available via Covenant Health and Encompass Health, is provided via attachment.

See Attachments, Economic Feasibility: Project Funding Sources

Covenant Health and Encompass Health

B. Net Operating Margin Ratio: The Net Operating Margin Radio demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following tables. Complete Project Only Chart and Total Facility Chart, if applicable.

Project Only Chart

Year	2nd Previous Year to Most Recent Year Year _____	1st Previous Year to Most Recent Year Year_____	Most Recent Year Year_____	Projected Year 1 Year_____	Projected Year 2 Year _____
Net Operating Margin Ratio					

Total Facility Chart

Year	2nd Previous Year to Most Recent Year Year _____	1st Previous Year to Most Recent Year Year_____	Most Recent Year Year_____	Projected Year 1 Year_____	Projected Year 2 Year _____
Net Operating Margin Ratio					

Response:

The project seeks to establish a new IRF so there is no historical or current information to report. The chart provides the requested information for each of the first two years of the new IRF project (i.e. based upon the Projected Data Chart). Additionally, the requested information for previous years is provided for the PRNC IRF unit at FSRMC for comparison purposes.

Total Facility Chart ("WEST")

Year	2nd Previous Year to Most Recent Year **PNRC 2017**	1st Previous Year to Most Recent Year **PNRC 2018**	Most Recent Year **PNRC 2019**	**Projected Year 1 2022**	**Projected Year 2 2023**
Net Operating Margin Ratio	**29.3 %**	**25.8 %**	**18.6 %**	**(7.7 %)**	**13.6 %**

Note: HSDA Formula used for calculation of Net Operating Margin Ratio:
(Earnings Before Interest, Taxes, and Depreciation / Net Operating Revenue)

C. Capitalization Ratio: The Long-term debt to capitalization ratio measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: ((Long-Term Debt)/Long-Term Debt + Total Equity {Net Assets}) X 100.

For self or parent company funded projects, provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. Capitalization Ratios are not expected from outside the company lenders that provide funding. **This question is applicable to all applications regardless of whether or not the project is being partially or totally funded by debt financing.**

Response:

As outlined within the required Organization Chart for this CON application, Covenant Health and Encompass Health are the two partner organizations (members) involved with this project. Together, as 50/50 partners, these organizations will provide all required funding for the proposed IRF project.

Covenant Health:

The most recent full year of audited financial statements currently available for Covenant Health are dated December 31, 2019. As of December 31, 2019, the Covenant Health Capitalization Ratio was 37.0.

Calculation Notes:

The Capitalization Ratio calculation information for Covenant Health is provided below, created from the Covenant Health Audited Financial Statements (12/31/2019) provided as a required attachment with the CON application:

Consistent with the CON Application Instructions, the formula for this capitalization ratio is:

(Long-Term Debt) / (Long-Term Debt + Total Equity {Net Assets}) X 100.

The Covenant Health Capitalization Ratio for this project includes the following:

- ***12/31/19 Long-Term Debt: $ 902,645,000***
- ***12/31/19 Total Equity: $ 1,533,831,000***

Therefore, the Covenant Health Capitalization Ratio Calculation:

- ***(902,645,000 / (902,645,000 + 1,533,831,000) = .37***
- ***.37 x 100 = 37.0***

Encompass Health:

The most recent full year of audited financial statements currently available for Encompass Health are dated December 31, 2019. As of December 31, 2019, the Encompass Health Capitalization Ratio was 64.1.

Calculation Notes:

The Capitalization Ratio calculation information for Encompass Health is provided below, created from the Encompass Health 10K (12/31/2019) provided as a required attachment with the CON application:

Consistent with the CON Application Instructions, the formula for this capitalization ratio is:

(Long-Term Debt) / (Long-Term Debt + Total Equity {Net Assets}) X 100.

The Encompass Health Capitalization Ratio for this project includes the following:

- ***12/31/19 Long-Term Debt: $ 3,023,300,000***
- ***12/31/19 Total Shareholders Equity: $ 1,693,100,000***

Therefore, the Encompass Health Capitalization Ratio Calculation:

- ***($ 3,023,300,000 / ($ 3,023,300,000 + $ 1,693,100,000) = .641***
- ***.641 x 100 = 64.1***

7. Discuss the project's participation in state and federal revenue programs, including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below. Complete Project Only Chart and Total Facility Chart, if applicable.

Applicant's Projected Payor Mix, Year 1
Project Only Chart

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Other (Specify)_____		
Total*		
Charity Care		

**Needs to match Gross Operating Revenue Year One on Projected Data Chart*

Applicant's Projected Payor Mix, Year 1
Total Facility Chart

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Other (Specify)_____		
Total*		
Charity Care		

**Needs to match Gross Operating Revenue Year One on Projected Data Chart*

Response:

Historically, the affiliates of both Covenant Health and Encompass Health have provided a significant level of care to patients participating in both Medicare and TennCare funded programs. The proposed new IRF project will participate in these government sponsored programs. Additionally, the proposed IRF project will implement an appropriate charity care policy and be accessible to uninsured (and underinsured) individuals.

The following chart provides the estimated dollar amount of Gross Revenue associated with patients covered by each key payer category.

Applicant's Projected Payor Mix, Year 1 ("West")
Total Facility Chart

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$10,334,000	63.3%
TennCare/Medicaid	$316,000	1.9%
Commercial/Other Managed Care	$4,861,000	29.8%
Self-Pay		
Other *(including Self-Pay & Charity)*	$820,000	5%
Total *	$16,333,000	100%
Charity Care	$430,000	2.6%

** Matches Gross Operating Revenue Year One on Projected Data Chart*

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources, such as the US Department of Labor. Wage data pertaining to healthcare professions can be found at the following link: https://www.bls.gov/oes/current/oes_tn.htm.

Position Classification	**Existing FTEs (enter year)**	**Projected FTEs Year 1**	**Average Wage (Contractual Rate)**	**Area Wide/Statewide Average Wage**
A. Direct Patient Care Positions				
Position 1				
Position 2				
Position "etc."				
Total Direct Patient Care Positions				

B. Non-Patient Care Positions				
Position 1				
Position 2				
Position "etc."				
Total Non-Patient Care Positions				
Total Employees *(A+B)*				
C. Contractual Staff				
Total Staff *(A+B+C)*				

Response:

The projected staffing for Year 1 of the proposed IRF project is provided in the chart below, including a comparison of clinical and support staff wage patterns for the project and the Statewide Average Wage.

Additionally, a summary of the direct patient care staff and non-patient care staff positions (by FTE) in the PRNC unit at FSRMC are provided via additional chart for informational purposes with appropriate footnote.

"West" Staffing Chart:

Position Classification	Existing FTEs	Projected FTEs Year 1	Average Wage	Area Wide/Statewide Average Wage **
A. Direct Patient Care Staff Positions				
Occupational Therapist		3.00	$78,848	$81,440
Occupational Therapy Assistant		2.00	$69,297	$61,050
Physical Therapist		3.00	$82,083	$83,600
Physical Therapist Asst.		1.50	$61,200	$55,910
Rehab Therapy Tech		1.50	$27,599	$27,650-$33,610
Speech Pathologist		1.50	$78,059	$71,020
Respiratory Therapist		1.50	$59,541	$50,160
Registered Nurse		11.00	$70,922	$59,140
LPN/LVN		2.00	$49,281	$39,900
Rehab Nursing Tech		8.50	$31,098	$26,770-$33,610
Total Direct Patient Care Staff Positions	*N/A**	**35.5**		

** Note: Not Applicable since proposed IRF will be a new institution. However, an additional chart has been provided regarding the PNRC unit at FSRMC for informational purposes.*
*** Statewide Wage Information Source:* https://www.bls.gov/oes/current/oes_tn.htm#29-0000

Position Classification	Existing FTEs	Projected FTEs Year 1	Average Wage	Area Wide/Statewide Average Wage **
B. Non-Patient Care Staff Positions				
Human Resources Director		1.00	$80,571	$53,150-$90,020

Business Development Director		1.00	$92,456	$88,840- $99,720
Controller		1.00	$100,422	$71,460- $102,070
Plant Operations Director		1.00	$75,897	$63,310-$90,030
Case Management Director I		1.00	$86,455	$69,140 -$99,720
Med Staff Credentialing Specialist		1.00	$47,870	$28,640-$48,070
Unit Secretary		2.50	$32,232	$28,640-$33,050
Cook		2.00	$31,029	$22,280-$26,660
Maintenance Mechanic		2.00	$41,951	$45,890-$54,210
Environmental Services Aide		2.00	$24,514	$23,363-$32,800
Administrative Assistant		1.00	$41,130	$26,180-$53,230
Receptionist		2.00	$27,860	$29,270
Admissions Representative		1.00	$35,059	$28,640-$48,070
Admissions Liaison		1.00	$62,316	$56,650
Rehab Liaison		2.50	$69,325	$56,650-$58,110
HIMS Supervisor		1.00	$57,677	$45,120- $53,610
Health Info Mgt Service Tech		1.50	$38,692	$29,770-$48,070
Certified Case Manager		1.50	$65,441	$45,910- $59,140
Patient Assess Standards Coordinator		1.50	$70,713	$59,140
Accounts Payable Specialist		1.00	$45,055	$40,360
Purchasing Coordinator		1.00	$40,174	$29,770
Director Therapy Operations		1.00	$108,176	$83,600- $102,070
Chief Nursing Officer		1.00	$112,572	$96,040- $102,070
Quality/Risk Director		1.00	$86,398	$65,060 - $88,840
Pharmacy Director		1.00	$137,261	$114,250
Nursing Staffing Coordinator		1.00	$37,639	$29,770
Hospital Educator		2.00	$73,372	$55,220

Nurse Supervisor		5.00	$82,617	$59,140-$102,070
Nutrition Services Manager		1.00	$55,254	$53,110
Dietitian		1.2	$49,947	$53,110
Nutrition Services Aide		1.6	$25,855	$23,980-$29,770
Pharmacy Technician		1.00	$35,661	$30,080
Pharmacist		1.60	$117,053	$114,250
Total Non- Patient Care Staff Positions		**47.9**		
Total Staff Employees (A+B)		**83.4**		
C. Contractual Staff		0		
Total Staff (A+B+C)	*N/A**	**83.4**		

** Note: Not Applicable since proposed IRF will be a new institution. However, an additional chart has been provided regarding the PNRC unit at FSRMC for informational purposes.*
*** Statewide Wage Information Source:* https://www.bls.gov/oes/current/oes_tn.htm#29-0000

Existing PNRC Unit at FSRMC – Staffing Chart:

	Position Classification	***Existing FTEs:*** *2020 PNRC**	Projected FTEs Year 1	Average Wage	Statewide Average Wage**
A.	**Direct Patient Care Staff Positions**				
	Clinical Nurse / RN	*19.2*			
	CNA	*9.5*			
	LPN	*3*			
	PCA/SNA	*5.5*			
	Behavioral Medicine Therapist	*1*			
	Occupational Therapist	*7.5*			
	Occupational Therapist Assistant	*1.5*			
	Physical Therapist	*8.5*			
	Physical Therapist Assistant	*2.5*			
	Therapy Tech	*5*			
	Speech Therapist	*7.5*			
	Speech Pathologist	*1*			
	Enterostomal Therapist	*1*			
	Total Direct Patient Care Staff Positions	***73****			

B.	**Non-Patient Care Staff Positions**				
	Administrative Assistant	*1*			
	Quality Coordinator	*2*			
	Registration Coordinator	*3*			
	Hospital Unit Coordinator (HUC)	*3*			
	Patient Representative	*1*			
	Liaison - Certified	*2*			
	Liaison – Non-Certified	*3*			
	RN Case Worker	*2*			
	Clinical Social Worker	*1*			
	Total Non-Patient Care Staff Positions	***18****			
	Total Staff Employees *(A+B)*	***91****			
C.	**Contractual Staff**	-			
	Total Staff *(A+B+C)*	***91****			

** Note: Existing staff FTEs for the PNRC Unit @ FSRMC are shown for comparison purposes. In addition to these FTEs whose "home department" is the PNRC Unit, approximately 22 FTEs of hours from other FSRMC departments were floated to the PNRC across the year in 2019 when needed to support operations of the PNRC unit at FSRMC. PRNC currently staffs only 48 of 73 licensed IRF beds.*

*** Statewide Wage Information Source:* https://www.bls.gov/oes/current/oes_tn.htm#29-0000

9. What alternatives to this project were considered? Discuss the advantages and disadvantages of each, including but not limited to:

Response:

Provided below is a brief summary of considerations related to the strengths, weaknesses, and potential costs associated with possible options for improving care environments and accessibility for the existing IRF beds needed in the service area.
Alternatives considered include the following:

Do nothing

Not an acceptable option considering perspectives of multiple key stakeholders (consumers, patients, patient families, payers, referring providers, Covenant Health, Encompass Health, and others), due to unmet and increasing demand for inpatient rehabilitation services in the region, and as regulatory requirements change for IRF care environments. The proposed project addresses all such considerations, value-based purchasing trends, the Tennessee State Health Plan, etc. Additionally, the project represents a unique opportunity for collaboration to modernize existing healthcare resources to benefit the community.

Retain and staff all 73 licensed IRF beds at the FSRMC campus (Downtown)

The option to retain and staff all 73 licensed IRF beds at the FSRMC campus is not possible due to facility space and infrastructure limitations of the existing areas utilized by PNRC. The current space cannot be modified practically, even via extensive and costly renovations, to accommodate all applicable requirements and expectations for a modern IRF unit to support all 73 licensed IRF beds. Moreover, even if adequate space were available to make this option possible, experienced experts from Covenant Health and Encompass have confirmed that the significant costs of such an effort, including capital cost for modernization and the cost of operational disruption, would not be prudent or acceptable compared to the projects set forth in this application and its companion.

Relocate all 73 licensed IRF beds to the FSW campus (West)

The scenario of moving all 73 licensed IRF beds to the FSW campus might be possible due to potential construction and operational efficiencies of a "green field" or "de novo" project, when compared to the renovation and modernization of an IRF unit operating at a downtown hospital where space is limited and needed to support other service lines. However, moving all 73 licensed beds would eliminate onsite access to important IRF services at the downtown Knoxville location of FSRMC, where continuation of IRF services is important to support major service lines and patients who are discharged from FSRMC.

Create freestanding IRF project using some existing beds at another location

This alternative was rejected because it would not make use of land owned by Covenant Health that is available at an optimal and well-known location in Knox County – an area that is accessible to all patients in the service area. The FSW campus location has been serving patients in the service area since 1985.

Complete the proposed CON project as proposed (along with its companion CON project filed simultaneously as required)

After careful evaluation by Encompass Health, Covenant Health, and experienced architectural and construction professionals, the applicant has created an optimal solution involving an appropriate division of the 73 existing licensed beds between two locations in Knox County. This approach allows utilization of all 73 licensed IRF beds at two suitable, accessible, and complementary sites within the service area. It is important to note that this selected option creates all community benefits of a modern, freestanding IRF (including at least 50 beds per current TDH freestanding IRF guidelines), while retaining at least 20 IRF beds within the "HIH" model (consistent with current TDH IRF unit guidelines). All parties involved concur that this is the most efficient and cost-effective approach to modernizing the existing IRF resources and improving access when all factors are considered.

To fully understand the merits of approach proposed by the companion CON projects, it is important to note that the existing physical plant utilized by the Patricia Neal Rehabilitation Center at FSRMC is within an older building with limited space that does not allow use of the full licensed bed complement considering all current facility regulations for an IRF, even if major renovation efforts occurred. As proposed, the companion CON projects will allow the existing physical plant at FSRMC to be used throughout project development stages – even as renovations and infrastructure improvements are underway to use the downtown hospital location for the 22 licensed beds that will remain at that location. Considered together, the proposed projects minimize operational disruption, construction inefficiencies, and significant unnecessary costs.

A. The availability of less costly, more effective and/or more efficient methods of providing the benefits intended by the project. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Response:

The applicant is unaware of a less costly, more effective, or more efficient approach to accomplish the goals of this IRF project that will benefit patients, referring providers, and communities within the service area. The proposed project represents an optimal use of licensed IRF beds and other existing healthcare resources, available land at a well-known location, and the experience of involved parties to optimize patient care, experience and accessibility for inpatient rehabilitation services within a modern rehabilitation hospital building to be constructed in Knox County. Additionally, this CON project is integrally linked to the companion CON application that was filed with the HSDA concurrently. The applicant has access to the financial resources needed to accomplish these related projects through its member organizations. Consideration of other alternatives is addressed in previous sections of the CON application as required.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response:

The project involves construction of a new inpatient rehabilitation facility – and the project represents a significant collaboration and sharing of resources to create a modern clinical care environment to address community needs for the foreseeable. The leadership teams of Covenant Health and Encompass Health gave appropriate consideration to various alternatives to new construction – and concluded that the project as proposed makes the most effective and efficient use of existing resources to address long-term community needs and partnership goals.

Also, considered together with its companion CON project simultaneously filed, the applicant is optimizing the balance between new construction and renovations to existing space at different locations in Knox County to improve patient care and consumer access. Additionally, these projects represent both the modernization of existing healthcare resources and a sharing arrangement framed via the new partnership.

The project will create a new IRF in the service area to better serve patients and address evolving market demands. The facility, infrastructure, and equipment upgrades of the proposed project will benefit residents of the service area as access to high quality IRF services is improved significantly.

QUALITY STANDARDS

1. Per PC 1043, Acts of 2016, any receiving a CON after July 1, 2016 must report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures Please verify that annual reporting will occur.

Response: The applicant will report annually using forms prescribed by the Agency as required.

2. Quality-The the proposal shall provide health care that meets appropriate quality standards. Please address each of the following questions:

   A. Does the applicant commit to the following?

   1) Maintaining the staffing comparable to the staffing chart presented in its CON application;

      Response: Yes.

   2) Obtaining and maintaining all applicable state licenses in good standing;

      Response: Yes.

   3) Obtain and maintaining TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

      Response: Yes.

   4) For an existing healthcare institution applying for a CON - Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions and what measures the applicant has or will put into place to avoid similar findings in the future

      Response: Not Applicable. The proposed project is for a new healthcare institution.

      However, for informational purposes, FSRMC/PNRC has maintained substantial compliance with applicable federal and state regulations for the three years prior to this CON application.

   5) For an existing healthcare institution applying for a CON - Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility)

      Response: Not Applicable. The proposed project is for a new healthcare institution.

      However, for informational purposes, FSRMC/PNRC has not been decertified within the past three years.

B. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

   a. Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

   b. Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

   c. Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response:

Entities and persons with more than 5% ownership in the applicant have been identified and are addressed below.

2) Been subjected to any of the following:

   a. Final Order or Judgment in a state licensure action;

   b. Criminal fines in cases involving a Federal or State health care offense;

   c. Civil monetary penalties in cases involving a Federal or State health care offense;

   d. Administrative monetary penalties in cases involving a Federal or State health care offense;

   e. Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

   f. Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

   g. Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

   h. Is presently subject to a corporate integrity agreement.

Response:

The newly formed applicant, Rehabilitation Hospital of Knox County, LLC, is not subject to any of the actions identified above.

Neither Fortress Corporation, one of the two members of the applicant entity and wholly-owned affiliate of Covenant Health, nor Covenant Health are subject to any of the actions identified above other than claims arising out of the normal course of business typical for a multi-service health system.

Encompass Health Knoxville Holdings, LLC, one of the two members of the applicant entity, is not subject to any of the actions identified above. Encompass Health Knoxville Holdings, LLC is an affiliate of Encompass Health Corporation. Please see pages F65-F67 of Encompass Health Corporation's 2019 10-K filing (which is provided via attachment: *Economic Feasibility: Project Funding Sources – Encompass Health*), for information responsive to the requests above on behalf of Encompass Health Corporation.

C. Does the applicant plan, within 2 years of implementation of the project, to participate in self-assessment and external assessment against nationally available benchmark data to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve? Note: Existing licensed, accredited and/or certified providers are encouraged to describe their process for same.

Response:

Yes, the applicant plans to participate in self-assessment and external assessment against appropriate national benchmark data to accurately assess ongoing levels of performance against established standards – and to determine, prioritize, and implement ways to continuously improve both patient care and overall operational effectiveness. Additionally, the applicant will ensure that all State, Federal, CMS, and other requirements for inpatient rehabilitation care environments are met – and will seek accreditation by the Joint Commission and other organizations as appropriate during initial years of operations. The applicant will report performance metrics as required by external agencies and regulatory bodies.

Patients to be cared for within the proposed rehabilitation hospital will benefit from the significant clinical collaboration and care management resources available through the integrated care networks of Covenant Health and Encompass Health. The applicant is committed to ensuring high-quality care for all patients to be cared for at the proposed inpatient rehabilitation facility. All services to be provided at the proposed rehabilitation hospital will occur under the oversight of experienced clinical leaders and physicians affiliated with Covenant Health and Encompass Health.

Please complete the chart below on accreditation, certification, and licensure plans.

1) If the applicant does not plan to participate in these type of assessments, explain why since quality healthcare must be demonstrated.

Credential	**Agency**	**Status (Active or Will Apply)**
Licensure	X Health □ Intellectual and Developmental Disabilities □ Mental Health and Substance Abuse Services	**Will Apply**
Certification	X Medicare X Medicaid/TennCare □ Other_____	**Will Apply**
Accreditation	**Joint Commission**	**Will Apply**

2) Based upon what was checked/completed in above table, will the applicant accept a condition placed on the certificate of need relating to obtaining/maintaining license, certification, and/or accreditation?

Response: The applicant should be willing to accept a condition placed upon the certificate of need regarding its plans to apply for the indicated licensure, certifications, and accreditation if necessary.

D. The following list of quality measures are service specific. Please indicate which standards you will be addressing in the annual Continuing Need and Quality Measure report if the project is approved.

☐	For Ambulatory Surgical Treatment Center projects: Estimating the number of physicians by specialty expected to utilize the facility, developing criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documenting the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site?
☐	For Cardiac Catheterization projects: a. Documenting a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies; and b. Describing how the applicant will agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee; and c. Describing how cardiology staff will be maintaining: d. Adult Program: 75 cases annually averaged over the previous 5 years; e. Pediatric Program: 50 cases annually averaged over the previous 5 years.
☐	For Open Heart projects: f. Describing how the applicant will staff and maintain the number of who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and maintain this volume in the future; g. Describing how at least a surgeon will be recruited and retained (at least one shall have 5 years experience); h. Describing how the applicant will participate in a data reporting, quality improvement, outcome monitoring, and external assessment system that benchmarks outcomes based on national norms (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard).
X	For Comprehensive Inpatient Rehabilitation Services projects: Retaining or recruiting a physiatrist?
☐	For Home Health projects: Documenting the existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system.
☐	For Hospice projects: Documenting the existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system.
☐	For Megavoltage Radiation Therapy projects: Describing or demonstrating how the staffing and quality assurance requirements will be met of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority.
☐	For Neonatal Intensive Care Unit projects: Documenting the existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; document the intention and ability to comply with the staffing guidelines and qualifications set forth by the

	Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and participating in the Tennessee Initiative for Perinatal Quality Care (TIPQC).
☐	For Nursing Home projects: Documenting the existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program.
☐	For Inpatient Psychiatric projects: • Describing or demonstrating appropriate accommodations for: • Seclusion/restraint of patients who present management problems and children who need quiet space, proper sleeping and bathing arrangements for all patients); • Proper sleeping and bathing arrangements; • Adequate staffing (i.e. that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times); • A staffing plan that will lead to quality care of the patient population served by the project. • An existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and • If other psychiatric facilities are owned or administered, providing information on satisfactory surveys and quality improvement programs at those facilities. • Involuntary admissions if identified in CON criteria and standard review
☐	For Freestanding Emergency Department projects: Demonstrating that it will be accredited with the Joint Commission or other applicable accrediting agency, subject to the same accrediting standards as the licensed hospital with which it is associated.
☐	For Organ Transplant projects: Describing how the applicant will achieve and maintain institutional membership in the national Organ Procurement and Transportation Network (OPTN), currently operating as the United Network for Organ Sharing (UNOS), within one year of program initiation. Describing how the applicant shall comply with CMS regulations set forth by 42 CFR Parts 405, 482, and 498, Medicare Program; Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers To Perform Organ Transplants.
☐	For Relocation and/or Replacement of Health Care Institution projects: Describing how facility and/or services specific measures will be met.

Response:

The applicant will address the quality measures and standards appropriate for an inpatient rehabilitation facility (hospital) as required in the annual *Continuing Need and Quality Measure Report* if the CON project is approved.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

The responses to this section of the application helps determine whether the project will contribute to the orderly development of healthcare within the service area.

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

   Response:

   The proposed inpatient rehabilitation facility plans to seek contracts with the following managed care organizations initially (and others over time as appropriate):

   - **Aetna**
   - **AmeriGroup**
   - **BlueCare/TennCare**
   - **Blue Cross Blue Shield of TN – Commercial (Network P, Network S)**
   - **Blue Cross Blue Shield of TN – Medicare Advantage**
   - **CIGNA**
   - **CIGNA HealthSpring Medicare Advantage**
   - **Humana**
   - **Humana ChoiceCare**
   - **Humana Medicare Advantage**
   - **Tri-Care (Champus) – Military**
   - **United HealthCare – Commercial**
   - **United HealthCare Medicare Advantage**
   - **United HealthCare Community Plan /TennCare**
   - **Direct to Employer Contacting**
   - **WellCare Medicare Advantage**
   - **Workers Compensation**
   - **Traditional Medicare**
   - **Others: TBA**

   The proposed inpatient rehabilitation facility will have appropriate transfer agreements and working arrangements with area hospitals, physicians, skilled nursing facilities, and other organizations in the service area.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Response:

The proposed project will have a positive effect on the health care system in the service area and will promote the orderly achievement of the Tennessee State Health Plan's core tenets. The project seeks to improve the delivery and access of high quality inpatient rehabilitation services within a new replacement facility that will be available to all service area residents and others in outlying geographies. The collaborative project will develop a modern inpatient rehabilitation hospital to support ongoing improvements in patient care performance, operational efficiency, and consumer access.

Additionally, this collaborative project creates a partnership between two well-known organizations that represent significant collective experience caring for many patients requiring IRF services. The project avoids unnecessary and costly duplication as two experienced organizations work together and combine resources and expertise to form a more efficient and effective patient-focused care network in East Tennessee. The project will address both unmet demand and increasing demand for IRF services across the region.

B. Negative Effects

Response:

The proposed project should have minimal, if any, negative effects on existing providers within the service area. The proposed project will not add any new licensed beds or healthcare services to the region. Rather, the project supports an important continuation and timely modernization of existing inpatient rehabilitation services at a different location within Knox County. Approval of the CON will result in a bed neutral project for the service area – and all licensed beds to be relocated and utilized for the proposed project existed for many years prior to any outstanding or unimplemented certificates of need in the region. The IRF beds to be relocated and utilized for this project are the only beds that remain operational in the service area at this time – and many of these beds will remain operational and accessible to the community until the proposed project is completed and the involved beds are transferred as appropriate from a licensure standpoint. A growing and aging population will increase demand for all IRF providers in the region as improved resources become available to consumers.

3. **A**. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response:

Many of the employees needed to support the proposed IRF project during the first few years of the project are already employed by Covenant Health or Encompass Health. Additionally, both organizations involved with this project have a proven track record of finding, hiring, and developing excellent clinical leadership and professional staff consistent with all relevant licensing and accreditation requirements.

B. Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response:

The applicant plans to seek licensure as an Inpatient Rehabilitation Facility (Rehabilitation Hospital) by the Tennessee Board of Licensing Health Care Facilities (BLHCF) if the proposed project is approved by the Tennessee Health Services and Development Agency (HSDA).

Additionally, the inpatient rehabilitation facility will seek both Medicare and Medicaid/TennCare certification if the CON is approved – and it is anticipated that the proposed IRF will receive accreditations from the Joint Commission and other organizations as appropriate over time.

The applicant has reviewed and understands all relevant licensing certification requirements of the State of Tennessee and appropriate accrediting agencies for medical/clinical staff. It is worth noting that both partner organizations involved with this IRF project have many years of combined experience operating inpatient rehabilitation facilities – and the combined leadership teams of Covenant Health and Encompass Health have significant experience seeking, securing, and maintaining various licensure requirements, certifications, and applicable accreditations.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response:

The applicant is a new organization and does not anticipated that the proposed IRF will be a clinical training site during its initial year of operations. However, organizations involved with the project have supported the training and development of many physicians, nurses, physical therapists, and other clinicians in the past and will continue to do so in the future across multiple settings as appropriate, including within the proposed IRF.

4. Outstanding Projects:

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	**Project Name**	**Date Approved**	***Annual Progress Report(s)**		**Expiration Date**
			Due Date	**Date Filed**	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response:

Outstanding Projects					
CON Number	**Project Name**	**Date Approved**	***Annual Progress Report(s)**		**Expiration Date**
			Due Date	**Date Filed**	
CN2004-006	**Covenant Health Diagnostic Center**	**June 24, 2020**	**August 2021**	**To be Filed by August 2021**	**August 2022**
CN1903-003	**Premier Covenant ASTC, LLC**	**June 26, 2019**	**August 2020**	**To be Filed by August 2020**	**August 2021**

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

B. Describe the current progress, and status of each applicable outstanding CON.

Response:

Covenant Health:

Consistent with information available on the HSDA website currently, Covenant Health affiliates have only two outstanding CONs at this time.

- **CN2004-006: Covenant Health Diagnostic Center (Knox County)**
  - **The CON application for an independently licensed ODC was filed in early 2020**
  - **The CON was unanimously approved by the TN HSDA on June 24, 2020**
  - **The project is wholly-owned and controlled by Covenant Health through Fortress Corporation, a wholly-owned subsidiary of Covenant Health**
  - **Development of the recently approved ODC project will begin in July 2021, consistent with the *Project Completion Forecast Chart* provided within that CON application**

- **CN1903-003: Premier Covenant ASTC, LLC (Knox County)**
  - **This CON application for a new joint venture ASTC was filed in early 2019**
  - **The CON was unanimously approved by the TN HSDA on June 26, 2019**
  - **Covenant Health has a minority ownership (40%) in this ASTC project through Fortress Corporation, a wholly-owned subsidiary of Covenant Health**
  - **The CON will not expire until August 1, 2021**
  - **Current ASTC Project Status: the approved ASTC project is proceeding as planned after a few unexpected scheduling delays (i.e. time to address required variances with city; related construction drawing delays until February 2020; State reviewers recently approved final plans; all project transactions and agreements are now complete; renovations and minor construction to modify the existing medical building began in June 2020. The required Annual Progress Report will be submitted in a timely manner by the CEO of Premier Surgical Associates, PLLC. Also, it is anticipated that the required Final Project Completion Form will be submitted in a timely manner upon project completion before CON expiration in August 2021.**

Encompass Health:

Not applicable. Encompass Health does not have any outstanding projects in Tennessee at this time.

5. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

Response:

The applicant is a new organization and does not own, lease, operate, or contract with any mobile equipment vendors for CT, Linear Accelerator, MRI, or PET equipment.

However, requested information for both partner organizations involved with this project are provided below

Covenant Health:

Two affiliates of Covenant Health currently operate approved mobile PET/CT equipment leased via vendor contracts: 1) Cumberland Medical Center and 2) LeConte Medical Center:

1. Cumberland County / HOSP: Cumberland Medical Center*
Mobile (Part): 2 days/week / Shared: No / Brand & Type: Siemens PET/CT

2. Sevier County / HOSP: LeConte Medical Center*
Mobile (Part): 2 days/month / Shared: No / Brand & Type: Siemens Biograph TruePoint PET/CT

(*) Source Notes: HSDA Equipment Registry and Data on the HSDA Website 04-15-20:

- ***Positron Emission Tomography Scanners: https://www.tn.gov/hsda/medical-equipment-registry/medical-equipment-statistics.html***
- ***Health Care Providers that Utilize PET Scanners – Trends; Medical Equipment Registry: https://www.tn.gov/content/dam/tn/hsda/documents/procedure%20trend-pet.pdf***

Encompass Health:

Not Applicable. Encompass Health no longer owns or operates any medical imaging equipment in Tennessee.

B. If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?_____

Response:

Covenant Health:

Yes. The required mobile equipment registration information for Covenant Health affiliates is submitted and/or updated annually during the first quarter of each year as required (typically in January or February). The information on the HSDA website is correct and current. Updated mobile equipment information for LeConte Medical Center was submitted to the HSDA office via email with confirmed receipt on January 29, 2020. The updated mobile equipment information for Cumberland Medical Center was submitted to the HSDA office via email with confirmed receipt on February 28, 2020.

Encompass Health:

Not Applicable.

C. If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

Response:

Covenant Health:

Yes. The required mobile equipment utilization information for Covenant Health affiliates is submitted and/or updated annually during the first quarter of each year as required (typically in January or February). The information on the HSDA website is correct and current. Updated mobile equipment information for LeConte Medical Center was submitted to the HSDA office via email with confirmed receipt on January 29, 2020. The updated mobile equipment information for Cumberland Medical Center was submitted to the HSDA office via email with confirmed receipt on February 28, 2020.

Encompass Health:

Not Applicable.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at https://www.tn.gov/health/health-program-areas/health-planning/state-health-plan.html) The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.

Response:

The proposed project will improve the health of Tennesseans by enhancing inpatient rehabilitation services, clinical care settings, and care collaboration in the service area.

2. Every citizen should have reasonable access to health care.

Response:

The proposed project will be accessible to all citizens in the service area and will serve all patients regardless of payment source. The applicant intends to participate in all TennCare MCOs that operate in the region.

3. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.

Response:

Considering operational, regulatory, economic, and other factors, the project represents the optimal way to improve existing healthcare resources in the region. The project will develop a modern clinical environment for inpatient rehabilitation services to enhance patient care and consumer access via a modern IRF facility. The partnership project will benefit from the combined experience of leaders and staff from Covenant Health and Encompass Health.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

Response:

The project will meet (or exceed) the regulatory standards required for licensing as an IRF in Tennessee. In addition, the proposed IRF will seek accreditation by the Joint Commission and other organizations as appropriate over time. Appropriate physicians and staff will oversee the patient care and clinical operations of the IRF – and will be required to meet all appropriate credentialing standards for an IRF. The IRF will adopt and maintain policies and procedures with regard to ongoing quality monitoring and quality improvement.

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

Response:

The organizations involved with this project have significant experience recruiting and retaining high-quality clinical, administrative, and support staff. Such experience helps assure that the proposed IRF will be successful in recruiting, developing, and retaining a sufficient and high-quality workforce.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Date LOI was Submitted: **July 10, 2020**

Date LOI was Published: **July 10, 2020**

See Attachment, Proof of Publication

NOTIFICATION REQUIREMENTS

1. T.C.A. §68-11-1607(c)(9)(A) states that "…Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

2. T.C.A §68-11-1607(c)(9)(B) states that "… If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response: Not Applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART ***

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast. Expected opening of both companion IRF CON projects: July 2022.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		October 2020
2. Architectural and engineering contract signed	1-5 Days	January 2021
3. Construction documents approved by the Tennessee Department of Health	60 Days	February 2021
4. Construction contract signed	1-5 Days	March 2021
5. Building permit secured	60 Days	April 2021
6. Site preparation completed	60 Days	June 2021
7. Building construction commenced	1-5 Days	July 2021
8. Construction 40% complete	120 Days	November 2021
9. Construction 80% complete	180 Days	April 2022
10. Construction 100% complete (approved for occupancy)	60 Days	June 2022
11. *Issuance of License	30 Days	July 2022
12. *Issuance of Service	1-5 Days	July 2022
13. Final Architectural Certification of Payment	60 Days	September 2022
14. Final Project Report Form submitted (Form HR0055)	1-5 Days	December 2022

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

****** Please note: if the HSDA decision date and/or any of the forecasted times within the chart (i.e. for construction document review by TDH; planned renovation and construction efforts; or licensure processes) are delayed under possible scenarios (public health concerns, labor and supply shortages, weather conditions, project prioritization, etc.), the Project Completion Forecast Chart will be modified accordingly. However, even with possible delays, it is fully anticipated that the proposed IRF project will be completed within the required three (3) year period for a hospital CON project.***

AFFIDAVIT

STATE OF _____

COUNTY OF _____

_____, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

_____
SIGNATURE/TITLE

Sworn to and subscribed before me this _____ day of _____, _____ a Notary
(Month) (Year)

Public in and for the County/State of _____.

_____
NOTARY PUBLIC

My commission expires _____, _____.
(Month/Day) (Year)

See Attachment, Signed and Notarized Affidavit

Attachments

Attachments

Rehabilitation Hospital of Knox County, LLC ("West")

Attachment, Section A-3A: Overview of Covenant Health and Encompass Health

Attachments, Section A-4A/B: Corporate Charter and Certificate of Corporate Existence

Attachment, Section A-4A/B: Organization Chart

Attachment, Section A-5: Draft Management Agreement

Attachment, Section A-6A: Deeds and Documentation of Intent to Transfer Property

Attachments, Section A-6A/B: Plot Plan (Site Plan)

Attachments, Section A-6A/B: Floor Plan

Attachment, Section 12-A: Architect and Construction Letter

Attachment, Section B-Need-4A/B: Service Area Population, Demographics, and TennCare

Attachment: Service Area Map

Attachment, Section B-Need-IRF Criteria 5: Quality Considerations

Attachment, Section B-Need-3: Service Area Maps

Attachment, Section B-Need-4A/B: Service Area Population, Demographics, and TennCare

Attachment, Section B-Need-5: IRF Healthcare Providers in Service Area

See Attachment, Section B-Need-6: Projected Annual Utilization – IRF Discharges

Attachments, Economic Feasibility-Project Cost Chart: Deeds; Letter of Intent to Transfer Property; FMV Letter; Architect & Construction Letter

Attachment, Economic Feasibility-Project Cost Chart: Architect & Construction Letter

Attachment, Economic Feasibility: Project Funding Sources – Covenant Health

Attachment, Economic Feasibility: Project Funding Sources – Encompass Health

Attachment: Proof of Publication

Attachment: Signed and Notarized Affidavit

Attachment, Section A-3A:

Overview of Covenant Health and Encompass Health

Covenant Health Overview:

Covenant Health is a comprehensive, community-owned health system dedicated to improving the health of the people it serves. Established in 1996 by the consolidation of Fort Sanders Health System, Knoxville, Tennessee, and MMC HealthCare System in Oak Ridge, Covenant Health is governed by a voluntary board of directors made up of community leaders and medical professionals.

Covenant Health includes nine acute care hospitals in East Tennessee: Methodist Medical Center of Oak Ridge, Fort Sanders Regional Medical Center and Parkwest Medical Center in Knoxville, Fort Loudoun Medical Center in Lenoir City, LeConte Medical Center in Sevierville, Morristown-Hamblen Healthcare System in Morristown, Roane Medical Center in Harriman, Claiborne Medical Center in Tazewell and Cumberland Medical Center in Crossville. It also includes Peninsula Hospital, a psychiatric hospital in East Tennessee's Blount County.

Member organizations also include the Patricia Neal Rehabilitation Center (a unit of Fort Sanders Regional Medical Center), Peninsula (a division of Parkwest Medical Center), Fortress Corporation, Thompson Cancer Survival Center, Fort Sanders West Diagnostic Center, Nanny's, Fort Sanders Health and Fitness Center, Covenant Medical Group, Covenant HomeCare and Hospice, and others.

More than 10,000 people are employed by Covenant Health and its member organizations. Working together with nearly 1,500 affiliated physicians, these healthcare professionals deliver quality care to thousands of patients throughout East Tennessee. Covenant Health is the Knoxville area's largest employer and has been named a Best Employer five times by Forbes.

Additional information regarding Covenant Health is available via the organization's website: **www.covenanthealth.com.**

Encompass Health Overview:

As a national leader in integrated healthcare services, Encompass Health (NYSE: EHC) offers both facility-based and home-based patient care through its network of inpatient rehabilitation hospitals, home health agencies and hospice agencies.

With a national footprint that includes 136 hospitals, 245 home health locations, and 83 hospice locations in 39 states and Puerto Rico, the Company is committed to delivering high-quality, cost-effective, integrated care across the healthcare continuum. Encompass Health is ranked as one of Fortune's 100 Best Companies to Work For.

Currently, Encompass Health is involved with the ownership and operations of the following Inpatient Rehabilitation Facilities that have been approved and licensed in Tennessee:

- Encompass Health Rehabilitation Hospital of Chattanooga
- Encompass Health Rehabilitation Hospital of Franklin
- Encompass Health Rehabilitation Hospital of Kingsport
- Quillen Rehabilitation Hospital
- West Tennessee Healthcare Rehabilitation Hospital Cane Creek
- Vanderbilt Stallworth Rehabilitation Hospital

Additional information regarding Encompass Health is available via the organization's website: **www.encompasshealth.com.**

Attachments, Section A-4A/B:

Corporate Charter and Certificate of Corporate Existence

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Rehabilitation Hospital of Knox County, LLC
9001 LIBERTY PKWY
BIRMINGHAM, AL 35242-7509

April 23, 2020

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**001092362**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	04/22/2020
Filing Date:	04/23/2020 1:27 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2021
Duration Term:	Perpetual	Image # :	B0860-2787
Managed By:	Member Managed		

Document Receipt

Receipt # : 005509004	Filing Fee:	$300.00
Payment-Credit Card - State Payment Center - CC #: 3780406380		$300.00

Registered Agent Address:
C T CORPORATION SYSTEM
300 MONTVUE RD
KNOXVILLE, TN 37919-5546

Principal Address:
9001 LIBERTY PKWY
BIRMINGHAM, AL 35242-7509

Congratulations on the successful filing of your **Application for Certificate of Authority** for **Rehabilitation Hospital of Knox County, LLC** in the State of Tennessee which is effective on the date shown above. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Kelli Wiggins

001092362

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY

SS-4233

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300.00, maximum fee = $3,000.00)

For Office Use Only

-FILED-

Control # 001092362

To the Secretary of the State of Tennessee:
Pursuant to the provisions of T.C.A. §48-249-904 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: Rehabilitation Hospital of Knox County, LLC
If different, the name under which the certificate of authority is to be obtained is:

NOTE: The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of T.C.A. §48-249-106 of the Tennessee Revised Limited Liability Company Act. If obtaining a certificate of authortiy under an assumed Limited Liability Company name, an application must be filed pursuant to T.C.A. §48-249-106(d).

2. The state or country under whose law it is formed is: DELAWARE
and the date (mm/dd/yyyy) of its formation is: 04/22/2020
and, if prior to qualifying, the date it commenced doing business in Tennessee is: (none)

NOTE: Additional filing fees and proof of tax clearance confirming good standing may apply if the Limited Liability Company commenced doing business in Tennessee prior to the approval of this application. See T.C.A. §48-249-913(d) and T.C.A. §48-249-905(c).

3. This company has the additional designation of: None

4. The name and complete address of its registered agent and office located in the state of Tennessee is:
C T CORPORATION SYSTEM
300 MONTVUE RD
KNOXVILLE, TN 37919-5546
KNOX COUNTY

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is:
(none) (Not to exceed 90 days)

7. The LLC will be: ☑ Member Managed ☐ Manager Managed ☐ Director Managed ☐ Board Managed ☐ Other

8. Number of Members at the date of filing: 2

9. Period of Duration: Perpetual

10. The complete address of its principal executive office is:
9001 LIBERTY PKWY
BIRMINGHAM, AL 35242-7509

B0860-2787 04/23/2020 1:27 PM Received by Tennessee Secretary of State Tre Hargett

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY

SS-4233

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300.00, maximum fee = $3,000.00)

For Office Use Only

Control # 001092362

The name of the Limited Liability Company is: Rehabilitation Hospital of Knox County, LLC

11. The complete mailing address of the entity (if different from the principal office) is:

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

☐ I certify that this entity meets the requirements of T.C.A. §48-249-1123(b)(3)

Licensed Profession:

14. Series LLC (optional)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(i)

If the provisions of T.C.A. §48-249-309(i) (relating to foreign series LLCs) apply, then the information required by that section should be attached as part of this document.

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) **Effective Date:** (none)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. Other Provisions:

Electronic	Authorized Representative
Signature	Title/Signer's Capacity
Patrick Darby	Apr 23, 2020 1:27PM
Printed Name	Date

B0860-2788 04/23/2020 1:27 PM Received by Tennessee Secretary of State Tre Hargett

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "REHABILITATION HOSPITAL OF KNOX COUNTY, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-THIRD DAY OF APRIL, A.D. 2020.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

7944150 8300

SR# 20203089382

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 202815390

Date: 04-23-20

B0860-2789 04/23/2020 1:27 PM Received by Tennessee Secretary Of State Tre Hargett

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "REHABILITATION HOSPITAL OF KNOX COUNTY, LLC", FILED IN THIS OFFICE ON THE TWENTY-SECOND DAY OF APRIL, A.D. 2020, AT 10 O`CLOCK A.M.

Jeffrey W. Bullock, Secretary of State

7944150 8100
SR# 20203045092

Authentication: 202814458
Date: 04-23-20

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 10:00 AM 04/22/2020
FILED 10:00 AM 04/22/2020
SR 20203045092 - File Number 7944150

CERTIFICATE OF FORMATION
OF
REHABILITATION HOSPITAL OF KNOX COUNTY, LLC

1. The name of the limited liability company is Rehabilitation Hospital of Knox County, LLC.

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

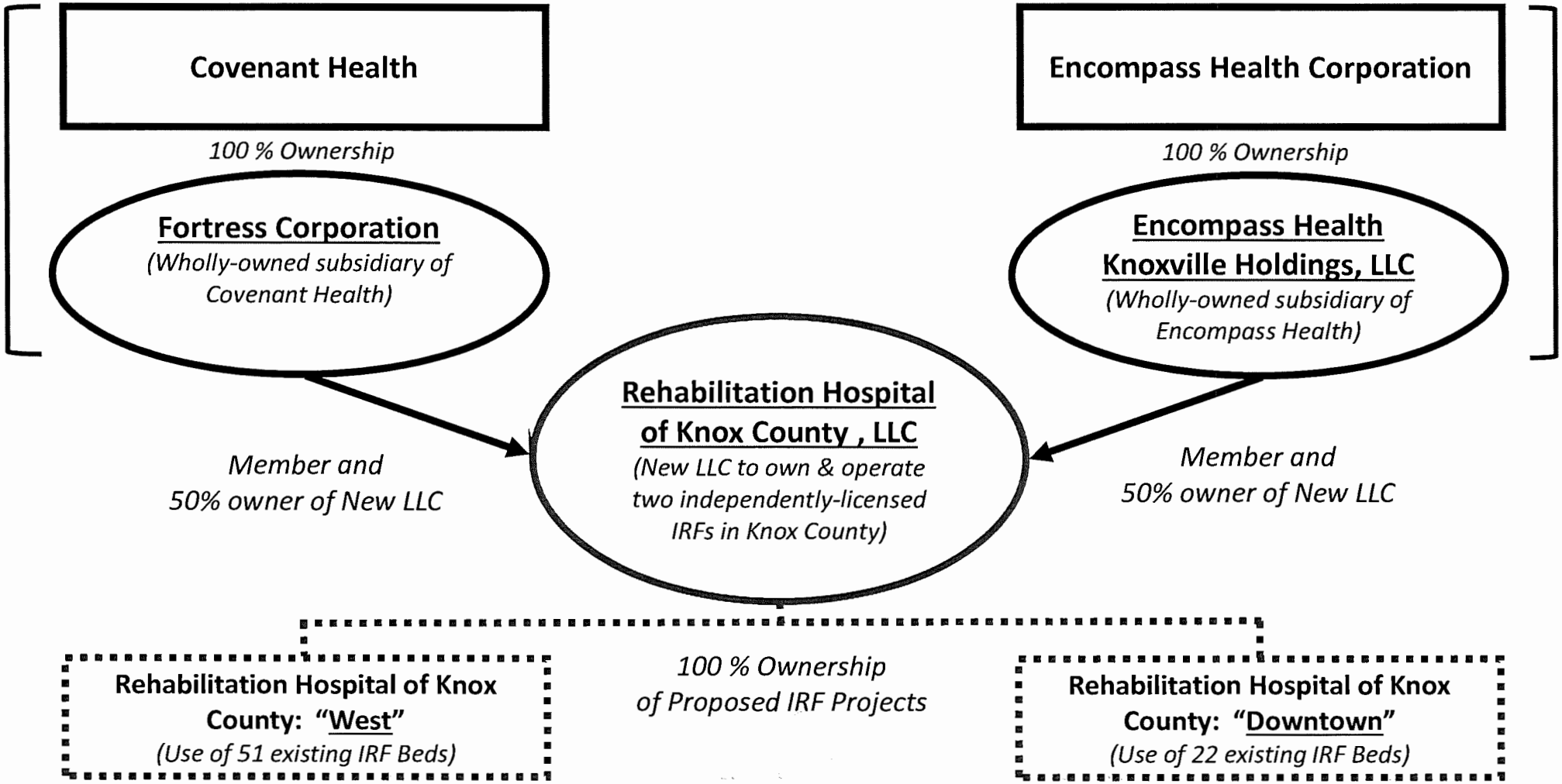
IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of Rehabilitation Hospital of Knox County, LLC this 21st day of April, 2020.

Patrick Darby, Authorized Person

Attachment, Section A-4A/B:

Organization Chart

Organization Chart: Rehabilitation Hospital of Knox County, LLC



Attachment, Section A-5:

Draft Management Agreement

MANAGEMENT AGREEMENT

THIS MANAGEMENT AGREEMENT (this "Agreement") made and entered into as of the ___ day of _____, 2020, by and between Encompass Health Corporation, a Delaware corporation (the "Manager"), and Rehabilitation Hospital of Knox County, LLC (the "Owner"), a Delaware limited liability company which owns and operates a rehabilitation hospital located in Knoxville, Tennessee (the "Hospital").

Section 1. MANAGEMENT SERVICES

1.1 Management Services. The Owner hereby retains the Manager for the purpose of rendering management, administration and purchasing services and support, and all other management support needed for operation, and in the best interest of the Hospital subject to the policies established by the Owner, which policies shall be consistent with applicable state and federal law, and consistent with the Budget, as defined below. The Manager will render all services, direction, advice, supervision and assistance in the operation of the Hospital, as necessary (collectively, the "Services").

Section 2. TERM

2.1 Term. The term of this Agreement shall commence as of the Effective Date and shall continue in full force and effect for a term of five (5) years, automatically renewing with terms of one (1) year each unless the Manager provides notice of nonrenewal no less than ninety (90) days prior to the beginning of the renewal term.

Section 3. FEE FOR SERVICES

3.1 Management Fee. The Owner shall pay the Manager for the Services a fee equal to five percent (5%) of the Net Revenue realized by the Owner from the operation of the Hospital (the "Management Fee"). All fees and expenses shall be paid monthly no later than the 15th day of the month following the month in which the fee was earned. Any subsequent adjustments to the Management Fee for a period resulting from a restatement of or adjustments to Net Revenue for such period shall be added to or deducted from the Management Fee otherwise due and owing for the next succeeding periods until paid or recouped in full. "Net Revenue" shall mean total patient revenues and other operating revenue (including the proceeds of claims under business interruption insurance policies) minus contractual allowances, provision for bad debt, and charity care. Revenue does not include condemnation awards, proceeds of claims under casualty insurance policies, proceeds from a sale or debt refinancing, and other capital transactions outside the ordinary course of business.

Section 4. COMPLIANCE

4.1 No Referrals or Splitting of Fees. The Manager and the Owner acknowledge and agree that the services and compensation provided hereunder do not require, are not payment for, and are not in any way contingent upon or related to the referral, admission, or any other arrangement for the Manager, the Owner or any member of the Owner to make referrals to, be in a position to make or influence referrals to, or otherwise generate business for any other such party. No such payment to Manager is or will be construed as splitting or sharing of Hospital's or any physician's professional fees, or any kind of commission, rebate or other remuneration for the referral of patients, nor any division of profits or partnership.

4.2 Adjustment of Management Fee. The parties agree and acknowledge that the Management Fee is intended to be a fair market rate and commercially reasonable. The parties further agree to adjust such Management Fee should either party determine that such Management Fee does not meet prevailing healthcare standards for fair market rates and commercial reasonableness, including, without limitation, a determination by the Manager that the Management Fee does not equal or exceed the costs incurred by the Manager to provide the management services described herein (excluding direct expenses and the cost of employing Hospital personnel).

4.4 No Exclusion; Standards of Business Conduct. The Manager hereby represents and warrants, and certifies that the Manager, its employees and agents providing services hereunder have not been excluded, debarred or otherwise ineligible from participation in any federal or state healthcare procurement program or any third party payor program and has not been convicted of a criminal offense relating to a federal or state healthcare procurement program. The Manager further represents and warrants, certifies and agrees that the Manager, its employees and agents providing the Services hereunder shall abide by Standards of Business Conduct, as amended from time to time and posted at https://investor.encompasshealth.com/uploads/sites/3/2018/02/Standards-of-Business-Conduct-Encompass-Health-2-7-2018.pdf.

4.5 Obligation to Protect Patient Information. The parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d and the Health Information Technology for Economic and Clinical Health Act and any current and future regulations promulgated under either act including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards as contained in 45 C.F.R. Part 162 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as the "HIPAA/HITECH Requirements." The parties agree not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 164.501) or Individually Identifiable Health Information (as defined in 42 C.F.R. § 1320d), other than as permitted by the HIPAA/HITECH Requirements, the terms of this Agreement, and the attached Business Associate Addendum. The parties will make their internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations. This Section shall survive termination or expiration of this Agreement.

Section 7. MISCELLANEOUS

7.5 Independent Contractor. The Manager and the Owner affirmatively state that by virtue of entering into this Agreement, the Manager is an independent contractor of the Owner, and nothing in this Agreement shall be deemed to create any membership, joint venture or other relationship (other than independent contractors) between the Owner and the Manager.

7.6 Notices. All notices, demands, requests and other communications or documents required or permitted to be provided under this Agreement shall duly be in writing and shall be given to the applicable party at its address set forth below or such other address as the party may later specify for that purpose by notice to the other party:

If to the Manager: Encompass Health Corporation
9001 Liberty Parkway
Birmingham, Alabama 35242
Attention: Executive Vice President, Operations

with copy to: Legal Services Department

Encompass Health Corporation
9001 Liberty Parkway
Birmingham, Alabama 35242
Attention: General Counsel

If to the Owner: Rehabilitation Hospital of Knox County, LLC
c/o Encompass Health Corporation
9001 Liberty Parkway
Birmingham, Alabama 35242
Attention: Executive Vice President, Operations

with copy to: Fortress Corporation
100 Fort Sanders West Blvd.
Knoxville, TN 37922
Attention: General Counsel

Each notice shall, for all purposes, be deemed given and received, (i) if by hand, when delivered; (ii) if given by nationally recognized and reputable overnight delivery service, the business day on which the notice is actually received by the party; or (iii) if given by certified mail, return receipt requested, postage prepaid, the business day on which the notice is actually received by the party.

7.7 Headings. Article headings are for convenience of reference only and shall not be used to construe the meaning of any provision of this Agreement.

7.8 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original and all of which shall together constitute one agreement. Facsimile or electronically submitted signatures on this Agreement shall be deemed to be original signatures for all purposes.

7.9 Severability. Should any part of this Agreement be invalid or unenforceable, such invalidity or unenforceability shall not affect the validity and enforceability of the remaining portions.

7.10 Authorization. Each individual signing this Agreement warrants that such execution has been duly authorized by the party for which it is signing. The execution and performance of this Agreement by each party has been duly authorized by all applicable laws and regulations and all necessary corporate action, and this Agreement constitutes the valid and enforceable obligation of each party in accordance with its terms.

7.11 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Delaware.

7.12 Modification. This Agreement may not be modified except in writing executed by the party to be charged.

7.13 Entire Agreement. This Agreement, together with the LLC Agreement and all other agreements executed in connection herewith or therewith, constitutes the entire agreement of the parties hereto and supersedes all prior agreements and representations with respect to the subject matter hereof.

[Signature Page Follows]

DRAFT

[Signature Page to Management Agreement]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

MANAGER:

ENCOMPASS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

OWNER:

REHABILITATION HOSPITAL OF KNOX COUNTY, LLC

By: Encompass Health Knoxville Holdings, LLC, Its Member

By: _____
Name: _____
Title: _____

By: Fortress Corporation, Its Member

By: _____
Name: _____
Title: _____

DRAFT

Attachment, Section A-6A:

Deeds and Documentation of Intent to Transfer Property

Covenant HEALTH

July 7, 2020

Mr. Logan Grant
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC ("West")

Dear Mr. Grant:

Covenant Health, through its wholly-owned subsidiary Fortress Corporation, currently owns and has full control of the 8.10 acre site to be used by Rehabilitation Hospital of Knox County, LLC for the "West" project that seeks Agency approval to develop a modern free-standing Inpatient Rehabilitation Facility ("IRF") utilizing 51 existing licensed beds in the service area. The site includes two contiguous parcels of land owned and controlled by Covenant Health, with the primary and larger parcel currently addressed as 10150 Kingston Pike, Knoxville, Tennessee 37922. Appropriate documentation regarding the property to be used for the proposed project will be included with the CON application via attachment as required, including both deeds and documentation of a recent FMV appraisal of the site by a credible third party who valued the 8.10 acre site at $ 3,700,000.

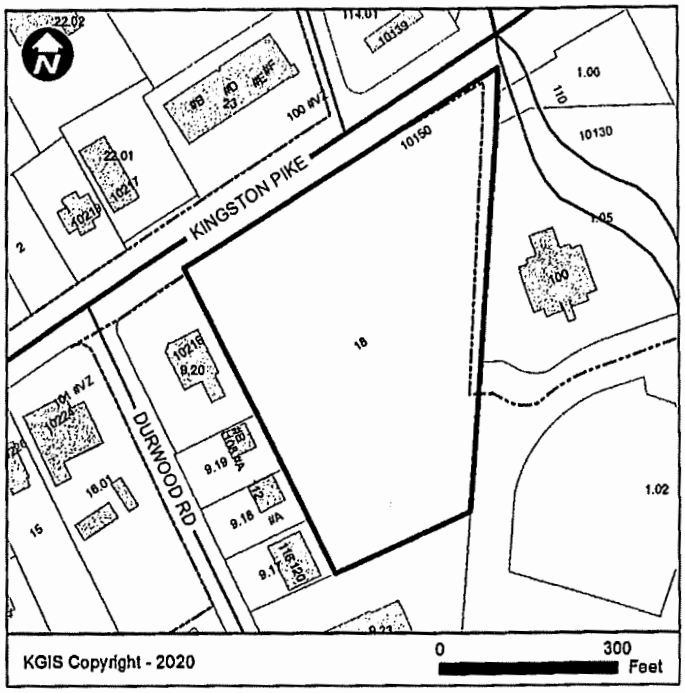
Please allow this letter to memorialize the intent of Covenant Health to contribute the two contiguous parcels of land and transfer ownership of the same to Rehabilitation Hospital of Knox County, LLC should the certificate of need request for the IRF be approved. The value of the land to be contributed represents a portion of the initial capital outlay for the proposed project that will be provided by Covenant Health as part of its initial contribution as a 50% partner in the joint venture. All transactions related to the proposed project will be subject to appropriate regulatory approvals.

Respectfully,

Ken Tucker
Assistant General Counsel

Corporate Office
100 Fort Sanders West Blvd. • Knoxville, TN 37922
(865) 531-5555 Office (865) 531-5272 Fax

Parcel 131NC018 - Property Map and Details Report



Property Information

Parcel ID:	131NC018
Location Address:	10150 KINGSTON PIKE
CLT Map:	131
Insert:	N
Group:	C
Condo Letter:	
Parcel:	18
Parcel Type:	
District:	W6
Ward:	
City Block:	
Subdivision:	
Rec. Acreage:	5.61
Calc. Acreage:	0
Recorded Plat:	-
Recorded Deed:	20160512 - 0065708
Deed Type:	Deed:Gift Deed
Deed Date:	5/12/2016

Address Information

Site Address:	10150 KINGSTON PIKE KNOXVILLE - 37922
Address Type:	UNUSED LAND
Site Name:	

Owner Information

FORTRESS CORPORATION
1420 CENTERPOINT BLVD #BLDG C
KNOXVILLE, TN 37932

The owner information shown in this section does **not** necessarily reflect the person(s) responsible for Last Year's property taxes. Report any errors to the Knox County Property Assessor's office at (865) 215-2365.

Jurisdiction Information

County:	KNOX COUNTY
City / Township:	

MPC Information

Census Tract:	58.07
Planning Sector:	Southwest County

Please contact Knox County Metropolitan Planning Commission (MPC) at (865) 215-2500 if you have questions.

Political Districts

Voting Precinct:	65E	
Voting Location:		Shoreline Church 9635 WESTLAND DR
TN State House:	14	Jason Zachary
TN State Senate:	6	Becky Duncan Massey
County Commission:	5	John Schoonmaker
(at large seat 10)		Larsen Jay
(at large seat 11)		Justin Biggs
School Board:	5	Susan Horn

Please contact Knox County Election Commission at (865) 215-2480 if you have questions.

School Zones

Elementary:	FARRAGUT PRIMARY
Intermediate:	FARRAGUT INTERMEDIATE
Middle:	FARRAGUT MIDDLE
High:	FARRAGUT HIGH

Please contact Knox County Schools Transportation and Zoning Department at (865) 594-1550 if you have questions.

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Source: KGIS

PROPERTY ASSESSOR'S OFFICE - KNOX COUNTY, TENNESSEE
MAP DEPARTMENT - OWNERSHIP CARD

ACTIVE NORMAL

07/02/2020

District	Map	Insert	Group	Parcel	Ward	Property Location
W6	131	N	C	18		10150 KINGSTON PIKE

Subdivision	Block	Lot	Plat	Dimensions (shown in ft.)	Acreage
	-	-	-	603 X 750 X IRR	5.61 - A.C. Deeded
					0.00 - A.C. Calculated

Owner	Sale Date	Book	Page	Sale Price	Mailing Address
FITZGERALD J B & LUCILE W	6/23/1954	951	599		2055 CHRISTUS WAY CONCORD, TN 37922
FORTRESS CORPORATION	5/10/2016	20160511	0065460	$ 1,750,000	1420 #BLDG C CENTERPOINT BLVD KNOXVILLE, TN 37932-1960
	5/10/2016	20160512	0065708		

Remarks

ATTRIBUTES FROM NCR LOADER

Parent Parcel	Parent Instrument Number

Previous Parcel (Split From)	Next Parcel (Merged Into)

131NC018

OWNER/RESPONSIBLE TAXPAYER:
Fortress Corporation Attn: Corp. Finance
1420 Center Point Blvd. Bldg C
Knoxville TN 37932
Map 131N, Group C, Parcel 018.00

THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 160539 (BMD)

WARRANTY DEED

THIS INDENTURE made as of this 10 day of May, 2016, between **LYLAN SHEPHERD-FITZGERALD and BRONCE M. FITZGERALD,** First Parties, and **FORTRESS CORPORATION, a Tennessee corporation,** Second Party:

WITNESSETH

THAT SAID FIRST PARTY, for and in consideration of the sum of **TEN AND NO/100 ($10.00) DOLLARS,** and other good and valuable consideration, to them in hand paid by said Second Party, the receipt of which is hereby acknowledged, have granted, bargained, sold and conveyed, and do by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein. **TO HAVE AND TO HOLD** the same unto the Second Party, its successors and assigns forever.

AND SAID FIRST PARTIES, for themselves and their heirs, representatives, successors and assigns, do hereby covenant with said Second Party, its successors and assigns, that they are lawfully seized in fee simple of the premises above conveyed and have full power, authority and right to convey the same, and that said premises are free from all encumbrances except applicable restrictions, easements and building setback lines as are shown in the records of the Knox County Register of Deeds Office, any matter and/or condition which would be disclosed by a current, accurate survey or inspection of the property herein described, and 2016 taxes, which shall be prorated as of the date of closing and which Second Party assumes and agrees to pay (the "Encumbrances"), and that they will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever, except as to the Encumbrances.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, or the masculine, feminine or neuter gender, as the case may demand.

Knox County Page: 1 of 4
REC'D FOR REC 05/11/2016 4:00:07PM
RECORD FEE: $23.00
M. TAX: $0.00 T. TAX: $6,475.00
20160511006546O

COUNTERSIGNED
KNOX COUNTY PROPERTY ASSESSOR
MAY 11 2016
PHIL BALLARD
BY

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

IN WITNESS WHEREOF, the said First Parties hereunder have executed this instrument as of the day and year first above written.

LYLAN SHEPHERD-FITZGERALD

BRONCE M. FITZGERALD

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **LYLAN SHEPHERD-FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that she executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10 day of May, 2016.

Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **BRONCE M. FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that he executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10 day of May, 2016.

Notary Public

My Commission Expires: 5-6-18

Page: 2 OF 4
201605110065460

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

I hereby swear or affirm that the actual consideration or true value of this transfer, whichever is greater, is $ 1,750,000.00 .

C Renee Orth agent
Affiant

Subscribed and sworn to before me this 11th day of May, 2016.

Sandra Bright
Notary Public

My Commission Expires: 2/5/2017

SANDRA BRIGHT
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 2-5-2017
KNOX COUNTY

Page: 3 OF 4
201605110065460

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

EXHIBIT "A"

SITUATED in District No. Six (6) of Knox County, Tennessee, lying on the south side of Kingston Pike or US Highway 70, and more particularly described as follows:

BEGINNING at an iron pin marking the northeastern corner of the property herein conveyed and the northwestern corner of Reynolds running thence South 4 deg. 41 min. West, 750.9 feet to an iron pin; thence South 67 deg. 54 min. West, 243.5 feet to an iron pin; Thence North 22 deg. 57 min. West, 577.1 feet to an iron pin in the south line of said US Highway 70; thence North 59 deg. 07 min. East, 603.98 feet to the **POINT OF BEGINNING,** containing 5.61 acres, more or less.

BEING the same property conveyed to J.B. Fitzgerald and wife, W. Lucile Fitzgerald, by Warranty Deed from J.K. Bondurant and wife, Evelyn B. Bondurant, and Anna Belle Boring, dated June 23, 1954, filed for record in Warranty Book 951, page 599 in the Knox County Register of Deeds Office. See Affidavit of Heirship filed for record herewith as Instrument No. 201605110065459, in the Knox County Register of Deeds Office.

TOGETHER WITH easement granted in Drainage Easement Agreement by and between Fortress Corporation, a Tennessee corporation, and Bronce Fitzgerald and Lylan Fitzgerald, dated as of May 6, 2015, filed for record as Instrument No. 201507310006929 in the Knox County Register of Deeds Office.

FURTHER TOGETHER WITH, but without warranty, all right, title and interest of First Parties in and to roads, easements and any strips or gores of land adjacent to, abutting or adjoining the property described above on all sides thereof.

Page: 4 OF 4
201605110065460

131NC 018

OWNER/RESPONSIBLE TAXPAYER:
Fortress Corporation Attn. Corp. Finance
1420 Center Point Blvd. BLDG. C
Knoxville TN 37932
Map 131NC Group C, Parcel 018.00

THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 160539 (BMD)

COUNTERSIGNED
KNOX COUNTY PROPERTY ASSESSOR
MAY 12 2016
BY PHIL BALLARD

Sherry Witt
Register of Deeds
Knox County

QUITCLAIM DEED

THIS INDENTURE made as of this 10th day of May, 2016, between **LYLAN SHEPHERD-FITZGERALD and BRONCE M. FITZGERALD,** First Parties, and **FORTRESS CORPORATION, a Tennessee corporation,** Second Party:

WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of **ONE AND NO/100 ($1.00) DOLLAR,** and other good and valuable consideration, to them in hand paid by said Second Party, the receipt of which is hereby acknowledged, have bargained, sold, remised, released and **QUITCLAIMED,** and do by these presents bargain, sell, remise, release and **QUITCLAIM** unto Second Party all of First Parties' right, title and interest in and to the following described premises, to-wit:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to the said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said First Parties have executed this instrument as of the day and year first above written.

Lylan Shepherd-Fitzgerald
LYLAN SHEPHERD-FITZGERALD

BRONCE M. FITZGERALD

Knox County Page: 1 of 4
REC'D FOR REC 05/12/2016 2:55:29PM
RECORD FEE: $22.00
M. TAX: $0.00 T. TAX: $0.00
201605120065708

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\QCD.doc

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **LYLAN SHEPHERD-FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that she executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10th day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **BRONCE M. FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that he executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10th day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

I hereby swear or affirm that the actual consideration of this transfer is $-0-.

Affiant

Subscribed and sworn to before me this 10th day of May, 2016.

Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

Page: 3 OF 4
201605120065708

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\QCD.doc

EXHIBIT "A"

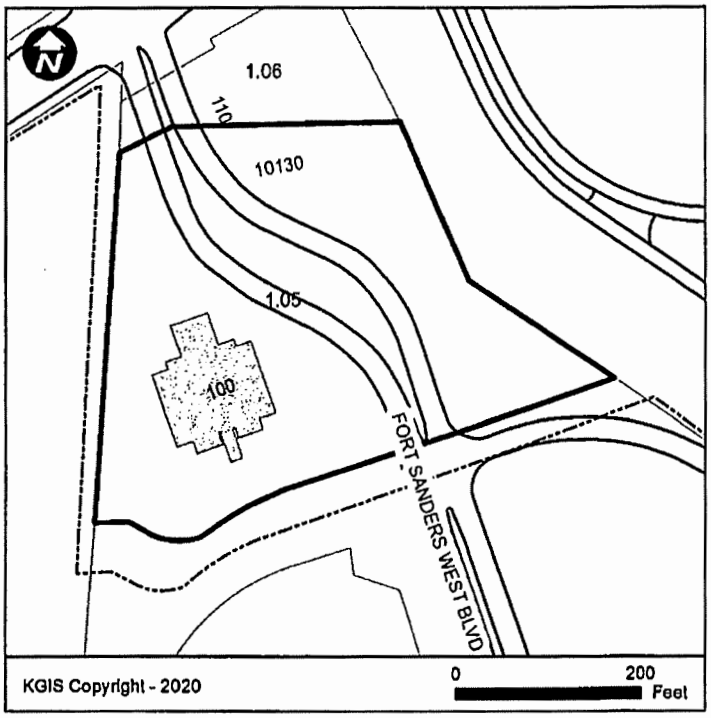
SITUATED in the Sixth (6th) Civil District of Knox County, Tennessee, without the corporate limits of the City of Knoxville, Tennessee, being 5.71 acre, more or less, tract located on the south side of Kingston Pike, and being more particularly bounded and described as follows:

BEGINNING at an iron pin found in the southerly right of way line of Kingston Pike, said iron pin being located in a easterly direction along said right of way line 151.89 feet from its point of intersection with the easterly right of way line of Durwood Road, said iron pin being located 40 feet in a southerly direction from the centerline of Kingston Pike; thence from said point of beginning, and with the southerly right of way line of Kingston Pike, North 67 deg. 33 min. 00 sec. East, 595.22 feet to an iron pin found; thence, continuing with the right of way line of Kingston Pike, and passing an iron pin found at a highway monument and then with the line of property now or formerly belonging to Fort Sanders Corp, South 13 deg. 15 min. 52 sec. West, 81.37 feet to an iron pin with cap found; thence with Fort Sanders West, South 13 deg. 19 min. 41 sec. West, 660.81 feet to an iron pipe found, said iron pipe marking common corner to property herein described and property (Lot 6 David Park Subdivision) now or formerly belonging to First Utility District (WB 1699, page 228); thence with the line of First Utility District, South 76 deg. 12 min. 00 sec. West, 242.97 feet to an iron pipe found, said iron pipe marking common corner between property herein described and Lot 5 in David Park Subdivision (Instrument No. 197808210032963); thence with the line of David Park Subdivision, and then for a short distance with the right of way line of Kingston Pike, North 14 deg. 31 min. 00 sec. West, 571.10 feet to the iron pin marking the **POINT OF BEGINNING,** as shown by survey of Richard E. LeMay, Surveyor, Tennessee RLS No. 769, dated May 10, 2016, bearing Drawing No. 5124. Surveyor's Address: LeMay & Associates, 10816 Kingston Pike, Knoxville, TN 37922.

FOR SOURCE OF TITLE see deed filed for record in Warranty Book 951, page 599 in the Knox County Register of Deeds Office. **SEE ALSO** Affidavit of Heirship filed for record herewith as Instrument No. 201605110065459 in the Knox County Register of Deeds Office.

Page: 4 OF 4
201605120065708

Parcel 131LA00105 - Property Map and Details Report



Property Information

Parcel ID:	131LA00105
Location Address:	100 FORT SANDERS WEST BLVD
CLT Map:	131
Insert:	L
Group:	A
Condo Letter:	
Parcel:	1.05
Parcel Type:	
District:	
Ward:	47
City Block:	46349
Subdivision:	ANX (99) 0-130-98
Rec. Acreage:	0
Calc. Acreage:	4.59
Recorded Plat:	-
Recorded Deed:	20010514 - 0078605
Deed Type:	Deed:Gift Deed
Deed Date:	5/14/2001

Address Information

Site Address:	100 FORT SANDERS WEST BLVD KNOXVILLE - 37922
Address Type:	BUSINESS
Site Name:	COVENANT HEALTH CORP OFFICE

Owner Information

FORTRESS CORP LSD TO FORTSANDERS WEST
1420 CENTERPOINT BLVD
BLDG C
KNOXVILLE, TN 37932

The owner information shown in this section does **not** necessarily reflect the person(s) responsible for Last Year's property taxes. Report any errors to the Knox County Property Assessor's office at (865) 215-2365.

Jurisdiction Information

County:	KNOX COUNTY
City / Township:	Knoxville

MPC Information

Census Tract:	58.07
Planning Sector:	Southwest County

Please contact Knox County Metropolitan Planning Commission (MPC) at (865) 215-2500 if you have questions.

Political Districts

Voting Precinct:	65E	
Voting Location:		Shoreline Church 9635 WESTLAND DR
TN State House:	14	Jason Zachary
TN State Senate:	6	Becky Duncan Massey
County Commission:	5	John Schoonmaker
(at large seat 10)		Larsen Jay
(at large seat 11)		Justin Biggs
City Council:	2	Andrew Roberto
(at large seat A)		Lynne Fugate
(at large seat B)		Janet Testerman
(at large seat C)		Amelia Parker
School Board:	5	Susan Horn

Please contact Knox County Election Commission at (865) 215-2480 if you have questions.

School Zones

Elementary:	FARRAGUT PRIMARY
Intermediate:	FARRAGUT INTERMEDIATE
Middle:	FARRAGUT MIDDLE
High:	FARRAGUT HIGH

Please contact Knox County Schools Transportation and Zoning Department at (865) 594-1550 if you have questions.

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Source: KGIS

PROPERTY ASSESSOR'S OFFICE - KNOX COUNTY, TENNESSEE
MAP DEPARTMENT - OWNERSHIP CARD

ACTIVE NORMAL 07/02/2020

District	Map	Insert	Group	Parcel	Ward	Property Location
	131	L	A	1.05	47	100 FORT SANDERS WEST BLVD

Subdivision	Block	Lot	Plat	Dimensions (shown in ft.)	Acreage
ANX (99) 0-130-98	-	-	:	450 X 180 X IRR	0.00 - A.C. Deeded
					4.59 - A.C. Calculated

Owner	Sale Date	Book	Page	Sale Price	Mailing Address
FORT SANDERS ALLIANCE LSD TO THE PROMETHEAN CO SUB LSD TO FORT SANDERS WEST INC - SUITE 109	6/1/1987	T2330	739		280 #STE 214 FORT SANDERS WEST BV KNOXVILLE, TN 37934
	12/21/1987	1935	588		
	12/29/1987	T2330	745		
	7/25/1988	1953	376		1420 #BLDG C CENTERPOINT BLVD KNOXVILLE, TN 37932-1960
FORTRESS CORP LSD TO FORTSANDERS WEST	4/17/2000	20010514	0078605		1420 CENTERPOINT BLVD BLDG C KNOXVILLE, TN 37932-1960

Remarks

ANX (99) 0-130-98 ADD

Parent Parcel	Parent Instrument Number

Previous Parcel (Split From)	Next Parcel (Merged Into)
131LA00101	

COUNTERSIGNED

131NC -9.14 -Tract 11 -(Lot 8)

MAY 1 4 2001

JOHN R. WHITESIDE
KNOX COUNTY
PROPERTY ASSESSOR
BY

OWNER/RESPONSIBLE TAXPAYER:	THIS INSTRUMENT PREPARED BY:
Covenant Health Suite 109, 280 Fort Sanders West Boulevard Knoxville, Tennessee 37922 Tax I.D. No.: _____	M. Douglas Campbell, Jr., Esq. Wagner, Myers and Sanger, P.C. 1801 First Tennessee Plaza Knoxville, Tennessee 37929

QUITCLAIM DEED
(CORPORATION)

THIS INDENTURE made this 17th day of April, 2000, between **COVENANT HEALTH**, a Tennessee non-profit corporation, First Party, and **FORTRESS CORPORATION**, a Tennessee corporation, Second Party:

WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of ONE DOLLAR ($1.00), and for other good and valuable consideration, the receipt and legal sufficiency of all of which is hereby acknowledged, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has granted, bargained, sold and conveyed, and does by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

BEING the same property conveyed to Fort Sanders Alliance from Consumer's Wholesale, Inc. by Warranty Deed dated November 30, 1986 of record in Book 1900, Page 522 in the Knox County Register of Deeds Office, as amended by Deed of Correction dated December 27, 1987 of record in Book 1935, Page 588 in the Knox County Register of Deeds Office, and as further amended by Deed of Correction dated July 25, 1988 of record in Book 1953, Page 376 in the Knox County Register of Deeds Office, and from Fred J. Byerley and wife, Martha E. Byerley by Warranty Deed dated December 29, 1986 of record in Book 1903, Page 63 in the Knox County Register of Deeds Office. Fort Sanders Alliance was merged into Covenant Health, successor by corporate name change to Tennessee Healthcare System, on September 9, 1996 of record in Book CH 126, Page 941 of the Knox County Register of Deeds Office.

THIS CONVEYANCE is made subject to any and all applicable restrictions, easements and building setback lines as are shown in the records of the Knox County Register's Office.

with the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said First Party has caused this instrument to be executed the day and year first above written.

COVENANT HEALTH,
a Tennessee non-profit corporation

By: Calvin C. Gunn

Its: President

H:\WPFILES\2744\198\QTCLDD2.WPD

Instr:200105140078005 Page: 1 OF 4
REC'D FOR REC 05/14/2001 11:17:05AM
RECORD FEE: $18.00
M. TAX: $0.00 T. TAX: $0.00

State Of Tennessee)
)
County Of Knox)

Before me, Tamara Hill, of the state and county mentioned, personally appeared Alan C. Guy with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be the President of **Covenant Health**, a Tennessee non-profit corporation, the within named bargainor, and that he as such President, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as President.

Witness my hand and seal, at office in Knoxville, this 17TH day of April, 2000.

Tamara Anne Hill
NOTARY PUBLIC

My Commission Expires: 1-02-01

I hereby swear or affirm that the actual consideration or true value of this transfer, whichever is greater, is $ -0- .

Alan C. Guy
Affiant

Subscribed and sworn to before me this 17TH day of April, 2000.

Tamara Anne Hill
Notary Public

My Commission Expires: 1-02-01

THE PREPARER OF THIS DEED HAS NOT BEEN REQUESTED BY THE PARTIES AND HAS NOT CONDUCTED AN EXAMINATION OF THE STATUS OF THE TITLE TO THE PROPERTY DESCRIBED IN THIS QUITCLAIM DEED, AND THEREFORE MAKES NO REPRESENTATIONS OR WARRANTIES OF ANY KIND OR NATURE WHATSOEVER AS TO THE STATUS OF TITLE TO SAID PROPERTY.

THE PROPERTY DESCRIPTION ATTACHED TO THIS DEED WAS TAKEN FROM THE PRIOR DEED OF CONVEYANCE, NO BOUNDARY SURVEY HAVING BEEN CONDUCTED AT THE TIME OF OR IN CONNECTION WITH THE CONVEYANCE HEREBY CONTEMPLATED.

131LA-001 & 001.01
(part)

TRACT I

SITUATED in District No. Six (6) of Knox County, Tennessee, without the corporate limits of the City of Knoxville, and being a portion of Lot 21 and a part of an unnumbered sometimes referred to as Lot 1 in the Mrs. J. S. Reynold's Subdivision as shown on map of record in Map Book 17, page 168, in the Knox County Register's Office, and being more fully described as follows:

TO FIND THE POINT OF BEGINNING, commence at an existing right-of-way monument in the South line of Kingston Pike at the Northwest corner of Lot 21 of the Mrs. J. S. Reynold's Subdivision; thence leaving Kingston Pike, South 6 deg. 40 min. West, 105 feet to an iron pin marking the point of BEGINNING herein, said point of BEGINNING being in the South right-of-way of the relocated Kingston Pike in the proposed Pellissippi Parkway Extension; thence with the Southern and Western distances as follows: North 64 deg. 34 min. East, 90 feet to an iron pin; thence North 84 deg. 44 min. 30 sec. East, 230 feet to an iron pin; thence South 19 deg. 23 min. 38 sec. East, 180 feet to an iron pin; thence South 51 deg. 53 min. 13 sec. East, 295.82 feet to an iron pin; thence South 50 deg. 41 min. 19 sec. East, 124.36 feet to an iron pin; thence South 39 deg. 21 min. 42 sec. East, 552.56 feet to an iron pin; thence South 13 deg. 21 min. 57 sec. East, 480.10 feet to an iron pin; thence South 17 deg. 16 min. 53 sec. East, 649.69 feet to an iron pin in a fence line; thence with said fence line, South 67 deg. 05 min. 23 sec. West, 1,659.79 feet to an iron pin in the line of Third National Bank; thence with the line of Third National Bank and with a fence line, five (5) calls and distances as follows: North 2 deg. 47 min. West, 183.80 feet to an iron pin; thence North 0 deg. 39 min. West, 304.66 feet to an iron pin; thence North 11 deg. 26 min. West, 75.35 feet to an iron pin; thence South 62 deg. 05 min. 08 sec. West, 11.27 feet to an iron pin; thence North 3 deg. 54 min. 45 sec. East, 57.29 feet to an iron pin corner to property of Jenkins; thence with said line, North 5 deg. 40 min. 45 sec. East, 375.05 feet to an iron pin corner to Ravenwood Subdivision; thence with said line, North 5 deg. 52 min. 31 sec. East, 410.12 feet to an iron pin corner to Byerley; thence with said line, North 6 deg. 12 min. 33 sec. East, 197.57 feet to a one-inch iron pipe, corner to Lot 7 of David Park Subdivision; thence with the line of Lot 7, North 6 deg. 24 min. 34 sec. East, 159.90 feet to an iron pin, corner to Lot 6; thence with the line of Lot 6, North 6 deg. 19 min. 20 sec. East, 149.99 feet to an iron pin, corner to property of Fitzgerald; thence with the line of Fitzgerald, North 5 deg. 40 min. East, 537.01 feet to the point of BEGINNING, as shown by survey of Sizemore-Lynch & Associates, dated August 1, 1986, and last revised on December 2, 1986.

THERE IS ALSO CONVEYED HEREWITH a non-exclusive permanent easement for ingress and egress and the placement of utility services in locations to be determined in the sole discretion of the Grantee herein, in, upon and over the following described property:

BEGINNING at a concrete R/W monument on the southern R/W line of Kingston Pike, said monument being 754.9 feet +- from the pont of intersection with the easterly R/W line of Durwood Road, Thence continuing with the southern R/W line of Kingston Pike, N 60 Deg. 46' E, 125.00 feet to an iron pin, thence S 29 Deg. 14' E, 134.05 feet to an iron pin, thence S 84 Deg. 44' 30" W, 105.90 feet to a point, thence S 64 Deg. 34' W, 90.00 feet to an iron pin at the common corner of Fitzgerald, Thompson and Fort Sanders Alliance, Thence N 6 Deg. 40' E, 105.00 Feet to the POINT OF BEGINNING as shown by survey of Sizemore-Lynch & Associates, dated May 14, 1988 and last revised June 22, 1988 being Project No. 1412.5.

TRACT II

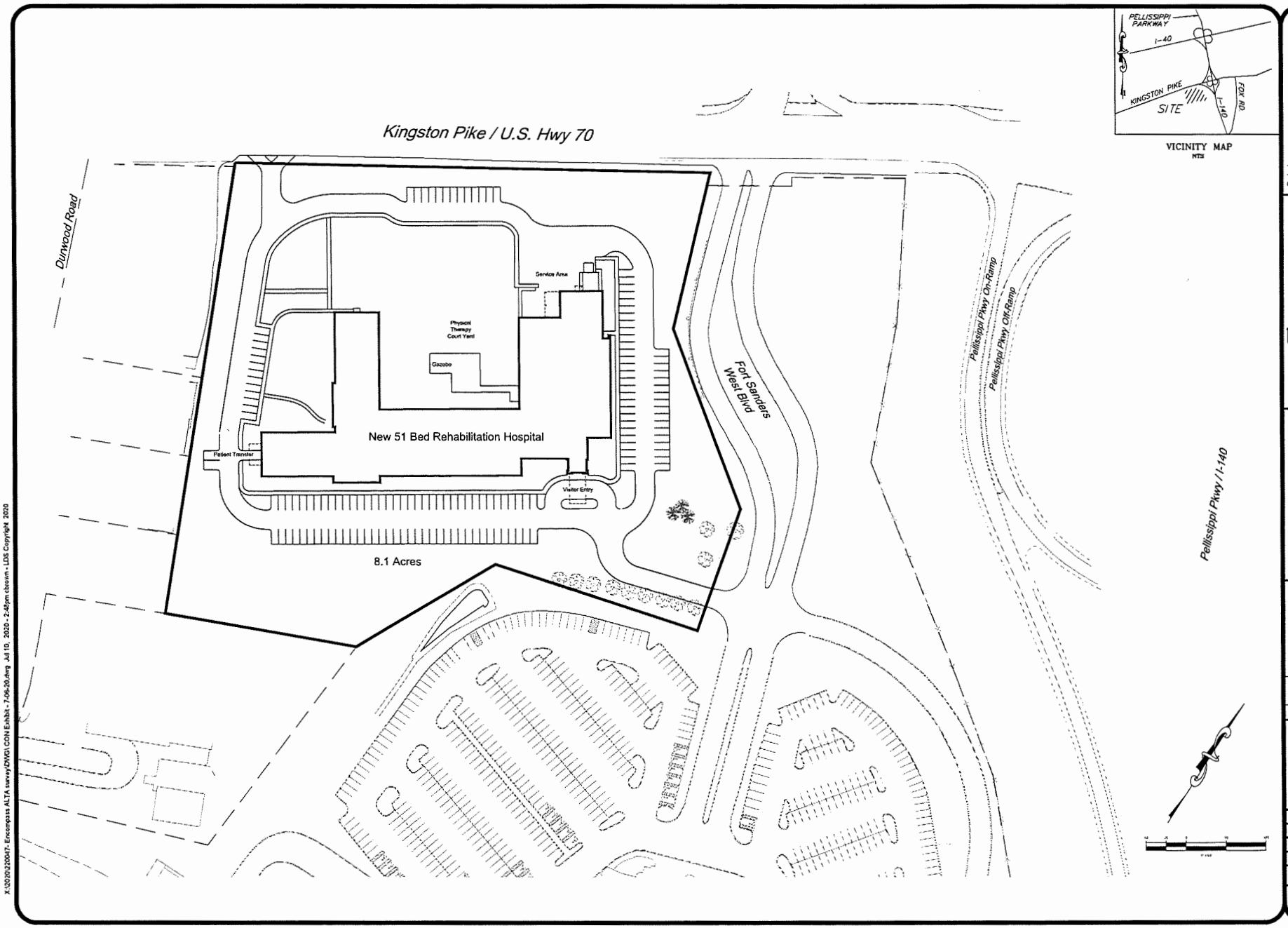
City of Knoxville, Tennessee, and being known and designated as Lot 8, in David Park Subdivision, a subdivision to Knox County, Tennessee, as shown by map of said subdivision, of record in Map Book 67-S, page 30, Cabinet E, Slide 291-C, in the Knox County Register's Office, said lot being more particularly bounded and described as shown on map aforesaid, to which map specific reference is hereby made for a more particular description.

BEING the same property conveyed to Fort Sanders Alliance by deed from Fred J. Byerley and wife, Martha E. Byerley, dated December 29, 1986, of record in Warranty Book 1903, page 63, in the Knox County Register's Office, and by deed from Consumer's Wholesale, Inc., dated November 30, 1986, of record in Deed Book 1900, Page 522, and corrected by Deed of Correction dated December 21, 1987 of record in Deed Book 1935, Page 588, and further corrected by Deed Book of Correction dated July 25, 1988 of record in Deed Book 1953, Page 0376, in the Register's Office of Knox County, Tennessee.

Instr:200105140070008
PAGE: 4 OF 4

Attachments, Section A-6A/B:

Plot Plan (Site Plan)



X:\2020\200047- Encompass ALTA survey\DWG\ CON Exhibit - 7-06-20.dwg Jul 10, 2020 - 2:48pm cbrown - LDS Copyright 2020

Project:
Rehabilitation Hospital of Knox County, LLC
West
Knox County, Tennessee

LAND DEVELOPMENT SOLUTIONS
310 SIMMONS RD., SUITE K • KNOXVILLE, TENNESSEE 37922
PH. 865-671-2281

Drawing Description:
West Site Plan
10150 Kingston Pike

No.	Date	Revision

Preliminary
Not For
Construction

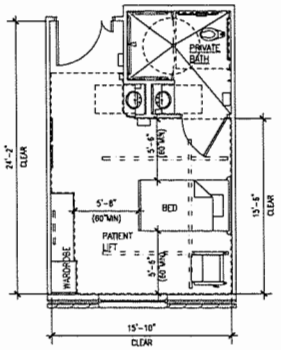
Drawn By	
Checked	
Approved	
Job No.	–
1"=50' Scale	7-06-2020 Date

C-1
Sheet No.

Attachments, Section A-6A/B:

Floor Plan

CODE COMPLIANCE					
PHASE	AREA (GSF)	BED COUNT	DINING/REC DAY SPACE REQUIREMENT	DRD AREA REQUIRED (SF)	DRD AREA PROVIDED (SF)
1	54,400	51	55 SF/BED (FGI)	2,805	2,910
TOTALS	54,400	51		2,805	2,910



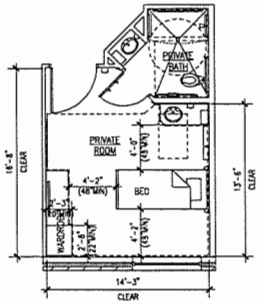
BARIATRIC PATIENT ROOM

SCALE: 1/4" = 1'-0"

MINIMUM DIMENSIONS SHOWN PER (FGI)

GROSS ROOM AREA: (200 S.F. REQ'D) 299 S.F.
NET ROOM AREA: 256 S.F.

GLASS AREA REQUIRED: (IBC) 299 x .08 = 23.92 S.F.
GLASS AREA PROVIDED: 28.7 S.F.



TYP. PRIVATE PATIENT ROOM

SCALE: 1/4" = 1'-0"

MINIMUM DIMENSIONS SHOWN PER (FGI)

GROSS ROOM AREA: (140 S.F. REQ'D) 217 S.F.
NET ROOM AREA: 161 S.F.

GLASS AREA REQUIRED: (IBC) 217 x .08 = 17.36 S.F.
GLASS AREA PROVIDED: 28.7 S.F.

GENERAL NOTES

1. REQUIRED SEPARATE AREA FOR PATIENT GROOMING IS ACCOMODATED WITHIN ADL SUITE AS PERMITTED BY AIA GUIDELINES 2.6-2.3.3
2. STAFF DINING IS LOCATED IN THE MAIN DINING AREA
3. FOOD SERVICE WASTE STORAGE IS IN THE DUMPSTER.

REHABILITATION BED COUNT

1. PRIVATE BEDS: 51

TOTAL PATIENT BEDS: 51

TYPE OF CONSTRUCTION

NEW BUILDING

1. I.B.C. TYPE 2-A
2. NFPA 220 TYPE II (1,1,1)
3. BUILDING IS FULLY SPRINKLERED

OCCUPANCY CATEGORY

1. I.B.C. INSTITUTIONAL GROUP I-2
2. NFPA NEW HEALTHCARE

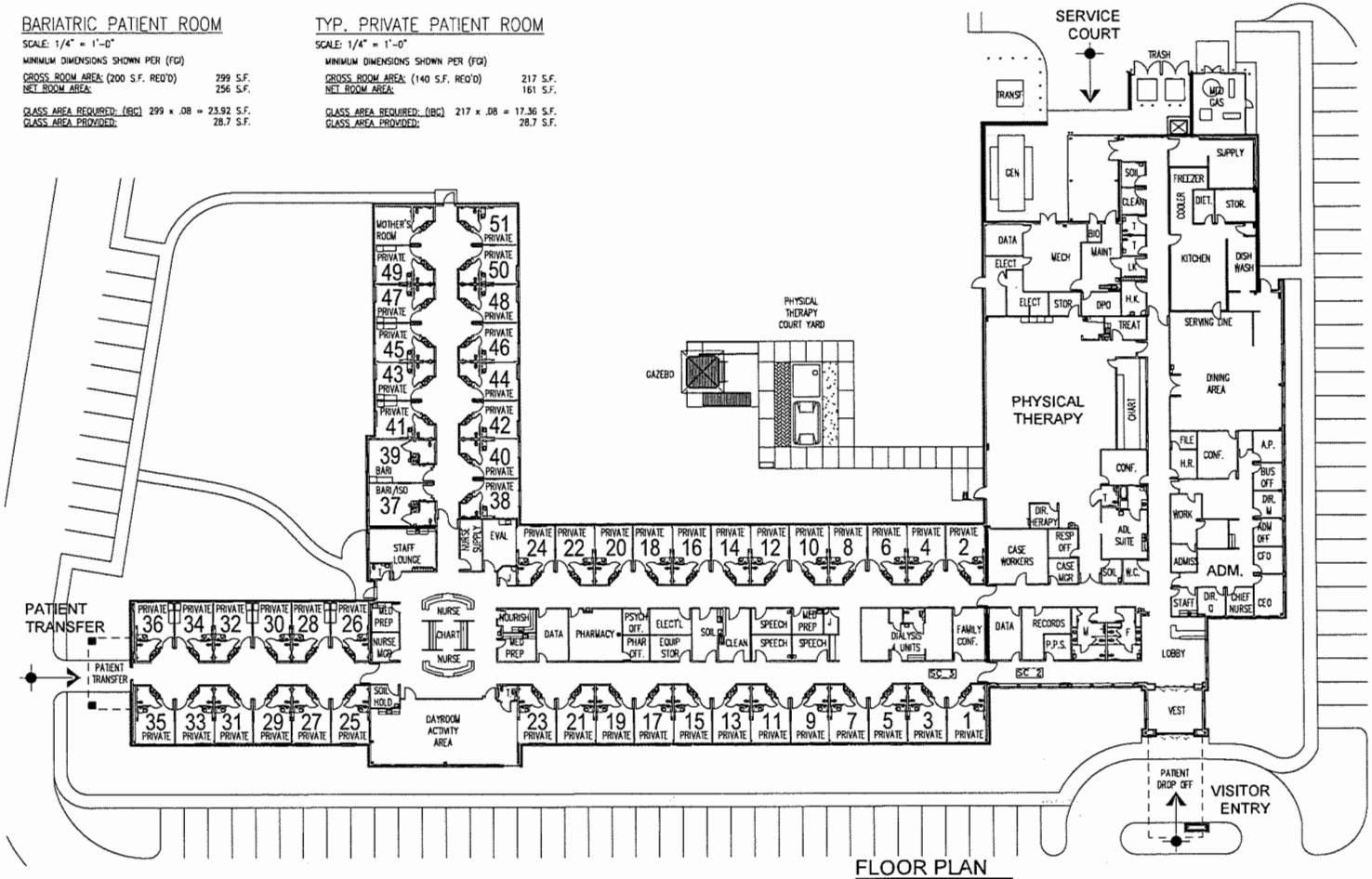
BUILDING AREA

ONE STORY 54,400 GSF

APPLICABLE CODES

- 2018 IBC INTERNATIONAL BUILDING CODE.
- 2018 ADA INTERNATIONAL ACCESSIBILITY CODE.
- 2018 IMC INTERNATIONAL MECHANICAL CODE.
- 2018 IPC INTERNATIONAL PLUMBING CODE.
- 2018 IFGC INTERNATIONAL FUEL GAS CODE.
- 2017 NEC NATIONAL ELECTRIC CODE.
- 2018 IFC INTERNATIONAL FIRE CODE.
- 2018 IEC INTERNATIONAL ENERGY CODE.

- 2018 GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTHCARE FACILITIES (FGI)
- 2012 NFPA 101 LIFE SAFETY CODE



FLOOR PLAN
51 PRIVATE BED REHABILATATION HOSPITAL

FREDERICK & ASSOCIATES ARCHITECTS
330 SOUTH PINEAPPLE AVENUE
SARASOTA, FLORIDA 34236
941. 366.3231

REHABILITATION HOSPITAL of KNOX COUNTY LLC., WEST

01 JULY '20

FLOOR PLAN
51 PRIVATE BED REHABILATION HOSPITAL

A-6B2

Attachment, Section 12-A:

Architect and Construction Letter

FREDERICK & ASSOCIATES

ARCHITECTS

July 1, 2020

Mr. Lawrence Whatley
Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242

RE: Rehabilitation Hospital of Knox County, LLC: (West)
Knoxville, Tennessee

Dear Mr. Whatley,

As part of the Certificate of Need process, please accept this letter of verification for construction cost and code compliance for the development of a 51-bed freestanding inpatient rehabilitation hospital in Knox County, Tennessee.

The new hospital is expected to be 54,400 square feet and we estimate construction costs, for the building and site (excluding equipment and design fees), will be $19,403,166.00 which is $356.68 per square foot. Based upon our experience, we believe that the construction cost for this project is reasonable and consistent with construction costs for similar facilities in this region.

The project will be designed and construction documents prepared to adhere to all current applicable codes of the State of Tennessee Division of Health Facilities Construction, and all authorities having jurisdiction. The Tennessee Building Codes currently include;

- 2018 IBC International Building, Plumbing, Mechanical, & Gas codes.
- 2018 IEC International Energy Conservation code.
- 2017 NEC National Electrical Code.
- 2018 IFC International Fire Code
- 2012 NFPA 101 Life Safety Code.
- 2018 ADA International Accessibility Code.
- 2018 FGI Guidelines for Design and Construction of Health Care Facilities.

The physical environment also conforms to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or comparable document in current use by the licensing authority.

We are pleased to assist you and Encompass Health in maintaining high standards of quality in design and operation of your facility.

Sincerely,

Fred C. Frederick, AIA
Principal

Cc; File

Frederick & Associates- Architects, Inc.
330 S. Pineapple Ave. - Suite 204 - Sarasota, Florida 34236 - 941.366.3231

Attachment, Section B-Need-4A/B:

Service Area Population, Demographics, and TennCare

Attachment: Service Area Population, Demographics, and TennCare
(CON Section B-Need-4.A/B)

Demographic Variable / Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year 2020	Total Population-Projected Year 2024	Total Population-% Change	Target Population-Current Year 2020 (Age 65+ Population)	Target Population-Projected Year 2024 (Age 65+ Population)	Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level *	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total Population
Knox County	472,696	488,136	3.3%	78,423	86,835	10.7%	17.8%	37.3	$54,437	62,396 *	13.2%	76,998	16.3%
Sevier County	102,302	107,574	5.2%	21,123	23,795	12.7%	22.1%	42.7	$45,943	14,220 *	13.9%	20,228	19.8%
Loudon County	54,039	56,310	4.2%	15,007	16,565	10.4%	29.4%	47.5	$56,078	4,918 *	9.1%	8,819	16.3%
Blount County	134,265	139,337	3.8%	28,617	32,011	11.9%	23.0%	43.4	$54,140	13,292 *	9.9%	21,366	15.9%
Anderson County	77,227	78,241	1.3%	16,662	18,079	8.5%	23.1%	43.3	$49,376	12,742 *	16.5%	16,467	21.3%
Service Area Total	*840,529*	*869,598*	*3.5%*	*159,832*	*177,285*	*10.9%*	*20.4%*	*42.8*	*$51,995*	*107,568*	*12.8%*	*143,878*	*17.1%*
State of TN Total	6,883,347	7,097,353	3.1%	1,189,428	1,318,822	10.9%	18.6%	38.9	$50,972	1,053,152 *	15.3%	1,421,442	20.7%

Source Notes:

- Projected Population Data: HSDA Staff and TDH, Division of Health Planning, Office of Informatics and Analytics (Data Available in June 2020)
- US Census Bureau: https://data.census.gov and https://www.census.gov (Data available in June 2020)
- TennCare Enrollment Data: https://www.tn.gov/tenncare/information-statistics/enrollment-data.html (Data Available in June 2020)

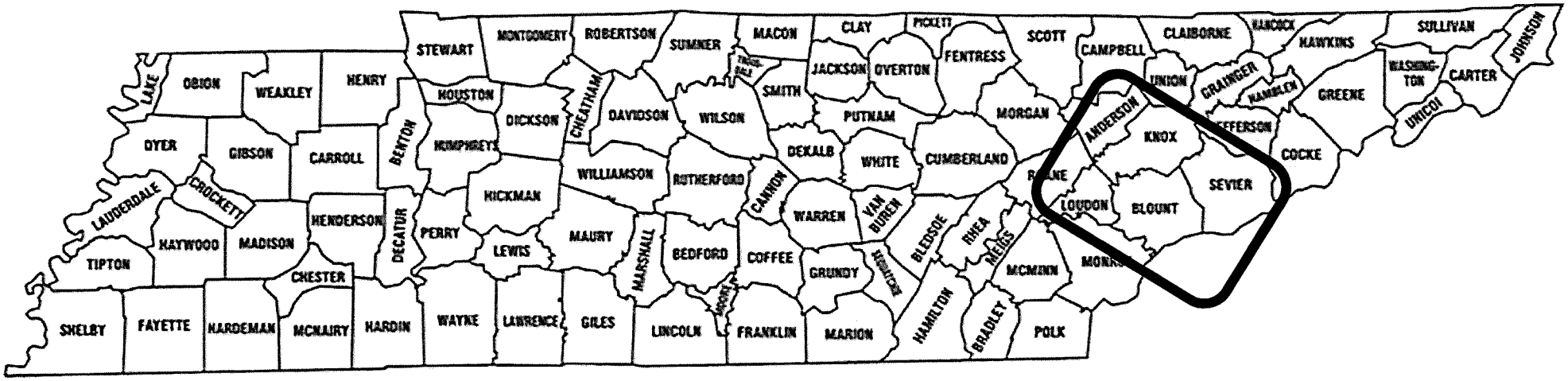
* *Calculation Note: Most Recent TN Department of Health Total Population Estimate x Most Recent US Census Bureau Estimated Poverty %*

Attachment:

Service Area Map

Project Service Area Map – Five (5) Counties in East Tennessee

(Knox, Anderson, Loudon, Sevier, Blount)



Attachment, Section B-Need-IRF Criteria 5:

Quality Considerations

First Quarter 2020

CMS Measure ID	Measure	National Average	PNRC	Facility Performance Category	Reporting Period
I001.01	Pressure Ulcer	0.6%	0.5% *	N/A	10/1/17 – 9/30/18
I013.01	Application of Falls	0.1%	0.0%	N/A	10/1/18 – 9/30/19
I008.02	Application of Functional Assessment	99.8%	100%	N/A	10/1/18 – 9/30/19
I006.01	CAUTI	1.152	** (7) see below	N/A	7/1/18 – 6/30/19
I015.01	CDI	0.570	0.187 (0.009, 0.922) **	Better than National Benchmark	7/1/18 – 6/30/19
I016.01	HCP Influenza Vaccine	88.3%	98.6%	N/A	7/1/17 – 6/30/18
I017.07	PPR 30-Day	6.22%	6.43% (5.21%, 7.85%) ***	No Different than National Benchmark	10/1/16 – 9/30/18
I018.01	PPR Within Stay	4.26%	3.55% (2.49%, 4.89%) ***	No Different than National Benchmark	10/1/16 – 9/30/18
I019.01	DTC	65.42%	57.85% (53.86, 61.84) ****	Worse than National Rate	10/1/16 – 9/30/18
I020.01	MSPB	1.01	0.96	N/A	10/1/16 – 9/30/18

* Facility Risk-Adjusted Percent

**Ratio of Reported to Predicted Infections

(7) Results cannot be calculated for this reporting period

*** Risk-Standardized Readmission Rate

****Risk-Standardized Discharge to Community Rate

Data Source: IQIES Report: IRF Provider Preview (Report Release Date 3/2/2020)

Fourth Quarter 2019

CMS Measure ID	Measure	National Average	PNRC	Facility Performance Category	Reporting Period
I001.02	Pressure Ulcer	0.6%	0.5% *	N/A	10/1/17 – 9/30/18
I013.01	Application of Falls	0.2%	0%	N/A	7/1/18 – 6/30/19
I008.01	Application of Functional Assessment	99.8%	100%	N/A	7/1/18 – 6/30/19
I006.01	CAUTI	1.156	0.987 (0.049, 4.869) **	No different than National Benchmark	4/1/18 – 3/31/19
I015.01	CDI	0.612	0.188 (0.009, 0.929) **	Better than National Benchmark	4/1/18 – 3/31/19
I016.01	HCP Influenza Vaccine	88.3%	98.6	N/A	7/1/17 – 6/30/18
I017.01	PPR 30-Day	6.22%	6.43% (5.21%, 7.85%) ***	No Different than National Benchmark	10/1/16 – 9/30/18
I018.01	PPR Within Stay	4.26%	3.55% (2.49%, 4.89%) ***	No Different than National Benchmark	10/1/16 – 9/30/18
I019.01	DTC	65.42%	57.85% (53.86%, 61.84%) ****	Worse than National Rate	10/1/16 – 9/30/18
I020.01	MSPB	1.01	0.96	N/A	10/1/16 – 9/30/18

* Facility Risk-Adjusted Percent

** Ratio of Reported to Predicted Infections

*** Risk-Standardized Readmission Rate

****Risk-Standardized Discharge to Community Rate

Data Source: IQIES Report: IRF Provider Preview (Report Release Date 12/9/2019)

Third Quarter 2019

CMS Measure ID	Measure	National Average	PNRC	Facility Performance Category	Reporting Period
I001.02	Pressure Ulcer	0.6%	0.5% *	N/A	10/1/17 – 9/30/18
I013.01	Application of Falls	0.1%	0.0%	N/A	4/1/18 – 3/31/19
I008.01	Application of Functional Assessment	99.8%	100%	N/A	4/1/18 – 3/31/19
I006.01	CAUTI	1.171	** (7) see below	N/A	1/1/18 – 13/31/18
I015.01	CDI	0.640	0.00 **	Better than National Benchmark	1/1/18 – 12/31/18
I016.01	HCP Influenza Vaccine	88.3%	98.6%	N/A	7/1/17 – 6/30/18
I017.01	PPR 30-Day	6.22%	6.43% (5.21, 7.85%) ***	No Different than National Rate	10/1/16 – 9/30/18
I018.01	PPR Within Stay	4.26%	3.55% (2.49%, 4.89%) ***	No Different than National Rate	10/1/16 – 9/30/18
I019.01	DTC	65.42%	57.85% ****	Worse than National Rate	10/1/16 – 9/30/18
I020.01	MSPB	1.01	0.96	N/A	10/1/16 – 9/30/18

* Facility Risk-Adjusted Percent

** Ratio of Reported to Predicted Infections

(7) Results cannot be calculated for this reporting period

*** Risk-Standardized Readmission Rate

****Risk-Standardized Discharge to Community Rate

Data Source: IQIES Report: IRF Provider Preview (Report Release Date 9/3/2019)

Second Quarter 2019

CMS Measure ID	Measure	National Average	PNRC	Facility Performance Category	Reporting Period
I001.02	Pressure Ulcer	0.6%	0.5% *	N/A	10/1/17 – 9/30/18
I002.01	Patient Influenza Vaccine	93.5%	100%	N/A	7/1/16 – 6/30/17
I013.01	Application of Falls	0.0%	0.2% **	N/A	1/1/18 – 12/31/18
I008.01	Application of Functional Assessment	99.8%	100%	N/A	1/1/18 – 12/31/18
I006.01	CAUTI	1.186	** (7) see below	N/A	10/1/17 – 9/30/18
I014.01	MRSA	0.937	** (7) see below	N/A	10/1/17 – 9/30/18
I015.01	CDI	0.682	0.00 **	Better than National Benchmark	10/1/17 – 9/30/18
I016.01	HCP Influenza Vaccine	87.0%	96.0%	N/A	7/1/16 – 6/30/17
I017.01	PPR 30-Day	6.22%	6.43% (5.21%, 7.85%) ***	No Different than National Rate	10/1/16 – 9/30/18
I018.01	PPR Within Stay	4.26%	3.55% (2.49%, 4.89%) ***	No Different than National Rate	10/1/16 – 9/30/18
I019.01	DTC	65.33%	57.61 (53.64%, 61.62%) ****	Worse than National Rate	10/1/16 – 9/30/18
I020.01	MSPB	1.01	0.96	N/A	10/1/16 – 9/30/18

* Facility Risk-Adjusted Percent

** Ratio of Reported to Predicted Infections

(7) Results cannot be calculated for this reporting period

*** Risk-Standardized Readmission Rate

****Risk-Standardized Discharge to Community Rate

Data Source: IQIES Report: IRF Provider Preview (Report Release Date 6/10/2019)

Quality Measures Table

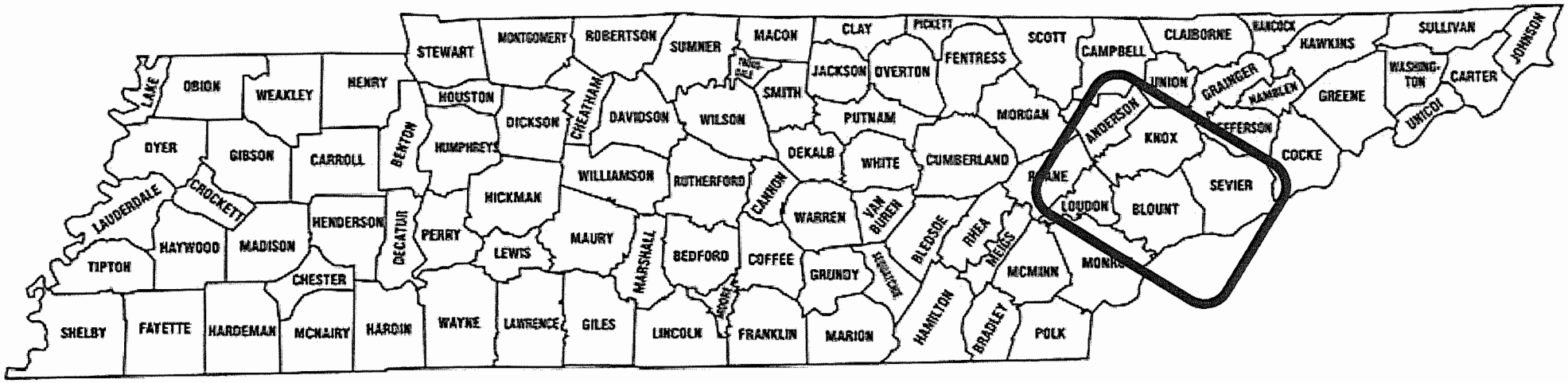
Short Name	Measure Name	Transmission
Pressure Ulcer	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (NQF #0678)	IRF-PAI
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)	IRF-PAI
Application of Functional Assessment	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF # 2631)	IRF-PAI
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF #0138)	NHSN
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF # 1717)	NHSN
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	NHSN
PPR 30-Day	Potentially Preventable 30-Day Post-Discharge Readmission Measure	Claims
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure	Claims
DTC	Discharge to Community	Claims
MSPB	Medicare Spending Per Beneficiary	Claims

Attachment, Section B-Need-3:

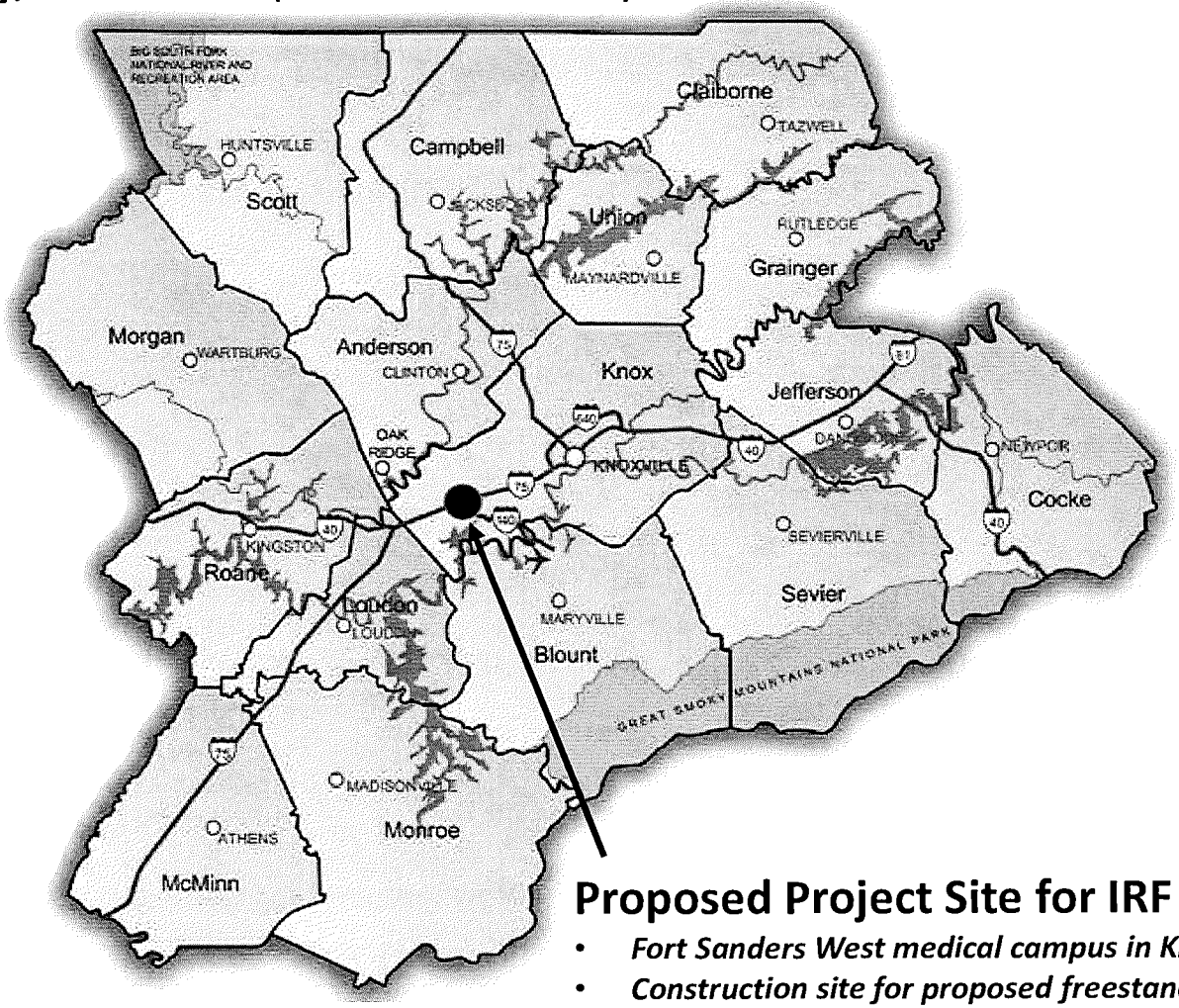
Service Area Maps

Project Service Area Map – Five (5) Counties in East Tennessee

(Knox, Anderson, Loudon, Sevier, Blount)



Knox County, Tennessee (and other nearby counties in East Tennessee)



Proposed Project Site for IRF (West)

- *Fort Sanders West medical campus in Knox County*
- *Construction site for proposed freestanding IRF building*

Attachment, Section B-Need-4A/B:

Service Area Population, Demographics, and TennCare

Attachment: Service Area Population, Demographics, and TennCare
(CON Section B-Need-4.A/B)

Demographic Variable / Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year 2020	Total Population-Projected Year 2024	Total Population-% Change	Target Population-Current Year 2020 (Age 65+ Population)	Target Population-Projected Year 2024 (Age 65+ Population)	Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level *	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total Population
Knox County	**472,696**	**488,136**	**3.3%**	**78,423**	**86,835**	**10.7%**	**17.8%**	**37.3**	**$54,437**	**62,396 ***	**13.2%**	**76,998**	**16.3%**
Sevier County	**102,302**	**107,574**	**5.2%**	**21,123**	**23,795**	**12.7%**	**22.1%**	**42.7**	**$45,943**	**14,220 ***	**13.9%**	**20,228**	**19.8%**
Loudon County	**54,039**	**56,310**	**4.2%**	**15,007**	**16,565**	**10.4%**	**29.4%**	**47.5**	**$56,078**	**4,918 ***	**9.1%**	**8,819**	**16.3%**
Blount County	**134,265**	**139,337**	**3.8%**	**28,617**	**32,011**	**11.9%**	**23.0%**	**43.4**	**$54,140**	**13,292 ***	**9.9%**	**21,366**	**15.9%**
Anderson County	**77,227**	**78,241**	**1.3%**	**16,662**	**18,079**	**8.5%**	**23.1%**	**43.3**	**$49,376**	**12,742 ***	**16.5%**	**16,467**	**21.3%**
Service Area Total	***840,529***	***869,598***	***3.5%***	***159,832***	***177,285***	***10.9%***	***20.4%***	***42.8***	***$51,995***	***107,568***	***12.8%***	***143,878***	***17.1%***
State of TN Total	**6,883,347**	**7,097,353**	**3.1%**	**1,189,428**	**1,318,822**	**10.9%**	**18.6%**	**38.9**	**$50,972**	**1,053,152 ***	**15.3%**	**1,421,442**	**20.7%**

Source Notes:

- Projected Population Data: HSDA Staff and TDH, Division of Health Planning, Office of Informatics and Analytics (Data Available in June 2020)
- US Census Bureau: https://data.census.gov and https://www.census.gov (Data available in June 2020)
- TennCare Enrollment Data: https://www.tn.gov/tenncare/information-statistics/enrollment-data.html (Data Available in June 2020)

* *Calculation Note: Most Recent TN Department of Health Total Population Estimate x Most Recent US Census Bureau Estimated Poverty %*

Attachment, Section B-Need-5:

IRF Healthcare Providers in Service Area

Attachment, Section B-Need-5: IRF Healthcare Providers in Service Area

Historical IRF Data:

IP Rehabilitation Facility (IRF)	Licensed Beds			# IP Admissions			# Inpatient Days			ALOS			% Occupancy		
	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Fort Sanders Regional Medical Center (Patricia Neal Rehab), Knox County	73	73	73	731	697	606	11966	11319	10010	16.4	16.2	16.5	44.9%	42.5%	37.6%
*Tennova - Lakeway Regional Hospital, Hamblen County (Closed 12/18)**	*26*	*26*	*27*	*154*	*137*	*167*	*2150*	*1978*	*2313*	*14.0*	*14.4*	*13.9*	*22.7%*	*20.8%*	*23.5%*
Tennova - Physicians Regional Medical Center, Knox County *(Closed 12/18)*	30	30	30	386	565	521	4944	7220	6425	12.8	12.8	12.3	45.2%	65.9%	58.7%
Total	**129**	**129**	**130**	**1271**	**1399**	**1294**	**19060**	**20517**	**18748**	**15.0**	**14.7**	**14.5**	**40.5%**	**43.6%**	**39.5%**

** Note: Lakeway Regional Hospital was not within project's primary service area; data included for informational purposes since inactive beds are to be relocated as part of CN1903-007*

Source: Tennessee JARs 2016-2018
Schedule D

Approved But Unimplemented IRF Services:

IP Rehabilitation Facility (IRF)	*Inactive Licensed Beds to be Relocated*			*# IP Admissions*			*# Inpatient Days*			*ALOS*			*% Occupancy*		
	2016	*2017*	*2018*	*2016*	*2017*	*2018*	*2016*	*2017*	*2018*	*2016*	*2017*	*2018*	*2016*	*2017*	*2018*
Knoxville Rehabilitation Hospital, Knox County (CN1903-007)	*57*	*57*	*57*	*0*	*0*	*0*	*0*	*0*	*0*	*0.0*	*0.0*	*0.0*	*0.0%*	*0.0%*	*0.0%*

** Note: CN1903-007 was approved by the HSDA in June 2019; the pending project seeks to relocate the 57 combined licensed IRF beds that were operated historically at Tennova's Lakeway Hospital (27 IRF beds) and Tennova's Physicians Regional Medical Center (30 IRF beds); both closed hospitals are included in the Historical IRF Data chart above.*

Source: CN1903-007

See Attachment, Section B-Need-6:

Projected Annual Utilization – IRF Discharges

Attachment, Section B-Need-6: Projected Annual Utilization – IRF Discharges

The IRF utilization projections for the Applicant's companion CON projects were estimated primarily from the acute care patient populations at the Covenant Health hospitals in the Primary Service Area – Fort Sanders Regional Medical Center (Knox), Parkwest Medical Center (Knox), Methodist Medical Center (Anderson), Fort Loudoun Medical Center (Loudon), and LeConte Medical Center (Sevier). The Applicant reviewed 2018 Medicare patient discharge data to estimate the number of patients from these hospitals who could be served by an inpatient rehabilitation hospital if the patients were to qualify for this type of intensive rehabilitation service. The Applicant estimated the need for both the proposed 22-bed HIH (Downtown) and 51-bed freestanding hospital (West) collectively. Therefore, the anticipated utilization for the total number of annual discharges for both projects was analyzed and then split amongst the two projects as appropriate.

The analysis resulted in projections of 1209 discharges in Year 1 and 1571 discharges in Year 2. The conservative projection of 1209 inpatient rehabilitation discharges in Year 1 represents a 2.1% inpatient rehabilitation conversion rate, which is far lower than the statewide average of 3.1%. The projection of 1571 inpatient rehabilitation discharges in Year 2 represents a 2.8% conversion rate, still below the statewide average.

The Applicant and its joint venture partners have significant experience in making these types of projections and have determined that these projections of future utilization are reasonable. Covenant Health has provided inpatient rehabilitation services in the community historically and has garnered a deep knowledge of the market and its patients' needs. As the largest provider of inpatient rehabilitation services in the country, Encompass is able to compare these projections to its operations throughout the country to verify their reasonableness and reliability.

Attachments, Economic Feasibility-Project Cost Chart: Deeds; Letter of Intent to Transfer Property; FMV Letter; Architect & Construction Letter

Covenant HEALTH

July 7, 2020

Mr. Logan Grant
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC ("West")

Dear Mr. Grant:

Covenant Health, through its wholly-owned subsidiary Fortress Corporation, currently owns and has full control of the 8.10 acre site to be used by Rehabilitation Hospital of Knox County, LLC for the "West" project that seeks Agency approval to develop a modern free-standing Inpatient Rehabilitation Facility ("IRF") utilizing 51 existing licensed beds in the service area. The site includes two contiguous parcels of land owned and controlled by Covenant Health, with the primary and larger parcel currently addressed as 10150 Kingston Pike, Knoxville, Tennessee 37922. Appropriate documentation regarding the property to be used for the proposed project will be included with the CON application via attachment as required, including both deeds and documentation of a recent FMV appraisal of the site by a credible third party who valued the 8.10 acre site at $ 3,700,000.

Please allow this letter to memorialize the intent of Covenant Health to contribute the two contiguous parcels of land and transfer ownership of the same to Rehabilitation Hospital of Knox County, LLC should the certificate of need request for the IRF be approved. The value of the land to be contributed represents a portion of the initial capital outlay for the proposed project that will be provided by Covenant Health as part of its initial contribution as a 50% partner in the joint venture. All transactions related to the proposed project will be subject to appropriate regulatory approvals.

Respectfully,

Ken Tucker
Assistant General Counsel

Corporate Office
100 Fort Sanders West Blvd. • Knoxville, TN 37922
(865) 531-5555 Office (865) 531-5272 Fax

Valbridge
PROPERTY ADVISORS

213 Fox Road
Knoxville, Tennessee 37922
865-522-2424 phone
865-522-0030 fax

1208 Pointe Centre Drive, Suite 211
Chattanooga, TN 37421
865-285-8435

valbridge.com

July 7, 2020

VIA E-Mail Only

M. Douglas Campbell, Jr.
General Counsel
Covenant Health
100 Fort Sanders West Boulevard
Knoxville, Tennessee 37922

Re: 8.10 Acre Development Site
Fort Sanders West Campus
Kingston Pike at Fort Sanders West Boulevard
Knoxville, Tennessee 37922

Dear Mr. Campbell:

At your request, we are pleased to submit this letter is support of your application for a Certificate of Need for a proposed 51-bed rehabilitation hospital on the Fort Sanders West campus. On May 8th, 2020 we performed an appraisal of the 8.10-acre site which is proposed for development of the rehabilitation hospital. Following is a summary of the conclusions developed in that appraisal.

- Date of Appraisal Report: May 8, 2020
- Date of the Value Conclusion: May 8, 2020
- Client & Intended Users: Covenant Health Properties & Encompass Health
- Report Conformity: We developed our analyses, opinions, and conclusions and prepared this report in conformity with the Uniform Standards of Professional Appraisal Practice (USPAP) of the Appraisal Foundation; the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.
- Property Appraised: Tax Parcels 131N-C-018 & part of 131L-A-001.05 consisting of two tracts totaling 8.10 acres.

- Hypothetical Conditions: The appraisal was based on the hypothetical condition that the existing improvements do not exist. We did not factor in the cost to raze the existing office building.
- Property Interest Appraised: Fee Simple
- Estimated Exposure Time: 9 months
- Value Conclusion: $3,700,000 ($10.49 per square foot of land area)

We appreciate this opportunity to be of service. If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Charles W. Benton, MAI, CCIM
Senior Managing Director
Tennessee Certified-General Appraiser #CG-1349

FREDERICK & ASSOCIATES

ARCHITECTS

July 1, 2020

Mr. Lawrence Whatley
Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242

RE: Rehabilitation Hospital of Knox County, LLC: (West)
Knoxville, Tennessee

Dear Mr. Whatley,

As part of the Certificate of Need process, please accept this letter of verification for construction cost and code compliance for the development of a 51-bed freestanding inpatient rehabilitation hospital in Knox County, Tennessee.

The new hospital is expected to be 54,400 square feet and we estimate construction costs, for the building and site (excluding equipment and design fees), will be $19,403,166.00 which is $356.68 per square foot. Based upon our experience, we believe that the construction cost for this project is reasonable and consistent with construction costs for similar facilities in this region.

The project will be designed and construction documents prepared to adhere to all current applicable codes of the State of Tennessee Division of Health Facilities Construction, and all authorities having jurisdiction. The Tennessee Building Codes currently include;

- 2018 IBC International Building, Plumbing, Mechanical, & Gas codes.
- 2018 IEC International Energy Conservation code.
- 2017 NEC National Electrical Code.
- 2018 IFC International Fire Code
- 2012 NFPA 101 Life Safety Code.
- 2018 ADA International Accessibility Code.
- 2018 FGI Guidelines for Design and Construction of Health Care Facilities.

The physical environment also conforms to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or comparable document in current use by the licensing authority.

We are pleased to assist you and Encompass Health in maintaining high standards of quality in design and operation of your facility.

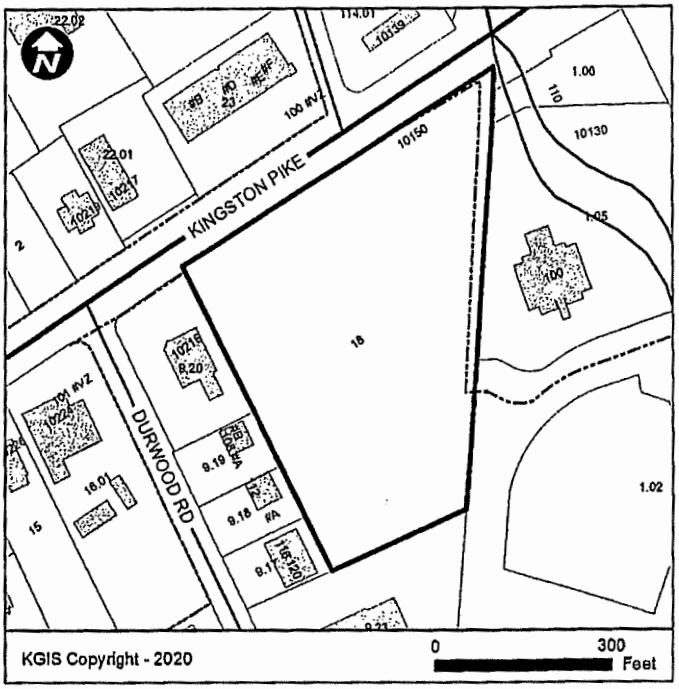
Sincerely,

Fred C. Frederick, AIA
Principal

Cc; File

Frederick & Associates- Architects, Inc.
330 S. Pineapple Ave. - Suite 204 - Sarasota, Florida 34236 - 941.366.3231

Parcel 131NC018 - Property Map and Details Report



Property Information

Parcel ID:	131NC018
Location Address:	10150 KINGSTON PIKE
CLT Map:	131
Insert:	N
Group:	C
Condo Letter:	
Parcel:	18
Parcel Type:	
District:	W6
Ward:	
City Block:	
Subdivision:	
Rec. Acreage:	5.61
Calc. Acreage:	0
Recorded Plat:	-
Recorded Deed:	20160512 - 0065708
Deed Type:	Deed:Gift Deed
Deed Date:	5/12/2016

Address Information

Site Address:	10150 KINGSTON PIKE KNOXVILLE - 37922
Address Type:	UNUSED LAND
Site Name:	

Owner Information

FORTRESS CORPORATION
1420 CENTERPOINT BLVD #BLDG C
KNOXVILLE, TN 37932

The owner information shown in this section does **not** necessarily reflect the person(s) responsible for Last Year's property taxes. Report any errors to the Knox County Property Assessor's office at (865) 215-2365.

Jurisdiction Information

County:	KNOX COUNTY
City / Township:	

MPC Information

Census Tract:	58.07
Planning Sector:	Southwest County

Please contact Knox County Metropolitan Planning Commission (MPC) at (865) 215-2500 if you have questions.

Political Districts

Voting Precinct:	65E	
Voting Location:		Shoreline Church 9635 WESTLAND DR
TN State House:	14	Jason Zachary
TN State Senate:	6	Becky Duncan Massey
County Commission:	5	John Schoonmaker
(at large seat 10)		Larsen Jay
(at large seat 11)		Justin Biggs
School Board:	5	Susan Horn

Please contact Knox County Election Commission at (865) 215-2480 if you have questions.

School Zones

Elementary:	FARRAGUT PRIMARY
Intermediate:	FARRAGUT INTERMEDIATE
Middle:	FARRAGUT MIDDLE
High:	FARRAGUT HIGH

Please contact Knox County Schools Transportation and Zoning Department at (865) 594-1550 if you have questions.

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PROPERTY ASSESSOR'S OFFICE - KNOX COUNTY, TENNESSEE
MAP DEPARTMENT - OWNERSHIP CARD

Source: KGIS

ACTIVE NORMAL 07/02/2020

District	Map	Insert	Group	Parcel	Ward	Property Location
W6	131	N	C	18		10150 KINGSTON PIKE

Subdivision	Block	Lot	Plat	Dimensions (shown in ft.)	Acreage
	-	-	-	603 X 750 X IRR	5.61 - A.C. Deeded
					0.00 - A.C. Calculated

Owner	Sale Date	Book	Page	Sale Price	Mailing Address
FITZGERALD J B & LUCILE W	6/23/1954	951	599		2055 CHRISTUS WAY CONCORD, TN 37922
FORTRESS CORPORATION	5/10/2016	20160511	0065460	$ 1,750,000	1420 #BLDG C CENTERPOINT BLVD KNOXVILLE, TN 37932-1960
	5/10/2016	20160512	0065708		

Remarks

ATTRIBUTES FROM NCR LOADER

Parent Parcel	Parent Instrument Number

Previous Parcel (Split From)	Next Parcel (Merged Into)

https://www.kgis.org/parcelreports/ownercard.aspx?id=131NC018

131NC018

OWNER/RESPONSIBLE TAXPAYER:
Fortress Corporation Attn: Corp. Finance
1420 Center Point Blvd. Bldg C
Knoxville TN 37932
Map 131N, Group C, Parcel 018.00

THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 160539 (BMD)

WARRANTY DEED

THIS INDENTURE made as of this 10 day of May, 2016, between **LYLAN SHEPHERD-FITZGERALD and BRONCE M. FITZGERALD,** First Parties, and **FORTRESS CORPORATION, a Tennessee corporation,** Second Party:

W I T N E S S E T H

THAT SAID FIRST PARTY, for and in consideration of the sum of **TEN AND NO/100 ($10.00) DOLLARS,** and other good and valuable consideration, to them in hand paid by said Second Party, the receipt of which is hereby acknowledged, have granted, bargained, sold and conveyed, and do by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein. **TO HAVE AND TO HOLD** the same unto the Second Party, its successors and assigns forever.

AND SAID FIRST PARTIES, for themselves and their heirs, representatives, successors and assigns, do hereby covenant with said Second Party, its successors and assigns, that they are lawfully seized in fee simple of the premises above conveyed and have full power, authority and right to convey the same, and that said premises are free from all encumbrances except applicable restrictions, easements and building setback lines as are shown in the records of the Knox County Register of Deeds Office, any matter and/or condition which would be disclosed by a current, accurate survey or inspection of the property herein described, and 2016 taxes, which shall be prorated as of the date of closing and which Second Party assumes and agrees to pay (the "Encumbrances"), and that they will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever, except as to the Encumbrances.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, or the masculine, feminine or neuter gender, as the case may demand.

Knox County Page: 1 of 4
REC'D FOR REC 05/11/2016 4:00:07PM
RECORD FEE: $23.00
M. TAX: $0.00 T. TAX: $6,475.00
20160511006546O

COUNTERSIGNED
KNOX COUNTY PROPERTY ASSESSOR
MAY 11 2016
BY PHIL BALLARD

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

IN WITNESS WHEREOF, the said First Parties hereunder have executed this instrument as of the day and year first above written.

Lylan Shepherd-Fitzgerald
LYLAN SHEPHERD-FITZGERALD

BRONCE M. FITZGERALD

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **LYLAN SHEPHERD-FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that she executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10 day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **BRONCE M. FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that he executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10 day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

Page: 2 OF 4
201605110065460

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

I hereby swear or affirm that the actual consideration or true value of this transfer, whichever is greater, is $ 1,750,000.00.

C Renee Oates agent

Affiant

Subscribed and sworn to before me this 11th day of May, 2016.

Sandra Bright

Notary Public

My Commission Expires: 2/5/2017

SANDRA BRIGHT
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 2-5-2017
KNOX COUNTY

Page: 3 OF 4
201605110065460

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\WD.doc

EXHIBIT "A"

SITUATED in District No. Six (6) of Knox County, Tennessee, lying on the south side of Kingston Pike or US Highway 70, and more particularly described as follows:

BEGINNING at an iron pin marking the northeastern corner of the property herein conveyed and the northwestern corner of Reynolds running thence South 4 deg. 41 min. West, 750.9 feet to an iron pin; thence South 67 deg. 54 min. West, 243.5 feet to an iron pin; Thence North 22 deg. 57 min. West, 577.1 feet to an iron pin in the south line of said US Highway 70; thence North 59 deg. 07 min. East, 603.98 feet to the **POINT OF BEGINNING**, containing 5.61 acres, more or less.

BEING the same property conveyed to J.B. Fitzgerald and wife, W. Lucile Fitzgerald, by Warranty Deed from J.K. Bondurant and wife, Evelyn B. Bondurant, and Anna Belle Boring, dated June 23, 1954, filed for record in Warranty Book 951, page 599 in the Knox County Register of Deeds Office. See Affidavit of Heirship filed for record herewith as Instrument No. 201605110065459, in the Knox County Register of Deeds Office.

TOGETHER WITH easement granted in Drainage Easement Agreement by and between Fortress Corporation, a Tennessee corporation, and Bronce Fitzgerald and Lylan Fitzgerald, dated as of May 6, 2015, filed for record as Instrument No. 201507310006929 in the Knox County Register of Deeds Office.

FURTHER TOGETHER WITH, but without warranty, all right, title and interest of First Parties in and to roads, easements and any strips or gores of land adjacent to, abutting or adjoining the property described above on all sides thereof.

Page: 4 OF 4
201605110065460

131NC 018

OWNER/RESPONSIBLE TAXPAYER:
Fortress Corporation Attn. Corp. Finance
1420 Center Point Blvd. BLDG. C
Knoxville TN 37932
Map 131NC Group C Parcel 018.00

THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 160539 (BMD)

COUNTERSIGNED
KNOX COUNTY PROPERTY ASSESSOR
MAY 12 2016
BY PHIL BALLARD

Sherry Witt
Register of Deeds
Knox County

QUITCLAIM DEED

THIS INDENTURE made as of this 10th day of May, 2016, between **LYLAN SHEPHERD-FITZGERALD and BRONCE M. FITZGERALD,** First Parties, and **FORTRESS CORPORATION, a Tennessee corporation,** Second Party:

WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of **ONE AND NO/100 ($1.00) DOLLAR,** and other good and valuable consideration, to them in hand paid by said Second Party, the receipt of which is hereby acknowledged, have bargained, sold, remised, released and **QUITCLAIMED,** and do by these presents bargain, sell, remise, release and **QUITCLAIM** unto Second Party all of First Parties' right, title and interest in and to the following described premises, to-wit:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to the said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said First Parties have executed this instrument as of the day and year first above written.

Lylan Shepherd-Fitzgerald
LYLAN SHEPHERD-FITZGERALD

Bronce M. Fitzgerald
BRONCE M. FITZGERALD

Knox County Page: 1 of 4
REC'D FOR REC 05/12/2016 2:55:29PM
RECORD FEE: $22.00
M. TAX: $0.00 T. TAX: $0.00
201605120065708

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\QCD.doc

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **LYLAN SHEPHERD-FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that she executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10th day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

STATE OF TENNESSEE)
) SS
COUNTY OF KNOX)

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State **BRONCE M. FITZGERALD,** the within named bargainor, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence and who, upon oath, acknowledged that he executed the within instrument for the purposes therein contained.

WITNESS my hand and official seal, this 10th day of May, 2016.

Carmen Renee Orth
Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

Page: 2 OF 4
201605120065708

I hereby swear or affirm that the actual consideration of this transfer is $-0-.

Affiant

Subscribed and sworn to before me this 10th day of May, 2016.

Notary Public

My Commission Expires: 5-6-18

CARMEN RENEE ORTH
STATE OF TENNESSEE NOTARY PUBLIC
Comm. Exp. 5-6-2018
KNOX COUNTY

Page: 3 OF 4
201605120065708

H:\sforte\2016 Files\160539 Fortress (10150 Kingston Pike)\QCD.doc

EXHIBIT "A"

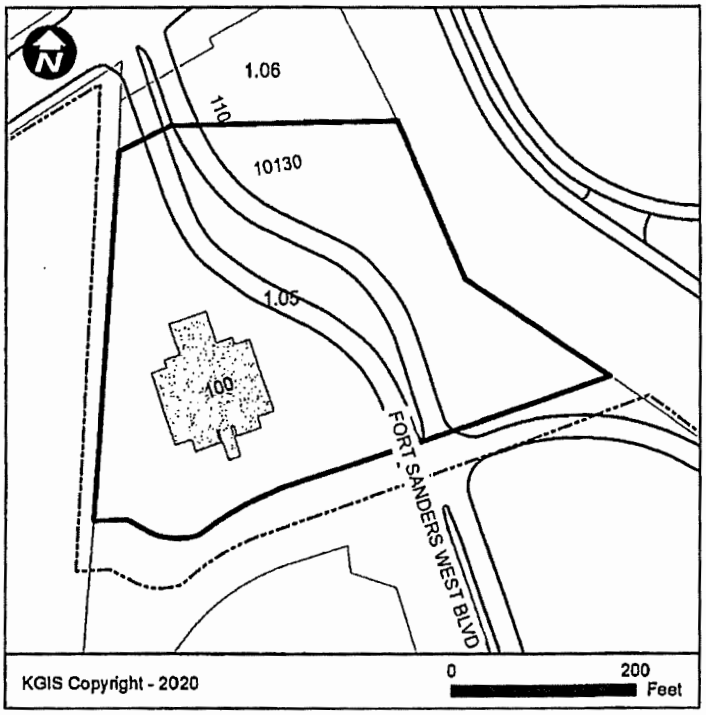
SITUATED in the Sixth (6th) Civil District of Knox County, Tennessee, without the corporate limits of the City of Knoxville, Tennessee, being 5.71 acre, more or less, tract located on the south side of Kingston Pike, and being more particularly bounded and described as follows:

BEGINNING at an iron pin found in the southerly right of way line of Kingston Pike, said iron pin being located in a easterly direction along said right of way line 151.89 feet from its point of intersection with the easterly right of way line of Durwood Road, said iron pin being located 40 feet in a southerly direction from the centerline of Kingston Pike; thence from said point of beginning, and with the southerly right of way line of Kingston Pike, North 67 deg. 33 min. 00 sec. East, 595.22 feet to an iron pin found; thence, continuing with the right of way line of Kingston Pike, and passing an iron pin found at a highway monument and then with the line of property now or formerly belonging to Fort Sanders Corp, South 13 deg. 15 min. 52 sec. West, 81.37 feet to an iron pin with cap found; thence with Fort Sanders West, South 13 deg. 19 min. 41 sec. West, 660.81 feet to an iron pipe found, said iron pipe marking common corner to property herein described and property (Lot 6 David Park Subdivision) now or formerly belonging to First Utility District (WB 1699, page 228); thence with the line of First Utility District, South 76 deg. 12 min. 00 sec. West, 242.97 feet to an iron pipe found, said iron pipe marking common corner between property herein described and Lot 5 in David Park Subdivision (Instrument No. 197808210032963); thence with the line of David Park Subdivision, and then for a short distance with the right of way line of Kingston Pike, North 14 deg. 31 min. 00 sec. West, 571.10 feet to the iron pin marking the **POINT OF BEGINNING,** as shown by survey of Richard E. LeMay, Surveyor, Tennessee RLS No. 769, dated May 10, 2016, bearing Drawing No. 5124. Surveyor's Address: LeMay & Associates, 10816 Kingston Pike, Knoxville, TN 37922.

FOR SOURCE OF TITLE see deed filed for record in Warranty Book 951, page 599 in the Knox County Register of Deeds Office. **SEE ALSO** Affidavit of Heirship filed for record herewith as Instrument No. 201605110065459 in the Knox County Register of Deeds Office.

Page: 4 OF 4
201605120065708

Parcel 131LA00105 - Property Map and Details Report



Property Information

Parcel ID:	131LA00105
Location Address:	100 FORT SANDERS WEST BLVD
CLT Map:	131
Insert:	L
Group:	A
Condo Letter:	
Parcel:	1.05
Parcel Type:	
District:	
Ward:	47
City Block:	46349
Subdivision:	ANX (99) 0-130-98
Rec. Acreage:	0
Calc. Acreage:	4.59
Recorded Plat:	-
Recorded Deed:	20010514 - 0078605
Deed Type:	Deed:Gift Deed
Deed Date:	5/14/2001

Address Information

Site Address:	100 FORT SANDERS WEST BLVD KNOXVILLE - 37922
Address Type:	BUSINESS
Site Name:	COVENANT HEALTH CORP OFFICE

Owner Information

FORTRESS CORP LSD TO FORTSANDERS WEST
1420 CENTERPOINT BLVD
BLDG C
KNOXVILLE, TN 37932

The owner information shown in this section does **not** necessarily reflect the person(s) responsible for Last Year's property taxes. Report any errors to the Knox County Property Assessor's office at (865) 215-2365.

Jurisdiction Information

County:	KNOX COUNTY
City / Township:	Knoxville

MPC Information

Census Tract:	58.07
Planning Sector:	Southwest County

Please contact Knox County Metropolitan Planning Commission (MPC) at (865) 215-2500 if you have questions.

Political Districts

Voting Precinct:	65E	
Voting Location:		Shoreline Church 9635 WESTLAND DR
TN State House:	14	Jason Zachary
TN State Senate:	6	Becky Duncan Massey
County Commission:	5	John Schoonmaker
(at large seat 10)		Larsen Jay
(at large seat 11)		Justin Biggs
City Council:	2	Andrew Roberto
(at large seat A)		Lynne Fugate
(at large seat B)		Janet Testerman
(at large seat C)		Amelia Parker
School Board:	5	Susan Horn

Please contact Knox County Election Commission at (865) 215-2480 if you have questions.

School Zones

Elementary:	FARRAGUT PRIMARY
Intermediate:	FARRAGUT INTERMEDIATE
Middle:	FARRAGUT MIDDLE
High:	FARRAGUT HIGH

Please contact Knox County Schools Transportation and Zoning Department at (865) 594-1550 if you have questions.

Disclaimer: KGIS makes no representation or warranty as to the accuracy of this map and its information nor to its fitness for use. Any user of this map product accepts the same AS IS, WITH ALL FAULTS, and assumes all responsibility for the use thereof, and further covenants and agrees to hold KGIS harmless from any damage, loss, or liability arising from any use of the map product. Independent verification of all information contained on this map should be obtained by any user.

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PROPERTY ASSESSOR'S OFFICE - KNOX COUNTY, TENNESSEE

MAP DEPARTMENT - OWNERSHIP CARD

Source: KGIS

ACTIVE NORMAL

07/02/2020

District	Map	Insert	Group	Parcel	Ward	Property Location
	131	L	A	1.05	47	100 FORT SANDERS WEST BLVD

Subdivision	Block	Lot	Plat	Dimensions (shown in ft.)	Acreage
ANX (99) 0-130-98	-	-	-	450 X 180 X IRR	0.00 - A.C. Deeded
					4.59 - A.C. Calculated

Owner	Sale Date	Book	Page	Sale Price	Mailing Address
FORT SANDERS ALLIANCE LSD TO THE PROMETHEAN CO SUB LSD TO FORT SANDERS WEST INC - SUITE 109	6/1/1987	T2330	739		280 #STE 214 FORT SANDERS WEST BV KNOXVILLE, TN 37934
	12/21/1987	1935	588		
	12/29/1987	T2330	745		
	7/25/1988	1953	376		1420 #BLDG C CENTERPOINT BLVD KNOXVILLE, TN 37932-1960
FORTRESS CORP LSD TO FORTSANDERS WEST	4/17/2000	20010514	0078605		1420 CENTERPOINT BLVD BLDG C KNOXVILLE, TN 37932-1960

Remarks

ANX (99) 0-130-98 ADD

Parent Parcel	Parent Instrument Number

Previous Parcel (Split From)	Next Parcel (Merged Into)
131LA00101	

COUNTERSIGNED

131NC-9.14 -Tract 11 -(Lot 8)

MAY 1 4 2001

JOHN R. WHITESIDE
KNOX COUNTY
PROPERTY ASSESSOR
BY

OWNER/RESPONSIBLE TAXPAYER:	THIS INSTRUMENT PREPARED BY:
Covenant Health Suite 109, 280 Fort Sanders West Boulevard Knoxville, Tennessee 37922 Tax I.D. No.: _____	M. Douglas Campbell, Jr., Esq. Wagner, Myers and Sanger, P.C. 1801 First Tennessee Plaza Knoxville, Tennessee 37929

QUITCLAIM DEED
(CORPORATION)

THIS INDENTURE made this 17th day of April, 2000, between **COVENANT HEALTH**, a Tennessee non-profit corporation, First Party, and **FORTRESS CORPORATION**, a Tennessee corporation, Second Party:

WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of ONE DOLLAR ($1.00), and for other good and valuable consideration, the receipt and legal sufficiency of all of which is hereby acknowledged, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has granted, bargained, sold and conveyed, and does by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

BEING the same property conveyed to Fort Sanders Alliance from Consumer's Wholesale, Inc. by Warranty Deed dated November 30, 1986 of record in Book 1900, Page 522 in the Knox County Register of Deeds Office, as amended by Deed of Correction dated December 27, 1987 of record in Book 1935, Page 588 in the Knox County Register of Deeds Office, and as further amended by Deed of Correction dated July 25, 1988 of record in Book 1953, Page 376 in the Knox County Register of Deeds Office, and from Fred J. Byerley and wife, Martha E. Byerley by Warranty Deed dated December 29, 1986 of record in Book 1903, Page 63 in the Knox County Register of Deeds Office. Fort Sanders Alliance was merged into Covenant Health, successor by corporate name change to Tennessee Healthcare System, on September 9, 1996 of record in Book CH 126, Page 941 of the Knox County Register of Deeds Office.

THIS CONVEYANCE is made subject to any and all applicable restrictions, easements and building setback lines as are shown in the records of the Knox County Register's Office.

with the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

IN WITNESS WHEREOF, the said First Party has caused this instrument to be executed the day and year first above written.

COVENANT HEALTH,
a Tennessee non-profit corporation

By: Calan C. Gray

Its: President

H:\WPFILES\2744\198\QTCLDD2.WPD

Instr:200105140070005 Page: 1 OF 4
REC'D FOR REC 05/14/2001 11:17:05AM
RECORD FEE: $18.00
M. TAX: $0.00 T. TAX: $0.00

State Of Tennessee)
)
County Of Knox)

Before me Tamara Hill, of the state and county mentioned, personally appeared Alan C. Guy with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be the President of **Covenant Health**, a Tennessee non-profit corporation, the within named bargainor, and that he as such President, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as President.

Witness my hand and seal, at office in Knoxville, this 17TH day of April, 2000.

Tamara Anne Hill
NOTARY PUBLIC

My Commission Expires: 1-02-01

I hereby swear or affirm that the actual consideration or true value of this transfer, whichever is greater, is $ -0- .

Alan C. Guy
Affiant

Subscribed and sworn to before me this 17TH day of April, 2000.

Tamara Anne Hill
Notary Public

My Commission Expires: 1-02-01

THE PREPARER OF THIS DEED HAS NOT BEEN REQUESTED BY THE PARTIES AND HAS NOT CONDUCTED AN EXAMINATION OF THE STATUS OF THE TITLE TO THE PROPERTY DESCRIBED IN THIS QUITCLAIM DEED, AND THEREFORE MAKES NO REPRESENTATIONS OR WARRANTIES OF ANY KIND OR NATURE WHATSOEVER AS TO THE STATUS OF TITLE TO SAID PROPERTY.

THE PROPERTY DESCRIPTION ATTACHED TO THIS DEED WAS TAKEN FROM THE PRIOR DEED OF CONVEYANCE, NO BOUNDARY SURVEY HAVING BEEN CONDUCTED AT THE TIME OF OR IN CONNECTION WITH THE CONVEYANCE HEREBY CONTEMPLATED.

131LA-001 & 001.01
(part)

TRACT I

SITUATED in District No. Six (6) of Knox County, Tennessee, without the corporate limits of the City of Knoxville, and being a portion of Lot 21 and a part of an unnumbered sometimes referred to as Lot 1 in the Mrs. J. S. Reynold's Subdivision as shown on map of record in Map Book 17, page 168, in the Knox County Register's Office, and being more fully described as follows:

TO FIND THE POINT OF BEGINNING, commence at an existing right-of-way monument in the South line of Kingston Pike at the Northwest corner of Lot 21 of the Mrs. J. S. Reynold's Subdivision; thence leaving Kingston Pike, South 6 deg. 40 min. West, 105 feet to an iron pin marking the point of BEGINNING herein, said point of BEGINNING being in the South right-of-way of the relocated Kingston Pike in the proposed Pellissippi Parkway Extension; thence with the Southern and Western distances as follows: North 64 deg. 34 min. East, 90 feet to an iron pin; thence North 84 deg. 44 min. 30 sec. East, 230 feet to an iron pin; thence South 19 deg. 23 min. 38 sec. East, 180 feet to an iron pin; thence South 51 deg. 53 min. 13 sec. East, 295.82 feet to an iron pin; thence South 50 deg. 41 min. 19 sec. East, 124.36 feet to an iron pin; thence South 39 deg. 21 min. 42 sec. East, 552.56 feet to an iron pin; thence South 13 deg. 21 min. 57 sec. East, 480.10 feet to an iron pin; thence South 17 deg. 16 min. 53 sec. East, 649.69 feet to an iron pin in a fence line; thence with said fence line, South 67 deg. 05 min. 23 sec. West, 1,659.79 feet to an iron pin in the line of Third National Bank; thence with the line of Third National Bank and with a fence line, five (5) calls and distances as follows: North 2 deg. 47 min. West, 183.80 feet to an iron pin; thence North 0 deg. 39 min. West, 304.66 feet to an iron pin; thence North 11 deg. 26 min. West, 75.35 feet to an iron pin; thence South 62 deg. 05 min. 08 sec. West, 11.27 feet to an iron pin; thence North 3 deg. 54 min. 45 sec. East, 57.29 feet to an iron pin corner to property of Jenkins; thence with said line, North 5 deg. 40 min. 45 sec. East, 375.05 feet to an iron pin corner to Ravenwood Subdivision; thence with said line, North 5 deg. 52 min. 31 sec. East, 410.12 feet to an iron pin corner to Byerley; thence with said line, North 6 deg. 12 min. 33 sec. East, 197.57 feet to a one-inch iron pipe, corner to Lot 7 of David Park Subdivision; thence with the line of Lot 7, North 6 deg. 24 min. 34 sec. East, 159.90 feet to an iron pin, corner to Lot 6; thence with the line of Lot 6, North 6 deg. 19 min. 20 sec. East, 149.99 feet to an iron pin, corner to property of Fitzgerald; thence with the line of Fitzgerald, North 5 deg. 40 min. East, 537.01 feet to the point of BEGINNING, as shown by survey of Sizemore-Lynch & Associates, dated August 1, 1986, and last revised on December 2, 1986.

THERE IS ALSO CONVEYED HEREWITH a non-exclusive permanent easement for ingress and egress and the placement of utility services in locations to be determined in the sole discretion of the Grantee herein, in, upon and over the following described property:

BEGINNING at a concrete R/W monument on the southern R/W line of Kingston Pike, said monument being 754.9 feet +- from the pont of intersection with the easterly R/W line of Durwood Road, Thence continuing with the southern R/W line of Kingston Pike, N 60 Deg. 46' E, 125.00 feet to an iron pin, thence S 29 Deg. 14' E, 134.05 feet to an iron pin, thence S 84 Deg. 44' 30" W, 105.90 feet to a point, thence S 64 Deg. 34' W, 90.00 feet to an iron pin at the common corner of Fitzgerald, Thompson and Fort Sanders Alliance, Thence N 6 Deg. 40' E, 105.00 Feet to the POINT OF BEGINNING as shown by survey of Sizemore-Lynch & Associates, dated May 14, 1988 and last revised June 22, 1988 being Project No. 1412.5.

TRACT II

City of Knoxville, Tennessee, and being known and designated as Lot 8, in David Park Subdivision, a subdivision to Knox County, Tennessee, as shown by map of said subdivision, of record in Map Book 67-S, page 30, Cabinet E, Slide 291-C, in the Knox County Register's Office, said lot being more particularly bounded and described as shown on map aforesaid, to which map specific reference is hereby made for a more particular description.

BEING the same property conveyed to Fort Sanders Alliance by deed from Fred J. Byerley and wife, Martha E. Byerley, dated December 29, 1986, of record in Warranty Book 1903, page 63, in the Knox County Register's Office, and by deed from Consumer's Wholesale, Inc., dated November 30, 1986, of record in Deed Book 1900, Page 522, and corrected by Deed of Correction dated December 21, 1987 of record in Deed Book 1935, Page 588, and further corrected by Deed Book of Correction dated July 25, 1988 of record in Deed Book 1953, Page 0376, in the Register's Office of Knox County, Tennessee.

Instr:200105140070005
PAGE: 4 OF 4

Attachment, Economic Feasibility-Project Cost Chart:

Architect & Construction Letter

FREDERICK & ASSOCIATES

ARCHITECTS

July 1, 2020

Mr. Lawrence Whatley
Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242

RE: Rehabilitation Hospital of Knox County, LLC: (West)
Knoxville, Tennessee

Dear Mr. Whatley,

As part of the Certificate of Need process, please accept this letter of verification for construction cost and code compliance for the development of a 51-bed freestanding inpatient rehabilitation hospital in Knox County, Tennessee.

The new hospital is expected to be 54,400 square feet and we estimate construction costs, for the building and site (excluding equipment and design fees), will be $19,403,166.00 which is $356.68 per square foot. Based upon our experience, we believe that the construction cost for this project is reasonable and consistent with construction costs for similar facilities in this region.

The project will be designed and construction documents prepared to adhere to all current applicable codes of the State of Tennessee Division of Health Facilities Construction, and all authorities having jurisdiction. The Tennessee Building Codes currently include;

- 2018 IBC International Building, Plumbing, Mechanical, & Gas codes.
- 2018 IEC International Energy Conservation code.
- 2017 NEC National Electrical Code.
- 2018 IFC International Fire Code
- 2012 NFPA 101 Life Safety Code.
- 2018 ADA International Accessibility Code.
- 2018 FGI Guidelines for Design and Construction of Health Care Facilities.

The physical environment also conforms to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or comparable document in current use by the licensing authority.

We are pleased to assist you and Encompass Health in maintaining high standards of quality in design and operation of your facility.

Sincerely,

Fred C. Frederick, AIA
Principal

Cc; File

Frederick & Associates- Architects, Inc.
330 S. Pineapple Ave. - Suite 204 - Sarasota, Florida 34236 - 941.366.3231

Attachment, Economic Feasibility:

Project Funding Sources – Covenant Health

JOHN T. GEPPI
Executive VP/CFO

Covenant HEALTH.

July 7, 2020

Mr. Logan Grant
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC ("West" and "Downtown" Projects)

Dear Mr. Grant:

Covenant Health has sufficient cash reserves to support the initial and ongoing funding needs of Fortress Corporation for the two companion CON projects proposed by Rehabilitation Hospital of Knox County, LLC. Fortress Corporation is a wholly-owned subsidiary of Covenant Health – and one of the two members of the 50/50 partnership created by Rehabilitation Hospital of Knox County, LLC.

A copy of Covenant Health's most recent audited Balance Sheet and Income Statement will be included with both CON applications for your consideration.

Respectfully,

John Geppi
Executive Vice President / Chief Financial Officer
Covenant Health

Corporate Office
100 Fort Sanders West Blvd. • Knoxville, TN 37922
(865) 531-5421 Office (865) 531-5272 Fax
www.covenanthealth.com

PYA

Certified Public Accountants

Consolidated Financial Statements

Covenant Health

Year Ended December 31, 2019

PYA
CERTIFIED PUBLIC ACCOUNTANTS

PYA, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Covenant Health:

We have audited the accompanying consolidated financial statements of Covenant Health (Covenant), which comprise the consolidated balance sheet as of December 31, 2019 and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to Covenant's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Covenant's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Covenant Health as of December 31, 2019 and the results of its operations, changes in net assets and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

PYA, PC

Knoxville, Tennessee
April 10, 2020

COVENANT HEALTH

Consolidated Balance Sheet
(Dollars in Thousands)

		December 31, 2019
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$	**145,103**
Assets limited as to use		**18,749**
Patient accounts receivable		**148,787**
Other current assets		**50,497**
TOTAL CURRENT ASSETS		**363,136**
INVESTMENTS		**1,336,986**
ASSETS LIMITED AS TO USE, less amounts required to meet current obligations		**115,381**
PROPERTY, PLANT AND EQUIPMENT, net of accumulated depreciation and amortization		**877,018**
OTHER ASSETS		
Goodwill and intangible assets		**25,508**
Right-of-use asset, operating leases		**7,393**
Right-of-use asset, finance leases		**2,031**
Other assets		**16,496**
TOTAL OTHER ASSETS		**51,428**
TOTAL ASSETS	$	**2,743,949**

COVENANT HEALTH

Consolidated Balance Sheet - Continued
(Dollars in Thousands)

		December 31, 2019
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Trade accounts payable, accrued expenses and other liabilities	$	**142,224**
Accrued salaries, wages, compensated absences and amounts withheld		**75,532**
Estimated third-party payer settlements		**4,920**
Current portion of operating lease liability		**3,892**
Current portion of finance lease liability		**591**
Current portion of long-term debt		**12,050**
TOTAL CURRENT LIABILITIES		**239,209**
OPERATING LEASE LIABILITY, less current portion		**3,501**
FINANCE LEASE LIABILITY, less current portion		**1,426**
LONG-TERM DEBT, less current portion		**901,219**
OTHER LONG-TERM LIABILITIES		**56,781**
TOTAL LIABILITIES		**1,202,136**
COMMITMENTS, CONTINGENCIES AND OTHER - Note J		
NET ASSETS		
Without donor restrictions		**1,533,831**
With donor restrictions		**7,982**
TOTAL NET ASSETS		**1,541,813**
TOTAL LIABILITIES AND NET ASSETS	$	**2,743,949**

COVENANT HEALTH

Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended December 31, 2019
Change in net assets without donor restrictions:	
Unrestricted revenue and support:	
Patient service revenue	**$ 1,351,862**
Other operating revenue	**53,451**
Net assets released from restrictions used for operations	**1,704**
TOTAL REVENUE AND SUPPORT	**1,407,017**
Expenses:	
Salaries and benefits	**707,324**
Supplies and other	**581,708**
Provision for depreciation and amortization	**76,237**
Interest	**17,874**
TOTAL OPERATING EXPENSES	**1,383,143**
INCOME FROM OPERATIONS	**23,874**
Non-operating gains (losses):	
Investment income	**147,014**
Loss on extinguishment of debt	**(4,238)**
TOTAL NON-OPERATING GAINS	**142,776**
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	**166,650**
Change in net unrealized gains on investments	**16,557**
Contributions of property	**435**
Net assets released from restrictions for capital additions	**377**
INCREASE IN NET ASSETS WITHOUT DONOR RESTRICTIONS	**184,019**

See notes to consolidated financial statements.

COVENANT HEALTH

Consolidated Statement of Operations and Changes in Net Assets - Continued
(Dollars in Thousands)

	Year Ended December 31, 2019
Change in net assets with donor restrictions:	
Restricted gifts and bequests	**1,918**
Investment income and realized/unrealized net gains on investments	**62**
Net assets released from restrictions	**(2,081)**
DECREASE IN NET ASSETS WITH DONOR RESTRICTIONS	**(101)**
INCREASE IN NET ASSETS	**183,918**
NET ASSETS, BEGINNING OF YEAR, as previously reported	**1,311,520**
Cumulative effect of change in accounting principle - Note B	**46,375**
NET ASSETS, BEGINNING OF YEAR, as restated	**1,357,895**
NET ASSETS, END OF YEAR	**$ 1,541,813**

COVENANT HEALTH

Consolidated Statement of Cash Flows
(Dollars in Thousands)

	Year Ended December 31, 2019
CASH FLOWS FROM OPERATING ACTIVITIES:	
Increase in net assets	$ 183,918
Adjustments to reconcile increase in net assets to net cash provided by operating activities	
Provision for depreciation and amortization	76,237
Net realized and unrealized gains on investments and assets limited as to use	(124,879)
Interest amortization/accretion on bond discounts, premiums and issue costs	(1,569)
Property contributions	(435)
Restricted contributions	(1,918)
Loss on extinguishment of debt	4,238
Gain on sale of unconsolidated affiliate	(715)
Increase (decrease) in cash due to changes in:	
Patient accounts receivable	(12,107)
Other current assets	(7,867)
Other assets	(6,504)
Trade accounts payable, accrued expenses and other liabilities	(15,336)
Accrued salaries, wages, compensated absences and amounts withheld	3,861
Estimated third-party payer settlements	(581)
Other long-term liabilities	5,487
Total adjustments	(82,088)
NET CASH PROVIDED BY OPERATING ACTIVITIES	101,830
CASH FLOWS FROM INVESTING ACTIVITIES:	
Capital expenditures	(152,823)
Proceeds from sale of property, plant and equipment	83
Purchases of investments	(151,395)
Proceeds from redemption or maturities of investments	152,935
Changes in assets limited as to use	14,894
Sale of investment in unconsolidated affiliates	1,069
Investment in unconsolidated affiliates	(8,101)
Distributions from unconsolidated affiliates	2,785
NET CASH USED IN INVESTING ACTIVITIES	(140,553)

See notes to consolidated financial statements.

COVENANT HEALTH

Consolidated Statement of Cash Flows - Continued
(Dollars in Thousands)

	Year Ended December 31, 2019
CASH FLOWS FROM FINANCING ACTIVITIES:	
Proceeds from issuance of long-term debt	**609,172**
Redemption of debt	**(461,687)**
Repayment of debt and finance lease obligations	**(16,391)**
Payment of acquisition and financing costs	**(1,008)**
Restricted contributions	**1,918**
NET CASH PROVIDED BY FINANCING ACTIVITIES	**132,004**
NET INCREASE IN CASH AND CASH EQUIVALENTS	**93,281**
CASH AND CASH EQUIVALENTS, beginning of year	**51,822**
CASH AND CASH EQUIVALENTS, end of year	**$ 145,103**
SUPPLEMENTAL INFORMATION:	
Cash paid for interest	**$ 26,101**
Capital additions in accounts payable	**$ 10,924**
Operating cash flows from finance leases	**$ (27)**
Operating cash flows from operating leases	**$ (4,798)**
Financing cash flows from finance leases	**$ (641)**

Attachment, Economic Feasibility:

Project Funding Sources – Encompass Health

Encompass Health

9001 Liberty Parkway
Birmingham, AL 35242

205.967.7116
encompasshealth.com

July 13, 2020

Logan Grant, Executive Director
Health Services and Development Agency
Andrew Jackson State Office Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC

Dear Mr. Grant:

Encompass Health Corporation has ample existing cash, cash flow from operations, and funds available under its credit facility to offer more than adequate funds for the two companion CON projects proposed by Rehabilitation Hospital of Knox County, LLC. Encompass Health Knoxville Holdings, LLC is a wholly-owned subsidiary of Encompass Health Corporation and is one of two members of Rehabilitation Hospital of Knox County, LLC.

Sincerely yours,

Edmund Fay
Senior Vice President and Treasurer
Encompass Health Corporation

Attachment:

Proof of Publication

LETTER OF INTENT

The Publication of Intent is to be published in the **Knoxville News Sentinel** (Name of Newspaper) which is a newspaper of general circulation in **Knox County** (County), Tennessee, on or before **July 10** (Month / day), **2020** (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Rehabilitation Hospital of Knox County ("West") (Name of Applicant) **(Not Applicable)** (Facility Type-Existing)

owned by: **Rehabilitation Hospital of Knox County, LLC** with an ownership type of **Limited Liability Company**

and to be managed by: **Encompass Health Corporation** intends to file an application for a Certificate of Need for: **the establishment of a 51-bed Inpatient Rehabilitation Facility (Rehabilitation Hospital) in a newly-constructed building to be located at a site currently addressed as 10150 Kingston Pike, Knoxville, TN 37922 (the site also includes a parcel of adjacent land). The applicant is jointly owned by a subsidiary of Covenant Health and a subsidiary of Encompass Health Corporation. The project will not result in the addition of inpatient rehabilitation beds to the market, because Fort Sanders Regional Medical Center ("Fort Sanders") will relinquish 51 of its 73 inpatient rehabilitation beds upon completion of the project. (A certificate of need application for a companion project will be filed concurrently that will result in Fort Sanders relinquishing the remaining 22 of its 73 inpatient rehabilitation beds.) This project does not seek to initiate any other service for which a certificate of need is required. The total estimated project cost is $ 37,105,128.**

The contact person for this project is **Mike Richardson** (Contact Name) **Vice President, Strategic Planning & Development** (Title)

who may be reached at: **Covenant Health** (Company Name) **280 Fort Sanders West Boulevard, Building 4, Suite 218** (Address)

Knoxville (City) **Tennessee** (State) **37922** (Zip Code) **(865) 531-5123** (Area Code / Phone Number)

(Signature) **July 10, 2020** (Date) **mdr@covhlth.com** (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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BEST DEAL
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SELLING
YOUR HOME?
FOR
SALE
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OF
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the job network

Public Notices

NOTIFICATION OF INTENT TO APPLY FOR
A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and to interested parties, in accordance with T.C.A. § 68-11-1607 et seq., and the Rules of the Health Services and Development Agency, that:

Rehabilitation Hospital of Knox County ("Hospital")
(Name of Applicant)
(Not Applicable)
(Facility Type Existing)

intends to: Rehabilitation Hospital of Knox County, LLC with an ownership type of Limited Liability Company and to be managed by: Encompass Health Corporation intends to file an application for a Certificate of Need for: the establishment of a Direct Inpatient Rehabilitation Facility ("Rehabilitation Hospital") in a newly constructed building to be located at 4 Cherry Hill Drive, Knoxville, Knox County, TN 37923 (the site also includes a parcel at adjacent land). The applicant is directly owned by a subsidiary of Encompass Health and a subsidiary of Encompass Health Corporation. The project will not result in the addition of inpatient rehabilitation beds to the market, because Fort Sanders Regional Medical Center ("Fort Sanders") will relocate 30 of its 31 inpatient rehabilitation beds upon completion of the project. A certificate of need application for a companion project will be filed concurrently that will result in Fort Sanders relocating the remaining 30 of its 31 inpatient rehabilitation beds. This project does not seek to initiate any other service for which a certificate of need is required. The total estimated project cost is $[illegible].

The anticipated date of filing the application is: July 16, 2018.

The contact person for this project is Mike Richardson, Vice President, Strategic Planning & Development who may be reached at: Covenant Health, 9[illegible] Fort Sanders West Boulevard, Building 5, Suite 205, Knoxville Tennessee 37922, (865) [illegible]

Upon written request to interested parties, a Non-Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
[illegible] Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1): "In any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (b) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the agency."

Public Notices Public Notices

NOTIFICATION OF INTENT TO APPLY FOR
A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and to interested parties, in accordance with T.C.A. § 68-11-1607 et seq., and the Rules of the Health Services and Development Agency, that:

Rehabilitation Hospital of Knox County ("Hospital")
(Name of Applicant)
(Not Applicable)
(Facility Type Existing)

intends to: Rehabilitation Hospital of Knox County, LLC with an ownership type of Limited Liability Company and to be managed by: Encompass Health Corporation intends to file an application for a Certificate of Need for: the establishment of a Direct Inpatient Rehabilitation Facility ("Rehabilitation Hospital") in [illegible] space leased from Fort Sanders Regional Medical Center ("Fort Sanders") located at 900 Clinch Avenue, Knoxville, TN 37916. The applicant is directly owned by a subsidiary of Covenant Health and a subsidiary of Encompass Health Corporation. The project will not result in additional inpatient rehabilitation beds, because Fort Sanders will relocate 30 of its 31 inpatient rehabilitation beds upon completion of the project. A certificate of need application for a companion project will be filed concurrently that will result in Fort Sanders relocating the remaining 30 of its 31 inpatient rehabilitation beds. This project does not seek to initiate any other service for which a certificate of need is required. The total estimated project cost is $[illegible].

The anticipated date of filing the application is: July 16, 2018.

The contact person for this project is Mike Richardson, Vice President, Strategic Planning & Development who may be reached at: Covenant Health, 9[illegible] Fort Sanders West Boulevard, Building 5, Suite 205, Knoxville Tennessee 37922, (865) [illegible]

Upon written request to interested parties, a Non-Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
[illegible] Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1): "In any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (b) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the agency."

Attachment:

Signed and Notarized Affidavit

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

Mike Richardson, being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Tennessee Health Services and Development Agency and T.C.A. § 68-11-1601, *et seq.*, and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

Signature/Title

Sworn to and subscribed before me this the 14 day of July, 2020, a Notary Public in and for the County of Knox, State of Tennessee.

NOTARY PUBLIC

My Commission expires 09-05-2022

SUZANNE F MOUNGER
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY
My Commission Expires 09-05-2022

HF-0056
Revised 7/02 - All forms prior to this date are obsolete

BUTLER | SNOW

July 15, 2020

VIA EMAIL AND U.S. MAIL

Logan Grant
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Request for Consent Calendar - Rehabilitation Hospital of Knox County, LLC (Downtown) and Rehabilitation Hospital of Knox County, LLC, (West)

Dear Mr. Grant:

This letter is submitted on behalf of Covenant Health as a part owner of the projects referenced above. Byron Trauger represents Encompass Health, the other owner of the projects, and he joins in the request stated below.

By way of introduction, the applications referenced above are companion projects involving the 73 inpatient rehabilitation beds currently licensed as part of Fort Sanders Regional Medical Center ("FSRMC"). Covenant Health (the parent of FSRMC) and Encompass Health (a leading provider of inpatient rehabilitation services in the nation) have entered into a business arrangement to modernize and partially relocate the existing 73 beds. The Downtown project will create a separately licensed, jointly-owned 22-bed rehabilitation hospital within renovated space leased from FSRMC. The West project will relocate 51 of the existing beds to a separately licensed, jointly-owned 51 bed rehabilitation hospital in a new facility on property owned by Covenant Health.

We respectfully request that the applications be placed on the consent calendar. The justification for consent calendar is set forth in the applications themselves, including the following points:

- The projects do not add any additional inpatient rehabilitation bed capacity to the market, but simply modernize and enhance the functionality of the existing 73 beds.

- Both projects will continue to serve patients from the same service area as the existing 73 beds.

The Pinnacle at Symphony Place
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

DAN H. ELROD
615.651.6702
dan.elrod@butlersnow.com

T 615.651.6700
F 615.651.6701
www.butlersnow.com

BUTLER SNOW LLP

- Both projects meet the applicable certificate of need criteria for approval.

We believe the projects qualify for consent calendar consideration, and we hope that you concur. Thank you for our attention to this request.

Very truly yours,

BUTLER SNOW LLP

Dan H. Elrod

cc: Byron Trauger

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

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

For the fiscal year ended December 31, 2019
OR

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

Commission File Number 001-10315

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)

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

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

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock, $0.01 par value	EHC	New York Stock Exchange

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

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

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

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 ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth 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 ☒ Accelerated filer ☐ Emerging growth company ☐

Non-Accelerated filer ☐ Smaller reporting company ☐

If an emerging growth company, indicate by check mark 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. ☐

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

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $6.2 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 98,433,352 shares of common stock of the registrant outstanding, net of treasury shares, as of February 13, 2020.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2020 annual meeting of stockholders is incorporated by reference in Part III to the extent described therein.

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NOTE TO READERS

As used in this report, the terms "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. We may refer to our consolidated subsidiary, EHHI Holdings, Inc. and its subsidiaries, which collectively operate our home health and hospice business, as "EHHI."

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to, among other things, future events, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy, our dividend and stock repurchase strategies, our financial plans, our growth plans, our future financial performance, our projected business results, or our projected capital expenditures. In some cases, the reader can identify forward-looking statements by terminology such as “may,” “will,” “should,” “could,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “predicts,” “targets,” “potential,” or “continue” or the negative of these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties, many of which are beyond our control. Any forward-looking statement is based on information current as of the date of this report and speaks only as of the date on which such statement is made. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ, such as decreases in revenues or increases in costs or charges, materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, *Risk Factors*; as well as uncertainties and factors, if any, discussed elsewhere in this Form 10-K, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;

- changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction (such as the re-basing of payment systems, the introduction of site neutral payments or case-mix weightings across post-acute settings, the Patient-Driven Groupings Model for home health, the new patient assessment measures, which we refer to as “Section GG functional measures,” for inpatient rehabilitation, and other payment system reforms), which may decrease revenues and increase the costs of complying with the rules and regulations;

- 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;

- 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;

- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including disclosed and undisclosed *qui tam* suits;

- the use by governmental agencies and contractors of statistical sampling and extrapolation to expand claims of overpayment or noncompliance;

- 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, including through recoupment of ongoing claims reimbursement by CMS;

- 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;

- a pandemic, epidemic, or other widespread outbreak of an infectious disease or other public health crisis, which could decrease our patient volumes and revenues and lead to staffing and supply shortages and associated cost increases;

- 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;

- 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;
- 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 or our vendors' or partners' information systems, including the patient information stored there;
- 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 and provider enrollment requirements, which is required to participate in the Medicare program;
- our ability to attract and retain key management personnel;
- changes in our payor mix or the acuity of our patients affecting reimbursement rates; and
- general conditions in the economy and capital markets, including any disruption, instability, or uncertainty related to armed conflict or an act of terrorism, a governmental impasse over approval of the United States federal budget, an increase to the debt ceiling, an international trade war, a sovereign debt crisis, or a widespread outbreak of an infectious disease.

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

PART I

Item 1. Business.

Overview of the Company

General

We are a leading provider of integrated healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2019, our national footprint spans 37 states and Puerto Rico and includes 133 hospitals and 245 home health and 83 hospice locations. We are committed to delivering high-quality, cost-effective, integrated patient care across the healthcare continuum with a primary focus on the post-acute sector.

In 2018, we undertook a rebranding to reinforce our strategy and position as an integrated provider of facility-based and home-based patient care. As part of the rebranding, we changed our corporate name from HealthSouth Corporation to Encompass Health Corporation and the NYSE ticker symbol for our common stock from "HLS" to "EHC." Our principal executive offices are located at 9001 Liberty Parkway, Birmingham, Alabama 35242, and the telephone number of the principal executive offices is (205) 967-7116. Our website address is www.encompasshealth.com.

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

We manage our operations in two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. The table below provides selected operating and financial data for our inpatient rehabilitation hospitals, home health agencies, and hospice agencies. See Note 19, *Segment Reporting,* to the accompanying consolidated financial statements for detailed financial information for each of our segments.

	As of or for the Year Ended December 31,		
	2019	2018	2017
Consolidated data:		(Actual Amounts)	
Inpatient rehabilitation:			
Number of hospitals [1]	133	130	127
Discharges	186,842	179,846	171,922
Number of licensed beds	9,249	8,966	8,851
Home health and hospice:			
Number of home health locations [2]	245	220	200
Home health admissions	159,727	137,396	124,870
Number of hospice locations	83	58	37
Hospice admissions	10,452	7,474	4,870
Net operating revenues:		(In Millions)	
Inpatient	$ 3,423.5	$ 3,247.9	$ 3,039.3
Outpatient and other	89.5	98.3	102.0
Total inpatient rehabilitation	3,513.0	3,346.2	3,141.3
Home health	918.0	814.6	702.4
Hospice	174.0	116.5	70.2
Total home health and hospice	1,092.0	931.1	772.6
Net operating revenues	$ 4,605.0	$ 4,277.3	$ 3,913.9

(1) These amounts include one hospital as of December 31, 2018, and 2017 operating as a joint venture, which we accounted for using the equity method of accounting. As a result of an amendment to the joint venture agreement related to this hospital, the accounting for it changed from the equity method to consolidated effective July 1, 2019.

(2) These amounts include two locations as of December 31, 2019, 2018, and 2017 which we account for using the equity method of accounting.

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 predominantly an inpatient basis. We operate hospitals in 33 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. In addition to our hospitals, we manage four inpatient rehabilitation units through management contracts.

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across an array of diagnoses and deliver comprehensive, high-quality, cost-effective patient care services. As participants in the Medicare program, our hospitals must be licensed and certified and otherwise comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Inpatient Rehabilitation" section. Substantially all (90%) of the patients we serve are admitted from acute care hospitals following physician referrals for specific acute inpatient rehabilitative care. Most of those patients have experienced significant physical and cognitive disabilities or injuries due to medical conditions, such as strokes, hip fractures, and a variety of debilitating neurological conditions, that are generally nondiscretionary in nature and require rehabilitative healthcare services in a facility-based setting. Our teams of highly skilled nurses and physical, occupational, and speech therapists utilize proven technology and clinical protocols with the objective of restoring our patients' physical and cognitive abilities. Patient care is provided by nursing and therapy staff as directed by physician orders while case managers monitor each patient's progress and provide documentation and oversight of patient status, achievement of goals, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leverages innovative technologies and advanced therapies and leads to superior outcomes.

Home Health and Hospice

Our home health business is the nation's fourth largest provider of Medicare-certified skilled home health services in terms of revenues. Our hospice business is the nation's eleventh largest provider of Medicare-certified hospice services in terms of revenues. We operate home health and hospice agencies in 31 states, with concentrations in the Southeast and Texas. As participants in the Medicare program, our agencies must comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Home Health" and "—Hospice" sections. We acquired a significant portion of our home health and hospice business when we purchased EHHI Holdings, Inc. ("EHHI") on December 31, 2014. In the acquisition, we acquired 83.3% of the issued and outstanding equity interests of EHHI, and certain members of EHHI management, including April Anthony, its chief executive officer, acquired the remaining interests. As of February 19, 2020, we own 98.8% of EHHI. See Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Liquidity and Capital Resources" for further discussion of the ownership structure of our home health and hospice business.

Our home health agencies provide a comprehensive range of Medicare-certified home care services. These services include, among others, skilled nursing, physical, occupational and speech therapy, medical social work, and home health aide services. We also offer evidence-based specialty programs related to post-operative care, fall prevention, chronic disease management, and transitional care. Home health patients are frequently referred to us following a stay in an acute care or inpatient rehabilitation hospital or other facility, but many patients are referred from primary care settings and specialty physicians without a preceding inpatient stay. Our patients are typically older adults with three or more chronic conditions and significant functional limitations, and require greater than ten medications. Our teams of registered nurses, licensed practical nurses, physical, speech and occupational therapists, medical social workers, and home health aides work closely with patients and their families and physicians to deliver patient-centered care plans focused on their needs and their goals.

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

Competitive Strengths

We believe we differentiate ourselves from our competitors based on, among other things, the quality of our clinical outcomes, our cost-effectiveness, our financial strength, and our extensive application of technology. We also believe our competitive strengths discussed below give us the ability to adapt and succeed in a healthcare industry shifting toward integrated delivery payment models, value-based purchasing, and post-acute site neutrality. For example, we believe we are well-positioned to treat all types of post-acute patients by leveraging our operational expertise across our network of facility- and home-based assets in the event multiple or all post-acute settings (long-term acute care, inpatient rehabilitation, skilled nursing, and home health) transition in the future to site neutral patient criteria for reimbursement. Our hospitals have the physical construct (including aspects such as the therapy gym and training areas), clinical staffing, and operating expertise to address the broad spectrum of needs for higher acuity post-acute patients needing inpatient care. Our home health agencies can

often treat patients leaving our or other inpatient facilities who need additional post-acute care services in lieu of skilled nursing facility-based care. Additionally, those agencies can serve the lower acuity patients that do not require facility-based care.

- People. We believe our employees share a steadfast commitment to providing outstanding care to our patients. We undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality care in the most cost-effective manner. We also have hospital staff trained for all patient acuity levels faced in the post-acute setting. We embrace the Encompass Health Way, our core set of values developed through input from a broad cross section of our employees. The Encompass Health Way calls on each of our employees to set the standard, lead with empathy, do what's right, focus on the positive, and ensure we are stronger together.

- Change Agility. We have a demonstrated ability to adapt in the face of numerous and significant regulatory and legislative changes. For example, we successfully managed through the significant regulatory, financial, and other challenges associated with the Centers for Medicare & Medicaid Services ("CMS") rule commonly referred to as the "75% Rule" in 2004, reimbursement rate reductions associated with the shift from the 75% Rule to the "60% Rule" in 2007, sequestration beginning in 2013, multiple reimbursement rate reductions associated with healthcare reform and otherwise, introduction of significantly more quality reporting requirements beginning in 2013, and implementation of both voluntary and mandatory alternative payment models in recent years.

- Strategic Relationships. We have a long and successful history of building strategic relationships with major healthcare systems. Our experience will be important in growing the Company as the industry evolves toward integrated delivery models. We entered into our first joint venture in 1991 with a nationally prominent university's acute care hospital. Approximately one-third of our inpatient rehabilitation hospitals currently operate as joint ventures with acute care hospitals or systems. Joint ventures with market leading acute care hospitals establish a solid foundation for operating our business within integrated delivery and alternative payment models.

  Our combined platform of facility-based and home-based services provides us with an opportunity to succeed in value-based purchasing programs and to participate in more coordinated care and integrated delivery payment models, such as accountable care organizations ("ACOs") and bundled payment arrangements. We believe clinical collaboration between our hospitals and home health agencies offers an excellent means to deliver the quality of care and the cost effectiveness the healthcare partners in these new models seek. We have focused, and will continue to focus, on increasing this collaboration. For additional discussion of our participation in these models, including the Bundled Payments for Care Improvement Advanced initiative, see Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview."

  In 2017, we formed the Post-Acute Innovation Center in collaboration with Cerner Corporation, a global leader in health information technology, to develop enhanced tools to manage patients across the continuum of care. The objective of the Post-Acute Innovation Center is to develop clinical decision support tools and other initiatives that enhance the effective and efficient management of patients across multiple post-acute care settings by facilitating high-quality patient care, enhanced care coordination, network provider performance and cost management.

  We also have a strategic sponsorship with the American Heart Association/American Stroke Association on a nationwide basis to increase patient independence after a stroke and reduce stroke mortality through community outreach and information campaigns. This strategic sponsorship is a three-year project beginning in 2019 to accelerate adoption of the AHA/ASA Stroke Rehabilitation Guidelines, increase patient awareness of their post-stroke options, and provide practical support to patients and their families to improve recovery outcomes. These Guidelines recommend, among other things, that stroke patients be treated at an inpatient rehabilitation facility, or "IRF," rather than a skilled nursing facility. In 2019, we began offering the patient, caregiver, and provider tools, the special events, and the educational programs developed in partnership with the AHA/ASA. Echoing the AHA/ASA Stroke Rehabilitation Guidelines, the Department of Veterans' Affairs and the Journal of the American Medical Association published in 2019 guidelines and an article, respectively, advocating for the treatment of stroke patients in inpatient rehabilitation facilities.

- Clinical Expertise and High-Quality Outcomes. We have extensive facility-based and home-based clinical experience from which we have developed standardized best practices and protocols. We believe these clinical best practices and protocols, particularly as leveraged with industry-leading technology, help ensure the delivery of consistently high-quality healthcare services. Our "TeamWorks" program is a series of operations-focused initiatives using identified and standardized best practices to reduce inefficiencies and improve performance

across a spectrum of operational areas. We believe these initiatives have enhanced, and will continue to enhance, patient-employee interactions, clinical collaboration, and communication among the patient, the patient's family, our treatment teams, other care providers, and payors, which, in turn, improves patient outcomes and satisfaction.

Our best practices and protocols have helped our hospitals consistently achieve patient outcomes, such as the rate of discharge to community, that exceed industry averages. Additionally, our hospitals participate in The Joint Commission's Disease-Specific Care Certification Program. Under this program, Joint Commission accredited organizations may seek certification for chronic diseases or conditions such as brain injury, stroke, or hip fracture rehabilitation by complying with Joint Commission standards, effectively using evidence-based, clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care. As of December 31, 2019, 123 of our hospitals held stroke-specific certifications, and some of those hospitals held other disease-specific certifications.

In home health, we place a significant emphasis on technology for the purpose of furthering clinical excellence and consistency. We have also developed programs to, among other things, create physician-specific custom treatment protocols and provide care transition from inpatient facilities to home for higher acuity patients. We consistently achieve an acute care readmission rate lower than the industry average along with an average quality of patient care star rating above the industry average.

Clinical collaboration between our inpatient rehabilitation hospitals and home health agencies furthers our pursuit of quality patient outcomes and improved patient experiences. Institutional programs and advanced treatment protocols connect facility-based and home-based care and allow seamless transition of patients across the healthcare continuum. An important component of clinical collaboration has been the placement of care transition coordinators in markets where we operate both inpatient rehabilitation hospitals and home health agencies, which we refer to as "overlap markets." These highly skilled professionals collaborate with clinicians and case managers in our hospitals to assess patients who may require home health services and prepare these patients for the care they will receive at home. The coordinators also work with patients' families to ensure those family members are prepared to bring their loved ones home safely. We believe our clinical collaboration efforts contributed to reductions in discharges to skilled nursing facilities, higher discharges to home, and improved patient satisfaction.

- Cost Effectiveness. Our size, data-driven business practices, and culture help us provide facility-based and home-based healthcare services on a cost-effective basis. For example, our inpatient rehabilitation hospitals historically have received, on average, a lower per discharge payment from Medicare than the industry average payment while also treating patients with higher average acuity. Additionally, our hospitals historically have received, on average, significantly less Medicare high cost outlier reimbursement than other inpatient rehabilitation providers have. High cost outlier payments are supplemental payments from Medicare intended to cover high cost cases in excess of a fixed-loss threshold amount.

  Specifically, we can leverage our comprehensive IT capabilities and centralized administrative functions, identify best practices, utilize proven staffing models, and take advantage of supply chain efficiencies across our extensive platform of operations. At the location level, we also enjoy economies of scale as our hospitals are often larger (more beds) than the industry average. Also, we target patient density in the home health markets we serve, which is central to our ability to deliver an efficient cost per visit. In addition, our proprietary information systems, discussed below, aggregate data from our business into a comprehensive reporting package and database used by management in the field and in the home office. Our information systems allow users to analyze data and trends and create custom reports on a timely basis.

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

- Financial Resources. We have a proven track record of generating strong cash flows from operations that have allowed us to successfully pursue our growth strategy, manage our financial leverage, and make significant shareholder distributions. As of December 31, 2019, we have a strong, well-capitalized balance sheet, including ownership of approximately 70% of our hospital real estate, no significant debt maturities prior to 2023, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide sufficient support for our business strategy.

- Advanced Technology and Innovation. We are focused on developing technology-enabled real-time strategies for the next generation of integrated healthcare. Our post-acute innovation strategy is based on leveraging our clinical expertise, our large post-acute datasets, and our proven capabilities in enterprise-level electronic medical record technologies, data analytics, data integration, and predictive analytics to drive value-based performance across the healthcare continuum for our patients, our partners, and our payors. We have devoted substantial resources, effort and expertise to leveraging technology to create post-acute solutions that improve patient care and operating efficiencies.

  We have developed and implemented information technology, such as our rehabilitation-specific electronic medical record system ("ACE-IT") and our internally developed management reporting system described above ("BEACON"), which we then leverage to enhance our clinical and business processes. ACE-IT allows us to interface with the clinical information systems of acute care hospitals to facilitate patient transfers, reduce readmissions, and enhance patient outcomes. We believe ACE-IT improves patient care and safety, streamlines operating efficiencies, and enhances staff recruitment and retention, making it a key competitive differentiator. BEACON gives us the ability to build from disparate data sources clinical and business dashboards that contribute to our ability to make data driven decisions in the day-to-day operation of our business and clinical care of our patients.

  Members of our home health management team developed 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, financial, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. Our knowledge of Homecare Homebase, of which we are now a licensee, as well as the thorough integration of it into the operating culture allow us to optimize the system's capability to drive superior clinical, operational, and financial outcomes. We also offer a number of evidence-based home health specialty programs, including post-operative care, fall prevention, chronic disease management and transitional care. In 2019, we began rolling out to our agencies a new data analytics tool designed to optimize patient health care plans and reduce emergency room visits and hospital readmissions.

  We intend to continue to design, pilot and implement post acute information system solutions to improve our clinical care, including clinical decision support tools and home health care plan optimization tools. In recent years, we have designed and implemented a program we refer to as ReAct that uses predictive modeling and an extensive proprietary database of our IRF patients in an effort to identify patients at risk for acute care transfers and to implement intervention strategies in the care plan. In 2019, we developed a post-acute readmission prediction model to reduce readmissions for our patients. We piloted this model in 9 hospitals and corresponding overlap home health locations and will roll it out to all of our hospitals in 2020. We will continue to expand the depth and reach of our tools and the development of new tools that will help maximize patient outcomes and reduce episodic costs across the post-acute continuum.

  We believe our information systems and post-acute solutions, in addition to improving patient care and operating efficiencies, 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. Systems such as ACE-IT and Homecare Homebase allow for interoperability with referral sources and other providers coordinating care. Homecare Homebase also allows us to share valuable data with payors to promote better patient outcomes on a more cost-effective basis.

Patients and Demographic Trends

Demographic trends, such as population aging, should continue to increase long-term demand for the services we provide. 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. Even more specifically, the average age of our patients is approximately 76, and the population group ranging in ages from 75 to 79 is expected to grow at approximately 5% per year through 2026. We believe the demand for the services we provide 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 those extremely fragmented industries.

Strategy and 2020 Strategic Priorities

Our strategy is to expand our network of inpatient rehabilitation hospitals and home health and hospice locations, further strengthen our relationships with healthcare systems, provider networks, and payors in order to connect patient care across the healthcare continuum, and to deliver superior patient outcomes. We believe this strategy, along with our demonstrated ability to adapt to changes in healthcare, will position us for success in the evolving healthcare delivery system. In pursuit of our strategy, we established the following strategic priorities for 2020.

Growth. We will continue to expand our portfolio of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. Each year we target adding four to six new inpatient rehabilitation hospitals and $50 million to $100 million in home health and hospice acquisitions. We also believe we will continue to have excellent organic growth opportunities in our inpatient rehabilitation and home health and hospice segments based on our track record of consistent growth in both segments, planned bed additions at a number of existing hospitals, and the maturation of acquired home health and hospice locations.

Operational Initiatives. Our priorities include operational initiatives that build on momentum from recent years. We will seek to continue to increase clinical collaboration. We believe our clinical collaboration efforts have and will continue to contribute to reductions in discharges to skilled nursing facilities, higher discharges to home, and improved patient experiences. Given the significant number of stroke patients in need of post-acute care, we are attempting to build our stroke market share by leveraging our strategic sponsorship of the American Heart Association/American Stroke Association, the IRF treatment recommendations published by the Department of Veterans' Affairs and the Journal of the American Medical Association, our clinical collaboration, and our hospitals' participation in The Joint Commission's Disease-Specific Care Certification Program. As of December 31, 2019, 123 of our 133 hospitals held stroke-specific certifications that required us to demonstrate effective use of evidence-based clinical practice guidelines to manage and optimize stroke care and an organized approach to performance measurement and evaluation of clinical outcomes. We will also continue to develop and implement post-acute solutions by leveraging our clinical expertise, large post-acute datasets, electronic medical record technologies, and strategic partnerships to drive improved patient outcomes and lower the cost of care across the entire post-acute episode. Additionally, we will continue the transition to the new Medicare reimbursement systems for both inpatient rehabilitation and home health, which are discussed further below under "—Sources of Revenue—Medicare Reimbursement."

Capital Structure. We will seek to maintain balance sheet flexibility, consider opportunistic refinancings and augment returns from investments in operations with shareholder distributions via common stock dividends and repurchases of our common stock.

For additional discussion of our strategic priorities as well as our progress toward our priorities in 2019, including operating results, growth, and shareholder distributions, and our business outlook, see Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview," "Results of Operations," and "Liquidity and Capital Resources."

Employees

As of December 31, 2019, we employed approximately 31,570 individuals, of whom approximately 18,980 were full-time employees, in our inpatient rehabilitation business and approximately 11,840 individuals, of whom approximately 8,990 were full-time employees, in our home health and hospice business. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 58 employees at one hospital (approximately 15% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2019. In some markets, the lack of availability of medical personnel is a significant operating issue facing healthcare providers. To address this challenge, we will continue to focus on maintaining the competitiveness of our compensation and benefit programs and improving our recruitment, retention, and productivity. Shortages of nurses and other medical personnel, including therapists, may, from time to time, require us to increase use of more expensive temporary personnel, which we refer to as "contract labor," and other types of premium pay programs.

Competition

Inpatient Rehabilitation. The inpatient rehabilitation industry, outside of our leading position, is highly fragmented. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units, most of which are within acute care hospitals, in the markets we serve. An acute care hospital, particularly one owned or operated by a large public company or not-for-profit that has a dominant position in the local market, can be a formidable competitor because 90% of our patients come from acute care hospitals. There are several privately held companies offering post-acute rehabilitation services that compete with us primarily in select geographic markets. In addition, there is a public company that is primarily focused on other post-acute care services, including approximately 1,700 outpatient clinics, but also operates approximately 29 inpatient rehabilitation hospitals.

Other providers of post-acute care services compete for some rehabilitation patients. For example, nursing homes may market themselves as offering certain rehabilitation services, particularly to patients not in need of intensive rehabilitation therapy, even though those nursing homes are not required to offer the same level of care, and are not licensed, as hospitals. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, the relationship and reputation with managed care and other private payors and the acute care hospitals, physicians, or other referral sources in the market, and the regulatory barriers to entry in certificate of need states. The ability to work as part of an integrated delivery payment model with other providers, including the ability to deliver quality patient outcomes and cost-effective care, is likely to become an increasingly important factor in competition. See the "Regulation—Relationships with Physicians and Other Providers" and "Regulation—Certificates of Need" sections below for further discussion of some of these factors. For a list of our inpatient rehabilitation markets by state, see the table in Item 2, *Properties.*

Home Health and Hospice. The home health and hospice services industries are also highly competitive and fragmented. There are more than 11,500 home health agencies and approximately 4,600 hospice agencies nationwide certified to participate in Medicare. We are the fourth largest provider of Medicare-certified skilled home health services in the United States in terms of Medicare revenues. Our primary competition varies from market to market. Providers of home health and hospice services include both not-for-profit and for-profit organizations. There are four other public healthcare companies with significant presences in the Medicare-certified home health industry, one of which is an insurance company that is one of the largest providers of Medicare-certified skilled home health services. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, the relationship and reputation with managed care and other private payors and the acute care hospitals, physicians, or other referral sources in the market, and the regulatory barriers to entry in certificate of need states. The ability to work as part of an integrated care delivery model with other providers is likely to become an increasingly important factor in competition. For example, we are currently the preferred home health provider in two ACOs serving approximately 26,000 patients. Home health providers with scale, which include the other public companies, may have competitive advantages, including professional management, efficient operations, sophisticated information systems, brand recognition, and large referral bases. For a list of our home health and hospice markets by state, see the table in Item 2, *Properties.*

Regulatory and Reimbursement Challenges

Healthcare is a highly regulated industry facing many well-publicized regulatory and reimbursement challenges driven by escalating costs and the pursuit of better quality of care. The industry also is facing uncertainty associated with the efforts to identify and implement workable coordinated care and integrated delivery payment models as well as post-acute site neutrality in Medicare reimbursement. The Medicare reimbursement systems for both inpatient rehabilitation and home health are undergoing significant changes. The future of many aspects of healthcare regulation remains uncertain. Any regulatory or legislative changes impacting the healthcare industry ultimately may affect, among other things, reimbursement of healthcare providers, consumers' access to coverage of health services, including among non-Medicare aged population segments within commercial insurance markets and Medicaid enrollees, and competition among providers. Changes may also affect the delivery of healthcare services to patients by providers and the regulatory compliance obligations associated with those services.

Successful healthcare providers are those 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. For more in-depth discussion of the primary challenges and risks related to our business, particularly the changes in Medicare reimbursement (including the impact of alternative payment models, value-based purchasing initiatives and site neutrality), increased compliance and enforcement burdens, and changes to our operating environment resulting from healthcare reform, see "Sources of Revenues—Medicare Reimbursement" and "Regulation" below in this section as well as Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), managed care plans and private insurers, and, to a considerably lesser degree, state governments (under their respective Medicaid or similar programs) and directly from patients. Revenues and receivables from Medicare are significant to our operations. The federal and state governments establish payment rates as described in more detail below. We negotiate the payment rates with non-governmental group purchasers of healthcare services that are included in "Managed care" in the tables below, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and other managed care plans. Patients are generally not responsible for the difference between established gross charges and amounts reimbursed for such services under Medicare, Medicaid, and other private insurance plans, HMOs, or PPOs but are responsible to the extent of any exclusions, deductibles, copayments, or coinsurance features of their coverage. Medicare, through its Medicare Advantage program, offers Medicare-eligible individuals an opportunity to participate in managed care plans. Revenues from Medicare and Medicare Advantage represent approximately 86% of total revenues.

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

Inpatient Rehabilitation

	For the Year Ended December 31,		
	2019	2018	2017
Medicare	72.2%	73.2%	73.6%
Medicare Advantage	10.7%	9.2%	8.3%
Managed care	9.8%	10.3%	10.7%
Medicaid	3.1%	3.0%	3.0%
Other third-party payors	1.2%	1.5%	1.6%
Workers' compensation	0.8%	0.8%	0.9%
Patients	0.7%	0.6%	0.6%
Other income	1.5%	1.4%	1.3%
Total	100.0%	100.0%	100.0%

Home Health and Hospice

	For the Year Ended December 31,		
	2019	2018	2017
Medicare	84.2%	85.3%	85.7%
Medicare Advantage	10.2%	9.5%	9.7%
Managed care	3.6%	3.6%	3.8%
Medicaid	1.7%	1.2%	0.6%
Workers' compensation	0.1%	0.2%	—%
Patients	0.1%	0.1%	0.1%
Other income	0.1%	0.1%	0.1%
Total	100.0%	100.0%	100.0%

Medicare Reimbursement

Medicare is a federal program that provides hospital and medical insurance benefits to persons aged 65 and over, qualified disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare providers, facilities, and services. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises the United States Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"), the home health prospective payment system (the "HH-PPS"), and the hospice payment system (the "Hospice-PS"). Congress is not obligated to

adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. However, MedPAC's recommendations have, and could in the future, become the basis for subsequent legislative or, as discussed below, regulatory action.

The Medicare statutes are subject to change from time to time. For example, in March 2010, President Obama signed the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). In December 2018, a federal district court in Texas invalidated the 2010 Healthcare Reform Laws in their entirety but postponed enforcement of that decision pending appeal. On December 18, 2019, the United States Court of Appeals for the Fifth Circuit affirmed the district court decision but remanded the case for additional analysis on the question of severability. With respect to Medicare reimbursement, the 2010 Healthcare Reform Laws provided for specific reductions to healthcare providers' annual market basket updates and other payment policy changes. In August 2011, President Obama signed into law the Budget Control Act of 2011 providing for an automatic 2% reduction, or "sequestration," of Medicare program payments for all healthcare providers. Sequestration took effect April 1, 2013 and, as a result of subsequent legislation, will continue through fiscal year 2029 unless Congress and the President take further action. On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (the "2018 Budget Act"), which includes several provisions affecting Medicare reimbursement. Among those changes, the 2018 Budget Act mandated the adoption of a new Medicare payment model for home health providers which went into effect January 1, 2020. In the future, concerns about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both. The future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain. The 2020 presidential election is likely to involve extensive debate over dramatically different approaches to federal healthcare policy.

From time to time, Medicare regulations, including reimbursement methodologies and rates, can be further modified by CMS. CMS, subject to its statutory authority, may make some prospective payment system changes, including in response to MedPAC recommendations. For example, CMS recently instituted a rebasing adjustment in the HH-PPS consistent with a MedPAC recommendation. In some instances, CMS's modifications can have a substantial impact on healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in prospective payment systems, including the IRF-PPS and HH-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS requires IRFs to submit data on certain quality of care measures for the IRF quality reporting program. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in a subsequent Medicare fiscal year. IRFs began submitting quality data to CMS in October 2012. All of our inpatient rehabilitation hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions. Similarly, home health and hospice agencies are required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update. For 2020, we expect no more than seven of our home health and hospice agencies will incur a reduction in their reimbursement rates.

We cannot predict the adjustments to Medicare payment rates Congress or CMS may make in the future. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. Any additional downward adjustment to rates or limitations on reimbursement for the types of facilities we operate and services we provide could have a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of the risks associated with our concentration of revenues from the federal government or with potential changes to the statutes or regulations governing Medicare reimbursement, including the 2018 Budget Act, see Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Although reductions or changes in reimbursement from governmental or third-party payors and regulatory changes affecting our business represent one of the most significant challenges to our business, our operations are also affected by other rules and regulations that indirectly affect reimbursement for our services, such as data coding rules and patient coverage rules and determinations. For example, Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable and necessary. Current CMS coverage rules require inpatient rehabilitation services to be ordered by a physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide the rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services that may be needed. Medicare contractors processing claims for CMS make coverage determinations regarding medical necessity that can represent restrictive interpretations of the CMS coverage rules.

Those interpretations are not made through a notice and comment review process. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

In the ordinary course, Medicare reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors ("MACs") that act as fiscal intermediaries for all Medicare billings, as well as the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG"), CMS, and state Medicaid programs. In addition to those audits conducted by existing MACs, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. Some contractors are paid a percentage of the overpayments recovered. The Recovery Audit Contractors ("RACs") conduct payment reviews of claims, which can examine coding, overall billing accuracy, and medical necessity. When conducting an audit, the RACs receive claims data directly from MACs on a monthly or quarterly basis.

CMS has also established Unified Program Integrity Contractors ("UPICs"), previously known as Zone Program Integrity Contractors, to perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the United States Department of Justice ("DOJ"). Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the payment errors they identify.

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

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

Inpatient Rehabilitation. As discussed above, our inpatient rehabilitation hospitals receive a fixed payment reimbursement amount per discharge under the IRF-PPS based on the patient's rehabilitation impairment category established by the United States Department of Health and Human Services ("HHS") and other characteristics and conditions identified by the attending clinicians. In order to qualify for reimbursement under the IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, pre-admission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. For example, a physician must admit each patient and in doing so determine that the treatment of the patient in an IRF setting is reasonable and necessary. In addition, to qualify as an IRF under Medicare rules, a facility must be primarily focused on treating patients with one of 13 specified medical conditions that typically require intensive therapy and supervision, such as stroke, brain injury, hip fracture, certain neurological conditions, and spinal cord injury. Specifically, at least 60% of a facility's patients must have a diagnosis from at least one of these 13 conditions, which requirement is known as the "60% Rule." Also, each patient admitted to an IRF must be able to tolerate a minimum of three hours of therapy per day for five days per week and must have a registered nurse available 24 hours, each day of the week.

Under IRF-PPS, CMS is required to adjust the payment rates based on an IRF-specific market basket index. The annual market basket update is designed to reflect changes over time in the prices of a mix of goods and services used by IRFs. In setting annual market basket updates, CMS uses data furnished by the Bureau of Labor Statistics for price proxy purposes, primarily in three categories: Producer Price Indexes, Consumer Price Indexes, and Employment Cost Indexes. With IRF-PPS, our inpatient rehabilitation hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers.

On July 31, 2018, CMS released its notice of final rulemaking for fiscal year 2019 IRF-PPS (the "2019 IRF Rule"). The 2019 IRF Rule implemented a 2.9% market basket update that was reduced by 75 basis points under the requirements of the 2010 Healthcare Reform Laws effective for discharges between October 1, 2018 and September 30, 2019. The 2010 Healthcare Reform Laws also required the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective October 1, 2018 decreased the market basket update by 80 basis points. Additionally, the 2019 IRF Rule included a change to the IRF-PPS, effective October 1, 2019, that replaced the

FIM™ assessment instrument with new patient assessment measures, which we refer to as “Section GG functional measures” or “Section GG” based on the designation CMS assigned to them.

On July 31, 2019, CMS released its notice of final rulemaking for fiscal year 2020 IRF-PPS (the “2020 IRF Rule”). The 2020 IRF Rule implements a net 2.5% market basket increase (market basket update of 2.9% reduced by a productivity adjustment of 40 basis points) effective for discharges between October 1, 2019 and September 30, 2020. The 2020 IRF Rule includes the final form of Section GG changes. Section GG affects patients’ classification into case-mix groupings, relative weights, and length-of-stay values under the IRF-PPS, which in turn will likely negatively impact our reimbursement amounts. The 2020 IRF Rule also includes changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index and labor-related share values. There are also changes to the IRF quality reporting program that require IRFs to collect and report more quality data and clinical information in the future. Based on the market basket update, our analysis of the Section GG changes and the other adjustments included in the 2020 IRF Rule and other factors, we currently estimate Medicare payment rates for our inpatient rehabilitation segment will be flat to up 0.75% in fiscal year 2020.

Unlike our inpatient services, our outpatient services are primarily reimbursed under the Medicare Part B physician fee schedule. On November 1, 2019, CMS released its final notice of rulemaking for the payment policies under the physician fee schedule and other revisions to Part B policies for calendar year 2020. The provisions of this rule, including the updates to the fee schedule, are not expected to be material to us.

Home Health. Medicare pays home health benefits for patients discharged from a hospital or patients otherwise suffering from chronic conditions that require ongoing but intermittent skilled care. As a condition of participation under Medicare, patients must be homebound (meaning unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, or have a continuing need for occupational therapy, and receive treatment under a plan of care established and periodically reviewed by a physician. A physician must document that he or she or a qualifying nurse practitioner has had a face-to-face encounter with the patient and then certify to CMS that a patient meets the eligibility requirements for the home health benefit. This initial certification of Medicare patient eligibility, plan of care, and comprehensive assessment is valid for a 60-day episode of care. Prior to January 1, 2020, Medicare paid home health providers under the HH-PPS for each 60-day episode of care for each patient. Providers typically received either 50% or 60% of the estimated base payment for the full 60 days for each patient upon submission of the initial claim at the beginning of the episode of care based on the patient’s condition and treatment needs. The provider received the remaining portion of the payment after the 60-day treatment period, subject to any applicable adjustments. This partial early payment process is referred to as the Request for Anticipated Payment or “RAP.”

Beginning January 1, 2020, Medicare reimburses home health providers under a new payment system, referred to as the Patient-Driven Groupings Model (“PDGM”). PDGM replaces the current 60-day episode of payment methodology with a 30-day payment period and relies more heavily on clinical characteristics and other patient information (such as principal diagnosis, functional level, referral source, and timing), rather than the current therapy service-use thresholds, to determine payments. Under PDGM, the initial certification will remain valid for 60-days. If a patient remains eligible for care after the initial period as certified by a physician, a new treatment period may begin. There are currently no limits to the number of home health treatment periods a Medicare patient may receive assuming there is eligibility for each successive period. PDGM also reduces the early payment opportunity available through RAP in 2020 and eliminates RAP completely in 2021. Additionally, beginning in 2022, home health providers will be required to submit a Notice of Admission, or “NOA,” within 5 days of the start of the initial treatment period and within 5 days of day 31 for the second 30-day payment period. CMS will reduce reimbursement for agencies that fail to submit a NOA timely. For additional discussion of PDGM and other regulatory and legislative initiatives that could impact our home health business, see Item 1A, *Risk Factors*, and Item 7, *Management’s Discussion and Analysis of Financial Condition and Results of Operations*, “Executive Overview—Key Challenges.”

Home health Medicare payments are adjusted based on each patient’s condition and clinical treatment. This is referred to as the case-mix adjustment. In addition to the case-mix adjustment, payments for periods of care may be adjusted for other reasons, including unusually large (outlier) costs, low-utilization patients (such as those requiring one to five visits based on the case-mix group), and geographic differences in wages. Payments are also made for non-routine medical supplies that are used in treatment.

On October 31, 2018, CMS released its notice of final rulemaking for calendar year 2019 for home health agencies under the HH-PPS (the “2019 HH Rule”). The 2019 HH Rule provided for a net market basket update of 2.2%, after taking into account a productivity adjustment reduction of 80 basis points and offsetting adjustments for the rural add-on program and outlier patients, effective for episodes ending in calendar year 2019. The 2019 HH Rule also included other pricing changes, such as a reduction to the case-mix weights for certain cases.

On October 31, 2019, CMS released its notice of final rulemaking for calendar year 2020 for home health agencies under the HH-PPS (the "2020 HH Rule"). Pursuant to the requirements of the 2018 Budget Act, the 2020 HH Rule finalized the implementation of PDGM for 2020. In addition to the significant changes to the home health reimbursement model related to PDGM discussed above, the 2020 HH Rule requires additional quality reporting measures and significantly increases the standardized patient assessment data elements collected by providers beginning in 2022. With respect to Medicare reimbursement rates, the 2020 HH Rule implements a net 1.3% market basket increase (market basket update of 1.5% reduced by 0.2% for an extension of the rural payment add-on factor) in 2020. The 2020 HH Rule then reduces the base payment rate by 4.4% to offset the provider behavioral changes that CMS assumes PDGM will drive. Based on the market basket update, our analysis of PDGM's significant changes to the reimbursement model and the other adjustments included in the 2020 HH Rule as well as other factors, we currently estimate Medicare payment rates for our home health business will decrease between 2.0% and 3.0% in 2020.

For additional discussion of PDGM and other regulatory and legislative initiatives that could impact our home health business, see Item 1A, *Risk Factors*, and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Hospice. Medicare pays hospice benefits for patients with life expectancies of six months or less, as documented by the patient's physician(s). Under Medicare rules, patients seeking hospice benefits must agree to forgo curative treatment for their terminal medical conditions. For each day a patient elects hospice benefits, Medicare pays an adjusted daily rate based on patient location, and payments represent a prospective per diem amount tied to one of four different categories or levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Medicare hospice reimbursements to each provider are also subject to two annual caps, one limiting total hospice payments based on the average annual payment per beneficiary and another limiting payments based on the number of days of inpatient care billed by the hospice provider. There are currently no limits to the number of hospice benefit periods an eligible Medicare patient may receive, and a patient may revoke the benefit at any time.

On August 1, 2018, CMS released its notice of final rulemaking for fiscal year 2019 for hospice agencies under the Hospice-PS (the "2019 Hospice Rule"). The final rule updated hospice payments between October 1, 2018 and September 30, 2019. The 2019 Hospice Rule provided for a net market basket update of 1.8%.

On July 31, 2019, CMS released its notice of final rulemaking for fiscal year 2020 for hospice agencies under the Hospice-PS (the "2020 Hospice Rule"). The 2020 Hospice Rule provides for various pricing updates for hospice payments between October 1, 2019 through September 30, 2020 and makes other policy updates, including adding a requirement to provide additional cost sharing information to beneficiaries if there are services that will not be covered by the hospice agency. Based on our analysis of the various pricing adjustments included in the 2020 Hospice Rule as well as other factors, we currently estimate Medicare payment rates for our hospice business will increase between 0.25% and 0.75% in fiscal year 2020.

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

Managed Care and Other Discount Plans

We negotiate payment rates with certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms between one and three years, although we have a number of managed care contracts that automatically renew each year (with pre-defined rate increases) unless a party elects to terminate the contract. In 2019, typical rate increases for our inpatient rehabilitation contracts ranged from 2-4% and for our home health and hospice contracts ranged from 0-3%. We cannot provide any assurance we will continue to receive increases in the future. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed unable to afford healthcare. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of some services. Continuing downward pressure on Medicaid payment rates could cause a decline in that portion of our *Net operating revenues*. However, for the year ended December 31, 2019, Medicaid payments represented only 2.8% of our consolidated *Net operating revenues*. In certain states in which we operate, we are experiencing an increase in Medicaid patients, partially the result of expanded coverage consistent

with the intent of the 2010 Healthcare Reform Laws. For additional discussion, see Item 1A, *Risk Factors*, “Changes in our payor mix or the acuity of our patients could adversely impact our revenues or our profitability.”

Cost Reports

Because of our participation in Medicare and Medicaid, we are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenue, costs, and expenses associated with the services provided by inpatient hospital, home health, and hospice providers to Medicare beneficiaries and Medicaid recipients. These annual cost reports are subject to routine audits which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. These audits are used for determining if any under- or over-payments were made to these programs and to set payment levels for future years. Medicare also makes retroactive adjustments to payments for certain low-income patients after comparing subsequently published statistical data from CMS to the cost report data. We cannot predict what retroactive adjustments, if any, will be made, but we do not anticipate these adjustments will have a material impact on us.

Regulation

The healthcare industry is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our operations, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth. State and local healthcare regulation may cover additional matters such as nurse staffing ratios, healthcare worker safety, marijuana legalization, and assisted suicide. We are also subject to the broader federal and state regulations that prohibit fraud and abuse in the delivery of healthcare services. Congress, HHS-OIG, and the DOJ have historically focused on fraud and abuse in healthcare. Since the 1980s, a steady stream of changes have stiffened penalties or made it easier for DOJ to impose liability on companies and individuals, and the pace of these changes has only been increasing. The 2018 Budget Act continues this emphasis by increasing the criminal and civil penalties that can be imposed for violating federal health care laws. As a healthcare provider, we are subject to periodic audits, examinations and investigations conducted by, or at the direction of, government investigative and oversight agencies. Failure to comply with applicable federal and state healthcare regulations can result in a provider’s exclusion from participation in government reimbursement programs and in substantial civil and criminal penalties.

We undertake significant effort and expense to provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as, for most facilities, accreditation standards of The Joint Commission and, for some facilities, the Commission on Accreditation of Rehabilitation Facilities. We also maintain accreditation for our home health and hospice agencies where required and in other instances where it facilitates more efficient Medicare enrollment. The Community Health Accreditation Program is the most common accrediting organization for our agencies. Accredited facilities and agencies are subject to periodic resurvey to ensure the standards are being met.

Beyond healthcare specific regulations, we face increasing state and local regulation in areas, such as labor and employment and data privacy, traditionally subject to only or primarily federal regulation. In addition to the risk and burden of new, additional, or more stringent regulatory standards, these state and local regulations often conflict with federal regulation, and with each other. Given the number of locations in which we operate, increasing state and local regulation, which may be more stringent than federal regulation and may even conflict with federal or other state or local regulation, represents a significant burden and risk to us.

We maintain a comprehensive ethics and compliance program to promote conduct and business practices that meet or exceed requirements under laws, regulations, and industry standards. The program monitors the Company’s performance on and raises awareness of various regulatory requirements among employees and emphasizes the importance of complying with governmental laws and regulations. As part of the compliance program, we provide annual compliance training to our employees, Board members, Medical Directors, vendors, and other non-employees that operate within our hospitals, and require all employees to report any violations to their supervisor or another person of authority or through a toll-free telephone hotline. Another integral part of our compliance program is a policy of non-retaliation against employees who report compliance concerns.

Licensure and Certification

Healthcare facility construction and operation are subject to numerous federal, state, and local regulations relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, acquisition and dispensing of pharmaceuticals and controlled substances, infection control, maintenance of adequate records and patient privacy, fire prevention, and compliance with building codes and environmental protection laws. Our inpatient rehabilitation

hospitals are subject to periodic inspection and other reviews by governmental and non-governmental certification authorities to ensure continued compliance with the various standards necessary for facility licensure. All of our hospitals are required to be licensed.

In addition, inpatient rehabilitation hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. Certification and participation in these programs involve numerous regulatory obligations. For example, hospitals must treat at least 30 patients free-of-charge prior to certification and eligibility for Medicare reimbursement. Once certified by Medicare, hospitals undergo periodic on-site surveys and revalidations in order to maintain their certification. All of our inpatient hospitals participate in the Medicare program.

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

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

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

We have developed operational systems to oversee compliance with the various standards and requirements of the Medicare program and have established ongoing quality assurance activities; however, given the complex nature of governmental healthcare regulations, there can be no assurance Medicare, Medicaid, or other regulatory authorities will not allege instances of noncompliance. A determination by a regulatory authority that a facility or agency is not in compliance with applicable requirements could also lead to the assessment of fines or other penalties, loss of licensure, exclusion from participation in Medicare and Medicaid, and the imposition of requirements that the offending facility or agency must take corrective action.

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities or agencies, or the introduction of new beds or inpatient, home health, and hospice services may be subject to review by and prior approval of state regulatory bodies under a “certificate of need,” or “CON,” law. As of December 31, 2019, approximately 51% of our licensed beds and 36% of our home health and hospice locations are in states or U.S. territories that have CON laws. CON laws require a reviewing authority or agency to determine the public need for additional or expanded healthcare facilities and services. These laws also generally require approvals for capital expenditures involving inpatient rehabilitation hospitals if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any instance where we are subject to a CON law, we must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility, starting a new healthcare program, or opening a new home health or hospice agency.

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

In an attempt to reduce regulation and increase competition, lawmakers in several states have recently proposed modification or even full repeal of CON laws. In 2019, Florida enacted legislation to repeal CON laws for several provider types, including IRFs, in two stages. Effective July 1, 2019, existing IRFs became eligible to expand without first obtaining a CON. Effective July 1, 2021, new IRFs may operate without first obtaining a CON. Other states are expected to consider CON-related legislation and regulation changes, including in some cases expanding CON requirements, in 2020 and beyond.

False Claims

The federal False Claims Act (the "FCA") imposes liability for the knowing presentation of a false claim to the United States government and provides for penalties equal to three times the actual amount of any overpayments plus up to approximately $23,000 per claim. Federal civil penalties will be adjusted to account for inflation each year. In addition, the FCA allows private persons, known as "relators," to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. The government and relators may also allege violations of the FCA for the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. This is known as a "reverse false claim." The government deems identification of the overpayment to occur when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error, cost reporting error or disagreement over physician medical judgment could result in significant damages and civil and criminal penalties under the FCA. Many states have also adopted similar laws relating to state government payments for healthcare services. The 2010 Healthcare Reform Laws amended the FCA to expand the definition of false claim, to make it easier for the government to initiate and conduct investigations, to enhance the monetary reward to relators where prosecutions are ultimately successful, and to extend the statute of limitations on claims by the government. The federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent FCA violations and in challenging the medical judgment of independent physicians as the basis for FCA allegations. Furthermore, well-publicized enforcement actions indicate that the federal government has increasingly sought to use statistical sampling to extrapolate allegations to larger pools of claims or to infer liability without proving knowledge of falsity of individual claims. For additional discussion, see Item 1A, *Risk Factors*, and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

Anti-Kickback Law. Various state and federal laws regulate relationships between providers of healthcare services, including management or service contracts and investment relationships. Among the most important of these restrictions is a federal law prohibiting the offer, payment, solicitation, or receipt of remuneration by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs (the "Anti-Kickback Law"). The 2010 Healthcare Reform Laws amended the federal Anti-Kickback Law to provide that proving violations of this law does not require proving actual knowledge or specific intent to commit a violation. Another amendment made it clear that Anti-Kickback Law violations can be the basis for claims under the FCA. These changes and those described above related to the FCA, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. In addition to standard federal criminal and civil sanctions, including imprisonment and penalties of up to $100,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. Federal civil penalties will be adjusted to account for inflation each year. In 1991, the HHS-OIG issued regulations describing compensation arrangements that are not viewed as illegal remuneration under the Anti-Kickback Law. Those regulations provide for certain safe harbors for identified types of compensation arrangements that, if fully complied with, assure participants in the particular arrangement that the HHS-OIG will not treat that participation as a criminal offense under the Anti-Kickback Law or as the basis for an exclusion from the Medicare and Medicaid programs or the imposition of civil sanctions. Failure to fall within a safe harbor does not constitute a violation of the Anti-Kickback Law, but the HHS-OIG has indicated failure to fall within a safe harbor may subject an arrangement to increased scrutiny. A violation of the Anti-Kickback Law by us or one or more of our joint ventures could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

We operate a number of our rehabilitation hospitals and a few of our home health agencies through joint ventures with institutional healthcare providers that may be in a position to make or influence referrals to us. In addition, we have a number of relationships with physicians and other healthcare providers, including management or service contracts. Some of these investment relationships and contractual relationships may not fall within the protection offered by a safe harbor. Despite our compliance and monitoring efforts, there can be no assurance violations of the Anti-Kickback Law will not be asserted in the future, nor can there be any assurance our defense against any such assertion would be successful.

For example, we have entered into agreements to manage our hospitals that are owned by joint ventures. Most of these agreements incorporate a percentage-based management fee. Although there is a safe harbor for personal services and management contracts, this safe harbor requires, among other things, the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, the fee

arrangement may not meet this requirement. However, we believe our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and comply with the Anti-Kickback Law.

Physician Self-Referral Law. The federal law commonly known as the "Stark law" and CMS regulations promulgated under the Stark law prohibit physicians from making referrals for "designated health services" including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, and home health services, to an entity in which the physician (or an immediate family member) has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing Medicare for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $26,000 for each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $172,000 for a circumvention scheme. Federal civil penalties will be adjusted to account for inflation each year. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.

Under the 2010 Healthcare Reform Laws, the exception to the Stark law that currently permits physicians to refer patients to hospitals in which they have an investment or ownership interest has been dramatically limited by providing that only physician-owned hospitals with a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the physician ownership percentage in the hospital after March 23, 2010. Additionally, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, except when certain market and regulatory approval conditions are met. Currently, we have no hospitals that would be considered physician-owned under this law.

The complexity of the Stark law and the associated regulations and their associated strict liability provisions are a challenge for healthcare providers, who do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet one or more exceptions to the Stark law, but the regulations implementing the exceptions are detailed and complex. Accordingly, we cannot assure that every relationship complies fully with the Stark law.

Additionally, no assurances can be given that any agency charged with enforcement of the Stark law and regulations might not assert a violation under the Stark law, nor can there be any assurance our defense against any such assertion would be successful or that new federal or state laws governing physician relationships, or new interpretations of existing laws governing such relationships, might not adversely affect relationships we have established with physicians or result in the imposition of penalties on us. A violation of the Stark law by us could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare or Medicaid beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive a monetary reward for providing information on Medicare fraud and abuse that leads to the recovery of at least Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties. The HHS Office of Civil Rights ("HHS-OCR") implemented a permanent HIPAA audit program for healthcare providers nationwide in 2016. As of December 31, 2019, we have not been selected for audit.

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

The Health Information Technology for Economic and Clinical Health ("HITECH") Act modifies and expands the privacy and security requirements of HIPAA. The HITECH Act applies certain of the HIPAA privacy and security requirements directly to business associates of covered entities. The modifications to existing HIPAA requirements include: expanded

accounting requirements for electronic health records, tighter restrictions on marketing and fundraising, and heightened penalties and enforcement associated with noncompliance. Significantly, the HITECH Act also establishes new mandatory federal requirements for notification of breaches of security involving protected health information. The HHS-OCR rules implementing the HITECH Act expand the potential liability for a breach involving protected health information to cover some instances where a subcontractor is responsible for the breaches and that individual or entity was acting within the scope of delegated authority under the related contract or engagement. These rules generally define “breach” to mean the acquisition, access, use or disclosure of protected health information in a manner not permitted by the HIPAA privacy standards, which compromises the security or privacy of protected health information. Under these rules, improper acquisition, access, use, or disclosure is presumed to be a reportable breach, unless the potentially breaching party can demonstrate a low probability that protected health information has been compromised.

HHS-OCR is responsible for enforcing the requirement that covered entities notify HHS and any individual whose protected health information has been improperly acquired, accessed, used, or disclosed. In certain cases, notice of a breach is required to be made to media outlets. The heightened penalties for noncompliance range from $100 to $50,000 per violation for most violations. In the event of violations due to willful neglect that are not corrected within 30 days, penalties start at $50,000 per violation and are not subject to a per violation statutory maximum. Penalties are also subject to an annual cap for multiple identical violations in a single calendar year. Pursuant to 2019 guidance from HHS-OCR, this enforcement caps ranges from $25,000 per year to $1,500,000 per year depending on an entity’s level of culpability. Importantly, HHS-OCR has indicated that the failure to conduct a security risk assessment or adequately implement HIPAA compliance policies could qualify as willful neglect.

In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Healthcare providers will continue to remain subject to any federal or state privacy-related laws, including but not limited to the California Consumer Privacy Act, that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. HHS-OIG and other regulators have also increasingly interpreted laws and regulations in a manner as to increase exposure of healthcare providers to allegations of noncompliance. Any actual or perceived violation of privacy-related laws and regulations, including HIPAA and the HITECH Act, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Civil Monetary Penalties Law

Under the Civil Monetary Penalties Law, HHS may impose civil monetary penalties on healthcare providers that present, or cause to be presented, ineligible reimbursement claims for services. The 2018 Budget Act increased the civil monetary penalties, which vary depending on the offense from $5,000 to $100,000 per violation, plus treble damages for the amount at issue and may include exclusion from federal health care programs such as Medicare and Medicaid. The penalties will be adjusted annually to account for inflation. HHS may seek to impose monetary penalties under this law for, among other things, offering inducements to beneficiaries for program services and filing false or fraudulent claims.

Available Information

We make available through our website, www.encompasshealth.com, the following documents, free of charge: our annual reports (Form 10-K), our quarterly reports (Form 10-Q), our current reports (Form 8-K), and any amendments to those reports promptly after we electronically file such material with, or furnish it to, the United States Securities and Exchange Commission.

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and the reader should take such risks into account in evaluating Encompass Health or any investment decision involving Encompass Health. This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of material risk factors. More detailed information concerning other risks and uncertainties as well as those described below is contained in other sections of this annual report. Still other risks and uncertainties we have not or cannot foresee as material to us may also adversely affect us in the future. If any of the risks below or other risks or uncertainties discussed elsewhere in this annual report are actually realized, our business and financial condition, results of operations, and cash flows could be adversely affected. In the event the impact is materially adverse, the trading price of our common stock could decline.

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

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

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). Many provisions within the 2010 Healthcare Reform Laws have impacted or could in the future impact our business, including Medicare reimbursement reductions and promotion of alternative payment models, such as accountable care organizations ("ACOs") and bundled payment initiatives. The Trump administration and the United States Congress have previously attempted, and may in the future attempt, to change or repeal provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. For example, on December 22, 2017, President Trump signed into law the Tax Cuts and Jobs Act, which eliminated the tax penalty for individuals for failing to enroll in health insurance beginning in 2019. On January 20, 2017, President Trump issued his first executive order titled "Minimizing the Economic Burden of the Patient Protection And Affordable Care Act Pending Repeal," that directs federal regulators to begin dismantling those laws through regulatory and policy-making processes and procedures, "to the maximum extent permitted by law." In December 2018, a federal district court in Texas invalidated the 2010 Healthcare Reform Laws in their entirety based on the elimination of the tax penalty but postponed enforcement of that decision pending appeal. On December 18, 2019, the United States Court of Appeals for the Fifth Circuit affirmed the district court decision but remanded the case for additional analysis on the question of severability. The future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain. The 2020 presidential election is likely to involve extensive debate over dramatically different approaches to federal healthcare policy. Any future changes may ultimately impact the provisions of the 2010 Healthcare Reform Laws discussed below or other laws or regulations that either currently affect, or may in the future affect, our business.

For Medicare providers like us, these laws include reductions in CMS's annual adjustments to Medicare reimbursement rates, commonly known as a "market basket update." In accordance with Medicare laws and statutes, CMS makes market basket updates by provider type in an effort to compensate providers for rising operating costs. The 2010 Healthcare Reform Laws required reductions, the last of which ended in 2019, in the annual market basket updates for hospital providers ranging from 10 to 75 basis points and for hospice agencies 30 basis points. For home health agencies, the 2010 Healthcare Reform Laws directed CMS to improve home health payment accuracy through rebasing home health payments over four years starting in 2014. In addition, the 2010 Healthcare Reform Laws require the market basket updates for hospital, home health, and hospice providers to be reduced by a productivity adjustment on an annual basis. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. To date, the productivity adjustments have resulted in decreases to the market basket updates ranging from 30 to 100 basis points.

Other federal legislation can also have a significant direct impact on our Medicare reimbursement. On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2% reduction of Medicare program payments. This automatic reduction, known as "sequestration," began affecting payments received after April 1, 2013. Sequestration has been extended by subsequent legislation, most recently by the Bipartisan Budget Act of 2019, which was

signed into law on August 2, 2019. Under current law each year through fiscal year 2029, the reimbursement we receive from Medicare, after first taking into account all annual payment adjustments including the market basket update, will be reduced by sequestration unless it is repealed or modified before then. The Bipartisan Budget Act of 2018 (the "2018 Budget Act"), signed into law by President Trump on February 9, 2018, includes several provisions affecting Medicare reimbursement. Among those changes, the 2018 Budget Act mandates the adoption of a new Medicare payment model for home health providers effective in 2020 and eliminates the payment adjustments mandated by the 2010 Health Care Reform Laws in favor of fixing a market basket update of 1.5% in 2020.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, or healthcare spending specifically could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. In October 2014, President Obama signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act"). The IMPACT Act 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 implementation of a new post-acute payment system, we believe this act lays 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. CMS has begun changing current post-acute payment systems to improve comparability of patient assessment data and clinical characteristics across settings, which will make it easier to create a unified payment system in the future. For example, CMS recently established new case-mix classification models for both home health, discussed further below, and skilled nursing facilities which rely on patient characteristics rather than the amount of therapy received to determine payments. Another example is CMS's implementation of the new patient assessment measures for IRFs discussed below. The IMPACT Act also creates additional data reporting requirements for our hospitals and home health agencies. The precise details of these new reporting requirements, including timing and content, are being developed and implemented by CMS through the regulatory process that we expect will continue to take place over the next several years. We cannot quantify the potential effects of the IMPACT Act on us.

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

In connection with CMS's final rulemaking for the IRF-PPS and the HH-PPS in each year since 2008, MedPAC has recommended either no updates to payments or reductions to payments. In a March 2019 report to Congress, MedPAC recommended, among other things, legislative changes to reduce by 2% the 2020 update for hospice agencies and reduce by 5% the base payments under the HH-PPS and IRF-PPS. In the March 2019 report, MedPAC also reiterated a previous recommendation for Congress to increase the outlier payment pool, to be funded by reductions to base Medicare payments rates under the IRF-PPS. This proposal would adversely affect us as we have a relatively low percentage of outlier patients compared to other inpatient rehabilitation providers.

In a June 2018 report mandated by the IMPACT Act, MedPAC reiterated its recommendation that Congress adopt a unified payment system for all post-acute care ("PAC-PPS") in lieu of separate systems for inpatient rehabilitation facilities ("IRFs"), skilled nursing facilities, long-term acute care hospitals, and home health agencies. A PAC-PPS would rely on "site neutral" reimbursement based on patients' medical conditions and other clinical factors rather than the care settings. MedPAC found a PAC-PPS to be feasible and desirable but also suggested many existing regulatory requirements, including the 60% rule discussed below and the requirement for a minimum of three hours of therapy per day, should be waived or modified as part of implementing a PAC-PPS. MedPAC previously estimated, although we cannot verify the methodology or the accuracy of that estimate, a PAC-PPS would result in 15% and 1% decreases to IRF and home health reimbursements, respectively. As a precursor to a unified PAC-PPS, MedPAC discussed in November 2017 a potential recommendation to change the case-mix weights in each post-acute setting for 2019 and 2020 to a blend of the current setting specific weight and the proposed unified PAC-PPS weight, which MedPAC suggested would shift money from for-profit and freestanding IRFs to non-profit and hospital-based IRFs. MedPAC has also called for aligning Medicare regulatory requirements across post-acute providers, although the agency has acknowledged it could take years to complete this effort. Additionally, MedPAC previously has suggested that Medicare should ultimately move from fee-for-service reimbursement to more integrated delivery payment models.

MedPAC also recommended significant changes to the HH-PPS, some of which CMS incorporated into the new payment system mandated by the 2018 Budget Act, referred to as the Patient-Driven Groupings Model ("PDGM"), and set out in the final rule for the 2019 HH-PPS. Beginning in 2020, PDGM replaces the current 60-day episode of payment methodology with a 30-day payment period and eliminates therapy usage as a factor in setting payments (that is, more therapy visits lead to higher reimbursement). CMS adopted a 4.4% reduction in the base payment rate for 2020 intended to offset the provider behavioral changes that CMS assumes PDGM will drive. The reimbursement and other changes associated with PDGM could have a significant impact on our home health agencies.

With respect to significant changes to the IRF-PPS, CMS finalized pursuant to a requirement of the IMPACT Act a change, effective October 1, 2019, that replaces the FIM™ assessment instrument with new patient assessment measures, which we refer to as "Section GG functional measures" or "Section GG" based on the designation CMS assigned to them. This change in how patients are assessed and reported to CMS affects patients' classification into case-mix groupings, relative weights, and length-of-stay values under the IRF-PPS, which in turn will likely negatively impact our reimbursement amounts.

We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post-acute care reforms, if any, will ultimately be adopted or enacted into law, or the timing or effect of any initiatives or reductions. Those initiatives or reductions would be in addition to many ordinary course reimbursement rate changes that CMS adopts each year as part of the market basket update rulemaking process for various provider categories. While we do not expect the drive toward integrated delivery payment models, value-based purchasing, and post-acute site neutrality in Medicare reimbursement to subside, there are well publicized efforts to repeal, or alter implementation of, various provisions of the 2010 Healthcare Reform Laws and substitute yet to be determined healthcare reforms. We cannot predict the nature or timing of any changes to the 2010 Healthcare Reform Laws or other laws or regulations that either currently affect, or may in the future affect, our business.

There can be no assurance future governmental action will not result in substantial changes to, or material reductions in, our reimbursements. Similarly, we may experience material increases in our operating costs. For example, in 2020, we expect our wage and benefit costs to increase at a rate in excess of our aggregate Medicare reimbursement rate increase. In any given year, the net effect of statutory and regulatory changes may result in a decrease in our reimbursement rate, and that decrease may occur at a time when our expenses are increasing. As a result, there could be a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of how we are reimbursed by Medicare, see Item 1, *Business*, "Regulatory and Reimbursement Challenges" and "Sources of Revenues—Medicare Reimbursement."

In addition, there are increasing pressures, including as a result of the 2010 Healthcare Reform Laws, from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors, such as health maintenance organizations and preferred provider organizations, are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. Our *Net operating revenue*s and our ability to grow our business with these payors could be adversely affected if we are unable to negotiate and maintain favorable agreements with third-party payors.

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

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

In recent years, HHS has been studying the feasibility of bundling, including conducting a voluntary, multi-year bundling pilot program to test and evaluate alternative payment methodologies. CMS' voluntary Bundled Payments for Care Improvement Advanced ("BPCI Advanced") initiative began October 1, 2018, runs through December 31, 2023, and covers 29 types of inpatient and three types of outpatient clinical episodes, including stroke and hip fracture. Providers participating in BPCI Advanced are subject to a semi-annual reconciliation process where CMS compares the aggregate Medicare expenditures for all items and services included in a clinical episode against the target price for that type of episode to determine whether the participant is eligible to receive a portion of the savings, or is required to repay a portion of the payment above target.

Accordingly, reimbursement may be increased or decreased, compared to what would otherwise be due, based on whether the total Medicare expenditures and patient outcomes meet, exceed or fall short of the targets.

Similarly, CMS has established per the 2010 Healthcare Reform Laws several separate ACO programs, the largest of which is the Medicare Shared Savings Program ("MSSP"), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Under the MSSP, there are two ACO tracks from which participants can choose. Each track offers a different degree to which participants share any savings realized or any obligation to repay losses suffered. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. According to CMS, 517 MSSP ACOs served 11.2 million patients as of January 1, 2020.

We continue to evaluate, on a case-by-case basis, appropriate BPCI Advanced and ACO participation opportunities for our hospitals and home health agencies. More than 20 of our inpatient rehabilitation hospitals have signed participation or preferred provider agreements with these alternative payment models. Given the timing of our involvement, those hospitals have treated only a limited number of patients under these alternative payment models to date. We have also partnered as the preferred home health provider with two ACOs serving approximately 26,000 total Medicare patients in Texas and Oklahoma, one of which met the minimum savings rate required to participate in Medicare shared savings for 2018.

On November 16, 2015, CMS published its final rule establishing the Comprehensive Care for Joint Replacement ("CJR") payment model, which holds acute care hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for lower extremity joint replacements (i.e., knees and hips) from surgery through recovery. The CJR originally was mandatory for the acute care hospitals in the 67 geographic areas covered. On November 30, 2017, CMS issued a final rule making the CJR voluntary in 33 of those areas. During the CJR model's five-year term that ends in December 2020, healthcare providers in the 34 geographic areas with mandatory participation will continue to be paid under existing Medicare payment systems. However, the acute-care hospital where the joint replacement takes place will be held accountable for the quality and costs of care for the entire episode of care — from the time of the original admission through 90 days after discharge. Depending on the quality and cost performance during the entire episode, the acute-care hospital may receive an additional payment or be required to repay Medicare a portion of the episode costs. As a result, CMS believes acute care hospitals will be incented to work with physicians and post-acute care providers to ensure beneficiaries receive the coordinated care they need in an efficient manner. Acute care hospitals participating in the CJR model may enter into risk-sharing financial arrangements with post-acute providers, including IRFs and home health agencies. We operate 25 inpatient rehabilitation hospitals in the 34 areas with mandatory participation.

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

Additionally, as the number and types of bundling and ACO models increase, the number of Medicare beneficiaries who are treated in one of the models increases. Our willingness or inability to participate in integrated delivery payment and other alternative payment models and the referral patterns of other providers participating in those models may limit our access to Medicare patients who would benefit from treatment in inpatient rehabilitation hospitals or by home care services. In an attempt to reduce costs, ACOs may seek to discourage referrals to post-acute care all together. To the extent that acute care hospitals participating in those models do not perceive our quality of care or cost efficiency favorably compared to alternative post-acute providers, we may experience a decrease in volumes and *Net operating revenues*, which could adversely affect our financial position, results of operations, and cash flows. For further discussion of new coordinated care and integrated delivery payment models and value-based purchasing initiatives, the associated challenges, and our efforts to respond to them, see the "Executive Overview—Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*.

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

In addition to the legislative and regulatory actions that directly affect our reimbursement rates or further the evolution of the current healthcare delivery system, other legislative and regulatory changes, including as a result of ongoing healthcare reform, affect healthcare providers like us from time to time. For example, the 2010 Healthcare Reform Laws provide for the expansion of the federal Anti-Kickback Law and the False Claims Act (the "FCA") that, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the FCA, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the HHS Office of Inspector General (the "HHS-OIG") or the United States Department of Justice ("DOJ"). Any such suspension would adversely affect our financial position, results of operations, and cash flows.

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

On September 30, 2019, CMS adopted a new rule as called for by the IMPACT Act that revises the discharge planning requirements applicable to our inpatient rehabilitation hospitals and home health agencies. Effective November 29, 2019, CMS now requires every hospital (including IRFs) to have a discharge planning process that focuses on patients' goals and preferences and on preparing them and, as appropriate, their caregivers, to be active partners in their post-discharge care. For our hospitals, this rule requires instituting standardized procedures to identify those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and to provide a discharge planning evaluation for such patients to ensure that appropriate arrangements for post-hospital care will be made before discharge. At the time of discharge, a hospital must transfer or refer the patient, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care. Patients must also be informed of all post-acute providers in the area and, for patients enrolled in managed care organizations, in network providers must be identified if the hospital has that information. Additional information must be provided to patients who are discharged home and referred for home health agency services or who are referred to other post-acute care services.

For home health agencies, the final rule includes several new requirements, including that home health agencies develop and implement an effective discharge planning process. Home health agencies must also send certain medical and other information to the post-discharge facility or health care practitioner, and comply with requests for additional information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner. The rule will likely require implementation of new processes and modification of existing discharge forms and reports, and patient visits may need to be extended in order to accommodate patient education. We expect to incur additional one-time and recurring expenses in both our segments to comply with the new requirements, but at this time we cannot predict what the final impact will be. In areas where we are not part of a managed care network with significant enrollment, this discharge planning rule may negatively affect the number of patients choosing us.

In accordance with requirements adopted pursuant to the IMPACT Act, CMS implemented requirements to publish certain Medicare spending per beneficiary measures for each inpatient rehabilitation hospital in October 2016 and each home health agency in January 2017. The intent of tracking and publishing this data is to evaluate a given provider's payment efficiency relative to the efficiency of the national median provider in that provider's post-acute segment. CMS believes this measure will encourage improved efficiency and coordination of care in the post-acute setting by holding providers accountable for Medicare resource use during an episode of care. However, the measures may be misleading as they do not incorporate patient outcomes associated with those resources used. CMS has not proposed to compare payment efficiency across provider segments.

In June 2019, CMS commenced the Home Health Review Choice Demonstration ("RCD") in Illinois. RCD is intended to test whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud and whether the pre-claim review helps reduce expenditures while maintaining or improving quality of care. Under RCD, providers may choose pre-claim review or post-payment review of all Medicare claims submitted or elect not to participate, in which case

they will incur a 25% payment reduction on all claims. If a home health agency elects to participate in the review and 90% or more of its claims are found to be valid during the six month pre-claim review period, that agency may then opt out of the RCD review, except for spot reviews of samples consisting of 5% of total claims. CMS implemented RCD in Ohio in September 2019. RCD is scheduled to expand to Texas in March 2020 and to North Carolina and Florida in May 2020. We operate agencies (representing approximately 44% of our home health Medicare claims) in these five states. We expect this demonstration project will require us to incur additional administrative and staffing costs and may impact the timeliness of claims payment given that Medicare administrative contractors in Illinois in a prior version of the project had difficulty processing pre-claim reviews on a timely basis. Accordingly, we may experience temporary decreases in *Net operating revenues* and in cash flow, or we may incur costs associated with patient care for which the Medicare claim is subsequently denied, which could have an adverse effect on our financial position, results of operations, and liquidity.

As discussed above, MedPAC makes healthcare policy recommendations to Congress and provides comments to CMS on Medicare payment related issues. Congress is not obligated to adopt MedPAC's recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt any given MedPAC recommendation. For example, in March and June 2019, MedPAC issued reports to Congress again recommending several possible changes, which MedPAC has advocated previously, to various post-acute payment systems. One possible change discussed was an increase to outlier payments to be funded by reductions to non-outlier payments rates under the IRF-PPS. This change would adversely impact us compared to other IRF providers because our hospitals have also historically averaged significantly less Medicare reimbursement for high cost outlier patients than other providers have averaged.

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

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

The focus on alternative payment models and value-based purchasing of healthcare services has, in turn, led to more extensive quality of care reporting requirements. In many cases, the new reporting requirements are linked to reimbursement incentives. For example, under the 2010 Healthcare Reform Laws, CMS established new quality data reporting, effective October 1, 2012, for all IRFs. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in the subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions. Similarly, home health and hospice agencies are required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket updates. For 2020, we expect no more than seven of our home health and hospice agencies will incur a reduction in their reimbursement rates.

As noted above, the IMPACT Act mandated that CMS adopt several new quality reporting measures for the various post-acute provider types. The adoption of additional quality reporting measures to track and report will require additional time and expense and could affect reimbursement in the future. In healthcare generally, the burdens associated with collecting, recording, and reporting quality data are increasing. Currently, CMS requires IRF and home health providers to track and submit patient assessment data to support the calculation of 15 and 19 quality reporting measures, respectively.

In 2015, CMS established a five-year home health value-based purchasing model in nine states to test whether incentives for better care can improve outcomes in the delivery of home health services. The model, which began in 2016, applies a reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, made to agencies in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. As of December 31, 2019, we have 44 home health locations in those states, which account for 23% of our home health Medicare revenue. Performance will be assessed based on several process, outcome, and care satisfaction measures, and the payment adjustments to be applied on an annual basis are set forth in the table below:

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

To date, we have not experienced a decrease in *Net operating revenues* in excess of $0.5 million in any year. Based on 2018 performance data, we anticipate almost no impact to our 2020 reimbursements. There can be no assurance all of our hospitals and agencies will meet quality reporting requirements or quality performance in the future which may result in one or more of our hospitals or agencies seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

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

Healthcare providers are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, enrollments, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under the 2007 Medicare Act;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- minimum staffing;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

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

In addition to specific compliance-related laws and regulations, examples of regulatory changes that can affect our business, beyond direct changes to Medicare reimbursement rates, can be found from time to time in CMS’s annual rulemaking.

For example, the final rule for the fiscal year 2010 IRF-PPS implemented new coverage requirements which provided in part that a patient medical record must document a reasonable expectation that, at the time of admission to an IRF, the patient generally required and was able to participate in the intensive rehabilitation therapy services uniquely provided at IRFs. CMS has also taken the position that a patient's medical file must appropriately document the rationale for the use of group therapies, as opposed to one-on-one therapy. Beginning on October 1, 2015, CMS instituted a new data collection requirement pursuant to which IRFs must capture the minutes and mode (individual, group, concurrent, or co-treatment) of therapy by specialty. CMS plans to use this data to potentially support future rulemaking in this area. Additionally, from time to time CMS has adopted changes in the medical conditions that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

Of note, the HHS-OIG periodically updates a work plan that identifies areas of compliance focus. In recent years, HHS-OIG work plans for IRFs have focused on, among other items, the appropriate utilization of concurrent and group therapy and adverse and temporary harm events occurring in IRFs. The HHS-OIG website indicates active work plans will focus on incentives under the IRF-PPS to discharge patients prematurely to home health agencies and appropriate documentation to support claims by home health and hospice agencies. Another active work plan provides HHS-OIG will determine if hospice patients are receiving the required visits by registered nurses. In September 2016, the HHS-OIG released a report purporting to identify a high error rate (approximately 80% of claims) among inpatient rehabilitation hospital admissions in a small sample of 220 claims. Based on its findings, the HHS-OIG extrapolated the error rate to the universe of inpatient rehabilitation claims and, among other things, recommended reevaluation of the IRF-PPS. However, that HHS-OIG report involved an extremely small sample size, was not a random sample of cases, included some citations to coverage requirements that did not match actual regulations, appeared to conflate technical documentation requirements with medical necessity determinations, and was at odds with actual Medicare Administrative Contractors ("MACs") reviews of claims during that same timeframe which found substantially lower error rates. The HHS-OIG work plan, audit or similar future efforts could result in proposed changes to the payment systems for providers or increased denials of Medicare claims for patients notwithstanding the referring physicians' judgment that treatment is appropriate.

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

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. Those subpoenas requested documents, including copies of patient medical records, related to reimbursement claims submitted during periods ranging from January 2008 through December 2013. The associated investigation led by DOJ was based on whistleblower claims of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requested documents and materials relating to practices, procedures, protocols and policies of certain pre- and post-admissions activities at these hospitals including marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% Rule," 60% or more of the patients of an IRF must have at least one of a specified list of medical conditions in order to be reimbursed at the IRF-PPS payment rates, rather than at the lower acute care hospital payment rates.

We settled the DOJ investigation, together with the related *qui tam* or whistleblower lawsuits, in 2019 for a total payment of $48 million. In return for the settlement payment, the plaintiffs dismissed with prejudice their pending *qui tam* claims, and DOJ provided Encompass Health and all its subsidiaries with a release from civil liability. See Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements for additional discussion of this matter.

Although we have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, we have in the past been, and could in the future be, required to return portions of reimbursements for discharges alleged after the fact to

have not been appropriate under the applicable reimbursement rules and change our patient admissions practices going forward. We could also be subjected to other liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs, which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement or debt instruments.

Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. As discussed above in connection with the 2010 Healthcare Reform Laws, the federal government has in the last couple of years made compliance enforcement and fighting healthcare fraud top priorities. In the past few years, DOJ and HHS as well as federal lawmakers have significantly increased efforts to ensure strict compliance with various reimbursement related regulations as well as combat healthcare fraud. DOJ has pursued and recovered record amounts based on alleged healthcare fraud. The increased enforcement efforts have frequently included aggressive arguments and interpretations of laws and regulations that pose risks for all providers. For example, the federal government has increasingly asserted that incidents of erroneous billing or record keeping may represent violations of the FCA. Human error and oversight in record keeping and documentation, particularly where those activities are the responsibility of non-employees, are always a risk in business, and healthcare providers and independent physicians are no different. Additionally, the federal government has been willing to challenge the medical judgment of independent physicians in determining issues such as the medical necessity of a given treatment plan.

Settlements of alleged violations or imposed reductions in reimbursements, substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation and could cost us significant time and expense to defend.

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

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

In the context of our inpatient rehabilitation business, one of the prevalent grounds for denying a claim or challenging a previously paid Medicare claim in an audit is that the patient's treatment in a hospital was not medically necessary. The medical record must support that both the documentation and coverage criteria requirements are met for the hospital stay to be considered medically reasonable and necessary. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. A Medicare claim may be denied or challenged based on an opinion of the auditor that the record did not evidence medical necessity for treatment in an IRF or lacked sufficient documentation to support the conclusion. In the past, we had a MAC that made determinations regarding medical necessity using its own uniquely restrictive interpretations of the CMS coverage rules or imposing otherwise arbitrary conditions not set out in the related rules, which resulted in a significant number of payment denials.

In some cases, we believe the reviewing party is not merely challenging the sufficiency of the medical record but is substituting its judgment of medical necessity for that of the attending physician or imposing documentation or other requirements that are not set out in the regulations. We argue that doing so is inappropriate and has no basis in law. When the government or its contractors reject the medical judgment of physicians or impose documentation and other requirements beyond the language of the statutes and regulations, patient access to inpatient rehabilitation as well as our Medicare reimbursement from the related claims may be adversely affected.

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 UPIC or RAC (defined below). As of December 31, 2019, none of our hospitals or agencies have progressed beyond the third round of reviews, so it is unclear how the review process after TPE would proceed. We cannot predict whether the TPE initiative or similar probes or reviews will affect our ability to collect a material amount of Medicare claims on a timely basis in the future.

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

RAC audits of IRFs initially focused on coding errors but subsequently expanded to include medical necessity and billing accuracy reviews. To date, the Medicare payments subject to RAC audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2019. We have appealed substantially all RAC denials arising from these audits using the same process we follow for appealing pre-payment denials by MACs. CMS has authorized RACs to conduct complex reviews of the medical records associated with both IRF and home health reimbursement claims.

CMS has also established contractors known as the Uniform Program Integrity Contractors ("UPICs," formerly known as "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 UPICs conduct audits and have the ability to refer matters to the HHS-OIG or DOJ. Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the error. We have, from time to time, received UPIC record requests which have resulted in claim denials on paid claims. In some cases, the UPICs have extrapolated error rates to larger pools of our claims. In the most significant example to date, a UPIC denied less than $2 million in claims but recouped an extrapolated amount of approximately $30 million. We have appealed substantially all UPIC denials, including the recoupment noted above, arising from these audits using the same process we follow for appealing other denials by contractors and will continue to contest the use of extrapolation in any context.

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

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations. Similarly, there can be no assurance that our current or future MACs will not take restrictive interpretations of Medicare coverage rules. Because one MAC has jurisdiction over a significant number of our hospitals and our hospitals derive a substantial portion of their revenue from Medicare, the adoption of restrictive interpretations of coverage rules by that MAC could result in a large number of payment denials and materially and adversely affect our financial position, results of operations, and cash flows.

The use of sub-regulatory guidance, statistical sampling, and extrapolation by CMS, Medicare contractors, HHS-OIG, and DOJ to deny claims, expand enforcement claims, and advocate for changes in reimbursement policy increases the risk that we could experience reduced revenue, suffer penalties, or be required to make significant changes to our operations.

Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Our ability to operate in a compliant manner impacts the claims denials, compliance enforcement, and regulatory processes discussed in other risks above. The federal government's reliance on sub-regulatory guidance, such as handbooks, FAQs, internal memoranda, and press releases, presents a unique challenge to compliance efforts. Such sub-regulatory guidance purports to explain validly promulgated regulations but often expands or supplements existing regulations without constitutionally and statutorily required notice and comment and other procedural protections. Without procedural protections, sub-regulatory guidance poses a risk above and beyond reasonable efforts to follow validly promulgated

regulations, particularly when the agency or MAC seeking to enforce such sub-regulatory guidance is not the agency or MAC issuing the guidance and therefore not as familiar with the substance and nature of the underlying regulations or even clinical issues involved.

Additionally, the federal government is increasingly turning to statistical sampling and extrapolation to expand claims denials and enforcement efforts and advocate for changes in reimbursement policy. Through sampling and extrapolation, the government takes a review of a small number of reimbursement claims and generalizes the results of that review to a much broader universe of claims, which can result in significant increases in the aggregate number and value of claims at issue. Increasing use of extrapolation can be found in payment review audits, such as those conducted by RACs and UPICs. In addition to payment reviews, government agencies may allege compliance violations, including submission of false claims, based on sampling and extrapolation and seek to change reimbursement policy. For example, the HHS-OIG issued a report in September 2018 purporting to identify a high error rate (approximately 80% of claims) among inpatient rehabilitation hospital admissions in a small sample of 220 claims. Based on its findings, the HHS-OIG extrapolated the error rate to the universe of inpatient rehabilitation claims and, among other things, recommended reevaluation of the IRF-PPS. However, the HHS-OIG report involves an extremely small sample size, is not a random sample of cases, includes incorrect references to coverage requirement regulations, appears to conflate technical documentation requirements with medical necessity determinations, and is at odds with actual MAC reviews of claims during that same timeframe which found substantially lower error rates. Notwithstanding the technical statistical flaws that can arise in sampling small groups of claims and the extremely problematic nature of extrapolation in the context of individualized decisions of medical judgment as some courts are beginning to note, sampling and extrapolation pose a growing risk to healthcare providers in the form of more significant claims of overpayments and increased legal costs to defend against these problematic regulatory practices. Any associated loss of revenue or increased legal costs could materially and adversely affect our financial position, results of operations, and cash flows.

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

Ordinary course Medicare pre-payment denials by MACs, as well as denials resulting from widespread probes and audits, are subject to appeal by providers. We have historically appealed a majority of our denials. For claims we choose to appeal to an administrative law judge, we have historically experienced a success rate of approximately 70%. Due to the sheer number of appeals and various administrative inefficiencies, including a shortage of judges, appeals that are due to be resolved in a matter of months commonly take years to complete. For example, most of our appeals heard in 2019 related to denials received in 2013 and 2014. We believe the process for resolving individual Medicare payment claims that are denied will continue to take several years. Additionally, the number of new denials far exceeds the number of appeals resolved in recent years (except 2018) as shown in the following summary of our inpatient rehabilitation segment activity:

	New Denials	Collections of Previously Denied Claims	Revenue Reserve for New Denials
		(In Millions)	
2019	$20.2	$14.9	$6.1
2018	10.2	14.1	3.0
2017	43.6	27.6	13.0
2016	74.9	26.2	20.6
2015	79.0	15.0	20.6

We currently record our estimates for pre-payment denials and for post-payment audit denials that will ultimately not be collected as a component of *Net operating revenues*. See Note 1, *Summary of Significant Accounting Policies*, “Net Operating Revenues,” to the accompanying consolidated financial statements. Given the continuing or increasing delays along with the increasing number of denials in the backlog, we may experience decreases in *Net operating revenues* and/or decreases in cash flow as a result of increasing accounts receivable, which may in turn lead to a change in the patients and conditions we treat. Any of these impacts could have an adverse effect on our financial position, results of operations, and liquidity. Although Congress has considered legislation to reform and improve the Medicare audit and appeals process, we cannot predict what, if any, legislation will be adopted or what, if any, effect that legislation might have on the audit and appeals process.

In May 2014, the American Hospital Association (the “AHA”) and others filed a lawsuit seeking to compel HHS to meet the statutory deadlines for adjudication of denied Medicare claims. In December 2016, the presiding federal district court judge in the lawsuit ordered HHS to eliminate the backlog of appeals by the end of 2020. HHS appealed the federal district

court decision, and an appeals court remanded the order for further consideration of how HHS can eliminate the backlog. On November 1, 2018, the district court again ordered HHS to achieve the following reductions: 19% by the end of fiscal year 2019; 49% by the end of fiscal year 2020; 75% by the end of fiscal year 2021; and 100% by the end of fiscal year 2022. We cannot predict what, if any, further action CMS will take to reduce the backlog or how long it will take to resolve our pending appeals of payment denials that are part of the backlog.

The Hospital Pricing Transparency Rule could adversely affect our business and results of operations.

On November 15, 2019, CMS released a final rule on hospital price transparency requirements that become effective on January 1, 2021. This rule requires hospitals to publish on the internet in a consumer-friendly format their standard charges based on negotiated rates for all items and services and up to 300 common shoppable services. Shoppable services are those routinely provided in non-urgent situations and include those ancillary services that customarily accompany the primary service being provided. The charges for an individual item or service to be published include:

- gross charge (charge as reflected on a hospital's chargemaster, absent any discounts),
- payer-specific negotiated charge (charge negotiated with a third party payer for an item or service),
- de-identified minimum negotiated charge (lowest charge negotiated with all third-party payers),
- de-identified maximum negotiated charge (highest charge negotiated with all third-party payers), and
- discounted cash price (charge that applies to an individual who pays cash).

This rule imposes significant initial and ongoing burdens on hospitals to track and publish various billing information. CMS estimates the total burden for hospitals to review and post their standard charges for the first year to be 150 man-hours and $11,898.60 per hospital. In the event a hospital fails to comply with the new requirements and does not complete the prescribed corrective action, CMS may impose a civil monetary penalty of up to $300 per day.

In December 2019, several hospital organizations, including the AHA, filed suit in federal court challenging this rule. The plaintiffs seek to invalidate the rule, but pending final adjudication, they asked the court to grant preliminary and permanent injunctions preventing HHS from enforcing the rule's requirements beginning in 2021. We cannot predict the outcome of any legal challenges to this rule.

Many states have also passed or are debating legislation establishing price transparency websites or mandating that health plans or hospitals make price information available to consumers. The associated reporting obligations vary from state to state. We cannot predict what the adverse effects of this new CMS rule or any state law or regulation, such as the effect on relations with managed care payors and referral sources, may be for us. The burden of compliance with the associated requirements will have an adverse impact on our operations, results of operations, and cash flows.

Medicaid Fiscal Accountability Proposed Rule, if adopted as proposed by CMS, may adversely affect our business and results of operations.

On November 12, 2019, CMS released a proposed rule intended to increase oversight and transparency in Medicaid supplemental payment programs, including Disproportionate Share Hospital payments, and how states finance these programs. This proposed rule includes new policies to ensure that states are complying with the statutory restriction on using impermissible provider taxes or donations to fund their share of Medicaid reimbursements. Specifically, CMS expands the definition of impermissible tax to include provider assessments which have the effect of sorting providers by levels of Medicaid activity. Currently, inpatient rehabilitation hospitals are exempted based upon the hospital licensure category or services provided in 15 states within which we operate. If CMS ultimately finds that those exemptions are based upon low Medicaid utilization in comparison to other hospitals, generally acute care hospitals, subject to the taxes, our hospitals in those states could be subjected to new provider taxes. The proposed rule also seeks to eliminate mitigation agreements between healthcare providers and state or local governments which CMS believes result in a "net effect" of holding those providers harmless from a provider tax. In 2019, our hospitals received approximately $10 million under mitigation agreements.

Because it is difficult to predict how any particular state might respond to the new requirements in this proposed rule should it be finalized as proposed, the impact on our Medicaid revenues cannot be determined. Some states may decide to limit federal matching dollars that could result in Medicaid reimbursement rate reductions, while other states may chose to maximize their Medicaid funding by increasing provider tax payments. Various changes in this proposal rule may adversely affect our *Net operating revenues*, results of operations, and cash flows.

We face intense competition for patients from other healthcare providers.

We operate in highly competitive, fragmented inpatient rehabilitation and home health and hospice industries. Although we are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals, in any particular market we may encounter competition from local or national entities with longer operating histories or other competitive advantages. For example, acute care hospitals, including those owned and operated by large public companies, may choose to expand or begin offering post-acute rehabilitation services. Given that approximately 90% of our hospitals' referrals come from acute care hospitals, that increase in competition could materially and adversely affect our admission referrals in the related markets. There are also large acute care systems that may have more resources available to compete than we have. Other providers of post-acute care services may attempt to become competitors in the future. For example, some nursing homes, including at least one public company operator, have been marketing themselves as offering certain rehabilitation services, even though nursing homes are not required to offer the same level of care, and are not licensed, as hospitals.

In the home health and hospice services industries, our primary competition comes from the home health division of a large insurance company, three other large public home health companies, locally owned private home health companies or acute care hospitals with adjunct home health services and typically varies from market to market. We also compete with a variety of other companies in providing home health and hospice services, some of which, including several large public companies, may have greater financial and other resources and may be more established in their respective communities. One public home health company has a strategy that emphasizes joint ventures with acute care hospitals, including a number of joint ventures with large systems, which frequently serve as the referral sources for home health patients in specific markets. Similarly, there is a large insurance company that offers Medicare Advantage coverage and owns a home health business. That insurance company is one of the largest providers of Medicare-certified skilled home health services. Additionally, nursing homes compete for referrals in some instances when the patients may be suitable for home-based care.

Competing companies may offer newer or different services from those we offer or have better relationships with referring physicians and may thereby attract patients who are presently, or would be candidates for, receiving our inpatient rehabilitation, home health, or hospice services. The other public companies and the insurance companies have or may obtain significantly greater marketing and financial resources or other advantages of scale than we have or may obtain. Relatively few barriers to entry exist in most of our local markets. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing competing services, may expand their services to include inpatient rehabilitation, home health, hospice care, community care, or similar services.

There can be no assurance this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, from time to time, there are efforts in states with certificate of need ("CON") laws to weaken those laws, which could potentially increase competition in those states. For example, in 2019, Florida enacted legislation to repeal CON regulations for several provider types, including IRFs, in two stages. Effective July 1, 2019, existing IRFs became eligible to expand without first obtaining a CON. Effective July 1, 2021, new IRFs can be built without first obtaining a CON. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations in those states. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, *Properties*.

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

Our success depends in large part on referrals from physicians, hospitals, case managers and other patient referral sources in the communities we serve. By law, referral sources cannot be contractually obligated to refer patients to any specific provider. However, there can be no assurance that individuals will not attempt to steer patients to competing post-acute providers or otherwise limit our access to potential referrals. The establishment of joint ventures or networks between referral sources, such as acute care hospitals, and other post-acute providers may hinder patient referrals to us. The growing emphasis on integrated care delivery across the healthcare continuum increases that risk.

Our growth and profitability depend on our ability to establish and maintain close working relationships with patient referral sources and to increase awareness and acceptance of the benefits of inpatient rehabilitation, home health, and hospice care by our referral sources and their patients. We cannot provide assurance that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to grow our business and operate profitably.

Efforts to reduce payments to healthcare providers undertaken by third-party payors, conveners, and referral sources may adversely affect our revenues and profitability.

Health insurers and managed care companies, including Medicare Advantage plans, may utilize certain third parties, known as conveners, to attempt to control costs. Conveners offer patient placement and care transition services to those payors as well as bundled payment participants, ACOs, and other healthcare providers with the intent of managing post-acute utilization and associated costs. Conveners may influence referral source decisions on which post-acute setting to recommend, as well as how long to remain in a particular setting. Given their focus on perceived financial savings, conveners customarily suggest that patients avoid higher acuity post-acute settings altogether or move as soon as practicable to lower acuity settings. Conveners are not healthcare providers and may suggest a post-acute setting or duration of care that may not be appropriate from a clinical perspective potentially resulting in a costly acute care hospital readmission.

We also depend on referrals from physicians, acute care hospitals, and other healthcare providers in the communities we serve. As a result of various alternative payment models, many referral sources are becoming increasingly focused on reducing post-acute costs by eliminating post-acute care referrals or referring patients to post-acute settings other than perceived high-cost rehabilitation hospitals, sometimes without understanding the potential impact on patient outcomes over an entire episode of care. Our ability to attract patients could be adversely affected if any of our hospitals or agencies fail to provide or maintain a reputation for providing high-quality care on a cost-effective basis as compared to other providers.

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

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

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

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

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

As part of our development activities, we intend to build new, or *de novo*, inpatient rehabilitation hospitals. The construction of new hospitals involves numerous risks, including the receipt of all zoning and other regulatory approvals, such as a CON where necessary, construction delays and cost over-runs and unforeseen environmental liability exposure. Once built,

new hospitals must undergo the state and Medicare certification process, the duration of which may be beyond our control. We may be unable to operate newly constructed hospitals as profitably as expected, and those hospitals may involve significant additional cash expenditures and operating expenses that could, in the aggregate, have an adverse effect on our business, financial position, results of operations, and cash flows.

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

We may undertake strategic acquisitions from time to time. For example, we completed the acquisitions of the home health and hospice business of Camellia Heathcare and Alacare Home Health and Hospice in 2018 and 2019, respectively. Prior to consummation of any acquisition, the acquired business will have operated independently of us, with its own procedures, corporate culture, locations, employees and systems. We expect to integrate acquired businesses into our existing business utilizing certain common information systems, operating procedures, administrative functions, financial and internal controls and human resources practices to the extent practicable. There may be substantial difficulties, costs and delays involved in the integration of an acquired business with our business. Additionally, an acquisition could cause disruption to our business and operations and our relationships with customers, employees and other parties. In some cases, the acquired business has itself grown through acquisitions, and there may be legacy systems, operating policies and procedures, financial and administrative practices yet to be fully integrated. To the extent we are attempting to integrate multiple businesses at the same time, we may not be able to do so as efficiently or effectively as we initially anticipate. The failure to successfully integrate on a timely basis any acquired business with our existing business could have an adverse effect on our business, financial position, results of operations, and cash flows.

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

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

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This issue may be exacerbated if immigration is more limited in the future. A shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

If our labor costs increase, we may not experience reimbursement rate or pricing increases to offset these additional costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual market basket update from Medicare, as is expected to happen in 2020, or we experience a significant shift in our payor mix to lower rate payors such as Medicaid, our results of operations and cash flows will be adversely affected. Conversely, decreases in reimbursement revenues, such as with sequestration and the PDGM reimbursement rate reductions, may limit our ability to increase compensation or benefits to the extent necessary to retain key employees, in turn increasing our turnover and associated costs. Union activity is another factor that may contribute to increased labor costs. We currently have a minimal number of union employees, so an increase in labor union activity could have a significant impact on our labor costs. Our failure to recruit and retain qualified medical personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

We operate in a highly regulated industry in which healthcare providers are routinely subject to litigation. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are a defendant in a number of lawsuits, most of which are general and professional liability matters inherent in treating patients with medical conditions. Our more significant lawsuits and investigations, including the recently settled DOJ

investigation, are discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Substantial damages, fines, or other remedies assessed against us or agreed to in settlements could have a material adverse effect on our business, financial position, results of operations, and cash flows, including indirectly as a result of the covenant defaults under our credit agreement or debt instruments or other claims such as those in securities actions. Additionally, the costs of defending litigation and investigations, even if frivolous or nonmeritorious, could be significant.

The FCA allows private citizens, called "relators," to institute civil proceedings on behalf of the United States alleging violations of the FCA. 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.

The settled DOJ investigation originated in 2013 based on the allegations made by relators. The seven-year investigation produced no evidence of falsity or fraudulent conduct. Eventually, the court overseeing the *qui tam* actions refused to give DOJ more time to decide whether to intervene and unsealed the cases. DOJ chose not to intervene and prosecute the matter. Even when a matter is without merit, as we believe was the case with this investigation, we may still incur significant costs of defense or settlement costs or both.

It is possible that other *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 FCA.

The healthcare services we provide involve substantial risk of general and professional liability. Inpatient rehabilitative care involves three hours of daily intensive therapy for patients who are usually elderly and come to our hospitals with debilitating medical conditions. Our clinicians must frequently assist patients who have difficulty with mobility. Home care services, by their very nature, are provided in an environment that is not in the substantial control of the healthcare provider. On any given day, we have thousands of care providers driving to and from the homes of patients. We cannot predict the impact any claims arising out of the travel, the home visits or the care being provided (regardless of their ultimate outcomes) could have on our business or reputation or on our ability to attract and retain patients and employees. We also cannot predict the adequacy of any reserves for such losses or recoveries from any insurance or re-insurance policies.

We insure a substantial portion of our professional, general, and workers' compensation liability risks, which may not include risks related to regulatory fines and penalties, through our captive insurance subsidiary, as discussed further in Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements. Changes in the number of these liability claims and the cost to resolve them impact the reserves for these risks. A variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the reserves for these liability risks, which could have an effect on our financial position and results of operations.

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

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

We expend significant capital to protect against the threat of security breaches, including cyber attacks, email phishing schemes, malware and ransomware. Substantial additional expenditures may be required to respond to and remediate any problems caused by breaches, including the unauthorized access to or theft of patient data and protected health information

stored in our information systems and the introduction of computer malware or ransomware to our systems. We also provide our employees annual training and regular reminders on important measures they can take to prevent breaches and other cyber threats, including phishing schemes. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. For example, it has been widely reported that many well-organized international interests, in certain cases with the backing of sovereign governments, are targeting the theft of patient information through the use of advance persistent threats. Similarly, in recent years, several hospitals have reported being victims of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. We are likely to face attempted attacks in the future. Accordingly, we may be vulnerable to losses associated with the improper functioning, breach or unavailability of our and our vendors' information systems, including systems used in acquired operations, and third-party systems we use. In January 2018, news reports widely circulated the discovery of two vulnerabilities, named Meltdown and Spectre, found in the most commonly used microchip processors. These vulnerabilities which affect nearly all computers could allow unauthorized parties to circumvent system protections exposing nearly any data device processes, such as passwords, proprietary information, or encrypted communications.

To date, we are not aware of having experienced a material cyber breach or attack. However, given the increasing cyber security threats in the healthcare industry, there can be no assurance we will not experience business interruptions; data loss, ransom, misappropriation or corruption; theft or misuse of proprietary, patient or other personally identifiable information; or litigation, investigation, or regulatory action related to any of those, any of which could have a material adverse effect on our patient care, financial position, and results of operations and harm our business reputation.

A compromise of our network security measures or other controls, or of those businesses or vendors with whom we interact, which results in confidential information being accessed, obtained, damaged or used by unauthorized persons or unavailability of systems necessary to the operation of our business, could impact patient care, harm our reputation, and expose us to significant remedial costs as well as regulatory actions (fines and penalties) and claims from patients, financial institutions, regulatory and law enforcement agencies, and other persons, any of which could have a material adverse effect on our business, financial position, results of operations and cash flows. The nature of our business requires the sharing of protected health information and other sensitive information among employees and healthcare partners, many of whom carry and access portable devices outside of our physical locations, which in turn increases the risk of loss, theft or inadvertent disclosure of that information. Moreover, a security breach, or threat thereof, could require that we expend significant resources to repair or improve our information systems and infrastructure and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber attack, the associated expenses and losses may exceed our current insurance coverage for such events. Some adverse consequences are not insurable, such as reputational harm and third-party business interruption. Failure to maintain proper function, security, or availability of our information systems or protect our data against unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows.

ACE-IT is subject to a licensing, implementation, technology hosting, and support agreement with Cerner Corporation. Similarly, we have an agreement to license, host, and support a comprehensive home care management and clinical information system, Homecare Homebase^{SM}. In addition, we have a number of partners and non-software vendors with whom we share data in order to provide patient care and otherwise operate our business. In fact, federal laws and regulations require interoperability among healthcare entities in many circumstances. Our inability, or the inability of our partners or vendors, to continue to maintain and upgrade information systems, software, and hardware could disrupt or reduce the efficiency of our operations, including affecting patient care. A security breach or other system failure involving Cerner, Homecare Homebase or another third-party with whom we share data or system connectivity could compromise our patient data or proprietary information or disrupt our ability to operate. In addition, costs, unexpected problems, and interruptions associated with the implementation or transition to new systems or technology or with adequate support of those systems or technology across numerous hospitals and agencies could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Efforts to comply with regulatory mandates to increase the use of electronic health data and health system interoperability may lead to negative publicity which could adversely affect our business.

For many years, a primary focus of the healthcare industry has been to increase the use of electronic health records, or "EHR," and the sharing of the health data among providers, payors and other members of the industry. The federal government has been a significant driver of that initiative through rules and regulations. In 2009, as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the federal government set aside $27 billion of incentives for hospitals and providers to adopt EHR systems. In 2019, CMS proposed policy changes supporting its MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the healthcare system. The

Interoperability and Patient Access Proposed Rule seeks to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats while reducing restrictive burdens on healthcare providers. In addition to this proposed rule, CMS released a request for information to obtain feedback on interoperability and health information technology adoption in post-acute care settings. As noted in connection with the release of the proposed rule, CMS seeks to break down existing barriers to important data exchange in all aspects of healthcare from patients to providers to payers and researchers.

The goals of increased use of electronic health data and interoperability are improved quality of care and lower healthcare costs generally. However, increased use of electronic health data and interoperability inherently magnifies the risk of security breaches involving that data and information systems, which risk is discussed above. Additionally, the sharing of health information, that is interoperability, has received increasingly negative publicity. There is at least one well publicized instance where organizations received significant negative publicity for sharing health data despite having appeared to comply in all respects with privacy law. There can be no assurance that our efforts to improve the care we deliver and to comply with the law through increasing use of electronic data and system interoperability will not receive negative publicity that may materially and adversely affect our ability to get patient referrals or enter into joint ventures with other providers or may lead to greater regulatory scrutiny. Negative publicity may also lead to federal or state regulation that conflicts with current federal policy and interferes with the healthcare industry's efforts to improve care and reduce costs through use of electronic data and interoperability.

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

The success of our current business plan depends in large part upon the leadership and performance of our executive management team and other key employees and our ability to retain and motivate these individuals. We rely upon their ability, expertise, experience, judgment, discretion, integrity and good faith. However, there is no guarantee we will be able to retain our key personnel. Our only employment agreements are with members of the home health and hospice senior management team. We entered into those agreements in connection with the acquisition of that business at the end of 2014. They expired at the end of 2019, but in the fourth quarter of 2019, we executed updated forms of the agreements with terms of three years. If we are unable to retain one or more key members of management, we may be unable to replace them with personnel of comparable experience in, or knowledge of, the healthcare provider industry or our specific post-acute segments. The loss of the services of any of these individuals could prevent us from successfully executing our business plan and could have a material adverse effect on our business and results of operations.

A pandemic, epidemic or other widespread outbreak of an infectious disease could adversely affect our operations.

If a pandemic, epidemic, or other widespread outbreak of an infectious disease or other public health crisis were to occur in areas in which we operate, our operations could be materially and adversely affected. State or local health departments may require us or a significant referral source for us to close one or more hospitals or limit patient admissions as a precautionary measure in a crisis to avoid the spread of a disease. Patients may choose to avoid elective procedures and hospital stays during a health crisis. Further, a pandemic, epidemic or other widespread outbreak might adversely affect our operations by causing staffing and supply shortages. We have infectious disease protocols, but the exact nature of a crisis stemming from a pandemic, epidemic or other widespread outbreak and how it would affect us is difficult to predict and could adversely affect our operations.

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

Many factors affect pricing of our services and, in turn, our revenues. For example, in the inpatient rehabilitation segment, these factors include the treating facility's urban or rural status, the length of stay, the payor and its applicable rate of reimbursement, and the patient's medical condition and impairment status (acuity). In recent years, our inpatient rehabilitation segment has experienced a shift in payor mix to a slightly larger percentage of Medicaid patients. We could also experience a shift to a lower average patient acuity. Both of these shifts adversely affect pricing growth. See the "Segment Results of Operations—Inpatient Rehabilitation—Net Operating Revenues" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations.* The expansion and growth of Medicaid resulting from provisions of the 2010 Healthcare Reform Laws have increased the number of those patients coming to us. Medicaid reimbursement rates are almost always the lowest among those of our payors, and frequently Medicaid patients come to us with other complicating conditions that make treatment more difficult and costly. We do not anticipate that Medicaid will continue to grow at the rate it has in recent years. However, we cannot predict what, if any, Medicaid changes will be adopted. We cannot predict whether our payor mix will to shift to lower reimbursement rate payors. In the future, we may experience shifts in our payor mix or the acuity of our patients that could adversely affect our pricing, *Net operating revenues,* and profitability.

We may incur additional indebtedness in the future, and that debt or the associated increased leverage may have negative consequences for our business.

As of December 31, 2019, we have approximately $2.7 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $384.1 million in finance leases). See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. Subject to specified limitations, our credit agreement and the indentures governing our debt securities permit us and our subsidiaries to incur material additional debt. If new debt is added to our current debt levels, the risks described here could intensify.

Our indebtedness could have important consequences, including:

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

We are subject to contingent liabilities, prevailing economic conditions, and financial, business, and other factors beyond our control. Although we expect to make scheduled interest payments and principal reductions, we cannot provide assurance that changes in our business or other factors will not occur that may have the effect of preventing us from satisfying obligations under our credit agreement or debt instruments. If we are unable to generate sufficient cash flow from operations in the future to service our debt and meet our other needs or have an unanticipated cash payment obligation, we may have to refinance all or a portion of our debt, obtain additional financing or reduce expenditures or sell assets we deem necessary to our business. We cannot provide assurance these measures would be possible or any additional financing could be obtained.

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

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

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

These covenants could adversely affect our ability to finance our future operations or capital needs and pursue available business opportunities. For additional discussion of our material debt covenants, see the “Liquidity and Capital

Resources" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

In addition, our credit agreement requires us to maintain specified financial ratios and satisfy certain financial condition tests. See the "Liquidity and Capital Resources" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. Although we remained in compliance with the financial ratios and financial condition tests as of December 31, 2019, we cannot provide assurance we will continue to do so. Events beyond our control, including changes in general economic and business conditions, may affect our ability to meet those financial ratios and financial condition tests. A severe downturn in earnings, failure to realize anticipated earnings from acquisitions, or, if we have outstanding borrowings under our credit facility at the time, a rapid increase in interest rates could impair our ability to comply with those financial ratios and financial condition tests and we may need to obtain waivers from the required proportion of the lenders to avoid being in default. If we try to obtain a waiver or other relief from the required lenders, we may not be able to obtain it or such relief might have a material cost to us or be on terms less favorable than those in our existing debt. If a default occurs, the lenders could exercise their rights, including declaring all the funds borrowed (together with accrued and unpaid interest) to be immediately due and payable, terminating their commitments or instituting foreclosure proceedings against our assets, which, in turn, could cause the default and acceleration of the maturity of our other indebtedness. A breach of any other restrictive covenants contained in our credit agreement or the indentures governing our senior notes would also (after giving effect to applicable grace periods, if any) result in an event of default with the same outcome.

As of December 31, 2019, approximately 70% of our consolidated *Property and equipment, net* was held by our company and its guarantor subsidiaries under its credit agreement. See Note 10, *Long-term Debt*, and Note 21, *Condensed Consolidating Financial Information*, to the accompanying consolidated financial statements, and Item 2, *Properties*.

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

In recent years, the global and sovereign credit markets have experienced significant disruptions, and the debt ceiling and federal budget disputes in the United States as well as international trade disputes affected capital markets. Future market shocks could negatively affect the availability or terms of certain types of debt and equity financing, including access to revolving lines of credit. Future business needs combined with market conditions at the time may cause us to seek alternative sources of potentially less attractive financing and may require us to adjust our business plan accordingly. For example, tight credit markets, such as might result from further turmoil in the sovereign debt markets, would likely make additional financing more expensive and difficult to obtain. The inability to obtain additional financing at attractive rates or prices could have a material adverse effect on our financial performance or our growth opportunities.

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

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

Each of our hospitals and home health and hospice agencies must comply with extensive enrollment requirements and conditions of participation for the Medicare program. If any fail to meet any of the Medicare enrollment requirements or conditions of participation, we may receive a notice of deficiency from the applicable survey agency or contractor, as applicable. If that hospital or agency then fails to institute an acceptable plan of correction and correct the deficiency within the applicable correction period, it could lose the ability to bill Medicare. A hospital or agency could be terminated from the Medicare program if it fails to address the deficiency within the applicable correction period. If CMS terminates one hospital or agency, it may increase its scrutiny of others under common control.

On September 5, 2019, CMS released a final rule that will implement over a period time additional provider enrollment provisions and create several new revocation and denial authorities in an attempt to bolster CMS' efforts to prevent waste, fraud and abuse. A few provisions of this new rule could significantly increase the complexity of filing enrollment applications for all of our provider entities, including increased burden related to tracking and identifying required reporting data from our joint venture partners. This rule requires Medicare and Medicaid providers and suppliers to disclose any current or previous (in the last five years), direct or indirect affiliation with a provider or supplier that has ever had a disclosable event. A disclosable event is any uncollected debt to Medicare or Medicaid, payment suspension under a federal health care program, denial, revocation or termination of enrollment (even if it is under appeal), or exclusion by the OIG from participation in a federal health care program. The rule also broadens the definition of an affiliation, including many indirect ownership or control

situations such as ownership interests in a publicly traded company. If CMS determines an affiliation with a disclosable event poses an undue risk of fraud, waste or abuse, then the provider reporting that affiliation may be subject to exclusion from Medicare. Currently, information regarding uncollected debt, payment suspensions and enrollment actions are not generally available, so obtaining such information on affiliates could prove difficult or impossible in some situations. CMS intends to issue further guidance on the level of effort it expects providers to undertake to uncover information on their affiliates.

Under this new rule, CMS may revoke a provider's Medicare enrollment, including all of the provider's locations, if the provider bills for services performed at or items furnished from one location that it knew or should have known did not comply with Medicare enrollment requirements, including making the disclosures discussed above. CMS has the ability to prevent applicants from enrolling in the program for up to three years if a provider is found to have submitted false or misleading information in its initial enrollment application. Additionally, CMS can now block providers and suppliers who are revoked from re-entering the Medicare program for up to 10 years. CMS may also revoke a provider's enrollment if it fails to report on a timely basis any change in ownership or control, revocation or suspension of a federal or state license or certification, or any other change in its enrollment data.

Any termination of one or more of our hospitals or agencies from the Medicare program for failure to satisfy the enrollment requirements or conditions of participation could materially adversely affect our business, financial position, results of operations, and cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We currently maintain our principal executive office at 9001 Liberty Parkway, Birmingham, Alabama, the lease for which expires in 2033 and has multiple renewal options for additional five-year terms.

In addition to our principal executive office, as of December 31, 2019, we leased or owned through various consolidated entities 453 physical locations to operate or support our business. All but three of our hospital leases, which represent the largest portion of our rent expense, have at least five years remaining on their terms after taking into consideration one or more renewal options. Our consolidated entities associated with our leased hospitals are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses. Our home health and hospice business is based in Dallas, Texas where it leases office space for corporate and administrative functions. The remaining home health and hospice locations are in the localities served by that business and are subject to relatively small space leases, primarily 5,000 square feet or less. Those space leases are typically five years or less in term. We do not believe any one of our individual properties is material to our consolidated operations.

The following table sets forth information regarding our hospitals and our home health and hospice locations (excluding two of the home health locations that operate as joint ventures which we account for using the equity method of accounting) as of December 31, 2019:

		Number of Hospitals				
State	Licensed Beds	Building and Land Owned	Building Owned and Land Leased	Building and Land Leased	Total	Home Health and Hospice Locations
Alabama *+	427	2	3	2	7	59
Arizona	396	1	2	3	6	5
Arkansas +	360	3	1	1	5	5
California	184	2	—	1	3	—
Colorado	104	1	—	1	2	6
Connecticut*	—	—	—	—	—	1
Delaware *	37	—	1	—	1	—
Florida *	947	10	—	2	12	18
Georgia *+	160	2 (1)	1		3	26
Idaho	40	—	1	—	1	12
Illinois *	65	—	1	—	1	3
Indiana	98	1	—	—	1	1
Kansas	242	1	—	2	3	6
Kentucky *+	323	2	1	—	3	3
Louisiana	47	1	—	—	1	3
Maine *	100	—	—	1	1	—
Maryland *+	64	1	—	—	1	3
Massachusetts *	560	2	—	2	4	5
Mississippi*+	33	—	—	1	1	20
Missouri *	191	—	2	—	2	2
Nevada *	219	2	—	1	3	4
New Hampshire	50	—	1	—	1	—
New Jersey *+	199	1	1	1	3	—
New Mexico	87	1	—	—	1	7
North Carolina *+	68	1	—	—	1	6
Ohio	210	1	—	2	3	1
Oklahoma	60	—	1	—	1	22
Oregon*	—	—	—	—	—	2
Pennsylvania	745	5	—	4	9	4
Puerto Rico *+	72	—	—	2	2	—
Rhode Island *+	—	—	—	—	—	1
South Carolina *+	456	2	4	1	7	4
Tennessee *+	493	5	4	—	9	8
Texas	1,573	12	3	9	24	63
Utah	84	1	—	—	1	15
Virginia *	297	2	1	3	6	11
West Virginia *+	258	1	3	—	4	—
Wyoming	—	—	—	—	—	2
	9,249	63	31	39	133	328 (2)

* Hospital certificate of need state or U.S. territory. In Florida, existing IRFs became eligible to expand without first obtaining a CON effective July 1, 2019, and new IRFs may operate without first obtaining a CON effective July 1, 2021.

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

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

(2) This total includes 245 locations where we provide home health services and 83 locations where we provide hospice services.

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

Item 3. Legal Proceedings

We provide services in the highly regulated healthcare industry. In the ordinary course of our business, we are a party to various legal actions, proceedings, and claims as well as regulatory and other governmental audits and investigations. These matters could potentially subject us to sanctions, damages, recoupments, fines, and other penalties. Some of these matters have been material to us in the past, and others in the future may, either individually or in the aggregate, be material and adverse to our business, financial position, results of operations, and liquidity. We do not believe any of our pending legal proceedings are material to us, but there can be no assurance our assessment will not change based on future developments.

Additionally, the False Claims Act (the "FCA") allows private citizens, called "relators," to institute civil proceedings on behalf of the United States alleging violations of the FCA. These lawsuits, also known as "*qui tam*" actions, are common in the healthcare industry and 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. 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. Therefore, from time to time, we may be party to one or more undisclosed *qui tam* cases brought pursuant to the FCA.

Information relating to certain legal proceedings in which we are involved is included in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market Information

Shares of our common stock trade on the New York Stock Exchange under the ticker symbol "EHC."

Holders

As of February 13, 2020, there were 98,433,352 shares of Encompass Health common stock issued and outstanding, net of treasury shares, held by approximately 7,453 holders of record (participant positions at The Depository Trust Corporation plus record holders).

Dividends

On February 20, 2020, our board of directors declared a cash dividend of $0.28 per share, payable on April 15, 2020 to stockholders of record on April 1, 2020. We expect quarterly dividends to continue to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board each quarter after consideration of various factors, including our capital position and alternative uses of funds.

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

The following table sets forth, as of December 31, 2019, information concerning compensation plans under which our securities are authorized for issuance. The table does not reflect grants, awards, exercises, terminations, or expirations since that date. All share amounts and exercise prices have been adjusted to reflect stock splits that occurred after the date on which any particular underlying plan was adopted, to the extent applicable.

	Number of securities to be issued upon exercise of outstanding options		Weighted-average exercise price of outstanding options[1]	Number of securities available for future issuance	
Plans approved by stockholders	2,744,223	[2]	$ 43.02	9,160,752	[3]
Plans not approved by stockholders	86,830	[4]		—	
Total	2,831,053		$ 43.02	9,160,752	

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

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

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

[4] This amount represents 86,830 restricted stock units issued under the 2004 Amended and Restated Director Incentive Plan, the material terms of which are described below.

2004 Amended and Restated Director Incentive Plan

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

board of directors or certain change in control events. The restricted stock units generally cannot be transferred. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

Purchases of Equity Securities

The following table summarizes our repurchases of equity securities during the three months ended December 31, 2019:

Period	Total Number of Shares (or Units) Purchased[1]	Average Price Paid per Share (or Unit) ($)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs[2]
October 1 through October 31, 2019	5,803	$ 67.41	—	$204,120,171
November 1 through November 30, 2019	—	—	—	204,120,171
December 1 through December 31, 2019	—	—	—	204,120,171
Total	5,803	$ 67.41	—	

(1) Except as noted in the following sentence, the number of shares reported in this column represents shares tendered by an employee as payment of the tax liabilities incident to the vesting of previously awarded shares of restricted stock. In October, 276 shares were purchased pursuant to our Directors' Deferred Stock Investment Plan. This plan is a nonqualified deferral plan allowing non-employee directors to make advance elections to defer a fixed percentage of their director fees. The plan administrator acquires the shares in the open market which are then held in a rabbi trust. The plan also provides that dividends paid on the shares held for the accounts of the directors will be reinvested in shares of our common stock which will also be held in the trust. The directors' rights to all shares in the trust are nonforfeitable, but the shares are only released to the directors after departure from our board.

(2) On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock. On February 14, 2014, our board approved an increase in this common stock repurchase authorization from $200 million to $250 million. On July 24, 2018, our board approved resetting the aggregate common stock repurchase authorization to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended.

Company Stock Performance

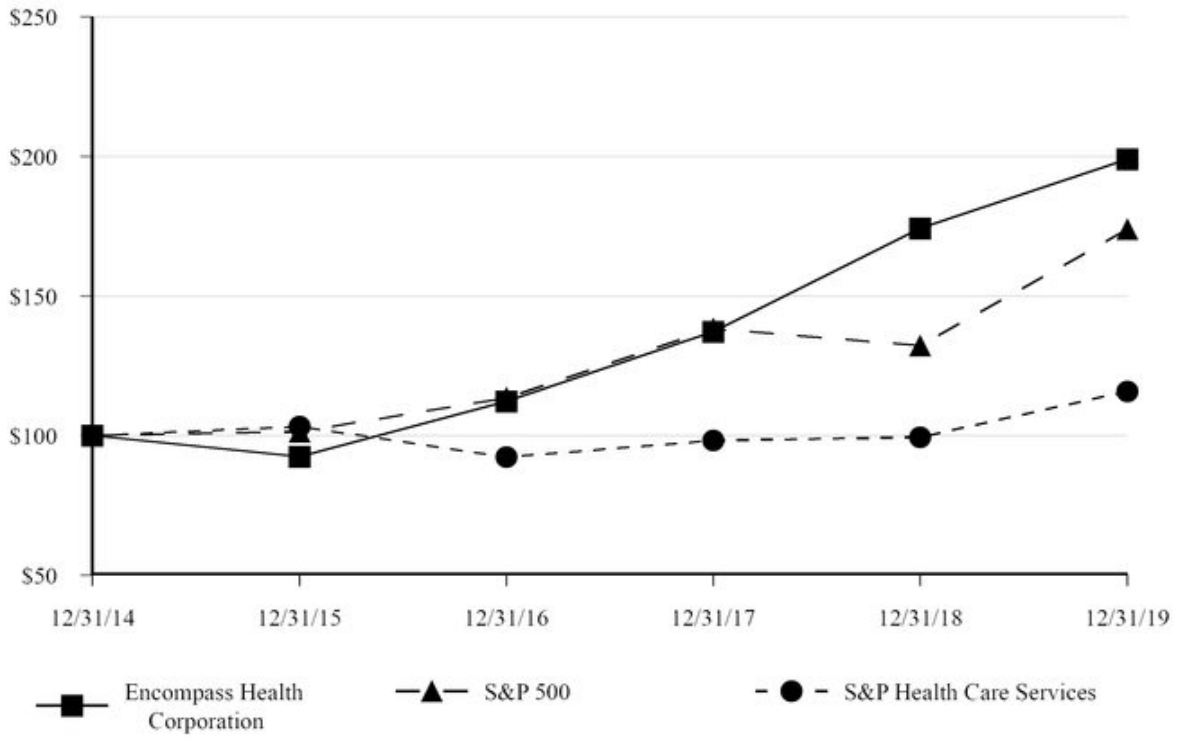
Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor's 500 Index ("S&P 500"), and the S&P Health Care Services Select Industry Index ("SPSIHP"), an equal-weighted index of at least 35 companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2014 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock. We have paid a quarterly cash dividend on our common stock since October 2013.

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

The comparisons in the graph below are based upon historical data and are not indicative of, nor intended to forecast, future performance of our common stock. Research Data Group, Inc. provided the data for the indices presented below. We assume no responsibility for the accuracy of the indices' data, but we are not aware of any reason to doubt its accuracy.

COMPARISON OF 5-YEAR CUMULATIVE TOTAL RETURN

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



	For the Year Ended December 31,					
	Base Period	Cumulative Total Return				
Company/Index Name	2014	2015	2016	2017	2018	2019
Encompass Health Corporation	100.00	92.50	112.22	137.31	174.20	198.99
Standard & Poor's 500 Index	100.00	101.38	113.51	138.29	132.23	173.86
S&P Health Care Services Select Industry Index	100.00	103.27	92.30	98.26	99.47	115.83

Item 6. Selected Financial Data

We derived the selected consolidated financial data presented below as of December 31, 2019 and 2018 and for the years ended December 31, 2019, 2018, and 2017 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below as of December 31, 2017 and as of and for the years ended December 31, 2016 and 2015 from our consolidated financial statements and related notes not included herein. Refer to Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* and the notes to the accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations.

	For the Year Ended December 31,				
	2019	2018	2017	2016	2015
	(In Millions, Except per Share Data)				
Statement of Operations Data:					
Net operating revenues	$ 4,605.0	$ 4,277.3	$ 3,913.9	$ 3,642.6	$ 3,115.7
Operating earnings [1]	612.1	555.2	578.3	588.1	485.7
Provision for income tax expense	115.9	118.9	145.8	163.9	141.9
Income from continuing operations	446.4	374.3	350.6	318.1	253.7
(Loss) income from discontinued operations, net of tax	(0.6)	1.1	(0.4)	—	(0.9)
Net income	445.8	375.4	350.2	318.1	252.8
Less: Net income attributable to noncontrolling interests	(87.1)	(83.1)	(79.1)	(70.5)	(69.7)
Net income attributable to Encompass Health	358.7	292.3	271.1	247.6	183.1
Less: Convertible perpetual preferred stock dividends	—	—	—	—	(1.6)
Net income attributable to Encompass Health common shareholders	$ 358.7	$ 292.3	$ 271.1	$ 247.6	$ 181.5
Weighted average common shares outstanding: [2] [3]					
Basic	98.0	97.9	93.7	89.1	89.4
Diluted	99.4	99.8	99.3	99.5	101.0
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders:					
Continuing operations	$ 3.66	$ 2.97	$ 2.88	$ 2.77	$ 2.03
Discontinued operations	(0.01)	0.01	—	—	(0.01)
Net income	$ 3.65	$ 2.98	$ 2.88	$ 2.77	$ 2.02
Diluted earnings per share attributable to Encompass Health common shareholders:					
Continuing operations	$ 3.62	$ 2.92	$ 2.84	$ 2.59	$ 1.92
Discontinued operations	(0.01)	0.01	—	—	(0.01)
Net income	$ 3.61	$ 2.93	$ 2.84	$ 2.59	$ 1.91
Cash dividends per common share	$ 1.10	$ 1.04	$ 0.98	$ 0.94	$ 0.88
Amounts attributable to Encompass Health:					
Income from continuing operations	$ 359.3	$ 291.2	$ 271.5	$ 247.6	$ 184.0
(Loss) income from discontinued operations, net of tax	(0.6)	1.1	(0.4)	—	(0.9)
Net income attributable to Encompass Health	$ 358.7	$ 292.3	$ 271.1	$ 247.6	$ 183.1

	As of December 31,				
	2019	2018	2017	2016	2015
	(In Millions)				
Balance Sheet Data:					
Working capital	$ 34.8	$ (10.4)	$ 184.7	$ 178.9	$ 172.3
Total assets [4]	6,080.7	5,175.0	4,864.5	4,663.8	4,592.2
Long-term debt, including current portion [2] [4]	3,062.6	2,514.4	2,577.7	3,016.4	3,171.5
Encompass Health shareholders' equity [2]	1,352.2	1,276.7	1,152.5	717.8	597.5

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

(2) During the fourth quarter of 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 ("Convertible Notes") for 257,110 shares of our then outstanding 6.50% Series A Convertible Perpetual Preferred Stock. On April 23, 2015, we exercised our rights to force conversion of all remaining outstanding shares of our *Convertible perpetual preferred stock* into common stock. During the second quarter of 2017, we exercised the early redemption option and subsequently retired all $320 million of the Convertible Notes reducing our long-term debt balance by approximately $278 million. Substantially all of the holders elected to convert their Convertible Notes to shares of our common stock, which resulted in the issuance of 8.9 million shares from treasury stock. See Note 10, *Long-term Debt* and Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements.

(3) During 2019, we repurchased 0.8 million million shares of our common stock in the open market for $45.9 million. During 2017, we repurchased 0.9 million shares of our common stock in the open market for $38.1 million. During 2016, we repurchased 1.7 million shares of our common stock in the open market for $65.6 million. During 2015, we repurchased 1.3 million shares of our common stock in the open market for $45.3 million.

(4) In May 2018, we acquired Camellia Healthcare and affiliated entities using cash on hand and borrowings under our revolving credit facility. In July 2019, we acquired privately owned Alacare Home Health & Hospice using cash on hand and borrowings under our revolving credit facility. See Note 2, *Business Combinations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

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

The following Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying consolidated financial statements and related notes. This MD&A is designed to provide the reader with information that will assist in understanding our consolidated financial statements, the changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes, as well as how certain accounting principles affect our consolidated financial statements. See "Cautionary Statement Regarding Forward-Looking Statements" on page ii of this report for a description of important factors that could cause actual results to differ from expected results. See also Item 1A, *Risk Factors*.

In addition, management's discussion and analysis of our results of operations and cash flows for the year ended December 31, 2018 compared to the year ended December 31, 2017 may be found in, Part II, Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations* of our Annual Report on Form 10-K for the year ended December 31, 2018, filed with the SEC on February 27, 2019.

Executive Overview

Our Business

We are a national leader in integrated healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2019, our national footprint spans 37 states and Puerto Rico. As discussed in this Item, "Segment Results of Operations," we manage our operations in two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. For additional information about our business and reportable segments, see Item 1, *Business* and

Item 1A, *Risk Factors*, of this report, Note 19, *Segment Reporting*, to the accompanying consolidated financial statements, and the "Results of Operations" section of this Item.

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 33 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. As of December 31, 2019, we operate 133 inpatient rehabilitation hospitals and manage four inpatient rehabilitation units through management contracts. Our inpatient rehabilitation segment represented approximately 76% of our *Net operating revenues* for the year ended December 31, 2019.

Home Health and Hospice

Our home health 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. Our hospice business is the nation's eleventh largest provider of Medicare-certified hospice services in terms of revenues. We 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 December 31, 2019, we provide home health services in 245 locations and hospice services in 83 locations across 31 states, with concentrations in the Southeast and Texas. In addition, two of these home health agencies operate as joint ventures that we account for using the equity method of accounting. Our home health and hospice segment represented approximately 24% of our *Net operating revenues* for the year ended December 31, 2019.

2019 Overview

In 2019, we focused on the following strategic priorities:

- providing high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing inpatient rehabilitation hospitals and home health and hospice locations;
- 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 locations 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 include increasing clinical collaboration between our inpatient rehabilitation hospitals and home health locations, building stroke market share, developing and implementing post-acute solutions, transitioning to the new inpatient rehabilitation patient assessment measures, commonly referred to as "Section GG" measures, and preparing for implementation of the home health Patient-Driven Groupings Model ("PDGM").

During 2019, *Net operating revenues* increased 7.7% over 2018 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 3.9% coupled with a 1.5% increase in inpatient revenue per discharge in 2019 generated 5.0% growth in net patient revenue compared to 2018. Discharge growth included a 1.8% increase in same-store discharges. Within our home health and hospice segment, home health admission growth of 16.3% and hospice admission growth of 39.8% contributed to 17.3% growth in home health and hospice revenue compared to 2018. Home health admission growth and hospice admission growth included a 7.7% and 12.2% increase, respectively, in same-store admissions. Many of our quality and outcome measures remained above both inpatient rehabilitation and home health industry averages. Not only did we treat more patients and enhance outcomes, we did so in a cost-effective manner. See the "Results of Operations" and "Segment Results of Operations" sections of this Item.

Our growth efforts continued to yield positive results in 2019. In our inpatient rehabilitation segment, we:

- began operating a 40-bed inpatient rehabilitation hospital in Lubbock, Texas with our joint venture partner, University Medical Center Health System, in May 2019;

- began operating a 40-bed inpatient rehabilitation hospital in Boise, Idaho with our joint venture partner, Saint Alphonsus Regional Medical Center, in July 2019;
- amended the joint venture agreement related to our 51-bed Yuma Rehabilitation Hospital which resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity;
- began operating our new 40-bed inpatient rehabilitation hospital in Katy, Texas in September 2019;
- continued our capacity expansions by adding 152 new beds to existing hospitals; and
- continued development of the following hospitals:

Location	# of Beds	Expected Operational Date
De novos:		
Murrieta, California*	50	Q1 2020
Sioux Falls, South Dakota	40	Q2 2020
Toledo, Ohio	40	Q4 2020
Cumming, Georgia	50	Q1 2021
North Tampa, Florida	50	Q2 2021
Stockbridge, Georgia	50	Q3 2021
Greenville, South Carolina	40	Q3 2021
Joint ventures:		
Coralville, Iowa	40	Q2 2020
San Angelo, Texas	40	Q2 2021

* We began operating this hospital in February 2020.

We also continued our growth efforts in our home health and hospice segment. On July 1, 2019, we completed the acquisition of privately owned Alacare Home Health and Hospice ("Alacare") for a cash purchase price of $217.8 million. The Alacare portfolio consisted of 23 home health and 23 hospice locations in Alabama. We funded the transaction with cash on hand and borrowings under our revolving credit facility. In connection with this transaction, we expect to realize an income tax benefit with an estimated present value of approximately $30 million. For additional information regarding this transaction, see Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

In addition to completing the Alacare transaction, we acquired two home health locations in East Providence, Rhode Island and Westport, Massachusetts and began accepting patients at our two new home health locations in Columbia, South Carolina and Vero Beach, Florida. We also began accepting patients at our two new hospice locations in Burleson, Texas and Greensburg, Pennsylvania.

To support our growth efforts, we continued taking steps to further increase the strength and flexibility of our balance sheet. Specifically, we redeemed $100 million of the outstanding principal balance of the 5.75% Senior Notes due 2024 (the "2024 Notes") in June 2019. In September 2019, we issued $500 million of 4.50% Senior Notes due 2028 at par and $500 million of 4.75% Senior Notes due 2030 (the "New Notes") at par, which resulted in approximately $983 million in net proceeds from the public offering. We used the proceeds to fund the purchase of equity and vested stock appreciation rights from management investors of our home health and hospice segment, redeem $400 million of our 2024 Notes, and repay borrowings under our revolving credit facility. In November 2019, we amended our existing credit agreement to, among other things, increase the size of our revolving credit facility from $700 million to $1 billion and extend the agreement's maturity by two years to 2024. For additional information regarding these transactions, see Note 10, *Long-term Debt*, Note 12, *Redeemable Noncontrolling Interests*, and Note 14, *Share-Based Payments*, to the accompanying consolidated financial statements and the "Liquidity and Capital Resources" section of this Item.

We also continued our shareholder distributions by paying a quarterly cash dividend of $0.27 per share on our common stock in January, April, and July of this year. On July 23, 2019, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.28 per share that was paid in October 2019. On October 25, 2019, our board of directors declared a cash dividend of $0.28 per share, that was paid on January 15, 2020 to stockholders of record on

January 2, 2020. In addition, we repurchased 0.8 million shares of our common stock in the open market for approximately $46 million during 2019. For additional information see the “Liquidity and Capital Resources” section of this Item.

During 2019, we continued to increase the clinical collaboration rate between our inpatient rehabilitation hospitals and home health locations. We increased stroke market share by continuing to meet the needs of patients recovering from a stroke, as discussed in Item 1, *Business*, “Competitive Strengths.” We developed and implemented post-acute solutions that focus on improving patient outcomes and lowering the cost of care by reducing hospital readmissions across the entire episode of care. Additionally, we transitioned to the new inpatient rehabilitation Section GG measures on October 1, 2019 and prepared for the implementation of the home health PDGM on January 1, 2020, which are both discussed further below and in Item 1, *Business,* and Item 1A, *Risk Factors*.

Business Outlook

We believe our business outlook remains positive. Demographic trends, such as population aging, should continue to increase long-term demand for the services we provide. 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. Even more specifically, the average age of our patients is approximately 76, and the population group ranging in ages from 75 to 79 is expected to grow at approximately 5% per year through 2026. We believe the demand for the services we provide 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 those extremely fragmented industries.

We are a leading provider of integrated healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. We are committed to delivering high-quality, cost-effective, integrated patient care across the healthcare continuum with a primary focus on the 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.

The nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain, 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, 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 2023. 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. Strong and consistent free cash flow generated by our Company, together with the unfunded commitment of our revolving credit facility, provides substantial capacity to pursue growth opportunities in both of our business segments while continuing to invest in our operational initiatives and capital structure strategy. 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. See also Item 1, *Business*, “Competitive Strengths” and “Strategy and 2020 Strategic Priorities.”

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 to identify and implement workable coordinated care and integrated delivery payment models as well as post-acute site neutrality in Medicare reimbursement. The Medicare reimbursement systems for both inpatient rehabilitation and home health are undergoing significant changes. The future of many aspects of healthcare regulation remains uncertain. 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*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. The federal government's reliance on sub-regulatory guidance, such as handbooks, FAQs, internal memoranda, and press releases, presents a unique challenge to compliance efforts. For additional details on sub-regulatory guidance, See Item 1A, *Risk Factors*.

  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, including recoupment of previously paid claims from current accounts receivable. Healthcare providers can challenge any denials through an administrative appeals process that can be extremely lengthy, taking several years. For additional details of these claim reviews, See Item 1, *Business*, "Sources of Revenues," Item 1A, *Risk Factors,* and Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues" and "Accounts Receivable," to the accompanying consolidated financial statements.

  In June 2019, CMS commenced the Home Health Review Choice Demonstration ("RCD") in Illinois. RCD is intended to test whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud and whether the pre-claim review helps reduce expenditures while maintaining or improving quality of care. The demonstration expanded to Ohio in September 2019 and will be expanded to Texas in March 2020 and in North Carolina and Florida in May 2020. We operate agencies (representing approximately 44% of our home health Medicare claims) in these five states. For additional details of the RCD program, see Item 1A, *Risk Factors*.

  See also Item 1, *Business*, "Regulation," and Item 1A, *Risk Factors*, to this report and Note 18, *Contingencies and Other Commitments*, "Governmental Inquiries and Investigations," to the accompanying consolidated financial statements.

- Changes to Our Operating Environment Resulting from Healthcare Reform. 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 what, if any, Medicare-related changes may ultimately be enacted and signed into law or otherwise implemented, 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.

  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 including the Bundled Payments for Care Improvement Initiative Advanced ("BPCI Advanced") and the Comprehensive Care for Joint Replacement ("CJR") program. The Center for Medicare and Medicaid Innovation ("CMMI") plays a key role in the development of many of these new payment and service delivery models. Our challenges related to healthcare reform are discussed in Item 1, *Business*, "Sources of Revenues," and Item 1A, *Risk Factors*.

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*, the future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain, 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 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 any 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.

Each year, CMS adopts rules that update pricing and otherwise amend the respective payment systems. On July 31, 2019, CMS released its notice of final rulemaking for fiscal year 2020 under the inpatient rehabilitation facility prospective payment system (the “2020 IRF Rule”). Based on the market basket update, our analysis of the Section GG changes and the other adjustments included in the 2020 IRF Rule and other factors, we currently estimate Medicare payment rates for our inpatient rehabilitation segment will be flat to up 0.75% in fiscal year 2020 (effective October 1, 2019). On October 31, 2019, CMS released its notice of final rulemaking for calendar year 2020 for home health agencies under the home health prospective payment system (the “2020 HH Rule”). Based on the market basket update, our analysis of PDGM’s significant changes to the reimbursement model and the other adjustments included in the 2020 HH Rule as well as other factors, we currently estimate Medicare payment rates for our home health business will decrease between 2.0% and 3.0% in 2020. For additional details of the 2020 IRF Rule, 2020 HH Rule, and other proposed and adopted legislative and regulatory actions that may be material to our business, see Item 1, *Business,* and Item 1A, *Risk Factors*.

- Maintaining Strong Volume Growth. Various factors, including competition and increasing regulatory and administrative burdens, may impact our ability to maintain and grow our hospital, home health, and hospice volumes. In any particular market, we may encounter competition from local or national entities with longer operating histories or other competitive advantages, such as acute care hospitals who provide post-acute services similar to ours or other post-acute providers with relationships with referring acute care hospitals or physicians. Aggressive payment review practices by Medicare contractors, aggressive enforcement of regulatory policies by government agencies, and restrictive or burdensome rules, regulations or statutes governing admissions practices may lead us to not accept patients who would be appropriate for and would benefit from the services we provide. In addition, from time to time, we must get regulatory approval to expand our services and locations in states with certificate of need laws. This approval may be withheld or take longer than expected. In the case of new-store volume growth, the addition of hospitals, home health agencies, and hospice agencies to our portfolio also may be difficult and take longer than expected.

- Recruiting and Retaining High-Quality Personnel. See Item 1A, *Risk Factors*, for a discussion of competition for staffing, shortages of qualified personnel, and other factors that may increase our labor costs. Recruiting and retaining qualified personnel, including management, 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.

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 adapt to external events and create value for our shareholders in 2020 and beyond.

Results of Operations

Payor Mix

During 2019, 2018, and 2017, we derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2019	**2018**	**2017**
Medicare	75.1%	75.9%	76.0%
Medicare Advantage	10.6%	9.2%	8.6%
Managed care	8.3%	8.8%	9.3%
Medicaid	2.8%	2.6%	2.5%
Other third-party payors	0.9%	1.1%	1.3%
Workers' compensation	0.7%	0.7%	0.7%
Patients	0.5%	0.5%	0.5%
Other income	1.1%	1.2%	1.1%
Total	100.0%	100.0%	100.0%

Our payor mix is weighted heavily towards Medicare. We receive Medicare reimbursements under the IRF-PPS, the HH-PPS, and the hospice payment system (the “Hospice-PS”). For additional information regarding Medicare reimbursement, see the “Sources of Revenues” section of Item 1, *Business*.

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

Our consolidated *Net operating revenues* consist primarily of revenues derived from patient care services. *Net operating revenues* also include other revenues generated from management and administrative fees and other non-patient care services. These other revenues are included in “other income” in the above table.

Our Results

From 2017 through 2019, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2019	2018	2017	2019 vs. 2018	2018 vs. 2017
	(In Millions)				
Net operating revenues	$ 4,605.0	$ 4,277.3	$ 3,913.9	7.7 %	9.3 %
Operating expenses:					
Salaries and benefits	2,573.0	2,354.0	2,154.6	9.3 %	9.3 %
Other operating expenses	623.6	585.1	531.6	6.6 %	10.1 %
Occupancy costs	82.3	78.0	73.5	5.5 %	6.1 %
Supplies	167.9	158.7	149.3	5.8 %	6.3 %
General and administrative expenses	247.0	220.2	171.7	12.2 %	28.2 %
Depreciation and amortization	218.7	199.7	183.8	9.5 %	8.7 %
Government, class action, and related settlements	—	52.0	—	(100.0)%	N/A
Total operating expenses	3,912.5	3,647.7	3,264.5	7.3 %	11.7 %
Loss on early extinguishment of debt	7.7	—	10.7	N/A	(100.0)%
Interest expense and amortization of debt discounts and fees	159.7	147.3	154.4	8.4 %	(4.6)%
Other income	(30.5)	(2.2)	(4.1)	1,286.4 %	(46.3)%
Equity in net income of nonconsolidated affiliates	(6.7)	(8.7)	(8.0)	(23.0)%	8.8 %
Income from continuing operations before income tax expense	562.3	493.2	496.4	14.0 %	(0.6)%
Provision for income tax expense	115.9	118.9	145.8	(2.5)%	(18.4)%
Income from continuing operations	446.4	374.3	350.6	19.3 %	6.8 %
(Loss) income from discontinued operations, net of tax	(0.6)	1.1	(0.4)	(154.5)%	(375.0)%
Net income	445.8	375.4	350.2	18.8 %	7.2 %
Less: Net income attributable to noncontrolling interests	(87.1)	(83.1)	(79.1)	4.8 %	5.1 %
Net income attributable to Encompass Health	$ 358.7	$ 292.3	$ 271.1	22.7 %	7.8 %

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2019	2018	2017
Operating expenses:			
Salaries and benefits	55.9%	55.0%	55.0%
Other operating expenses	13.5%	13.7%	13.6%
Occupancy costs	1.8%	1.8%	1.9%
Supplies	3.6%	3.7%	3.8%
General and administrative expenses	5.4%	5.1%	4.4%
Depreciation and amortization	4.7%	4.7%	4.7%
Government, class action, and related settlements	—%	1.2%	—%
Total operating expenses	85.0%	85.3%	83.4%

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 home health and hospice locations open throughout both the full current period and prior periods presented. These comparisons include the

financial results of market consolidation transactions in existing markets, as it is difficult to determine, with precision, the incremental impact of these transactions on our results of operations.

2019 Compared to 2018

Net Operating Revenues

Our consolidated *Net operating revenues* increased in 2019 compared to 2018 primarily from pricing and volume growth in our inpatient rehabilitation segment and volume growth in our home health and hospice segment. See additional discussion in the “Segment Results of Operations” section of this Item.

Salaries and Benefits

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

Salaries and benefits increased in 2019 compared to 2018 primarily due to salary increases for our employees, increased benefits costs, and increased patient volumes, including an increase in the number of full-time equivalents as a result of our development activities. As a percent of *Net operating revenues, Salaries and benefits* increased during 2019 compared to 2018 primarily as a result of higher salaries and benefits cost increases compared to revenue pricing increases. See additional discussion in the “Segment Results of Operations” section of this Item.

Other Operating Expenses

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

Other operating expenses increased during 2019 compared to 2018 primarily due to increased patient volumes. As a percent of *Net operating revenues*, *Other operating expenses* decreased during 2019 compared to 2018 primarily due to operating leverage resulting from revenue growth. See additional discussion in the “Segment Results of Operations” section of this Item.

General and Administrative Expenses

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

General and administrative expenses increased in 2019 compared to 2018 in terms of dollars and as a percent of *Net operating revenues* due primarily to increased corporate salaries and benefits costs, including expenses associated with stock appreciation rights (“SARs”), offset by lower costs associated with our rebranding. The 2019 SARs expense was approximately $82 million compared to approximately $56 million in 2018. The 2019 rebranding expenses were approximately $1 million compared to approximately $11 million in 2018. For additional information on SARs, see Note 14, *Share-Based Payments*, to the accompanying consolidated financial statements, and on the rebranding, see Item 1, *Business*.

Depreciation and Amortization

Depreciation and amortization increased during 2019 compared to 2018 due to our capital expenditures and development activities throughout 2018 and 2019. We expect *Depreciation and amortization* to increase going forward as a result of our recent and ongoing capital investments.

Government, Class Action, and Related Settlements

The amount in *Government, class action, and related settlements* in 2018 related primarily to a $48 million loss contingency accrual we established in the fourth quarter of 2018 for the potential settlement of the investigation being conducted by the United States Department of Justice (the “DOJ”). We settled the DOJ investigation in 2019. See Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements for additional information on this matter.

Loss on Early Extinguishment of Debt

The *Loss on early extinguishment of debt* during 2019 resulted from the June and November redemptions of our 2024 Notes. See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* in 2019 compared to 2018 primarily resulted from the September 2019 issuances of our 2028 Notes and 2030 Notes offset by the June and November 2019 redemptions of our 2024 Notes. Cash paid for interest approximated $156 million and $150 million in 2019 and 2018, respectively. See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Other Income

Other income for 2019 included a $19.2 million gain as a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. See Note 9, *Investments in and Advances to Nonconsolidated Affiliates*, to the consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations in 2019 increased compared to 2018 primarily due to increased *Net operating revenues* and the gain resulting from the consolidation of Yuma Rehabilitation Hospital, as discussed above, offset by the contingency accrual we established in the fourth quarter of 2018, as discussed above.

Provision for Income Tax Expense

Our *Provision for income tax expense* declined in 2019 compared to 2018 due primarily to the *Government, class action, and related settlements* discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements. See also Note 16, *Income Taxes*, to the accompanying consolidated financial statements.

On December 22, 2017, the US enacted the 2017 Tax Cuts and Jobs Act (the “Tax Act”). The Tax Act, which is commonly referred to as “US tax reform,” significantly changed US corporate income tax laws by, among other things, reducing the US corporate income tax rate from 35% to 21% starting in 2018. See Note 16, *Income Taxes*, to the accompanying consolidated financial statements for further discussion.

Our cash payments for income taxes approximated $104 million, net of refunds, in 2019. These payments were based on estimates of taxable income for 2019. We estimate we will pay approximately $60 million to $80 million of cash income taxes, net of refunds, in 2020. In 2019 and 2018, current income tax expense was $75.9 million and $128.0 million, respectively.

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, if the timing of future tax deductions differs from our expectations, or pursuant to changes in state tax laws and rates.

See Note 16, *Income Taxes*, to the accompanying consolidated financial statements and the “Critical Accounting Estimates” section of this Item.

Net Income Attributable to Noncontrolling Interests

The increase in *Net income attributable to noncontrolling interests* during 2019 compared to the same period of 2018 primarily resulted from increased profitability of our joint ventures and the July 1, 2019 consolidation of our Yuma Rehabilitation Hospital, as discussed above, which created a new noncontrolling interest.

Impact of Inflation

The impact of inflation on the Company will be primarily in the area of labor costs. The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace.

There can be no guarantee we will not experience increases in the cost of labor, as the need for clinical healthcare professionals is expected to grow. In addition, increases in healthcare costs are typically higher than inflation and impact our costs under our employee benefit plans. Managing these costs remains a significant challenge and priority for us.

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

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

Relationships and Transactions with Related Parties

Related party transactions were not material to our operations in 2019, 2018, or 2017, and therefore, are not presented as a separate discussion within this Item.

Segment Results of Operations

Our internal financial reporting and management structure is focused on the major types of services provided by 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 19, *Segment Reporting*, to the accompanying consolidated financial statements.

Inpatient Rehabilitation

During the years ended December 31, 2019, 2018 and 2017, our inpatient rehabilitation segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2019	**2018**	**2017**
Medicare	72.2%	73.2%	73.6%
Medicare Advantage	10.7%	9.2%	8.3%
Managed care	9.8%	10.3%	10.7%
Medicaid	3.1%	3.0%	3.0%
Other third-party payors	1.2%	1.5%	1.6%
Workers' compensation	0.8%	0.8%	0.9%
Patients	0.7%	0.6%	0.6%
Other income	1.5%	1.4%	1.3%
Total	100.0%	100.0%	100.0%

Additional information regarding our inpatient rehabilitation segment's operating results for the years ended December 31, 2019, 2018 and 2017, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2019	2018	2017	2019 vs. 2018	2018 vs. 2017
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Inpatient	$ 3,423.5	$ 3,247.9	$ 3,039.3	5.4 %	6.9 %
Outpatient and other	89.5	98.3	102.0	(9.0)%	(3.6)%
Inpatient rehabilitation segment revenues	3,513.0	3,346.2	3,141.3	5.0 %	6.5 %
Operating expenses:					
Salaries and benefits	1,813.1	1,701.5	1,603.8	6.6 %	6.1 %
Other operating expenses	521.9	502.3	462.5	3.9 %	8.6 %
Supplies	147.0	140.6	135.7	4.6 %	3.6 %
Occupancy costs	64.8	63.8	61.9	1.6 %	3.1 %
Other income	(10.5)	(3.6)	(4.1)	191.7 %	(12.2)%
Equity in net income of nonconsolidated affiliates	(5.5)	(7.5)	(7.3)	(26.7)%	2.7 %
Noncontrolling interests	82.6	77.2	67.6	7.0 %	14.2 %
Segment Adjusted EBITDA	$ 899.6	$ 871.9	$ 821.2	3.2 %	6.2 %
	(Actual Amounts)				
Discharges	186,842	179,846	171,922	3.9 %	4.6 %
Net patient revenue per discharge	$ 18,323	$ 18,059	$ 17,678	1.5 %	2.2 %
Outpatient visits	375,525	488,754	576,345	(23.2)%	(15.2)%
Average length of stay (days)	12.6	12.6	12.7	— %	(0.8)%
Occupancy %	69.5%	69.3%	67.8%	0.3 %	2.2 %
# of licensed beds	9,249	8,966	8,851	3.2 %	1.3 %
Full-time equivalents*	21,967	21,335	20,802	3.0 %	2.6 %
Employees per occupied bed	3.42	3.43	3.47	(0.3)%	(1.2)%

* Full-time equivalents included in the above table represent our employees who participate in or support the operations of our hospitals and include an estimate of full-time equivalents related to contract labor.

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

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2019	2018	2017
Operating expenses:			
Salaries and benefits	51.6%	50.8%	51.1%
Other operating expenses	14.9%	15.0%	14.7%
Supplies	4.2%	4.2%	4.3%
Occupancy costs	1.8%	1.9%	2.0%

2019 Compared to 2018

Net Operating Revenues

Revenue growth during 2019 compared to 2018 resulted from volume growth and an increase in net patient revenue per discharge. Discharge growth from new stores resulted from our joint ventures in Murrells Inlet, South Carolina (September 2018), Winston-Salem, North Carolina (October 2018), Lubbock, Texas (May 2019), and Boise, Idaho (July 2019), as well as wholly owned hospitals in Shelby County, Alabama (April 2018), Bluffton, South Carolina (June 2018), and Katy, Texas (September 2019). New-store growth also resulted from the consolidation of our Yuma Rehabilitation Hospital effective July 1, 2019. Discharge growth included a 1.8% increase in same-store discharges. Growth in net patient revenue per discharge primarily resulted from an increase in reimbursement rates and improvements in discharge destinations. The decrease in outpatient and other revenues in 2019 compared to 2018 was primarily due to the continued closures of hospital-based outpatient programs.

See Note 2, *Business Combinations*, to the accompanying consolidated financial statements for information regarding our joint ventures discussed above. See Note 9, *Investments in and Advances to Nonconsolidated Affiliates*, to the consolidated financial statements for information regarding the consolidation of our Yuma Rehabilitation Hospital.

Adjusted EBITDA

The increase in Adjusted EBITDA for the inpatient rehabilitation segment in 2019 compared to 2018 primarily resulted from revenue growth, as discussed above. *Salaries and benefits* as a percent of *Net operating revenues* increased primarily due to higher salaries and wages per full-time equivalent, inclusive of approximately $3.5 million of training and education costs associated with the transition to CMS Section GG, as discussed in Item 1, *Business,* and Item 1A, *Risk Factors*.

Home Health and Hospice

During the years ended December 31, 2019, 2018 and 2017, our home health and hospice segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2019	**2018**	**2017**
Medicare	84.2%	85.3%	85.7%
Medicare Advantage	10.2%	9.5%	9.7%
Managed care	3.6%	3.6%	3.8%
Medicaid	1.7%	1.2%	0.6%
Workers' compensation	0.1%	0.2%	—%
Patients	0.1%	0.1%	0.1%
Other income	0.1%	0.1%	0.1%
Total	100.0%	100.0%	100.0%

Additional information regarding our home health and hospice segment's operating results for the years ended December 31, 2019, 2018 and 2017, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2019	2018	2017	2019 vs. 2018	2018 vs. 2017
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Home health	$ 918.0	$ 814.6	$ 702.4	12.7 %	16.0 %
Hospice	174.0	116.5	70.2	49.4 %	66.0 %
Home health and hospice segment revenues	1,092.0	931.1	772.6	17.3 %	20.5 %
Operating expenses:					
Cost of services sold (excluding depreciation and amortization)	506.2	438.4	363.3	15.5 %	20.7 %
Support and overhead costs	381.7	323.5	277.2	18.0 %	16.7 %
Other income	—	(0.5)	—	100.0 %	N/A
Equity in net income of nonconsolidated affiliates	(1.2)	(1.2)	(0.7)	— %	71.4 %
Noncontrolling interests	9.5	8.5	6.9	11.8 %	23.2 %
Segment Adjusted EBITDA	$ 195.8	$ 162.4	$ 125.9	20.6 %	29.0 %
	(Actual Amounts)				
Home health:					
Admissions	159,727	137,396	124,870	16.3 %	10.0 %
Recertifications	116,084	111,581	92,989	4.0 %	20.0 %
Episodes	275,578	243,698	211,743	13.1 %	15.1 %
Revenue per episode	$ 2,972	$ 2,968	$ 2,984	0.1 %	(0.5)%
Episodic visits per episode	17.1	17.6	17.9	(2.8)%	(1.7)%
Total visits	5,431,621	4,959,645	4,390,958	9.5 %	13.0 %
Cost per visit	$ 77	$ 76	$ 75	1.3 %	1.3 %
Hospice:					
Admissions	10,452	7,474	4,870	39.8 %	53.5 %
Patient days	1,197,927	790,984	479,350	51.4 %	65.0 %
Average daily census	3,282	2,167	1,313	51.5 %	65.0 %
Revenue per day	$ 145	$ 147	$ 146	(1.4)%	0.7 %

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2019	2018	2017
Operating expenses:			
Cost of services sold (excluding depreciation and amortization)	46.4%	47.1%	47.0%
Support and overhead costs	35.0%	34.7%	35.9%

2019 Compared to 2018

Net Operating Revenues

Revenue growth during 2019 compared to 2018 was primarily driven from volume growth. Volume growth included a 7.7% increase in home health same-store admissions and the impact of the acquisition of Alacare on July 1, 2019 and Camellia Healthcare on May 1, 2018. Revenue per episode decreased primarily due to the patient mix of the former Alacare locations and the timing of episodes. Hospice revenue increased primarily due to the acquisition of Alacare and same-store admissions growth of 12.2%.

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

Adjusted EBITDA

The increase in Adjusted EBITDA during 2019 compared to 2018 primarily resulted from revenue growth, as discussed above. *Cost of services* as a percent of *Net operating revenues* for 2019 compared to 2018 decreased primarily due to improvements in caregiver optimization and productivity in home health partially offset by higher costs at the former Alacare locations. *Support and overhead costs* as a percent of *Net operating revenues* for 2019 compared to 2018 increased primarily due to expenses associated with the integration of Alacare.

Liquidity and Capital Resources

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

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

Consistent with these objectives, in June 2019, we redeemed $100 million of the outstanding principal amount of the 2024 Notes using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 101.917%, which resulted in a total cash outlay of approximately $102 million. As a result of this redemption, we recorded a $2.3 million *Loss on early extinguishment of debt* in the second quarter of 2019.

In September 2019, we issued $500 million of the 2028 Notes at par and $500 million of the 2030 Notes at par (the “New Notes”), which resulted in approximately $983 million in net proceeds from the public offering. We used the net proceeds from the offering of the New Notes to fund the purchase of equity and vested stock appreciation rights from management investors of our home health and hospice segment, redeem $400 million of our 2024 Notes as described below, and repay borrowings under our revolving credit facility.

In November 2019, we redeemed $400 million of the outstanding principal amount of our 2024 Notes. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 100.958%, which resulted in a total cash outlay of approximately $404 million. As a result of this redemption, we recorded a $5.4 million *Loss on early extinguishment* of debt in the fourth quarter of 2019. Also in November 2019, we amended our existing credit agreement to, among other things, increase the size of our revolving credit facility from $700 million to $1 billion and extend the agreement's maturity by two years to 2024.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2023. We continue to have a strong, well-capitalized balance sheet, including a substantial portfolio of owned real estate, and we have significant availability under our revolving credit facility. We continue to generate strong cash flows from operations, and we have significant flexibility with how we choose to invest our cash and return capital to shareholders.

See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Current Liquidity

As of December 31, 2019, we had $94.8 million in *Cash and cash equivalents*. This amount excludes $64.8 million in restricted cash ($57.4 million included in *Restricted cash* and $7.4 million included in *Other long-term assets* in our consolidated balance sheet) and $76.1 million of restricted marketable securities (included in *Other long-term assets* in our consolidated balance sheet). Our restricted assets pertain primarily to obligations associated with our captive insurance company, as well as obligations we have under agreements with joint venture partners. See Note 4, *Cash and Marketable Securities*, to the accompanying consolidated financial statements.

In addition to *Cash and cash equivalents*, as of December 31, 2019, we had approximately $916 million available to us under our revolving credit facility. Our credit agreement governs the substantial majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $300 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. In calculating the leverage ratio under our credit agreement, we are permitted to use pro forma Adjusted EBITDA, the calculation of which includes historical income statement items and pro forma adjustments resulting from (1) the dispositions and repayments or incurrence of debt and (2) the investments, acquisitions, mergers, amalgamations, consolidations and operational changes from acquisitions to the extent such items or effects are not yet reflected in our trailing four-quarter financial statements. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2019, the maximum leverage ratio requirement per our credit agreement was 4.50x and the minimum interest coverage ratio requirement was 3.0x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2019 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2019, if we had drawn on the first day and maintained the maximum amount of outstanding draws under our revolving credit facility for the entire year, we would still be in compliance with the maximum leverage ratio and minimum interest coverage ratio requirements.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2024, and our bonds all mature in 2023 and beyond. See the “Contractual Obligations” section below for information related to our contractual obligations as of December 31, 2019.

We acquired a significant portion of our home health and hospice business when we purchased EHHI Holdings, Inc. (“EHHI”) on December 31, 2014. 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. The fair value is determined using the product of the trailing twelve-month adjusted EBITDA measure for Holdings 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. 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. In July 2019, we received additional exercise notices, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. In September 2019, Encompass Health settled the acquisition of those shares upon payment of approximately $163 million in cash. As of December 31, 2019, the fair value of those outstanding shares of Holdings owned by management investors is approximately $208 million. In January 2020, we received additional exercise notices, representing approximately 4.3% of the outstanding shares of the common stock of Holdings. In February 2020, Encompass Health settled the acquisition of those shares upon payment of approximately $162 million in cash. Upon settlement of these exercises, approximately $46 million of the shares of Holdings held by two management investors remained outstanding.

On February 20, 2020, Encompass Health entered into exchange agreements (each, an “Exchange Agreement”) with these two management investors, pursuant to which they have the right to exchange all of the remaining shares of Holdings

held by them for shares of common stock of Encompass Health (the "EHC Shares"). Each of the Exchange Agreements provides that the management investor must deliver a written exchange notice (an "Exchange Notice") to Encompass Health in order to exchange his or her remaining shares of Holdings for EHC Shares. Each Exchange Agreement further provides that the number of EHC Shares to be delivered to the management investor is to be determined by dividing the fair value of the shares of Holdings held by the management investor on the date of the Exchange Agreement by the last reported sales price of Encompass Health's common stock on the New York Stock Exchange (the "NYSE") on the date of delivery of the Exchange Notice.

On February 20, 2020, Encompass Health received an Exchange Notice from each of the management investors. Based on the last sales price of Encompass Health's common stock on the NYSE on February 20, 2020, Encompass Health anticipates delivering an aggregate of approximately 561,000 EHC Shares, less than 0.6% of the total number of outstanding shares of the Encompass Health's common stock, to the management investors. The settlement of the exchanges is expected to occur prior to the end of the first quarter of 2020. Encompass Health anticipates issuing the EHC Shares from its treasury shares. See also Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

In conjunction with the EHHI acquisition, we granted stock appreciation rights ("SARs") based on Holdings common stock to certain members of EHHI management at closing. Half of the SARs vested on December 31, 2018 with the remainder vesting on December 31, 2019. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings' common stock on the exercise date exceeds the per share fair value on the grant date. In February 2019, members of the management team exercised a portion of their vested SARs for approximately $13 million in cash. In July 2019, members of the management team exercised the remainder of the vested SARs, which resulted in cash distributions of approximately $55 million. As of December 31, 2019, the fair value of the remaining 115,545 SARs is approximately $101 million, all of which is included in *Other current liabilities* in the accompanying consolidated balance sheet. In January 2020, members of the management team exercised the remaining SARs and in February 2020, we settled those awards upon payment of approximately $101 million in cash. See also Note 14, *Share-Based Payments*, to the accompanying consolidated financial statements.

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

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

Sources and Uses of Cash

The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2019, 2018, and 2017 (in millions):

	For the Year Ended December 31,		
	2019	**2018**	**2017**
Net cash provided by operating activities	$ 635.3	$ 762.4	$ 658.3
Net cash used in investing activities	(657.4)	(424.5)	(283.0)
Net cash provided by (used in) financing activities	48.2	(321.2)	(359.9)
Increase in cash, cash equivalents, and restricted cash	$ 26.1	$ 16.7	$ 15.4

2019 Compared to 2018

Operating activities. The decrease in *Net cash provided by operating activities* during 2019 compared to 2018 primarily resulted from the payment to management investors of our home health and hospice segment for vested stock appreciation rights, the settlement payment associated with the investigation conducted by the United States Department of Justice, and an increase in *Accounts receivable* due to volume increases in both segments during 2019. See Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Investing activities. The increase in *Net cash used in investing activities* during 2019 compared to 2018 resulted primarily from the acquisition of Alacare, as described in Note 2, *Business Combinations*, to the accompanying consolidated financial statements, and an increase in purchases of property and equipment during 2019.

Financing activities. The increase in *Net cash provided by financing activities* during 2019 compared to 2018 primarily resulted from the public offering of the New Notes in September 2019 offset by cash used for principal payments on net debt, repurchases of common stock, and the purchase of equity interests held by the home health and hospice management team during the third quarter of 2019. See also See Note 10, *Long-term Debt*, and Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2019 are as follows (in millions):

	Total	2020	2021-2022	2023-2024	2025 and thereafter
Long-term debt obligations:					
Long-term debt, excluding revolving credit facility and finance lease obligations [a]	$ 2,633.5	$ 18.3	$ 41.5	$ 1,236.8	$ 1,336.9
Revolving credit facility	45.0	—	—	45.0	—
Interest on long-term debt [b]	840.0	135.8	269.3	230.2	204.7
Finance lease obligations [c]	640.5	50.4	94.4	90.0	405.7
Operating lease obligations [d]	384.2	57.5	98.6	75.1	153.0
Purchase obligations [e]	143.0	61.4	56.8	17.7	7.1
Other long-term liabilities [f][g]	3.3	0.3	0.4	0.4	2.2
Total	$ 4,689.5	$ 323.7	$ 561.0	$ 1,695.2	$ 2,109.6

[a] Included in long-term debt are amounts owed on our bonds payable and other notes payable. These borrowings are further explained in Note 10, *Long-term Debt,* to the accompanying consolidated financial statements.

[b] Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2019. Interest pertaining to our credit agreement and bonds is included to their respective ultimate maturity dates. Interest related to finance lease obligations is excluded from this line (see Note 7, *Leases*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements). Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of operations.

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

[d] Our inpatient rehabilitation segment leases approximately 14% of its hospitals as well as other property and equipment under operating leases in the normal course of business. Our home health and hospice segment leases relatively small office spaces in the localities it serves, space for its corporate office, and other equipment under operating leases in the normal course of business. Amounts include interest portion of future minimum operating lease payments. For more information, see Note 7, *Leases,* to the accompanying consolidated financial statements.

[e] Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on Encompass Health and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support and medical equipment. Purchase obligations are not recognized in our consolidated balance sheet.

[f] Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: general liability, professional liability, and workers' compensation risks, noncurrent amounts related to third-party billing audits, SARs, and deferred income taxes. As discussed above, the remaining SARs were exercised and settled during the first quarter of 2020. For more information, see Note 11, *Self-Insured Risks,* Note 14, *Share-Based*

Payments, and Note 18, *Contingencies and Other Commitments,* to the accompanying consolidated financial statements.

(g) The table above does not include *Redeemable noncontrolling interests* of $239.6 million because of the uncertainty surrounding the timing and amounts of any related cash outflows. As discussed above, a portion of the outstanding shares of Holdings were exercised and settled during the first quarter of 2020. See Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

Our capital expenditures include costs associated with our hospital refresh program, de novo projects, capacity expansions, technology initiatives, and building and equipment upgrades and purchases. During the year ended December 31, 2019, we made capital expenditures of approximately $404 million for property and equipment, intangible assets, and capitalized software. These expenditures in 2019 are exclusive of approximately $232 million in net cash related to our acquisition activity. During 2020, we expect to spend approximately $440 million to $510 million for capital expenditures. Approximately $155 million to $165 million of this budgeted amount is considered nondiscretionary expenditures, which we may refer to in other filings as “maintenance” expenditures. In addition, we expect to spend approximately $50 million to $100 million on home health and hospice acquisitions during 2020. Actual amounts spent will be dependent upon the timing of construction projects and acquisition opportunities for our home health and hospice business.

Authorizations for Returning Capital to Stakeholders

In October 2018, February 2019, and May 2019, our board of directors declared cash dividends of $0.27 per share that were paid in January 2019, April 2019, and July 2019, respectively. On July 23, 2019, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.28 per share, that was paid on October 15, 2019. On October 25, 2019, our board of directors declared a cash dividend of $0.28 per share, that was paid on January 15, 2020 to stockholders of record on January 2, 2020. We expect quarterly dividends to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board of directors after consideration of various factors, including our capital position and alternative uses of funds. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our revolving credit facility.

On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock, which amount was subsequently increased to $250 million. On July 24, 2018, our board approved resetting the aggregate common stock repurchase authorization to $250 million. As of December 31, 2019, approximately $204 million remained under this authorization. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. During 2019, we repurchased 0.8 million shares of our common stock in the open market for approximately $46 million under this repurchase authorization using cash on hand. Future repurchases under this authorization generally are expected to be funded using a combination of cash on hand and availability under our $1 billion revolving credit facility.

Adjusted EBITDA

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

We use Adjusted EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our credit agreement, which is discussed in more detail in Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under our credit agreement—our interest coverage ratio and our leverage ratio—could result in our lenders requiring us to immediately repay all amounts borrowed. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might be on terms less favorable to us than those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, therein referred to as "Adjusted Consolidated EBITDA," allows us to add back to consolidated *Net income* interest expense, income taxes, and depreciation and amortization and then add back to consolidated *Net income* (1) all unusual or nonrecurring items reducing consolidated *Net income* (of which only up to $10 million in a year may be cash expenditures), (2) any losses from discontinued operations, (3) non-ordinary course fees, costs and expenses incurred with respect to any litigation or settlement, (4) share-based compensation expense, (5) costs and expenses associated with changes in the fair value of marketable securities, (6) costs and expenses associated with the issuance or prepayment debt and acquisitions, and (7) any restructuring charges not in excess of 20% of Adjusted Consolidated EBITDA. We also subtract from consolidated *Net income* all unusual or nonrecurring items to the extent they increase consolidated *Net income*.

Under the credit agreement, the Adjusted EBITDA calculation does not require us to deduct net income attributable to noncontrolling interests or gains on fair value adjustments of hedging and equity instruments, disposal of assets, and development activities. It also does not allow us to add back losses on fair value adjustments of hedging instruments or unusual or nonrecurring cash expenditures in excess of $10 million. These items and amounts, in addition to the items falling within the credit agreement's "unusual or nonrecurring" classification, may occur in future periods, but can vary significantly from period to period and may not directly relate to, or be indicative of, our ongoing liquidity or operating performance. Accordingly, the Adjusted EBITDA calculation presented here includes adjustments for them.

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

Our Adjusted EBITDA for the years ended December 31, 2019, 2018, and 2017 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,		
	2019	**2018**	**2017**
Net income	$ 445.8	$ 375.4	$ 350.2
Loss (income) from discontinued operations, net of tax, attributable to Encompass Health	0.6	(1.1)	0.4
Provision for income tax expense	115.9	118.9	145.8
Interest expense and amortization of debt discounts and fees	159.7	147.3	154.4
Loss on early extinguishment of debt	7.7	—	10.7
Government, class action, and related settlements	—	52.0	—
Net noncash loss on disposal of assets	11.1	5.7	4.6
Depreciation and amortization	218.7	199.7	183.8
Stock-based compensation expense	114.4	85.9	47.7
Net income attributable to noncontrolling interests	(87.1)	(83.1)	(79.1)
Transaction costs	2.1	1.0	—
Gain on consolidation of Yuma	(19.2)	—	—
SARs mark-to-market impact on noncontrolling interests	(5.0)	(2.6)	—
Change in fair market value of equity securities	(0.8)	1.9	—
Tax reform impact on noncontrolling interests	—	—	4.6
Payroll taxes on SARs exercise	1.0	—	—
Adjusted EBITDA	$ 964.9	$ 901.0	$ 823.1

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,		
	2019	2018	2017
Net cash provided by operating activities	$ 635.3	$ 762.4	$ 658.3
Interest expense and amortization of debt discounts and fees	159.7	147.3	154.4
Equity in net income of nonconsolidated affiliates	6.7	8.7	8.0
Net income attributable to noncontrolling interests in continuing operations	(87.1)	(83.1)	(79.1)
Amortization of debt-related items	(4.5)	(4.0)	(8.7)
Distributions from nonconsolidated affiliates	(6.6)	(8.3)	(8.6)
Current portion of income tax expense	75.9	128.0	85.0
Change in assets and liabilities	180.1	(46.0)	7.4
Tax reform impact on noncontrolling interests	—	—	4.6
Cash used in operating activities of discontinued operations	4.4	(0.8)	0.6
Transaction costs	2.1	1.0	—
SARs mark-to-market impact on noncontrolling interests	(5.0)	(2.6)	—
Change in fair market value of equity securities	(0.8)	1.9	—
Payroll taxes on SARs exercise	1.0	—	—
Other	3.7	(3.5)	1.2
Adjusted EBITDA	$ 964.9	$ 901.0	$ 823.1

Growth in Adjusted EBITDA in 2019 compared to 2018 resulted primarily from revenue growth. For additional information see the “Results of Operations” and “Segment Results of Operations” sections of this Item.

Off-Balance Sheet Arrangements

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

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

As of December 31, 2019, we do not have any material off-balance sheet arrangements.

As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (“SPEs”), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2019, we are not involved in any unconsolidated SPE transactions.

Critical Accounting Estimates

Our consolidated financial statements are prepared in accordance with GAAP. In connection with the preparation of our financial statements, we are required to make assumptions and estimates about future events and apply judgments that affect the reported amounts of assets, liabilities, revenue, expenses, and the related disclosures. We base our assumptions, estimates, and judgments on historical experience, current trends, and other factors we believe to be relevant at the time we prepared our consolidated financial statements. On a regular basis, we review the accounting policies, assumptions, estimates, and judgments to ensure our consolidated financial statements are presented fairly and in accordance with GAAP. However,

because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

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

Revenue Recognition

We recognize net operating revenue in the reporting period in which we perform the service based on 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 (principally for patients covered by Medicare, Medicare Advantage, Medicaid, and other third-party payors), potential adjustments that may arise from payment and other reviews, and uncollectible amounts. See Note 1, *Summary of Significant Accounting Policies*, “Net Operating Revenues,” to the accompanying consolidated financial statements of this report for a complete discussion of our revenue recognition policies.

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

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. In addition, laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation and review, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. However, we continually review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective.

The collection of outstanding receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to patient responsibility amounts and claims reviews conducted by MACs or other contractors.

The table below shows a summary of our net accounts receivable balances as of December 31, 2019 and 2018. Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, *Summary of Significant Accounting Policies*, "Accounts Receivable," to the accompanying consolidated financial statements.

	As of December 31,	
	2019	2018
	(In Millions)	
Current:		
0 - 30 Days	$ 385.6	$ 362.5
31 - 60 Days	45.2	43.7
61 - 90 Days	25.4	18.4
91 - 120 Days	12.7	10.0
120 + Days	29.8	25.3
Patient accounts receivable	498.7	459.9
Other accounts receivable	7.4	7.8
	506.1	467.7
Noncurrent patient accounts receivable	152.1	155.5
Accounts receivable	$ 658.2	$ 623.2

Changes in general economic conditions (such as increased unemployment rates or periods of recession), business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable. Our collection risks include patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding, pre-payment claim reviews by our respective MACs, and reimbursement claims audits by governmental or other payors and their agents. As of December 31, 2019 and 2018, $144.5 million and $149.3 million of our patient accounts receivable represented denials that were under review or audit in our inpatient rehabilitation segment. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues" and "Accounts Receivable," to the accompanying consolidated financial statements of this report.

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers' compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers' compensation risks are insured through a wholly owned insurance subsidiary. See Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

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

Periodically, we review our assumptions and the valuations provided by third-party actuaries to determine the adequacy of our self-insurance reserves. The following are certain of the key assumptions and other factors that significantly influence our estimate of self-insurance reserves: historical claims experience; trending of loss development factors; trends in the frequency and severity of claims; coverage limits of third-party insurance; demographic information; statistical confidence levels; medical cost inflation; payroll dollars; and hospital patient census.

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

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

Net self-insurance reserves as of December 31, 2019:	
As reported, with 50% statistical confidence level	130.9
With 70% statistical confidence level	139.9

We believe our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. See Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements for additional information.

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

Goodwill

Absent any impairment indicators, we evaluate goodwill for impairment as of October 1st of each year. We test goodwill for impairment at the reporting unit level and are required to make certain subjective and complex judgments on a number of matters, including assumptions and estimates used to determine the fair value of our inpatient rehabilitation and home health and hospice reporting units. We assess qualitative factors in each reporting unit to determine whether it is necessary to perform the quantitative goodwill impairment test. The quantitative impairment test is required only if we conclude it is more likely than not a reporting unit's fair value is less than its carrying amount.

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

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

See Note 1, *Summary of Significant Accounting Policies*, "Goodwill and Other Intangibles," and Note 8, *Goodwill and Other Intangible Assets*, to the accompanying consolidated financial statements for additional information.

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

- Macroeconomic conditions, such as deterioration in general economic conditions, limitations on accessing capital, or other developments in equity and credit markets;
- Industry and market considerations and changes in healthcare regulations, including reimbursement and compliance requirements under the Medicare and Medicaid programs;
- Cost factors, such as an increase in labor, supply, or other costs;
- Overall financial performance, such as negative or declining cash flows or a decline in actual or forecasted revenue or earnings;

- Other relevant company-specific events, such as material changes in management or key personnel or outstanding litigation;
- Material events, such as a change in the composition or carrying amount of each reporting unit's net assets, including acquisitions and dispositions;
- Consideration of the relationship of our market capitalization to our book value, as well as a sustained decrease in our share price; and
- Length of time since most recent qualitative analysis.

In the fourth quarter of 2019, we performed our annual evaluation of goodwill and determined no adjustment to impair goodwill was necessary. If actual results are not consistent with our assumptions and estimates, we may be exposed to goodwill impairment charges. However, at this time, we continue to believe our inpatient rehabilitation and home health and hospice reporting units are not at risk for any impairment charges.

Income Taxes

We provide for income taxes using the asset and liability method. We also evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," and Note 16, *Income Taxes*, to the accompanying consolidated financial statements for a more complete discussion of income taxes and our policies related to income taxes.

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

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

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

During the year ended December 31, 2019, we increased our valuation allowance by $4.7 million. As of December 31, 2019, we had a remaining valuation allowance of $38.4 million which primarily related to state NOLs. At the state jurisdiction level, we determined it was necessary to maintain a valuation allowance due to uncertainties related to our ability to utilize a portion of the NOLs before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence, as described above, including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable.

While management believes the assumptions included in its forecast of future earnings are reasonable and it is more likely than not the net deferred tax asset balance as of December 31, 2019 will be realized, no such assurances can be provided. If management's expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to increase our valuation allowance, or reverse amounts recorded currently in the valuation allowance, for all or a portion of our deferred tax assets. Similarly, future adjustments to our valuation allowance may be necessary if the timing of future tax deductions is different than currently expected. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. See Note 1, *Summary of Significant Accounting Policies*, "Litigation Reserves," and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements for additional information.

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

Business Combinations

We account for acquisitions of entities that qualify as business combinations under the acquisition method of accounting. Under the acquisition method of accounting, the total consideration is allocated to the tangible and identifiable intangible assets acquired and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the purchase price over the fair values of these identifiable assets and liabilities is recorded as goodwill. During the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill.

In determining the fair value of assets acquired and liabilities assumed in a business combination, we primarily use the income and multi-period excess earnings approaches to estimate the value of our most significant acquired intangible assets. Both income approaches utilize projected operating results and cash flows and include significant assumptions such as base revenue, revenue growth rate, projected EBITDA margin, discount rates, rates of increase in operating expenses, and the future effective income tax rates. The valuations of our significant acquired businesses have been performed by a third-party valuation specialist under our management's supervision. We believe that the estimated fair value assigned to the assets acquired and liabilities assumed is based on reasonable assumptions and estimates that marketplace participants would use. However, such assumptions are inherently uncertain and actual results could differ from those estimates. Future changes in our assumptions or the interrelationship of those assumptions may result in purchase price allocations that are different than those recorded in recent years.

Acquisition related costs are not considered part of the consideration paid and are expensed as operating expenses as incurred. Contingent consideration, if any, is measured at fair value initially on the acquisition date as well as subsequently at the end of each reporting period until the contingency is resolved and settlement occurs. Subsequent adjustments to contingent considerations are recorded in our consolidated statements of operations. We include the results of operations of the businesses acquired as of the beginning of the acquisition dates.

Recent Accounting Pronouncements

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

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use a sensitivity analysis model to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2019, our primary variable rate debt outstanding related to $45.0 million in advances under our revolving credit facility and $265.2 million outstanding under our term loan facilities. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $2.7 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $2.7 million over the next 12 months.

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

	December 31, 2019		December 31, 2018	
Financial Instrument:	**Book Value**	**Market Value**	**Book Value**	**Market Value**
5.125% Senior Notes due 2023				
Carrying Value	$ 297.3	$ —	$ 296.6	$ —
Unamortized debt discount and fees	2.7	—	3.4	—
Principal amount	300.0	306.6	300.0	298.5
5.75% Senior Notes due 2024				
Carrying Value	697.3	—	1,194.7	—
Unamortized debt discount and fees	2.7	—	5.3	—
Principal amount	700.0	708.8	1,200.0	1,200.0
5.75% Senior Notes due 2025				
Carrying Value	345.6	—	345.0	—
Unamortized debt discount and fees	4.4	—	5.0	—
Principal amount	350.0	369.7	350.0	339.5
4.50% Senior Notes due 2028				
Carrying Value	491.7	—	—	—
Unamortized debt discount and fees	8.3	—	—	—
Principal amount	500.0	519.4	—	—
4.75% Senior Notes due 2030				
Carrying Value	491.7	—	—	—
Unamortized debt discount and fees	8.3	—	—	—
Principal amount	500.0	520.0	—	—

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

See also Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Item 8. Financial Statements and Supplementary Data

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

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, an evaluation was carried out by our management, including our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”). Our disclosure controls and procedures are designed to ensure that information required to be disclosed in reports we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2019, our disclosure controls and procedures were effective.

Management's Report on Internal Control Over Financial Reporting

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

Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2019. In making this assessment, management used the criteria set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, the COSO framework. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2019, our internal control over financial reporting was effective.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2019 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears herein.

Changes in Internal Control Over Financial Reporting

There were no changes in the Company's internal controls over financial reporting that occurred during the quarter ended December 31, 2019 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

PART III

We expect to file a definitive proxy statement relating to our 2020 Annual Meeting of Stockholders (the "2020 Proxy Statement") with the United States Securities and Exchange Commission, pursuant to Regulation 14A, not later than 120 days after the end of our most recent fiscal year. Accordingly, certain information required by Part III has been omitted under General Instruction G(3) to Form 10-K. Only the information from the 2020 Proxy Statement that specifically addresses disclosure requirements of Items 10-14 below is incorporated by reference.

Item 10. Directors and Executive Officers of the Registrant

The information required by Item 10 is hereby incorporated by reference from our 2020 Proxy Statement under the captions "Items of Business Requiring Your Vote—Proposal 1—Election of Directors," "Corporate Governance and Board Structure—Corporate Governance—Code of Ethics," "—Board Structure and Committees—Audit Committee," "—Board Composition and Director Nomination Process—Director Nominees Proposed by Stockholders," and "Executive Officers."

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2020 Proxy Statement under the captions "Corporate Governance and Board Structure—Compensation of Directors," "Compensation and Human Capital Committee Matters," and "Executive Compensation."

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

The information required by Item 12 is hereby incorporated by reference from our 2020 Proxy Statement under the captions "Executive Compensation—Equity Compensation Plans" and "Security Ownership of Certain Beneficial Owners and Management."

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by Item 13 is hereby incorporated by reference from our 2020 Proxy Statement under the captions "Corporate Governance and Board Structure—Director Independence" and "Certain Relationships and Related Transactions."

Item 14. Principal Accountant Fees and Services

The information required by Item 14 is hereby incorporated by reference from our 2020 Proxy Statement under the caption "Items of Business Requiring Your Vote—Proposal 2—Ratification of Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

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

Financial Statement Schedules

None.

Exhibits

See Exhibit Index immediately following page F-80 of this report.

Item 16. Form 10-K Summary

Not applicable.

SIGNATURES

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

ENCOMPASS HEALTH CORPORATION

By: /s/ Mark J. Tarr

Mark J. Tarr
President and Chief Executive Officer

Date: February 27, 2020

[Signatures continue on the following page]

POWER OF ATTORNEY

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

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

Signature	Capacity	Date
/s/ Mark J. Tarr **Mark J. Tarr**	President and Chief Executive Officer and Director	February 27, 2020
/s/ Douglas E. Coltharp **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 27, 2020
/s/ Andrew L. Price **Andrew L. Price**	Chief Accounting Officer	February 27, 2020
/s/ Leo I. Higdon, Jr. **Leo I. Higdon, Jr.**	Chairman of the Board of Directors	February 27, 2020
/s/ Greg D. Carmichael **Greg D. Carmichael**	Director	February 27, 2020
/s/ John W. Chidsey **John W. Chidsey**	Director	February 27, 2020
/s/ Donald L. Correll **Donald L. Correll**	Director	February 27, 2020
/s/ Yvonne M. Curl **Yvonne M. Curl**	Director	February 27, 2020
/s/ Charles M. Elson **Charles M. Elson**	Director	February 27, 2020
/s/ Joan E. Herman **Joan E. Herman**	Director	February 27, 2020
/s/ Leslye G. Katz **Leslye G. Katz**	Director	February 27, 2020
/s/ Patricia A. Maryland **Patricia A. Maryland**	Director	February 27, 2020
/s/ John E. Maupin, Jr. **John E. Maupin, Jr.**	Director	February 27, 2020
/s/ Nancy M. Schlichting **Nancy M. Schlichting**	Director	February 27, 2020
/s/ L. Edward Shaw, Jr. **L. Edward Shaw, Jr.**	Director	February 27, 2020
/s/ Terrance Williams **Terrance Williams**	Director	February 27, 2020

Item 15. Financial Statements

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Encompass Health Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Encompass Health Corporation and its subsidiaries (the "Company") as of December 31, 2019 and 2018, and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2019, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, the Company changed the manner in which it accounts for leases in 2019.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

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

company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Inpatient Rehabilitation Segment Patient Accounts Receivable - Contractual Allowances and Uncollectible Amounts

As described in Notes 1 and 5 to the consolidated financial statements, revenues for inpatient rehabilitation services are recognized (or measured) using the input method as therapy, nursing, and auxiliary services are provided based on management's estimate of the respective transaction price. Management's 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. Revenues recognized by the 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 patient accounts receivable. Factors considered by management 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. Management assumes these additional factors will remain consistent with the experience for patients discharged in similar time periods for the same payor classes. The Company's consolidated accounts receivable balance is $658.2 million as of December 31, 2019. Management estimates the allowance for uncollectible amounts based on the aging of accounts receivable, historical collection experience for each type of payor, and other relevant factors. As disclosed by management, changes in general economic conditions (such as increased unemployment rates or periods of recession) are also considered.

The principal considerations for our determination that performing procedures relating to the valuation of inpatient rehabilitation segment patient accounts receivable - contractual allowances and uncollectible amounts is a critical audit matter are there was significant judgment by management to estimate patient accounts receivable and the amount that will ultimately be collected under the terms of the third-party payor contracts. This in turn led to significant auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of inpatient rehabilitation segment patient accounts receivable.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of inpatient rehabilitation patient accounts receivable, which included controls over management's approach, assumptions, and data used to estimate contractual allowances and uncollectible amounts and determine patient accounts receivable. These procedures also included, among others, i) evaluating management's process for developing the estimate for contractual allowances and uncollectible amounts, as well as the relevance and use of the historical billing and collection data as an input to the valuation model, ii) testing the accuracy of a sample of revenue transactions and a sample of cash collections from the historical billing data and historical collection data which is used in management's estimation of contractual allowances and uncollectible amounts, iii) and evaluating the historical accuracy of management's process for developing the estimate of the amount which will ultimately be collected by comparing actual cash collections to the previously recorded patient accounts receivable.

Valuation of Inpatient Rehabilitation Segment Patient Accounts Receivable - Denied Claims

As described in Note 1 to the consolidated financial statements, the Company's Medicare claims have been subject to review by Medicare Administrative Contractors ("MACs") under various programs such as "widespread probes" and the Targeted Probe and Educate initiative. The MACs reviews have resulted in denial of payment for claims billed under certain diagnosis codes. As of December 31, 2019, $144.5 million of the Company's patient accounts receivable represented denials that were under review or audit. While the Company generally appeals most of the denials of claims by the MACs, the resolution of these appeals may take several years, and the future success rate of these appeals is uncertain. Adjustments related to payment reviews by third-party payors or their agents are based on its historical experience and success rates in the claims adjudication process.

The principal considerations for our determination that performing procedures relating to the valuation of inpatient rehabilitation patient accounts receivable - denied claims is a critical audit matter are there was significant judgment by management to estimate the ultimate expected amount of collectible accounts receivable related to denied claims. This in turn led to a high degree of auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of such denied claims.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of inpatient rehabilitation patient accounts receivable related to denied claims, which included controls around the identification of denied claims at period-end, as well as controls to assess the reasonableness of the success rate estimates. These procedures also included, among others, i) evaluating management's process for developing the estimate for collectible amounts related to denied claims, as well as the relevance and use of the historical billing and collection data as an input to the valuation analysis, ii) evaluating the reasonableness of management's analysis and success rate estimate for denied claims by comparing it to the Company's adjudicated denied claim results, iii) performing testing over a sample of denied revenue transactions by inspecting evidence that the claim was denied, and iv) performing testing over a sample of cash collections from the historical collection data used in management's estimation of collectability.

Acquisition of Alacare Home Health & Hospice

As discussed in Note 2 to the consolidated financial statements, the Company acquired Alacare Home Health & Hospice ("Alacare") for consideration of $217.8 million in 2019, which resulted in $51.0 million of intangible assets being recorded. As disclosed by management, in determining the fair value of assets acquired and liabilities assumed, management used the income and multi-period excess earnings approaches to estimate the value of the most significant acquired intangible assets. Both income approaches utilize projected operating results and cash flows and include significant assumptions such as base revenue, revenue growth rate, projected EBITDA margin, discount rates, rates of increase in operating expenses, and the future effective income tax rates.

The principal considerations for our determination that performing procedures relating to the acquisition of Alacare is a critical audit matter are (i) there was a high degree of auditor judgment and subjectivity in applying procedures relating to the valuation of the acquired intangible assets due to the significant amount of judgement by management when developing the estimates; (ii) significant audit effort was required in evaluating assumptions relating to the cash flow projections, including revenue growth rates, projected EBITDA margins, and the discount rate; and (iii) the audit effort involved the use of professionals with specialized skill and knowledge, to evaluate the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the financial statements. These procedures included testing the effectiveness of controls relating to the acquisition accounting, including controls over management's valuation of the intangible assets and controls over development of the assumptions related to the valuation of the intangible assets, such as cash flow projections, including revenue growth rates, projected EBITDA margins, and the discount rate. These procedures also included, among others, (i) reading the purchase agreement, (ii) testing management's process for estimating the fair value of intangible assets, and (iii) testing management's cash flow projections used to estimate the fair value of the intangible assets, using professionals with specialized skill and knowledge to assist in doing so. Testing management's process included evaluating the appropriateness of the valuation methods and the reasonableness of significant assumptions in the cash flow projections, including revenue growth rates, projected EBITDA margins, and the discount rate for intangible assets. Evaluating the reasonableness of the cash flow projections, including the revenue growth rates and projected EBITDA margins, involved considering past performance of the acquired business, as well as economic and industry forecasts and the performance of peer companies in the market. The discount rate was evaluated by the aforementioned professionals with specialized skill and knowledge by considering the cost

of capital of comparable businesses and other industry factors. These professionals also assisted in the evaluation of the appropriateness of the Company's valuation models.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 27, 2020

We have served as the Company's auditor since 2003.

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Operations

	For the Year Ended December 31,		
	2019	**2018**	**2017**
	(In Millions, Except Per Share Data)		
Net operating revenues	**$ 4,605.0**	$ 4,277.3	$ 3,913.9
Operating expenses:			
Salaries and benefits	**2,573.0**	2,354.0	2,154.6
Other operating expenses	**623.6**	585.1	531.6
Occupancy costs	**82.3**	78.0	73.5
Supplies	**167.9**	158.7	149.3
General and administrative expenses	**247.0**	220.2	171.7
Depreciation and amortization	**218.7**	199.7	183.8
Government, class action, and related settlements	**—**	52.0	—
Total operating expenses	**3,912.5**	3,647.7	3,264.5
Loss on early extinguishment of debt	**7.7**	—	10.7
Interest expense and amortization of debt discounts and fees	**159.7**	147.3	154.4
Other income	**(30.5)**	(2.2)	(4.1)
Equity in net income of nonconsolidated affiliates	**(6.7)**	(8.7)	(8.0)
Income from continuing operations before income tax expense	**562.3**	493.2	496.4
Provision for income tax expense	**115.9**	118.9	145.8
Income from continuing operations	**446.4**	374.3	350.6
(Loss) income from discontinued operations, net of tax	**(0.6)**	1.1	(0.4)
Net income	**445.8**	375.4	350.2
Less: Net income attributable to noncontrolling interests	**(87.1)**	(83.1)	(79.1)
Net income attributable to Encompass Health	**$ 358.7**	$ 292.3	$ 271.1
Weighted average common shares outstanding:			
Basic	**98.0**	97.9	93.7
Diluted	**99.4**	99.8	99.3
Earnings per common share:			
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 3.66**	$ 2.97	$ 2.88
Discontinued operations	**(0.01)**	0.01	—
Net income	**$ 3.65**	$ 2.98	$ 2.88
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 3.62**	$ 2.92	$ 2.84
Discontinued operations	**(0.01)**	0.01	—
Net income	**$ 3.61**	$ 2.93	$ 2.84
Amounts attributable to Encompass Health:			
Income from continuing operations	**$ 359.3**	$ 291.2	$ 271.5
(Loss) income from discontinued operations, net of tax	**(0.6)**	1.1	(0.4)
Net income attributable to Encompass Health	**$ 358.7**	$ 292.3	$ 271.1

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2019	**2018**	**2017**
		(In Millions)	
COMPREHENSIVE INCOME			
Net income	**$ 445.8**	$ 375.4	$ 350.2
Other comprehensive loss, net of tax:			
Net change in unrealized loss on available-for-sale securities:			
Unrealized net holding loss arising during the period	—	—	(0.1)
Other comprehensive loss before income taxes	—	—	(0.1)
Provision for income tax benefit related to other comprehensive loss items	—	—	—
Other comprehensive loss, net of tax:	—	—	(0.1)
Comprehensive income	**445.8**	375.4	350.1
Comprehensive income attributable to noncontrolling interests	**(87.1)**	(83.1)	(79.1)
Comprehensive income attributable to Encompass Health	**$ 358.7**	$ 292.3	$ 271.0

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

Encompass Health Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31,	
	2019	2018
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	$ 94.8	$ 69.2
Restricted cash	57.4	59.0
Accounts receivable	506.1	467.7
Prepaid expenses and other current assets	97.5	66.2
Total current assets	755.8	662.1
Property and equipment, net	1,959.3	1,634.8
Operating lease right-of-use assets	276.5	—
Goodwill	2,305.2	2,100.8
Intangible assets, net	476.3	443.4
Deferred income tax assets	2.9	42.9
Other long-term assets	304.7	291.0
Total assets[1]	$ 6,080.7	$ 5,175.0
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	$ 39.3	$ 35.8
Current operating lease liabilities	40.4	—
Accounts payable	94.6	90.0
Accrued payroll	210.5	188.4
Accrued interest payable	32.4	24.4
Other current liabilities	303.8	333.9
Total current liabilities	721.0	672.5
Long-term debt, net of current portion	3,023.3	2,478.6
Long-term operating lease liabilities	243.8	—
Self-insured risks	117.2	119.6
Other long-term liabilities	42.7	85.6
	4,148.0	3,356.3
Commitments and contingencies		
Redeemable noncontrolling interests	239.6	261.7
Shareholders' equity:		
Encompass Health shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 113,230,774 in 2019; 112,492,690 in 2018	1.1	1.1
Capital in excess of par value	2,369.9	2,588.7
Accumulated deficit	(526.5)	(885.2)
Treasury stock, at cost (14,637,858 shares in 2019 and 13,566,209 shares in 2018)	(492.3)	(427.9)
Total Encompass Health shareholders' equity	1,352.2	1,276.7
Noncontrolling interests	340.9	280.3
Total shareholders' equity	1,693.1	1,557.0
Total liabilities[1] and shareholders' equity	$ 6,080.7	$ 5,175.0

(1) Our consolidated assets as of December 31, 2019 and December 31, 2018 include total assets of variable interest entities of $215.0 million and $197.5 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2019 and December 31, 2018 include total liabilities of the variable interest entities of $41.1 million and $50.8 million, respectively. See Note 3, *Variable Interest Entities.*

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	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
	(In Millions)							
December 31, 2016	88.9	$ 1.1	$ 2,781.0	$ (1,448.4)	$ (1.2)	$ (614.7)	$ 192.8	$ 910.6
Net income	—	—	—	271.1	—	—	61.2	332.3
Receipt of treasury stock	(0.9)	—	—	—	—	(19.8)	—	(19.8)
Dividends declared ($0.98 per share)	—	—	(95.2)	—	—	—	—	(95.2)
Stock-based compensation	—	—	21.3	—	—	—	—	21.3
Stock options exercised	1.1	—	20.4	—	—	(19.3)	—	1.1
Stock warrants exercised	0.7	—	26.6	—	—	—	—	26.6
Distributions declared	—	—	—	—	—	—	(50.5)	(50.5)
Repurchases of common stock in open market	(0.9)	—	—	—	—	(38.1)	—	(38.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	46.2	46.2
Fair value adjustments to redeemable noncontrolling interests	—	—	(67.0)	—	—	—	—	(67.0)
Conversion of convertible debt, net of tax	8.9	—	53.7	—	—	274.5	—	328.2
Other	0.5	—	6.6	1.1	(0.1)	(1.1)	(6.8)	(0.3)
December 31, 2017	98.3	1.1	2,747.4	(1,176.2)	(1.3)	(418.5)	242.9	1,395.4
Net income	—	—	—	292.3	—	—	69.2	361.5
Receipt of treasury stock	(0.2)	—	—	—	—	(8.3)	—	(8.3)
Dividends declared ($1.04 per share)	—	—	(103.7)	—	—	—	—	(103.7)
Stock-based compensation	—	—	28.9	—	—	—	—	28.9
Stock options exercised	0.1	—	3.2	—	—	—	—	3.2
Distributions declared	—	—	—	—	—	—	(71.1)	(71.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	38.8	38.8
Fair value adjustments to redeemable noncontrolling interests	—	—	(91.0)	—	—	—	—	(91.0)
Other	0.7	—	3.9	(1.3)	1.3	(1.1)	0.5	3.3
December 31, 2018	98.9	1.1	2,588.7	(885.2)	—	(427.9)	280.3	1,557.0
Net income	**—**	**—**	**—**	**358.7**	**—**	**—**	**74.5**	**433.2**
Receipt of treasury stock	**(0.3)**	**—**	**—**	**—**	**—**	**(16.6)**	**—**	**(16.6)**
Dividends declared ($1.10 per share)	**—**	**—**	**(109.3)**	**—**	**—**	**—**	**—**	**(109.3)**
Stock-based compensation	**—**	**—**	**32.4**	**—**	**—**	**—**	**—**	**32.4**
Stock options exercised	**0.1**	**—**	**1.4**	**—**	**—**	**—**	**—**	**1.4**
Distributions declared	**—**	**—**	**—**	**—**	**—**	**—**	**(70.2)**	**(70.2)**
Repurchases of common stock in open market	**(0.8)**	**—**	**—**	**—**	**—**	**(45.9)**	**—**	**(45.9)**
Capital contributions from consolidated affiliates	**—**	**—**	**—**	**—**	**—**	**—**	**20.0**	**20.0**
Fair value adjustments to redeemable noncontrolling interests	**—**	**—**	**(147.6)**	**—**	**—**	**—**	**—**	**(147.6)**
Consolidation of Yuma Rehabilitation Hospital	**—**	**—**	**—**	**—**	**—**	**—**	**25.0**	**25.0**
Other	**0.7**	**—**	**4.3**	**—**	**—**	**(1.9)**	**11.3**	**13.7**
December 31, 2019	**98.6**	**$ 1.1**	**$ 2,369.9**	**$ (526.5)**	**$ —**	**$ (492.3)**	**$ 340.9**	**$ 1,693.1**

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2019	**2018**	**2017**
		(In Millions)	
Cash flows from operating activities:			
Net income	**$ 445.8**	$ 375.4	$ 350.2
Loss (income) from discontinued operations, net of tax	**0.6**	(1.1)	0.4
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for government, class action, and related settlements	**—**	52.0	—
Depreciation and amortization	**218.7**	199.7	183.8
Amortization of debt-related items	**4.5**	4.0	8.7
Loss on early extinguishment of debt	**7.7**	—	10.7
Equity in net income of nonconsolidated affiliates	**(6.7)**	(8.7)	(8.0)
Distributions from nonconsolidated affiliates	**6.6**	8.3	8.6
Stock-based compensation	**114.4**	85.9	47.7
Deferred tax expense (benefit)	**40.0**	(9.1)	60.8
Gain on consolidation of Yuma Rehabilitation Hospital	**(19.2)**	—	—
Other, net	**7.4**	9.2	3.4
Changes in assets and liabilities, net of acquisitions —			
Accounts receivable	**(22.9)**	7.0	(31.5)
Prepaid expenses and other assets	**(35.4)**	11.5	(12.6)
Accounts payable	**(6.1)**	6.6	7.5
Accrued payroll	**13.2**	14.8	24.4
Other liabilities	**(128.9)**	6.1	4.8
Net cash (used in) provided by operating activities of discontinued operations	**(4.4)**	0.8	(0.6)
Total adjustments	**188.9**	388.1	307.7
Net cash provided by operating activities	**635.3**	762.4	658.3
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	**(231.5)**	(143.9)	(38.8)
Purchases of property and equipment	**(372.4)**	(254.5)	(225.8)
Additions to capitalized software costs	**(13.0)**	(16.0)	(19.2)
Purchases of intangible assets	**(18.7)**	(5.7)	(3.7)
Proceeds from sale of restricted investments	**17.6**	11.6	4.2
Purchases of restricted investments	**(32.9)**	(13.3)	(8.5)
Other, net	**(6.5)**	(2.7)	8.8
Net cash used in investing activities	**(657.4)**	**(424.5)**	**(283.0)**

(Continued)

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2019	**2018**	**2017**
		(In Millions)	
Cash flows from financing activities:			
Proceeds from bond issuance	**1,000.0**	—	—
Principal payments on debt, including pre-payments	**(519.5)**	(20.6)	(129.9)
Borrowings on revolving credit facility	**635.0**	325.0	273.3
Payments on revolving credit facility	**(620.0)**	(390.0)	(330.3)
Principal payments under finance lease obligations	**(19.5)**	(17.9)	(15.3)
Debt amendment and issuance costs	**(21.5)**	(0.1)	(4.1)
Repurchases of common stock, including fees and expenses	**(45.9)**	—	(38.1)
Dividends paid on common stock	**(108.7)**	(100.8)	(91.5)
Purchase of equity interests in consolidated affiliates	**(162.9)**	(65.1)	—
Proceeds from exercising stock warrants	—	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	**(79.8)**	(75.4)	(51.9)
Taxes paid on behalf of employees for shares withheld	**(16.6)**	(8.3)	(19.8)
Contributions from consolidated affiliates	**15.9**	12.6	20.8
Other, net	**(8.3)**	19.4	0.3
Net cash provided by (used in) financing activities	**48.2**	(321.2)	(359.9)
Increase in cash, cash equivalents, and restricted cash	**26.1**	16.7	15.4
Cash, cash equivalents. and restricted cash at beginning of year	**133.5**	116.8	101.4
Cash, cash equivalents, and restricted cash at end of year	**$ 159.6**	$ 133.5	$ 116.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash			
Cash and cash equivalents at beginning of period	$ 69.2	$ 54.4	$ 40.5
Restricted cash at beginning of period	59.0	62.4	60.9
Restricted cash included in other long-term assets at beginning of period	5.3	—	—
Cash, cash equivalents, and restricted cash at beginning of period	$ 133.5	$ 116.8	$ 101.4
Cash and cash equivalents at end of period	$ 94.8	$ 69.2	$ 54.4
Restricted cash at end of period	57.4	59.0	62.4
Restricted cash included in other long-term assets at end of period	7.4	5.3	—
Cash, cash equivalents, and restricted cash at end of period	$ 159.6	$ 133.5	$ 116.8
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	**$ (155.7)**	$ (149.6)	$ (150.5)
Income tax refunds	**0.1**	0.6	1.9
Income tax payments	**(104.2)**	(115.4)	(96.4)
Supplemental schedule of noncash financing activities:			
Conversion of convertible debt	**$ —**	$ —	$ 319.4

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

1. Summary of Significant Accounting Policies:

Organization and Description of Business—

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 post-acute services in 37 states and Puerto Rico through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. We manage our operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. See Note 19, *Segment Reporting*.

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of Encompass Health and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly-owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to Encompass Health* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

We use the cost method to account for our investments in entities we do not control and for which we do not have the ability to exercise significant influence over operating and financial policies. In accordance with the cost method, these investments are recorded at the lower of cost or fair value, as appropriate.

We eliminate all significant intercompany accounts and transactions from our financial results.

Variable Interest Entities—

Any entity considered a variable interest entity ("VIE") is evaluated to determine which party is the primary beneficiary and thus should consolidate the VIE. This analysis is complex, involves uncertainties, and requires significant judgment on various matters. In order to determine if we are the primary beneficiary of a VIE, we must determine what activities most significantly impact the economic performance of the entity, whether we have the power to direct those activities, and if our obligation to absorb losses or receive benefits from the VIE could potentially be significant to the VIE.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) revenue reserves for contractual adjustments and uncollectible amounts; (2) fair value of acquired assets and assumed liabilities in business combinations; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) income tax valuation allowances; (8) uncertain tax positions; (9) fair value of stock options and restricted stock containing a market condition; (10) fair value of redeemable noncontrolling interests; (11) reserves for self-insured healthcare plans; (12) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (13) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties—

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

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

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

If we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements deemed after the fact to have not been appropriate. We could also be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals or agencies, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Specifically, reductions in reimbursements, substantial damages, and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operation, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions. Because we receive a significant percentage of our revenues from Medicare, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows.

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

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

As discussed in Note 18, *Contingencies and Other Commitments*, we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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		
	Year Ended December 31,			Year Ended December 31,			Year Ended December 31,		
	2019	2018	2017	2019	2018	2017	2019	2018	2017
Medicare	$ 2,537.3	$ 2,451.7	$ 2,313.6	$ 920.0	$ 794.5	$ 662.9	$ 3,457.3	$ 3,246.2	$ 2,976.5
Medicare Advantage	375.5	306.5	261.0	111.9	88.6	74.8	487.4	395.1	335.8
Managed care	342.7	343.3	335.6	39.1	33.2	29.1	381.8	376.5	364.7
Medicaid	110.3	101.3	93.2	18.4	11.6	4.3	128.7	112.9	97.5
Other third-party payors	43.4	49.0	49.9	—	—	—	43.4	49.0	49.9
Workers' compensation	29.2	27.4	27.5	1.0	1.5	0.1	30.2	28.9	27.6
Patients	23.3	18.7	18.4	0.6	0.8	0.7	23.9	19.5	19.1
Other income	51.3	48.3	42.1	1.0	0.9	0.7	52.3	49.2	42.8
Total	$ 3,513.0	$ 3,346.2	$ 3,141.3	$ 1,092.0	$ 931.1	$ 772.6	$ 4,605.0	$ 4,277.3	$ 3,913.9

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.

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 (the "DOJ"). 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 Medicare appeals adjudication process is administered by the Office of Medicare Hearings and Appeals ("OMHA"). For a period of years, OHMA has failed to adjudicate appeals in accordance with timelines established by Congress. Due to the sheer number of appeals and various administrative inefficiencies, appeals that are due to be resolved in a matter of months commonly take years to complete. The growing backlog of appeals contributes further to the delay. We currently have appeals pending for claims that were denied up to eight years ago. Accordingly, we believe the process for resolving individual Medicare payment claims that are denied will continue to take several years. 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 if necessary 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 UPIC 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 2019 to review certain patient files for discharges occurring from 2010 to 2019. 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 Unified Program Integrity Contractors ("UPICs"), previously known as Zone Program Integrity Contractors. These contractors perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the error as a result of UPIC audits. We have, from time to time, received UPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all UPIC 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 2019. 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 by MACs. Due to the delays announced by CMS in the related adjudication process discussed above, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take several years. In addition, because we have limited experience with UPICs 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 by MACs. During 2019, 2018, and 2017, our adjustment to *Net operating revenues* for claims that are part of this post-payment claims review process 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.

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.

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.

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 December 31, 2019 and December 31, 2018, 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 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 December 31, 2019 and December 31, 2018.

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 MAC. Adjustments to the transaction price for these caps were not material as of December 31, 2019 and December 31, 2018.

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*.

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

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 consolidated statements of operations. We record debt securities with readily determinable fair values and for which we do not exercise significant influence as available-for-sale securities. We carry the available-for-sale securities at fair value and report unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive loss*, which is a separate component of shareholders' equity. We recognize realized gains and losses in our consolidated statements of operations using the specific identification method. Unrealized losses are charged against earnings when a decline in fair value was determined to be other than temporary. Management reviews several factors to determine whether a loss is 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 are 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:

	As of December 31,	
	2019	2018
Medicare	72.1%	73.2%
Managed care and other discount plans, including Medicare Advantage	20.1%	19.3%
Medicaid	3.1%	2.8%
Other third-party payors	2.6%	2.7%
Workers' compensation	1.2%	1.1%
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.

Property and Equipment—

We report land, buildings, improvements, vehicles, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Vehicles	5
Furniture, fixtures, and equipment	2 to 10

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

Leases—

We determine if an arrangement is a lease or contains a lease at inception and perform an analysis to determine whether the lease is an operating lease or a finance lease. We measure right-of-use assets and lease liabilities at the lease commencement date based on the present value of the remaining lease payments. As most of our leases do not provide a readily determinable implicit rate, we estimate an incremental borrowing rate based on the credit quality of the Company and by comparing interest rates available in the market for similar borrowings, and adjusting this amount based on the impact of collateral over the term of each lease. We use this rate to discount the remaining lease payments in measuring the right-of-use asset and lease liability. We use the implicit rate when readily determinable. We recognize lease expense for operating leases on a straight-line basis over the lease term. For our finance leases, we recognize amortization expense from the amortization of the right-of-use asset and interest expense on the related lease liability. Certain of our lease agreements contain annual escalation clauses based on changes in the Consumer Price Index. The changes to the Consumer Price Index, as compared to our initial estimate at the lease commencement date, are treated as variable lease payments and recognized in the period in which the obligation for those payments was incurred. We do not account for lease and nonlease components separately for purposes of establishing right-of-use assets and lease liabilities.

Leases with an initial term of twelve months or less are not recorded on the consolidated balance sheet. We recognize lease expense for these leases on a straight-line basis over the lease term.

Goodwill and Other Intangible Assets—

We are required to test our goodwill and indefinite-lived intangible asset for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform this impairment testing as of October 1st of each year. We recognize an impairment charge for any amount by which the carrying amount of the asset exceeds its implied fair value. We present an impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our inpatient rehabilitation and home health and hospice reporting units to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe

we must perform the quantitative goodwill impairment test, we would determine the fair value of our reporting units using generally accepted valuation techniques including the income approach and the market approach. The income approach includes the use of each reporting unit's discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting units to our market capitalization. When we dispose of a hospital or home health or hospice agency, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

We assess qualitative factors related to our indefinite-lived intangible asset to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe we must perform the quantitative goodwill impairment test, we would determine the fair value of our indefinite-lived intangible asset using generally accepted valuation techniques including the relief-from-royalty method. This method is a form of the income approach in which value is equated to a series of cash flows and discounted at a risk-adjusted rate. It is based on a hypothetical royalty, calculated as a percentage of forecasted revenue, that we would otherwise be willing to pay to use the asset, assuming it were not already owned. This approach includes assumptions related to pricing and volume, as well as a royalty rate a hypothetical third party would be willing to pay for use of the asset. When making our royalty rate assumption, we consider rates paid in arms-length licensing transactions for assets comparable to our asset.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2019, none of our finite useful lived intangible assets has an estimated residual value. We also review these assets for impairment whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount.

The range of estimated useful lives and the amortization basis for our intangible assets, excluding goodwill, are generally as follows:

	Estimated Useful Life and Amortization Basis
Certificates of need	10 to 30 years using straight-line basis
Licenses	10 to 20 years using straight-line basis
Noncompete agreements	1 to 18 years using straight-line basis
Trade names:	
Encompass	indefinite-lived asset
All other	1 to 20 years using straight-line basis
Internal-use software	3 to 7 years using straight-line basis
Market access assets	20 years using accelerated basis

We capitalize the costs of obtaining or developing internal-use software, including external direct costs of material and services and directly related payroll costs. Amortization begins when the internal-use software is ready for its intended use. Costs incurred during the preliminary project and post-implementation stages, as well as maintenance and training costs, are expensed as incurred.

Our market access assets are valued using discounted cash flows under the income approach. The value of the market access assets is attributable to our ability to gain access to and penetrate an acquired facility's historical market patient base. To determine this value, we first develop a debt-free net cash flow forecast under various patient volume scenarios. The debt-free net cash flow is then discounted back to present value using a discount factor, which includes an adjustment for company-specific risk. As noted in the above table, we amortize these assets over 20 years using an accelerated basis that reflects the pattern in which we believe the economic benefits of the market access will be consumed.

Impairment of Long-Lived Assets and Other Intangible Assets—

We assess the recoverability of long-lived assets (excluding goodwill and our indefinite-lived asset) and identifiable acquired intangible assets with finite useful lives, whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with finite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with finite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised values. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and we cease depreciation.

Investments in and Advances to Nonconsolidated Affiliates—

Investments in entities we do not control but in which we have the ability to exercise significant influence over the operating and financial policies of the investee are accounted for under the equity method. Equity method investments are recorded at original cost and adjusted periodically to recognize our proportionate share of the investees' net income or losses after the date of investment, additional contributions made, dividends or distributions received, and impairment losses resulting from adjustments to net realizable value. We record equity method losses in excess of the carrying amount of an investment when we guarantee obligations or we are otherwise committed to provide further financial support to the affiliate.

We use the cost method to account for equity investments for which the equity securities do not have readily determinable fair values and for which we do not have the ability to exercise significant influence. Under the cost method of accounting, private equity investments are carried at cost and are adjusted only for other-than-temporary declines in fair value, additional investments, or distributions deemed to be a return of capital.

Management periodically assesses the recoverability of our equity method and cost method investments and equity method goodwill for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate, and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds, and external appraisals, as appropriate. If an investment or equity method goodwill is considered to be impaired and the decline in value is other than temporary, we record an appropriate write-down.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. Excluding financing costs related to our revolving line of credit (which are included in *Other long-term assets*), financing costs are presented as a direct deduction from the face amount of the financings. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

We accrete discounts and amortize premiums using the effective interest method over the expected life of the related debt, and we report discounts or premiums as a direct deduction from, or addition to, the face amount of the financing. The related income or expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

Fair Value Measurements—

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions market participants would use in pricing an asset or liability.

The basis for these assumptions establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- *Level 1* – Observable inputs such as quoted prices in active markets;
- *Level 2* – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3* – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future cash flows to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, restricted marketable securities, accounts receivable, accounts payable, letters of credit, and long-term debt. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, and accounts payable approximate fair value because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt using quoted market prices, when available, or discounted cash flows based on various factors, including maturity schedules, call features, and current market rates.

On a recurring basis, we are required to measure our restricted marketable securities at fair value. 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.

On a nonrecurring basis, we are required to measure property and equipment, goodwill, other intangible assets, investments in nonconsolidated affiliates, and assets and liabilities of discontinued operations at fair value. 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. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using quoted prices in private markets, discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the “Redeemable Noncontrolling Interests” section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders’ balance.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Likewise, certain members of the home health and hospice management team hold similar put rights regarding their interests in our home health and hospice business, as discussed in Note 12, *Redeemable Noncontrolling Interests*. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value*.

The fair value of the *Redeemable noncontrolling interests* related to our home health segment is determined using the product of a 12-month specified performance measure and a specified median market price multiple based on a basket of public health companies and publicly disclosed home health acquisitions with a value of $400 million or more. The fair value of our *Redeemable noncontrolling interests* in our joint venture hospitals is determined primarily using the income approach. The income approach includes the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable hospitals, or *Level 3* inputs. 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.

Share-Based Payments—

Encompass Health has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees, excluding stock appreciation rights ("SARs"), are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period. Share-based payments to employees in the form of SARs are recognized in the financial statements based on their current fair value and expensed ratably over the applicable service period.

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than $5.0 million, we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length to complete, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of operations, were $6.1 million, $6.7 million, and $6.3 million in each of the years ended December 31, 2019, 2018, and 2017, respectively.

Income Taxes—

We provide for income taxes using the asset and liability method. This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of

taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly. We have used the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation.

Encompass Health and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

Effective January 1, 2015, in connection with a new standard issued by the FASB, we changed our criteria for determining which disposals are presented as discontinued operations. Historically, any component that had been disposed of or was classified as held for sale qualified for discontinued operations reporting unless there was significant continuing involvement with the disposed component or continuing cash flows. In contrast, we now report the disposal of the component, or group of components, as discontinued operations only when it represents a strategic shift that has, or will have, a major effect on our operations and financial results. As a result, the sale or disposal of a single Encompass Health facility or location no longer qualifies as a discontinued operation. This accounting change was made prospectively. No new components were recognized as discontinued operations since this guidance became effective.

In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *(Loss) income from discontinued operations, net of tax*. In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Prepaid expenses and other current assets*, *Other long-term assets*, *Other current liabilities*, and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares, including warrants, that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

We used the if-converted method to include our convertible senior subordinated notes in our computation of 2017 diluted earnings per share. All other potential dilutive shares, including warrants, are included in our weighted-average diluted share count using the treasury stock method.

Treasury Stock—

Shares of common stock repurchased by us are recorded at cost as treasury stock. When shares are reissued, we use an average cost method to determine cost. The difference between the cost of the shares and the re-issuance price is added to or deducted from *Capital in excess of par value*. We account for the retirement of treasury stock as a reduction of retained

earnings. However, due to our *Accumulated deficit*, the retirement of treasury stock is currently recorded as a reduction of *Capital in excess of par value*.

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recent Adopted Accounting Pronouncements—

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)," and has subsequently issued supplemental and/or clarifying ASUs (collectively "ASC 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. We adopted ASC 842 using the modified retrospective approach and applied the transition provisions with an effective date as of January 1, 2019 for leases that existed on that date. Prior period results continue to be presented under ASC 840 based on the accounting originally in effect for such periods. ASC 842 provides optional practical expedients in transition. We elected the 'package of practical expedients,' which permits us to not reassess under ASC 842 our prior conclusions about lease identification, lease classification and initial direct costs, and the practical expedient to not reassess certain land easements. We did not elect the use-of-hindsight practical expedient during the transition to ASC 842. The adoption of ASC 842 resulted in the addition of approximately $349 million in assets and $347 million in liabilities to our consolidated balance sheet as of January 1, 2019, with the remaining $2 million being recorded as an adjustment to *Capital in excess of par value*. The adoption of ASC 842 also resulted in increased disclosure, including qualitative and quantitative disclosures about the nature, amount, timing and uncertainty of cash flows arising from leases. See the "Leases" section of this note and Note 7, *Leases*, and Note 10, *Long-term Debt*, for additional information about our leases.

Recent Accounting Pronouncements Not Yet Adopted—

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 us beginning January 1, 2020, including interim periods within that reporting period. The adoption of this guidance will result in an immaterial change to our consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, "Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract." The update helps entities evaluate the accounting for fees paid by a customer in a cloud computing arrangement (hosting arrangement), by providing guidance in determining when the arrangement includes a software license. It requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The new guidance is effective for us beginning January 1, 2020, including interim periods within that reporting period. We do not expect the adoption of this guidance to have a material impact to our consolidated financial statements.

In December 2019, the FASB issues ASU 2019-12, "Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes." The standard removes certain exceptions to the general principles of ASC 740 and simplifies other areas such as accounting for outside basis differences of equity method investments. Either prospective or retrospective transition of this standard is dependent upon the specific amendments. The new guidance is effective for us beginning January 1, 2021, including interim periods within that reporting period. Early adoption is permitted. We continue to review the requirements of this standard and any potential impact it may have on our consolidated financial statements.

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

2. Business Combinations:

2019 Acquisitions

Inpatient Rehabilitation

During 2019, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In July 2019, we acquired approximately 51% of the operations of a 30-bed inpatient rehabilitation unit in Boise, Idaho when Saint Alphonsus Regional Medical Center contributed those operations to a joint venture with us. We funded our ownership interest in that consolidated joint venture through contributions of cash which the joint venture entity used to fund the construction of a 40-bed de novo inpatient rehabilitation hospital.
- In September 2019, we acquired 75% of the operations of Heritage Valley Sewickley Hospital's 11-bed inpatient rehabilitation unit in Sewickley, Pennsylvania, when Heritage Valley Health System, Inc. contributed those operations to our existing joint venture entity in connection with the opening of a new hospital.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from its respective date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including an income approach using primarily discounted cash flow techniques for the noncompete intangible assets and an income approach utilizing the relief from royalty method for the trade name intangible asset. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result from these transactions are deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Identifiable intangible assets:	
Noncompete agreements (useful lives of 2 years)	$ 0.1
Trade name (useful life of 20 years)	0.4
Goodwill	4.8
Total assets acquired	5.3
Total liabilities assumed	0.2
Net assets acquired	$ 5.1

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2019 is as follows (in millions):

Fair value of assets acquired	$ 0.5
Goodwill	4.8
Fair value of liabilities assumed	(0.2)
Fair value of noncontrolling interest owned by joint venture partner	(5.1)
Net cash paid for acquisitions	$ —

Home Health and Hospice

Alacare Acquisition

In July 2019, we completed the acquisition of privately owned Alacare Home Health & Hospice ("Alacare") for a cash purchase price of $217.8 million. The Alacare portfolio consisted of 23 home health locations and 23 hospice locations in Alabama. The acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients across Alabama. We funded the transaction with cash on hand and borrowings under our revolving credit facility.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Alacare from its date of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and certain license intangible assets; an income approach utilizing the relief-from-royalty method for the trade name intangible asset; an income approach utilizing the excess earnings method for the certificates of need; and present value of the remaining lease payments for leases. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. All goodwill recorded as a result from this transaction is deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Accounts receivable	$	10.2
Prepaid expenses and other current assets		1.7
Property and equipment, net		0.7
Identifiable intangible assets:		
Noncompete agreements (useful lives of 5 years)		1.0
Trade name (useful life of 6 months)		1.0
Certificates of need (useful lives of 10 years)		34.3
Licenses (useful lives of 10 years)		14.6
Internal-use software (useful lives of 3 years)		0.1
Goodwill		163.9
Other long-term assets		5.0
Total assets acquired		232.5
Liabilities assumed:		
Current portion of long-term debt		0.3
Accounts payable		1.2
Accrued payroll		8.1
Other current liabilities		2.0
Long-term operating lease liabilities		3.1
Total liabilities assumed		14.7
Net assets acquired	$	217.8

Information regarding the net cash paid for Alacare is as follows (in millions):

Fair value of assets acquired	$	68.6
Goodwill		163.9
Fair value of liabilities assumed		(14.7)
Net cash paid for acquisition	$	217.8

Other Home Health and Hospice Acquisitions

During 2019, we completed the following home health and hospice acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In February 2019, we acquired the assets of Tidewater Home Health, PA in Columbia, South Carolina.
- In March 2019, we acquired the assets and assumed the liabilities of two home health locations from Care Resource Group in East Providence, Rhode Island and Westport, Massachusetts.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Operating lease right-of-use assets	$	0.2
Identifiable intangible assets:		
Noncompete agreements (useful lives of 5 years)		0.2
Certificates of need (useful lives of 10 years)		2.0
License (useful life of 10 years)		0.8
Goodwill		10.8
Total assets acquired		14.0
Liabilities assumed:		
Current operating lease liabilities		0.1
Accrued payroll		0.1
Long-term lease liabilities		0.1
Total liabilities assumed		0.3
Net assets acquired	$	13.7

Information regarding the net cash paid for the other home health and hospice acquisitions during each period presented is as follows (in millions):

Fair value of assets acquired	$ 3.2
Goodwill	10.8
Fair value of liabilities assumed	(0.3)
Net cash paid for acquisitions	$ 13.7

2019 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2018 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2019		
Inpatient Rehabilitation	$ 4.4	$ (1.3)
Alacare	58.5	1.6
Home Health and Hospice	6.5	(1.5)
Combined entity: Supplemental pro forma from 01/01/2019-12/31/2019 (unaudited)	4,674.6	364.3
Combined entity: Supplemental pro forma from 01/01/2018-12/31/2018 (unaudited)	4,415.9	301.8

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2018 period.

2018 Acquisitions

Inpatient Rehabilitation

During 2018, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In September 2018, we acquired approximately 62% of a 29-bed inpatient rehabilitation unit, including a 60-bed certificate of need, in Murrells Inlet, South Carolina through a joint venture with Tidelands Health. The acquisition was funded through contributions of funds to be utilized by the consolidated joint venture to build a 46-bed de novo inpatient rehabilitation satellite location.
- In October 2018, we acquired approximately 50% of a 68-bed inpatient rehabilitation unit in Winston-Salem, North Carolina through a joint venture with Novant Health Inc. This acquisition was funded through a contribution of a 68-bed de novo inpatient rehabilitation hospital to the consolidated joint venture.
- In November 2018, we acquired approximately 68% of a 17-bed inpatient rehabilitation unit in Littleton, Colorado through a joint venture with Portercare Adventist Health System. The acquisition was funded through the contribution of our existing inpatient rehabilitation hospital in Littleton, Colorado to the consolidated joint venture.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from its respective date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: an income approach

using primarily discounted cash flow techniques for the noncompete intangible asset; an income approach utilizing the relief from royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need intangible asset. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result from these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		1.4
Trade names (useful lives of 20 years)		2.3
Certificates of need (useful lives of 20 years)		12.5
Goodwill		23.2
Total assets acquired		39.5
Total liabilities assumed		(0.2)
Net assets acquired	$	39.3

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2018 is as follows (in millions):

Fair value of assets acquired	$	16.3
Goodwill		23.2
Fair value of liabilities assumed		(0.2)
Fair value of noncontrolling interest owned by joint venture partner		(39.3)
Net cash paid for acquisitions	$	—

Home Health and Hospice

Camellia Acquisition

On May 1, 2018, we completed the previously announced acquisition of privately owned Camellia Healthcare and affiliated entities ("Camellia"). The Camellia portfolio consists 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. We funded the cash purchase price of the acquisition with cash on hand and borrowings under our revolving credit facility.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Camellia from its date of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and certain license intangible assets; an income approach utilizing the relief-from-royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need and certain license intangible assets. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value

of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. All goodwill recorded as a result from this transaction is deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions)

Cash and cash equivalents	$ 1.3
Prepaid expenses and other current assets	0.3
Property and equipment, net	0.6
Identifiable intangible assets:	
Noncompete agreements (useful lives of 5 years)	0.5
Trade name (useful life of 1 year)	1.4
Certificates of need (useful lives of 10 years)	16.6
Licenses (useful lives of 10 years)	21.6
Goodwill	96.1
Total assets acquired	138.4
Liabilities assumed:	
Accounts payable	1.7
Accrued payroll	4.0
Total liabilities assumed	5.7
Net assets acquired	$ 132.7

Information regarding the net cash paid for Camellia is as follows (in millions):

Fair value of assets acquired, net of $1.3 million of cash acquired	$ 41.0
Goodwill	96.1
Fair value of liabilities assumed	(5.7)
Net cash paid for acquisition	$ 131.4

Other Home Health and Hospice Acquisitions

During 2018, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In January 2018, we acquired the assets of one hospice location from Golden Age Hospice, Inc. in Oklahoma City, Oklahoma.
- In June 2018, we acquired the assets of one hospice location from Medical Services of America in Las Vegas, Nevada.
- In November 2018, we acquired the assets of one home health and one hospice location from Tenet Hospital Limited in Birmingham, Alabama and El Paso, Texas. We also acquired 75% of the assets of a home health location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.
- In December 2018, we acquired 75% of the assets of a hospice location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Total current assets	$	0.1
Identifiable intangible asset:		
Noncompete agreements (useful lives of 5 years)		0.2
Certificates of need (useful lives of 10 years)		2.5
Licenses (useful lives of 10 years)		1.5
Goodwill		8.9
Total assets acquired		13.2
Total liabilities assumed		(0.1)
Net assets acquired	$	13.1

Information regarding the net cash paid for the home health acquisitions during 2018 is as follows (in millions):

Fair value of assets acquired	$	4.3
Goodwill		8.9
Fair value of liabilities assumed		(0.1)
Fair value of noncontrolling interest owned by joint venture partner		(0.6)
Net cash paid for acquisitions	$	12.5

2018 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2017 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2018		
Inpatient Rehabilitation	$ 9.1	$ (1.6)
Camellia	50.0	(0.9)
All Other Home Health and Hospice	3.5	(0.3)
Combined entity: Supplemental pro forma from 01/01/2018-12/31/2018 (unaudited)	4,337.4	300.0
Combined entity: Supplemental pro forma from 01/01/2017-12/31/2017 (unaudited)	4,039.9	289.0

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2017 reporting period.

2017 Acquisitions

Inpatient Rehabilitation

During 2017, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In April 2017, we acquired 80% of the 33-bed inpatient rehabilitation unit of Memorial Hospital at Gulfport in Gulfport, Mississippi, through a joint venture with Memorial Hospital at Gulfport. This acquisition was funded on March 31, 2017 using cash on hand.
- In April 2017, we also acquired approximately 80% of the inpatient rehabilitation unit of Mount Carmel West in Columbus, Ohio, through a joint venture with Mount Carmel Health System. This acquisition was funded through a contribution of a 60-bed de novo inpatient rehabilitation hospital to the consolidated joint venture.
- In July 2017, we acquired 50% of the inpatient rehabilitation unit at Jackson-Madison County General Hospital through a joint venture with West Tennessee Healthcare. The acquisition was funded through a contribution of our existing inpatient rehabilitation hospital in Martin, Tennessee to the consolidated joint venture.
- In September 2017, we acquired 75% of Heritage Valley Beaver Hospital's inpatient rehabilitation unit in Beaver, Pennsylvania, through a joint venture with Heritage Valley Health System, Inc. The acquisition was funded through the exchange of 25% of our existing inpatient rehabilitation hospital in Sewickley, Pennsylvania.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. The fair values of the identifiable intangible assets were based on valuations using the income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. None of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		0.6
Trade name (useful life of 20 years)		0.5
Certificate of need (useful life of 20 years)		9.8
Goodwill		24.0
Total assets acquired	$	35.0

Information regarding the net cash paid for all inpatient rehabilitation acquisitions during 2017 is as follows (in millions):

Fair value of assets acquired	$	11.0
Goodwill		24.0
Fair value of noncontrolling interest owned by joint venture partner		(24.1)
Net cash paid for acquisitions	$	10.9

Home Health and Hospice

During 2017, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In February 2017, we acquired the assets of Celtic Healthcare of Maryland, Inc., a home health provider with locations in Owings Mill, Maryland and Rockville, Maryland.
- In February 2017, we also acquired the assets of two home health locations from Community Health Services, Inc., located in Owensboro, Kentucky and Elizabethtown, Kentucky.
- In May 2017, we acquired the assets of two home health locations from Bio Care Home Health Services, Inc. and Kinsman Enterprises, Inc., located in Irving, Texas and Longview, Texas.
- In July 2017, we acquired the assets of four home health locations from VNA Healthtrends, located in Bourbonnais, Illinois; Des Plaines, Illinois; Schererville, Indiana; and Tempe, Arizona.
- In August 2017, we acquired the assets of two home health locations from VNA Healthtrends, located in Canton, Ohio and Forsyth, Illinois.
- In October 2017, we acquired the assets of a home health location from Ware Visiting Nurses Services, Inc. located in Savannah, Georgia; and
- In October 2017, we also acquired the assets of a home health location from Pickens County Health Care Authority located in Carrollton, Alabama.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired or liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using the cost and income approaches. The cost approach is based on amounts that would be required to replace the asset (i.e., replacement cost). The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill

reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

The fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Total current assets	$ 0.1
Identifiable intangible asset:	
Noncompete agreements (useful lives of 5 years)	0.8
Trade name (useful life of 1 year)	0.1
Certificates of need (useful lives of 10 years)	1.8
Licenses (useful lives of 10 years)	4.0
Goodwill	21.4
Total assets acquired	28.2
Total liabilities assumed	(0.3)
Net assets acquired	$ 27.9

Information regarding the net cash paid for home health and hospice acquisitions during 2017 is as follows (in millions):

Fair value of assets acquired	$ 6.8
Goodwill	21.4
Fair value of liabilities assumed	(0.3)
Net cash paid for acquisitions	$ 27.9

2017 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned inpatient rehabilitation hospitals and home health and hospice agencies from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2016 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2017	$ 32.9	$ (6.3)
Combined entity: Supplemental pro forma from 01/01/2017-12/31/2017 (unaudited)	3,996.1	260.3
Combined entity: Supplemental pro forma from 01/01/2016-12/31/2016 (unaudited)	3,771.5	254.8

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2016 reporting period.

3. Variable Interest Entities:

As of December 31, 2019 and December 31, 2018, we consolidated eight 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 50.0% to 75.0% as of December 31, 2019. 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 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):

	December 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 0.2	$ 0.3
Accounts receivable	29.3	31.0
Other current assets	6.4	4.9
Total current assets	35.9	36.2
Property and equipment, net	122.6	111.5
Operating lease right-of-use assets	6.0	—
Goodwill	15.9	15.9
Intangible assets, net	3.3	4.3
Deferred income tax assets	0.7	0.6
Other long-term assets	30.6	29.0
Total assets	$ 215.0	$ 197.5
Liabilities		
Current liabilities:		
Current portion of long-term debt	$ 0.8	$ 0.6
Current operating lease liabilities	1.4	—
Accounts payable	6.7	5.2
Accrued payroll	7.7	7.0
Other current liabilities	9.3	38.0
Total current liabilities	25.9	50.8
Long-term debt, net of current portion	10.5	—
Long-term operating lease liabilities	4.7	—
Total liabilities	$ 41.1	$ 50.8

4. Cash and Marketable Securities:

The components of our investments as of December 31, 2019 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 94.8	$ 64.8	$ —	$ 159.6
Equity securities	—	—	63.5	63.5
Debt securities	—	—	12.6	12.6
Total	$ 94.8	$ 64.8	$ 76.1	$ 235.7

The components of our investments as of December 31, 2018 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 69.2	$ 64.3	$ —	$ 133.5
Equity securities	—	—	55.6	55.6
Debt securities	—	—	6.4	6.4
Total	$ 69.2	$ 64.3	$ 62.0	$ 195.5

Restricted Cash—

As of December 31, 2019 and 2018, *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2019	2018
Current:		
Affiliate cash	$ 16.0	$ 16.4
Self-insured captive funds	41.4	42.6
	57.4	59.0
Noncurrent:		
Self-insured captive funds	7.4	5.3
Total restricted cash	$ 64.8	$ 64.3

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 11, *Self-Insured Risks*. These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures a substantial portion of Encompass Health's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2019 and 2018, $76.1 million and $62.0 million, respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets. During the year ended December 31, 2019 and 2018, $1.2 million and $(1.7) million, respectively, of unrealized net gains (losses) were recognized in our consolidated statement of operations on marketable securities still held at the reporting date.

A summary of our available-for-sale marketable securities as of December 31, 2019 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities	$ 12.6	$ —	$ —	$ 12.6

A summary of our available-for-sale marketable securities as of December 31, 2018 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities	$ 6.4	$ —	$ —	$ 6.4

Cost in the above tables includes adjustments made to the cost basis of our debt securities for other-than-temporary impairments. During the years ended December 31, 2019, 2018, and 2017, we did not record any impairment charges related to our restricted marketable securities.

Investing information related to our available-for-sale marketable securities is as follows (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Proceeds from sales and maturities of available-for-sale marketable securities	$ 6.4	$ —	$ 4.0

Our portfolio of marketable securities is comprised of investments in mutual funds that hold investments in a variety of industries and geographies. As discussed in Note 1, *Summary of Significant Accounting Policies*, "Marketable Securities," when our portfolio included marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examined the severity and duration of the impairments in relation to the cost of the individual investments. We also considered the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

Scheduled maturities of investments in debt securities at December 31, 2019 were as follows (in millions):

	Cost	Fair Value
Due in one year or less	$ 12.6	$ 12.6
Due after one year through five years	—	—
Due after five years through ten years	—	—
Due after ten years	—	—
Total	$ 12.6	$ 12.6

5. Accounts Receivable:

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2019	2018
Current:		
Patient accounts receivable	$ 498.7	$ 459.9
Other accounts receivable	7.4	7.8
	506.1	467.7
Noncurrent patient accounts receivable	152.1	155.5
Accounts receivable	$ 658.2	$ 623.2

Because the resolution of claims that are part of Medicare audit programs can take several years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheet. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for additional information.

6. Property and Equipment:

Property and equipment consists of the following (in millions):

	As of December 31,	
	2019	2018
Land	$ 169.6	$ 142.4
Buildings	2,084.8	1,875.2
Leasehold improvements	192.6	147.5
Vehicles	31.2	24.6
Furniture, fixtures, and equipment	505.1	441.6
	2,983.3	2,631.3
Less: Accumulated depreciation and amortization	(1,211.8)	(1,147.0)
	1,771.5	1,484.3
Construction in progress	187.8	150.5
Property and equipment, net	$ 1,959.3	$ 1,634.8

As of December 31, 2019, approximately 70% of our consolidated *Property and equipment, net* held by Encompass Health Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 10, *Long-term Debt*, and Note 21, *Condensed Consolidating Financial Information*.

The amount of depreciation expense and interest capitalized is as follows (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Depreciation expense	$ 130.0	$ 124.2	$ 111.8
Interest capitalized	$ 8.3	$ 6.0	$ 3.7

In February 2016, we entered into a development/lease agreement with CR HQ, LLC (the "Developer") to construct our new home office in Birmingham, Alabama. Under the terms of this agreement, the Developer was responsible for all costs of constructing the new facility 'shell' which is being leased to us for an initial term of 15 years with four, five-year renewal options. The lease commenced in April of 2018. We were responsible for the costs associated with improvements to the interior of the building. Due to the nature and extent of the tenant improvements we made to the new home office and certain provisions of the development/lease agreement, we were deemed to be the accounting owner of the new home office during the construction period. Construction commenced in the second quarter of 2016. As of December 31, 2018, *Property and equipment, net* included $55.0 million for the construction costs incurred by the Developer, and *Long-term debt, net of current portion* included a corresponding financing obligation liability of $54.8 million. The remaining corresponding financing obligation liability of $0.2 million as of December 31, 2018 is included in the *Current portion of long-term debt*. The amounts recorded for construction costs and the corresponding liability are noncash activities for purposes of our consolidated statement of cash flows. As a result of adopting ASC 842 on January 1, 2019, this lease became a finance lease obligation. See Note 1, *Summary of Significant Accounting Policies*, "Recent Accounting Pronouncements," for additional information on ASC 842. See also Note 10, *Long-term Debt.*

7. Leases:

We lease real estate, vehicles, and equipment under operating and finance leases with non-cancelable terms generally expiring at various dates through 2037. Our operating and finance leases generally have 1- to 25-year terms, with one or more renewal options, primarily relating to our real estate leases, with terms to be determined at the time of renewal. The exercise of such lease renewal options is at our sole discretion, and to the extent we are reasonably certain we will exercise a renewal option, the years related to that option are included in our determination of the lease term for purposes of classifying and measuring a given lease. Certain leases also include options to purchase the leased property.

The components of lease costs are as follows (in millions):

	For the Year Ended December 31, 2019
Operating lease cost	$ 72.9
Finance lease cost:	
Amortization of right-of-use assets	30.3
Interest on lease liabilities	29.5
Total finance lease cost	59.8
Variable lease cost	1.5
Sublease income	(3.2)
Total lease cost	$ 131.0

Supplemental consolidated balance sheet information related to leases is as follows (in millions):

	Classification	As of December 31, 2019
Assets		
Operating lease	Operating lease right-of-use assets	$ 276.5
Finance lease [1]	Property and equipment, net	327.0
Total leased assets		$ 603.5
Liabilities		
Current liabilities:		
Operating lease	Current operating lease liabilities	$ 40.4
Finance lease	Current portion of long-term debt	21.0
Noncurrent liabilities:		
Operating lease	Long-term operating lease liabilities	243.8
Finance lease	Long-term debt, net of current portion	363.1
Total leased liabilities		$ 668.3

[1] Finance lease assets are recorded net of accumulated amortization of $99.6 million as of December 31, 2019.

	As of December 31, 2019
Weighted Average Remaining Lease Term	
Operating lease	9.1 years
Finance lease	13.4 years
Weighted Average Discount Rate	
Operating lease	6.2%
Finance lease	7.9%

Maturities of lease liabilities as of December 31, 2019 are as follows (in millions):

Year Ending December 31,	Operating Leases	Finance Leases
2020	$ 57.5	$ 50.4
2021	53.2	48.9
2022	45.4	45.5
2023	40.7	45.3
2024	34.4	44.7
2025 and thereafter	153.0	405.7
Total lease payments	384.2	640.5
Less: Interest portion	(100.0)	(256.4)
Total lease liabilities	$ 284.2	$ 384.1

Supplemental cash flow information related to our leases is as follows (in millions):

	For the Year Ended December 31, 2019
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	$ 70.4
Operating cash flows from finance leases	30.0
Financing cash flows from finance leases	19.5
Right-of-use assets obtained in exchange for lease obligations:	
Operating leases	$ 43.8
Finance leases	34.2

Information prior to the adoption of ASC 842—

Information related to assets under capital lease obligations is as follows (in millions):

	As of December 31, 2018
Assets under capital lease obligations:	
Buildings	$ 329.6
Vehicles	21.1
Equipment	0.3
	351.0
Less: Accumulated amortization	(126.9)
Assets under capital lease obligations, net	$ 224.1

The amount of amortization expense relating to assets under capital lease obligations and rent expense under operating leases is as follows (in millions):

	For the Year Ended December 31,	
	2018	2017
Amortization expense	$ 24.1	$ 22.7
Rent expense:		
Minimum rent payments	$ 69.8	$ 66.5
Contingent and other rents	24.9	24.1
Other	9.1	8.9
Total rent expense	$ 103.8	$ 99.5

Future minimum lease payments at December 31, 2018, for those leases having an initial or remaining noncancelable lease term in excess of one year, are as follows (in millions):

Year Ending December 31,	Operating Leases	Capital Lease Obligations
2019	$ 71.4	$ 36.2
2020	65.8	32.3
2021	54.3	30.3
2022	41.0	28.7
2023	35.3	28.0
2024 and thereafter	148.2	299.7
	$ 416.0	455.2
Less: Interest portion		(191.4)
Obligations under capital leases		$ 263.8

Rental income from subleases approximated $3.0 million and $2.9 million for the years ended December 31, 2018 and 2017, respectively.

8. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2019, 2018, and 2017 (in millions):

	Inpatient Rehabilitation	Home Health and Hospice	Consolidated
Goodwill as of December 31, 2016	$ 1,142.0	$ 785.2	$ 1,927.2
Acquisitions	24.0	21.4	45.4
Goodwill as of December 31, 2017	1,166.0	806.6	1,972.6
Acquisitions	23.2	105.0	128.2
Goodwill as of December 31, 2018	1,189.2	911.6	2,100.8
Acquisitions	4.8	174.7	179.5
Consolidation of joint venture formerly accounted for under the equity method of accounting	24.9	—	24.9
Goodwill as of December 31, 2019	$ 1,218.9	$ 1,086.3	$ 2,305.2

Goodwill increased in 2017 as a result of our acquisitions of inpatient and home health operations. *Goodwill* increased in 2018 as a result of our acquisitions of Camellia and other inpatient and home health and hospice operations. *Goodwill* increased in 2019 as a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value and our acquisitions of Alacare and other inpatient and home health and hospice operations. See Note 2, *Business Combinations,* and Note 9, *Investments in and Advances to Nonconsolidated Affiliates.*

We performed impairment reviews as of October 1, 2019, 2018, and 2017 and concluded no *Goodwill* impairment existed. As of December 31, 2019, we had no accumulated impairment losses related to *Goodwill*.

The following table provides information regarding our other intangible assets (in millions):

	Gross Carrying Amount	Accumulated Amortization	Net
Certificates of need:			
2019	$ 197.2	$ (40.4)	$ 156.8
2018	148.3	(28.2)	120.1
Licenses:			
2019	$ 187.3	$ (94.1)	$ 93.2
2018	169.1	(82.2)	86.9
Noncompete agreements:			
2019	$ 74.2	$ (62.3)	$ 11.9
2018	65.6	(58.6)	7.0
Trade name - Encompass:			
2019	$ 135.2	$ —	$ 135.2
2018	135.2	—	135.2
Trade names - all other:			
2019	$ 41.6	$ (22.4)	$ 19.2
2018	38.9	(19.4)	19.5
Internal-use software:			
2019	$ 173.8	$ (116.0)	$ 57.8
2018	161.3	(89.3)	72.0
Market access assets:			
2019	$ 13.2	$ (11.0)	$ 2.2
2018	13.2	(10.5)	2.7
Total intangible assets:			
2019	$ 822.5	$ (346.2)	$ 476.3
2018	731.6	(288.2)	443.4

Amortization expense for other intangible assets is as follows (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Amortization expense	$ 58.4	$ 51.4	$ 49.3

Total estimated amortization expense for our other intangible assets for the next five years is as follows (in millions):

Year Ending December 31,	Estimated Amortization Expense
2020	$ 55.9
2021	46.2
2022	38.2
2023	33.9
2024	31.0

9. Investments in and Advances to Nonconsolidated Affiliates:

Investments in and advances to nonconsolidated affiliates as of December 31, 2019 represents our investment in five partially owned subsidiaries, of which four 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 8% to 60%. We account for these investments using the cost and equity methods of accounting. Our investments, which are included in *Other long-term assets* in our consolidated balance sheets, consist of the following (in millions):

	As of December 31,	
	2019	2018
Equity method investments:		
Capital contributions	$ 0.9	$ 0.9
Cumulative share of income	68.1	114.0
Cumulative share of distributions	(63.6)	(102.7)
	5.4	12.2
Cost method investments:		
Capital contributions, net of distributions and impairments	2.0	—
Total investments in and advances to nonconsolidated affiliates	$ 7.4	$ 12.2

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

	As of December 31,	
	2019	2018
Assets—		
Current	$ 4.2	$ 9.9
Noncurrent	9.3	17.8
Total assets	$ 13.5	$ 27.7
Liabilities and equity—		
Current liabilities	$ 0.5	$ 1.4
Noncurrent liabilities	0.3	0.1
Partners' capital and shareholders' equity—		
Encompass Health	4.9	12.2
Outside partners	7.8	14.0
Total liabilities and equity	$ 13.5	$ 27.7

Condensed statements of operations (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Net operating revenues	$ 32.6	$ 42.6	$ 40.9
Operating expenses	(19.1)	(25.6)	(24.1)
Income from continuing operations, net of tax	13.4	17.1	17.0
Net income	13.4	17.1	17.0

As a result of an amendment to the joint venture agreement related to Yuma Rehabilitation Hospital, the accounting for this hospital changed from the equity method of accounting to a consolidated entity effective July 1, 2019. The amendment revised certain participatory rights held by our joint venture partner resulting in Encompass Health gaining control of this entity from an accounting perspective. We accounted for this change in control as a business combination and consolidated this entity using the acquisition method. The consolidation of Yuma Rehabilitation Hospital did not have a material impact on our financial position, results of operations, or cash flows. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $24.9 million and we recorded a $19.2 million gain as part of *Other income* during the year ended December 31, 2019.

10. Long-term Debt:

Our long-term debt outstanding consists of the following (in millions):

	As of December 31,	
	2019	2018
Credit Agreement—		
Advances under revolving credit facility	$ 45.0	$ 30.0
Term loan facilities	265.2	280.1
Bonds payable—		
5.125% Senior Notes due 2023	297.3	296.6
5.75% Senior Notes due 2024	697.3	1,194.7
5.75% Senior Notes due 2025	345.6	345.0
4.50% Senior Notes due 2028	491.7	—
4.75% Senior Notes due 2030	491.7	—
Other notes payable	44.7	104.2
Finance lease obligations	384.1	263.8
	3,062.6	2,514.4
Less: Current portion	(39.3)	(35.8)
Long-term debt, net of current portion	$ 3,023.3	$ 2,478.6

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2020	$ 39.3	$ 39.3
2021	35.5	35.5
2022	46.3	46.3
2023	335.1	332.4
2024	995.7	991.6
Thereafter	1,638.6	1,617.5
Total	$ 3,090.5	$ 3,062.6

As a result of the 2019 and 2017 redemptions discussed below, we recorded a $7.7 million and $10.7 million *Loss on early extinguishment of debt* in 2019 and 2017, respectively. There were no redemptions resulting in a *Loss on early extinguishment of debt* during 2018.

Senior Secured Credit Agreement—

Credit Agreement

In November 2019, we amended our existing credit agreement, previously amended in September 2017 (the "Credit Agreement"). The Credit Agreement provided for a $270 million term loan commitment and a $1 billion revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in November 2024. Outstanding term loan borrowings are payable in equal consecutive quarterly installments, commencing on December 31, 2019, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2019, with the remainder due at maturity. We have the right at any time to prepay, in whole or in part, any borrowing under the term loan facilities.

Amounts drawn on the term loan facilities and the revolving credit facility bear interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays Bank PLC's ("Barclays") prime rate and (b) the federal funds rate plus 0.5%, in each case, plus, in each case, an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.375% per annum on the daily amount of the unutilized commitments under the term loan facilities and revolving credit facility. The current interest rate on borrowings under the Credit Agreement is LIBOR plus 1.50%.

The Credit Agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, making certain investments, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the Credit Agreement and (2) our senior secured leverage ratio, as defined in the Credit Agreement, does not exceed 2x. In the event the senior secured leverage ratio exceeds 2x, these payments are subject to a limit of $200 million plus an amount equal to a portion of available excess cash flows each fiscal year. Our obligations under the Credit Agreement are secured by the current and future personal property of the Company and its subsidiary guarantors. The maximum leverage ratio in the financial covenants is 4.50x through December 2021 and 4.25x from then until maturity.

As of December 31, 2019 and 2018, $45 million and $30 million were drawn under the revolving credit facility with an interest rate of 3.2% and 3.9%, respectively. Amounts drawn as of December 31, 2019 and 2018 exclude $38.9 million and $37.4 million, respectively, utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes. Currently, there are no undrawn term loan commitments under the Credit Agreement.

2017 Credit Agreement

In September 2017, we amended our existing credit agreement (the " 2017 Credit Agreement"). The 2017 Credit Agreement provided for a $300 million term loan commitment and a $700 million revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which would have matured in September 2022. Outstanding term loan borrowings were payable in equal consecutive quarterly installments, commencing on December 31, 2017, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2017, with the remainder due at maturity. The 2017 Credit Agreement contained similar affirmative and negative covenants and default and acceleration provisions as the Credit Agreement. The 2017 amendment to our existing credit agreement included a net repayment of approximately $110 million to our existing term loan facility.

Bonds Payable—

Nonconvertible Notes

The Company's 2023 Notes, 2024 Notes, 2025 Notes, 2028 Notes, and 2030 Notes (collectively, the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009, as supplemented by each Senior Notes' respective supplemental indenture (together with the Base Indenture, the "Indenture"). Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our Credit Agreement and other capital markets debt (see Note 21, *Condensed Consolidating Financial Information*). The Senior Notes are senior, unsecured obligations of Encompass Health and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

2023 Notes

In March 2015, we issued $300 million of 5.125% Senior Notes due 2023 ("the 2023 Notes") at par, which resulted in approximately $295 million in net proceeds from the public offering. The 2023 Notes mature on March 15, 2023 and bear interest at a per annum rate of 5.125%. Inclusive of financing costs, the effective interest rate on the 2023 Notes is 5.4%. Interest on the 2023 Notes is payable semiannually in arrears on March 15 and September 15. We may redeem the 2023 Notes, in whole or in part, at any time on or after March 15, 2018 at the redemption prices set forth below:

Period	Redemption Price*
2019	102.563%
2020	101.281%
2021 and thereafter	100.000%

* Expressed in percentage of principal amount

2024 Notes

In September 2012, we completed a public offering of $275 million aggregate principal amount of the 5.75% Senior Notes due 2024 ("the 2024 Notes") at par. In September 2014, we issued an additional $175 million of the 2024 Notes at a price of 103.625% of the principal amount, in January 2015, we issued an additional $400 million of the 2024 Notes at a price of 102% of the principal amount, and in August 2015, we issued an additional $350 million of our 2024 Notes at a price of 100.5% of the principal amount. The 2024 Notes mature on November 1, 2024 and bear interest at a per annum rate of 5.75%.

Inclusive of premiums and financing costs, the effective interest rate on the 2024 Notes is 5.8%. Interest is payable semiannually in arrears on May 1 and November 1 of each year.

In June 2019, we redeemed $100 million of outstanding principal amount of our 2024 Notes using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 101.917%, which resulted in a total cash outlay of approximately $102 million. In November 2019, we redeemed $400 million of the outstanding principal amount of our 2024 Notes. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 100.958%, which resulted in a total cash outlay of approximately $404 million.

We may redeem the 2024 Notes, in whole or in part, at any time on or after November 1, 2017, at the redemption prices set forth below:

Period	Redemption Price*
2019	100.958%
2020 and thereafter	100.000%

* Expressed in percentage of principal amount

2025 Notes

In September 2015, we issued $350 million of 5.75% Senior Notes due 2025 (“the 2025 Notes”) at par. The 2025 Notes mature on September 15, 2025 and bear interest at a per annum rate of 5.75%. Inclusive of financing costs, the effective interest rate on the 2025 Notes is 6.0%. Interest on the 2025 Notes is payable semiannually in arrears on March 15 and September 15.

We may redeem the 2025 Notes, in whole or in part, at any time on or after September 15, 2020, at the redemption prices set forth below:

Period	Redemption Price*
2020	102.875%
2021	101.917%
2022	100.958%
2023 and thereafter	100.000%

* Expressed in percentage of principal amount

2028 and 2030 Notes

In September 2019, we issued $500 million of 4.50% Senior Notes due 2028 (the "2028 Notes") at par and $500 million of 4.75% Senior Notes due 2030 (the "2030 Notes") at par. The proceeds from this offering were used to fund the purchase of equity and vested stock appreciation rights from management investors of our home health and hospice segment, redeem a portion of our 2024 Notes as discussed above, and repay borrowings under our revolving credit facility.

The 2028 Notes mature on February 1, 2028. Inclusive of financing costs, the effective interest rate on the 2028 Notes is 4.7%. Interest on the 2028 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2028 Notes, in whole or in part, at any time on or after February 1, 2023 at the redemption prices set forth below:

Period	Redemption Price*
2023	102.250%
2024	101.125%
2025 and thereafter	100.000%

* Expressed in percentage of principal amount

The 2030 Notes mature on February 1, 2030. Inclusive of financing costs, the effective interest rate on the 2030 Notes is 5.0%. Interest on the 2030 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2030 Notes, in whole or in part, at any time on or after February 1, 2025 at the redemption prices set forth below:

Period	Redemption Price*
2025	102.375%
2026	101.583%
2027	100.792%
2028 and thereafter	100.000%

* Expressed in percentage of principal amount

Convertible Notes

Former Convertible Senior Subordinated Notes Due 2043

In November 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 (the "Former Convertible Notes") for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. Our Former Convertible Notes were issued pursuant to an indenture dated November 18, 2013 (the " Former Convertible Notes Indenture") between us and Wells Fargo Bank, National Association, as trustee and conversion agent.

In May 2017, we provided notice of our intent to exercise our early redemption option on the $320 million outstanding principal amount of the Former Convertible Notes. Pursuant to the Former Convertible Notes Indenture, the holders had the right to convert their Former Convertible Notes into shares of our common stock at a conversion rate of 27.2221 shares per $1,000 principal amount of Former Convertible Notes, which rate was increased by the make-whole premium. Holders of $319.4 million in principal of these Former Convertible Notes chose to convert their notes to shares of our common stock resulting in the issuance of 8.9 million shares from treasury stock, including 0.2 million shares due to the make-whole premium. Approximately 8.6 million of these shares were included in *Diluted earnings per share attributable to Encompass Health common shareholders* as of March 31, 2017. We redeemed the remaining $0.6 million in principal at par in cash. The redemption and all conversions occurred in the second quarter of 2017. The Former Convertible Notes would have matured on

December 1, 2043. Inclusive of discounts and financing costs, the effective interest rate on the Former Convertible Notes was 6.0%. Interest was payable semiannually in arrears in cash on June 1 and December 1 of each year.

Other Notes Payable—

Our notes payable consist of the following (in millions):

	As of December 31,		
	2019	2018	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 28.0	$ 82.8	8.1% to 11.2% as of December 31, 2019; 7.8% to 11.2% as of December 31, 2018
Construction of a new hospital	12.9	14.6	5.0% as of December 31, 2019; 4.8% to 5.0% as of December 31, 2018
Other	3.8	6.8	4.3% to 6.8%
Other notes payable	$ 44.7	$ 104.2	

As a result of adopting ASC 842 on January 1, 2019, notes payable of approximately $52 million related to a sale/leaseback transaction involving real estate became a finance lease obligation. See Note 1, *Summary of Significant Accounting Policies*, "Recent Accounting Pronouncements," for additional information on ASC 842.

11. Self-Insured Risks:

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an insurance company licensed by the Cayman Island Monetary Authority. We use HCS to fund our first layer of insurance coverage up to approximately $30 million for annual aggregate losses associated with general and professional liability risks. Workers' compensation exposures are capped on a per claim basis. Risks in excess of specified limits per claim and in excess of our aggregate SIR amount are covered by unrelated commercial carriers.

The following table presents the changes in our self-insurance reserves for the years ended December 31, 2019, 2018, and 2017 (in millions):

	2019	2018	2017
Balance at beginning of period, gross	$ 160.9	$ 171.0	$ 171.4
Less: Reinsurance receivables	(25.6)	(39.9)	(41.4)
Balance at beginning of period, net	135.3	131.1	130.0
Increase for the provision of current year claims	46.9	47.1	44.7
Decrease for the provision of prior year claims	(12.6)	(8.7)	(3.0)
Expenses related to discontinued operations	(0.1)	(0.2)	(0.5)
Payments related to current year claims	(7.5)	(7.0)	(5.0)
Payments related to prior year claims	(31.1)	(27.0)	(35.1)
Balance at end of period, net	130.9	135.3	131.1
Add: Reinsurance receivables	26.4	25.6	39.9
Balance at end of period, gross	$ 157.3	$ 160.9	$ 171.0

As of December 31, 2019 and 2018, $40.1 million and $41.3 million, respectively, of these reserves are included in *Other current liabilities* in our consolidated balance sheets.

Provisions for these risks are based primarily upon actuarially determined estimates. These reserves represent the unpaid portion of the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated ultimate loss amounts are included in current operating results.

The reserves for these self-insured risks cover approximately 1,000 individual claims at December 31, 2019 and 2018, and estimates for potential unreported claims. The time period required to resolve these claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed management's estimates.

12. Redeemable Noncontrolling Interests:

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Balance at beginning of period	$ 261.7	$ 220.9	$ 138.3
Net income attributable to noncontrolling interests	12.6	13.9	17.9
Distributions declared	(9.2)	(8.6)	(4.6)
Contribution to joint venture	1.0	9.6	2.3
Reclassification to noncontrolling interests	(11.2)	—	—
Purchase of redeemable noncontrolling interests	(162.9)	(65.1)	—
Change in fair value	147.6	91.0	67.0
Balance at end of period	$ 239.6	$ 261.7	$ 220.9

The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests*, as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests*, as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented in the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Net income attributable to nonredeemable noncontrolling interests	$ 74.5	$ 69.2	$ 61.2
Net income attributable to redeemable noncontrolling interests	12.6	13.9	17.9
Net income attributable to noncontrolling interests	$ 87.1	$ 83.1	$ 79.1

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. In July 2019, we received additional exercise notices, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. In September 2019, Encompass Health settled the acquisition of those shares upon payment of approximately $163 million in cash. As of December 31, 2019, the value of the outstanding shares of Holdings owned by management investors was approximately $208 million. In January 2020, we received additional exercise notices, representing approximately 4.3% of the outstanding shares of the common stock of Holdings. On February 18, 2020, Encompass Health settled the acquisition of those shares upon payment of approximately $162 million in cash. Upon settlement of these exercises, approximately $46 million of the shares of Holdings held by two management investors remained outstanding.

On February 20, 2020, Encompass Health entered into exchange agreements (each, an "Exchange Agreement") with these two management investors, pursuant to which they have the right to exchange all of the remaining shares of Holdings held by them for shares of common stock of Encompass Health (the "EHC Shares"). Each of the Exchange Agreements provides that the management investor must deliver a written exchange notice (an "Exchange Notice") to Encompass Health in order to exchange his or her remaining shares of Holdings for EHC Shares. Each Exchange Agreement further provides that the number of EHC Shares to be delivered to the management investor is to be determined by dividing the fair value of the shares of Holdings held by the management investor on the date of the Exchange Agreement by the last reported sales price of Encompass Health's common stock on the New York Stock Exchange (the "NYSE") on the date of delivery of the Exchange Notice.

On February 20, 2020, Encompass Health received an Exchange Notice from each of the management investors. Based on the last sales price of Encompass Health's common stock on the NYSE on February 20, 2020, Encompass Health anticipates delivering an aggregate of approximately 561,000 EHC Shares, less than 0.6% of the total number of outstanding shares of the Encompass Health's common stock, to the management investors. The settlement of the exchanges is expected to occur prior to the end of the first quarter of 2020. Encompass Health anticipates issuing the EHC Shares from its treasury shares.

See also Note 13, *Fair Value Measurements*.

13. Fair Value Measurements:

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

		Fair Value Measurements at Reporting Date Using			
As of December 31, 2019	**Fair Value**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Valuation Technique [1]**
Other long-term assets:					
Equity securities	$ 63.5	$ —	$ 63.5	$ —	M
Debt securities	12.6	12.6	—	—	M
Redeemable noncontrolling interests	239.6	—	—	239.6	I
As of December 31, 2018					
Other long-term assets:					
Equity securities	$ 55.6	$ —	$ 55.6	$ —	M
Debt securities	6.4	6.4	—	—	M
Redeemable noncontrolling interests	261.7	—	—	261.7	I

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

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.

As a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value, we recorded a $19.2 million gain as part of *Other income* during the year ended December 31, 2019. We determined the fair value of our previously held equity interest using the income approach valuation technique. The income approach included the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the hospital. The projected operating results use management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. During the years ended December 31, 2018 and 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.

As discussed in Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements," 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 consolidated balance sheets. The carrying amounts and estimated fair values for our other financial instruments are presented in the following table (in millions):

	As of December 31, 2019		As of December 31, 2018	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 45.0	$ 45.0	$ 30.0	$ 30.0
Term loan facilities	265.2	266.6	280.1	281.3
5.125% Senior Notes due 2023	297.3	306.6	296.6	298.5
5.75% Senior Notes due 2024	697.3	708.8	1,194.7	1,200.0
5.75% Senior Notes due 2025	345.6	369.7	345.0	339.5
4.50% Senior Notes due 2028	491.7	519.4	—	—
4.75% Senior Notes due 2030	491.7	520.0	—	—
Other notes payable	44.7	44.7	104.2	104.2
Financial commitments:				
Letters of credit	—	38.9	—	37.4

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" and "Redeemable Noncontrolling Interests."

14. Share-Based Payments:

The Company has awarded employee stock-based compensation in the form of stock options, SARs, and restricted stock awards ("RSAs") under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded during 2019, 2018, and 2017 was issued under the 2016 Omnibus Performance Incentive Plan, a stockholder-approved plan that reserves and provides for the grant of up to 14,000,000 shares of common stock. This plan allows for the grants of nonqualified stock options, incentive stock options, restricted stock, SARs, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of Encompass Health common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation and human capital committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which are generally three years.

The fair values of the options granted during the years ended December 31, 2019, 2018, and 2017 have been estimated at the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,		
	2019	2018	2017
Expected volatility	25.3%	29.2%	30.5%
Risk-free interest rate	2.7%	2.7%	2.1%
Expected life (years)	7.1	7.1	7.7
Dividend yield	2.1%	2.2%	2.2%

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, the Black-Scholes option-pricing model requires the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected term of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. We estimated our dividend yield based on our annual dividend rate and our stock price on the dividend payment dates. Under the Black-Scholes option-pricing model, the weighted-average grant date fair value per share of employee stock options granted during the years ended December 31, 2019, 2018, and 2017 was $15.45, $14.57, and $11.55, respectively.

A summary of our stock option activity and related information is as follows:

	Shares (In Thousands)	Weighted- Average Exercise Price per Share	Weighted- Average Remaining Life (Years)	Aggregate Intrinsic Value (In Millions)
Outstanding, December 31, 2018	537	$ 35.22		
Granted	106	63.77		
Exercised	(78)	17.73		
Outstanding, December 31, 2019	565	43.02	6.3	$ 14.8
Exercisable, December 31, 2019	364	35.16	5.1	12.4

We recognized approximately $1.4 million, $1.1 million, and $0.8 million of compensation expense related to our stock options for the years ended December 31, 2019, 2018, and 2017, respectively. As of December 31, 2019, there was $1.8 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 22 months. The total intrinsic value of options exercised during the years ended December 31, 2019, 2018, and 2017 was $3.6 million, $5.2 million, and $29.0 million, respectively.

Stock Appreciation Rights—

In conjunction with the EHHI acquisition, we granted SARs based on Encompass Health Home Health Holdings, Inc. (“Holdings”) common stock to certain members of EHHI management at closing on December 31, 2014. Under a separate plan, we granted 122,976 SARs that vest based on continued employment and an additional maximum number of 129,124 SARs that vest based on continued employment and the extent of the attainment of a specified 2017 performance measure. The maximum number of performance SARs was achieved. Half of the SARs of each type vested on December 31, 2018 with the remainder vested on December 31, 2019. The vested SARs will expire on the tenth anniversary of the grant date or within a specified period following any earlier termination of employment. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings’ common stock on the exercise date exceeds the per share fair value on the grant date. The fair value of Holdings’ common stock is determined using the product of the trailing 12-month specified

performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies and publicly disclosed home health acquisitions with a value of $400 million or more.

The fair value of the SARs granted in conjunction with the EHHI acquisition has been estimated using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	As of December 31,	
	2019	2018
Expected volatility	38.6%	27.1%
Risk-free interest rate	1.5%	2.6%
Expected life (years)	0.3	1.3
Dividend yield	—%	—%

We did not include a dividend payment as part of our pricing model because Holdings currently does not pay dividends on its common stock. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of SARs granted in conjunction with the EHHI acquisition was $870.28 and $419.28 as of December 31, 2019 and 2018, respectively. In February 2019, members of the management team exercised a portion of their vested SARs for approximately $13 million in cash. In July 2019, members of the management team exercised the remainder of the vested SARs for approximately $55 million in cash. As of December 31, 2019, the fair value of the remaining 115,545 SARs is approximately $101 million, all of which is included in *Other current liabilities*. In January 2020, members of the management team exercised the remaining SARs, and in February 2020, we settled those awards upon payment of approximately $101 million in cash.

We recognized approximately $81.9 million, $56.2 million, and $26.0 million of compensation expense related to our SARs for the years ended December 31, 2019, 2018 and 2017, respectively. As of December 31, 2019, there was no unrecognized compensation cost related to unvested SARs.

Restricted Stock—

The RSAs granted in 2019, 2018, and 2017 included service-based awards and performance-based awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For RSAs with a service and/or performance requirement, the fair value of the RSA is determined by the closing price of our common stock on the grant date.

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2018	907	$ 37.61
Granted	660	49.84
Vested	(718)	34.84
Forfeited	(31)	48.65
Nonvested shares at December 31, 2019	818	49.49

The weighted-average grant-date fair value of restricted stock granted during the years ended December 31, 2018 and 2017 was $37.61 and $42.85 per share, respectively. We recognized approximately $29.5 million, $27.1 million, and $19.6 million of compensation expense related to our restricted stock awards for the years ended December 31, 2019, 2018, and 2017, respectively. As of December 31, 2019, there was $32.3 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 21 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31,

2019, 2018, and 2017 was $45.2 million, $22.1 million, and $17.7 million, respectively. We accrue dividends on outstanding RSAs, which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2019, 2018, and 2017, we provided incentives to our nonemployee members of our board of directors through the issuance of RSUs out of our share-based incentive plans. RSUs are fully vested when awarded and receive dividend equivalents in the form of additional RSUs upon the payment of a cash dividend on our common stock. During the years ended December 31, 2019, 2018, and 2017, we issued 23,270, 24,771, and 27,594 RSUs, respectively, with a fair value of $64.48, $62.88, and $47.30, respectively, per unit. We recognized approximately $1.5 million, $1.6 million, and $1.3 million, respectively, of compensation expense upon their issuance in 2019, 2018, and 2017. There was no unrecognized compensation related to unvested shares as of December 31, 2019. During the years ended 2019, 2018, and 2017, we issued an additional 8,876, 8,045, and 9,968, respectively, of RSUs as dividend equivalents. As of December 31, 2019, 536,658 RSUs were outstanding.

15. Employee Benefit Plans:

Substantially all Encompass Health employees are eligible to enroll in Encompass Health-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2019, 2018, and 2017, costs associated with these plans, net of amounts paid by employees and stop-loss recoveries, approximated $178.4 million, $164.7 million, and $145.0 million, respectively.

Encompass Health offers two qualified 401(k) savings plans, the Encompass Health Retirement Investment Plan (the “RIP”) and the Encompass Home Health Savings Plan (the “HHSP”). The RIP allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. Inpatient rehabilitation employees who are at least 21 years of age are eligible to participate in the RIP and all contributions to the plan are in the form of cash. Encompass Health’s employer matching contribution under the RIP is 50% of the first 6% of each participant’s elective deferrals, which vest 100% after three years of service. Participants are always fully vested in their own contributions.

The HHSP allows eligible employees to contribute up to 60% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. All home health and hospice full-time and part-time employees are eligible to participate in the HHSP and all contributions to the plan are in the form of cash. Encompass Health’s employer matching contribution under the HHSP is 25% of the first 3% of each participant’s elective deferrals, which vest gradually over a six-year service period. Participants are always fully vested in their own contributions.

Employer contributions to the RIP and HHSP approximated $23.4 million, $21.5 million, and $19.3 million in 2019, 2018, and 2017, respectively. In 2019, 2018, and 2017, approximately $1.4 million, $2.5 million, and $1.5 million, respectively, from forfeited accounts were used to fund the matching contributions in accordance with the terms of the RIP and HHSP.

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals and individual goals. The corporate and regional goals are approved on an annual basis by our board of directors as part of our routine budgeting and financial planning process. The individual goals, which are weighted according to importance, are determined between each participant and his or her immediate supervisor. The program applies to persons who join the Company in, or are promoted to, senior management positions. In 2020, we expect to pay approximately $18.6 million under the program for the year ended December 31, 2019. In March 2019 and March 2018, we paid $19.7 million and $14.7 million, respectively, under the program for the years ended December 31, 2018 and 2017.

16. Income Taxes:

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Current:			
Federal	$ 58.1	$ 103.8	$ 72.2
State and other	17.8	24.2	12.8
Total current expense	75.9	128.0	85.0
Deferred:			
Federal	32.0	(13.7)	58.4
State and other	8.0	4.6	2.4
Total deferred expense (benefit)	40.0	(9.1)	60.8
Total income tax expense related to continuing operations	$ 115.9	$ 118.9	$ 145.8

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, which include federal, state, and other income taxes, is presented below:

	For the Year Ended December 31,		
	2019	2018	2017
Tax expense at statutory rate	21.0 %	21.0 %	35.0 %
Increase (decrease) in tax rate resulting from:			
State and other income taxes, net of federal tax benefit	4.3 %	4.5 %	3.5 %
Increase (decrease) in valuation allowance	0.8 %	(0.4)%	0.4 %
Government, class action, and related settlements	(1.2)%	2.7 %	— %
Noncontrolling interests	(3.0)%	(3.2)%	(4.6)%
Share-based windfall tax benefits	(1.0)%	(0.4)%	(1.8)%
Tax Act	— %	— %	(2.8)%
Other, net	(0.3)%	(0.1)%	(0.3)%
Income tax expense	20.6 %	24.1 %	29.4 %

The *Provision for income tax expense* in 2019 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests, (2) government, class action, and related settlements, and (3) share-based windfall tax benefits offset by (4) state and other income tax expense. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion. The *Provision for income tax expense* in 2018 was greater than the federal statutory rate primarily due to: (1) state and other income tax expense and (2) government, class action, and related settlements offset by (3) the impact of noncontrolling interests. The *Provision for income tax expense* in 2017 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests, (2) the impact of the 2017 Tax Cuts and Jobs Act (the "Tax Act") and (3) share-based windfall tax benefits offset by (4) state and other income tax expense.

On December 22, 2017, the US enacted the Tax Act. The Tax Act, which is commonly referred to as "US tax reform," significantly changes US corporate income tax laws by, among other things, reducing the US corporate income tax rate from 35% to 21% starting in 2018. As a result, we recorded a net benefit of $13.6 million during the fourth quarter of 2017. This amount, which is included in *Provision for income tax expense* in the consolidated statement of operations,

consists of three components: (i) a $5.8 million credit resulting from the remeasurement of our net federal deferred tax assets based on the new lower corporate income tax rate, (ii) a $13.8 million credit resulting from the remeasurement of our net state deferred tax assets as a result of the decreased federal benefit implicit in the new lower corporate income tax rate, and (iii) a $5.8 million charge resulting from the remeasurement of our net valuation allowances for state NOLs as a result of the decreased federal benefit implicit in the new lower corporate income tax rate. In addition, we adopted the Tax Act's provisions allowing for 100% bonus depreciation on qualifying assets placed in service after September 27, 2017, which resulted in additional bonus depreciation deductions of $8.8 million in the fourth quarter of 2017.

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of our deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2019	2018
Deferred income tax assets:		
Net operating loss	$ 61.8	$ 66.0
Property, net	33.9	30.8
Insurance reserve	17.0	16.8
Stock-based compensation	38.3	33.0
Revenue reserves	—	6.1
Operating lease liabilities	30.6	—
Other accruals	23.4	22.5
Tax credits	6.8	4.7
Other	0.2	0.6
Total deferred income tax assets	212.0	180.5
Less: Valuation allowance	(38.4)	(33.7)
Net deferred income tax assets	173.6	146.8
Deferred income tax liabilities:		
Revenue reserves	(11.6)	—
Intangibles	(94.6)	(88.5)
Operating lease right-of-use assets	(30.3)	—
Carrying value of partnerships	(34.0)	(15.2)
Other	(0.2)	(0.2)
Total deferred income tax liabilities	(170.7)	(103.9)
Net deferred income tax assets	$ 2.9	$ 42.9

We have state NOLs of $61.8 million that expire in various amounts at varying times through 2031. For the years ended December 31, 2019, 2018, and 2017, the net increase (decrease) in our valuation allowance was $4.7 million, $(2.1) million, and $7.9 million, respectively. The increase in our valuation allowance in 2019 related primarily to our expected inability to realize related net operating losses prior to their expiration. The decrease in our valuation allowance in 2018 related primarily to expirations of state net operating losses.

As of December 31, 2019, we have a remaining valuation allowance of $38.4 million. This valuation allowance remains recorded 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, if the timing of future tax deductions differs from our expectations, or pursuant to changes in state tax laws and rates.

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 establishment of a deferred tax liability and additional cash tax benefits of approximately $51.3 million through December 31, 2017. This amount was reduced to $33.7 million after considering the federal tax rate reduction to 21% provided for in the Tax Act. The Tax Act included revisions to Internal Revenue Code §451 that might have eliminated a portion of this deferral of revenue for tax purposes. Accordingly, we reversed $23.6 million of our revenue reserves and carrying value of partnerships deferred tax liabilities and recorded a current tax payable for the same amount in the first quarter of 2018. In September 2019, a Treasury Regulation was issued that supported the accounting method change we received calling for continued deferral of denied prepayment claims. As a result, we have recorded additional deferred tax liabilities of $22.2 million and a corresponding benefit to our income tax receivable to fully defer taxable income related to pre-payment claim denials as of December 31, 2019. These changes did not have a material impact on our effective tax rate in any period of adjustment and all benefits are expected to reverse as pre-payment claims denials are settled or collected.

As of January 1, 2017, total remaining gross unrecognized tax benefits were $2.8 million, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits decreased $2.5 million during 2017, primarily related to the favorable settlement of a federal interest claim. Total remaining gross unrecognized tax benefits were $0.3 million as of December 31, 2017, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2018 or 2019. Total remaining gross unrecognized tax benefits were $0.9 million and $0.4 million as of December 31, 2018 and 2019, respectively, all of which would have affected 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
January 1, 2017	$ 2.8	$ —
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.4)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(2.1)	—
December 31, 2017	0.3	—
Gross amount of increases in unrecognized tax benefits related to prior periods	0.8	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.2)	—
December 31, 2018	0.9	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.5)	—
December 31, 2019	$ 0.4	$ 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 2019, 2018, and 2017 was not material. Accrued interest income related to income taxes as of December 31, 2019 and 2018 was not material.

In December 2016, we signed an agreement with the IRS to participate in their Compliance Assurance Process (“CAP”) for the 2017 tax year. CAP is 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 returns. We renewed this agreement in January 2018 for the 2018 tax year, in December 2018 for the 2019 tax year, and in February 2020 for the 2020 tax year. As a result of these agreements, the IRS is currently examining the 2018, 2019, and 2020 tax years. In July 2019, the IRS issued a no-change Letter effectively closing our 2017 tax year audit. The statute of limitations has expired or we have settled federal income tax examinations with the IRS for

all tax years through 2017. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are not currently under audit by any states.

For the tax years that remain open under the applicable statutes of limitations, 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 $0.3 million of our unrecognized tax benefits will be released within the next 12 months.

17. 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):

	For the Year Ended December 31,		
	2019	2018	2017
Basic:			
Numerator:			
Income from continuing operations	$ 446.4	$ 374.3	$ 350.6
Less: Net income attributable to noncontrolling interests included in continuing operations	(87.1)	(83.1)	(79.1)
Less: Income allocated to participating securities	(1.3)	(0.9)	(0.9)
Income from continuing operations attributable to Encompass Health common shareholders	358.0	290.3	270.6
(Loss) income from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.6)	1.1	(0.4)
Net income attributable to Encompass Health common shareholders	$ 357.4	$ 291.4	$ 270.2
Denominator:			
Basic weighted average common shares outstanding	98.0	97.9	93.7
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 3.66	$ 2.97	$ 2.88
Discontinued operations	(0.01)	0.01	—
Net income	$ 3.65	$ 2.98	$ 2.88
Diluted:			
Numerator:			
Income from continuing operations	$ 446.4	$ 374.3	$ 350.6
Less: Net income attributable to noncontrolling interests included in continuing operations	(87.1)	(83.1)	(79.1)
Add: Interest on convertible debt, net of tax	—	—	4.6
Add: Loss on extinguishment of convertible debt, net of tax	—	—	6.2
Income from continuing operations attributable to Encompass Health common shareholders	359.3	291.2	282.3
(Loss) income from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.6)	1.1	(0.4)
Net income attributable to Encompass Health common shareholders	$ 358.7	$ 292.3	$ 281.9
Denominator:			
Diluted weighted average common shares outstanding	99.4	99.8	99.3
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 3.62	$ 2.92	$ 2.84
Discontinued operations	(0.01)	0.01	—
Net income	$ 3.61	$ 2.93	$ 2.84

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

	For the Year Ended December 31,		
	2019	2018	2017
Basic weighted average common shares outstanding	98.0	97.9	93.7
Convertible senior subordinated notes	—	—	4.0
Restricted stock awards, dilutive stock options, and restricted stock units	1.4	1.9	1.6
Diluted weighted average common shares outstanding	99.4	99.8	99.3

Options to purchase approximately 0.1 million and 0.2 million shares of common stock were outstanding as of December 31, 2019 and 2017, respectively, but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive. There were no antidilutive options to purchase shares of common stock outstanding as of December 31, 2018.

In February 2014, our board of directors approved an increase in our common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. On July 24, 2018, the Company's board approved resetting the aggregate common stock repurchase authorization to $250 million. During 2019 and 2017, we repurchased 0.8 million and 0.9 million shares of our common stock in the open market for $45.9 million and $38.1 million, respectively. There were no repurchases of our common stock during 2018.

In July 2016, our board of directors approved an increase in the quarterly cash dividend on our common stock and declared a dividend of $0.24 per share. The cash dividend of $0.24 per common share was declared and paid each quarter through July 2017. In July 2017, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.25 per share. The cash dividend of $0.25 per common share was declared and paid in each quarter through July 2018. In July 2018, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.27 per share. The cash dividend of $0.27 per common share was declared and paid in each quarter through July 2019. In July 2019, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.28 per share. The cash dividend of $0.28 per share was declared in July 2019 and October 2019 and paid in October 2019 and January 2020, respectively. As of December 31, 2019 and 2018, accrued common stock dividends of $29.0 million and $28.4 million were included in *Other current liabilities* in our consolidated balance sheet. 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. Prior to their expiration on January 17, 2017, 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 2016.

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 in January 2017. Cash exercises resulted in gross proceeds of $26.7 million in January 2017.

See also Note 10, *Long-term Debt.*

18. Contingencies and Other Commitments:

We operate in a highly regulated industry in which healthcare providers are routinely subject to litigation. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. 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 were 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*. In July 2019, we entered into settlement agreements with all but one plaintiff and paid those settling plaintiffs an aggregate amount of cash less than $0.1 million. The remaining plaintiff alleges that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiff is seeking compensatory and punitive damages.

This case was stayed in the circuit court on August 8, 2005. However, the complaint has been amended from time to time, including to request certification as a class action. Additionally, one of the former officers named as a defendant has repeatedly attempted to remove the case to federal district court. 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 December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lacked standing because their claims were derivative in nature, and the claims were time-barred by the statute of limitations. On May 26, 2016, the trial court granted our motion to dismiss. On appeal, the Supreme Court of Alabama reversed the trial court's dismissal on March 23, 2018. On April 6, 2018, we filed an application for rehearing with the Alabama Supreme Court. On March 22, 2019, the Alabama Supreme Court denied our application for rehearing and remanded the case to the trial court for further proceedings. The court has scheduled the trial to begin August 10, 2020.

We intend to vigorously defend ourselves in this case against the sole remaining plaintiff. 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 September 28, 2018, the Alabama Supreme Court reversed the trial court's judgment and remanded the case for a new trial.

As a result of the Alabama Supreme Court's reversal, we reduced the associated liability below our insurance retention level of $6.0 million, and no longer maintained an insurance receivable in our consolidated balance sheet because we believed the liability did not exceed that retention level. As of December 31, 2018, we maintained a liability included in *Other current liabilities* in our consolidated balance sheet in connection with this matter. On February 27, 2019, we entered into a settlement with the plaintiff for an amount less than the remaining liability reserved and not material to us.

Governmental Inquiries and Investigations—

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. The associated investigation led by the United States Department of Justice ("DOJ") was based on relator claims of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requested 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.

The investigation focused on a specific set diagnoses made by independent physicians at our hospitals. We relied on the medical judgment of these independent physicians to code the diagnoses. DOJ claimed, among other things, that under CMS regulations we improperly used the codes. However, CMS periodically reviewed industry usage of the codes and confirmed our reliance was appropriate. In addition, throughout the period of the investigation, CMS continued to pay our claims under those codes. The seven-year investigation produced no evidence of falsity or fraudulent conduct. Eventually, the court refused to give DOJ more time to decide whether to intervene and unsealed the related *qui tam* cases. DOJ chose not to intervene to prosecute the matter.

Based on discussions with the government during the fourth quarter of 2018 as well as the burdens and distractions associated with continuing the investigation and the likely costs of future litigation, we estimated a settlement value of $48 million and accrued a loss contingency in that amount which was included in *Other current liabilities* in our consolidated balance sheet for the year ended December 31, 2018. Following further discussions, we settled the DOJ investigation, together with related *qui tam* or "whistleblower" lawsuits, in 2019 for a payment of $48 million, and we expressly denied any wrongdoing. In return for the settlement payment, the plaintiffs dismissed with prejudice their pending *qui tam* claims, and the DOJ provided Encompass Health and all its subsidiaries with a release from civil liability.

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.

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are $61.4 million in 2020, $41.7 million in 2021, $15.1 million in 2022, $10.8 million in 2023, $6.9 million in 2024, and $7.1 million thereafter. These contracts primarily relate to software licensing and support.

19. 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 33 states and Puerto Rico, with a concentration of hospitals in the eastern half of the United States and Texas. As of December 31, 2019, we operate 133 inpatient rehabilitation hospitals. We are the sole owner of 86 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 47 jointly owned hospitals. In addition, we manage four inpatient rehabilitation 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 December 31, 2019, we provide home health services in 245 locations and hospice services in 83 locations across 31 states with concentrations in the Southeast and Texas. In addition, two of these home health agencies operate as joint ventures which we account for using the equity method of accounting. We are the sole owner of 320 of these locations. We retain 50.0% to 81.0% ownership in the remaining eight jointly owned locations. 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 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, *Summary of Significant Accounting Policies*. All revenues for our services are generated through external customers. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for the disaggregation 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			Home Health and Hospice		
	For the Year Ended December 31,			For the Year Ended December 31,		
	2019	2018	2017	2019	2018	2017
Net operating revenues	$ 3,513.0	$ 3,346.2	$ 3,141.3	$ 1,092.0	$ 931.1	$ 772.6
Operating expenses:						
Inpatient rehabilitation:						
Salaries and benefits	1,813.1	1,701.5	1,603.8	—	—	—
Other operating expenses	521.9	502.3	462.5	—	—	—
Supplies	147.0	140.6	135.7	—	—	—
Occupancy costs	64.8	63.8	61.9	—	—	—
Home health and hospice:						
Cost of services sold (excluding depreciation and amortization)	—	—	—	506.2	438.4	363.3
Support and overhead costs	—	—	—	381.7	323.5	277.2
	2,546.8	2,408.2	2,263.9	887.9	761.9	640.5
Other income	(10.5)	(3.6)	(4.1)	—	(0.5)	—
Equity in net income of nonconsolidated affiliates	(5.5)	(7.5)	(7.3)	(1.2)	(1.2)	(0.7)
Noncontrolling interests	82.6	77.2	67.6	9.5	8.5	6.9
Segment Adjusted EBITDA	$ 899.6	$ 871.9	$ 821.2	$ 195.8	$ 162.4	$ 125.9
Capital expenditures	$ 391.4	$ 264.6	$ 238.0	$ 12.7	$ 11.6	$ 10.7

	Inpatient Rehabilitation	Home Health and Hospice	Encompass Health Consolidated
As of December 31, 2019			
Total assets	$ 4,501.4	$ 1,612.8	$ 6,080.7
Investments in and advances to nonconsolidated affiliates	2.0	5.4	7.4
As of December 31, 2018			
Total assets	$ 3,900.9	$ 1,314.6	$ 5,175.0
Investments in and advances to nonconsolidated affiliates	9.5	2.7	12.2

Segment reconciliations (in millions):

	For the Year Ended December 31,		
	2019	2018	2017
Total segment Adjusted EBITDA	$ 1,095.4	$ 1,034.3	$ 947.1
General and administrative expenses	(247.0)	(220.2)	(171.7)
Depreciation and amortization	(218.7)	(199.7)	(183.8)
Loss on disposal of assets	(11.1)	(5.7)	(4.6)
Government, class action, and related settlements	—	(52.0)	—
Loss on early extinguishment of debt	(7.7)	—	(10.7)
Interest expense and amortization of debt discounts and fees	(159.7)	(147.3)	(154.4)
Net income attributable to noncontrolling interests	87.1	83.1	79.1
SARs mark-to-market impact on noncontrolling interests	5.0	2.6	—
Change in fair market value of equity securities	0.8	(1.9)	—
Tax reform impact on noncontrolling interests	—	—	(4.6)
Gain on consolidation of Yuma	19.2	—	—
Payroll taxes on SARs exercise	(1.0)	—	—
Income from continuing operations before income tax expense	$ 562.3	$ 493.2	$ 496.4

	As of December 31, 2019	As of December 31, 2018
Total assets for reportable segments	$ 6,114.2	$ 5,215.5
Reclassification of noncurrent deferred income tax liabilities to net noncurrent deferred income tax assets	(33.5)	(40.5)
Total consolidated assets	$ 6,080.7	$ 5,175.0

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

	For the Year Ended December 31,		
	2019	2018	2017
Inpatient rehabilitation:			
Inpatient	$ 3,423.5	$ 3,247.9	$ 3,039.3
Outpatient and other	89.5	98.3	102.0
Total inpatient rehabilitation	3,513.0	3,346.2	3,141.3
Home health and hospice:			
Home health	918.0	814.6	702.4
Hospice	174.0	116.5	70.2
Total home health and hospice	1,092.0	931.1	772.6
Total net operating revenues	$ 4,605.0	$ 4,277.3	$ 3,913.9

20. Quarterly Data (Unaudited):

	2019				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 1,124.0	$ 1,135.0	$ 1,161.6	$ 1,184.4	$ 4,605.0
Operating earnings [a]	167.1	152.6	151.2	141.2	612.1
Provision for income tax expense	30.8	23.5	34.3	27.3	115.9
Income from continuing operations	125.7	111.0	119.5	90.2	446.4
Loss from discontinued operations, net of tax	(0.5)	(0.1)	—	—	(0.6)
Net income	125.2	110.9	119.5	90.2	445.8
Less: Net income attributable to noncontrolling interests	(22.9)	(19.7)	(21.9)	(22.6)	(87.1)
Net income attributable to Encompass Health	$ 102.3	$ 91.2	$ 97.6	$ 67.6	$ 358.7
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 1.05	$ 0.93	$ 0.99	$ 0.69	$ 3.66
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 1.04	$ 0.93	$ 0.99	$ 0.69	$ 3.65
Diluted earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 1.04	$ 0.92	$ 0.98	$ 0.68	$ 3.62
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 1.03	$ 0.92	$ 0.98	$ 0.68	$ 3.61

(a) We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

	2018				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 1,046.0	$ 1,067.7	$ 1,067.6	$ 1,096.0	$ 4,277.3
Operating earnings [a]	150.0	157.3	154.5	93.4	555.2
Provision for income tax expense	30.0	29.3	30.2	29.4	118.9
Income from continuing operations	105.7	113.0	109.4	46.2	374.3
(Loss) income from discontinued operations, net of tax	(0.5)	0.2	(0.1)	1.5	1.1
Net income	105.2	113.2	109.3	47.7	375.4
Less: Net income attributable to noncontrolling interests	(21.4)	(21.4)	(20.7)	(19.6)	(83.1)
Net income attributable to Encompass Health	$ 83.8	$ 91.8	$ 88.6	$ 28.1	$ 292.3
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.86	$ 0.93	$ 0.90	$ 0.27	$ 2.97
Discontinued operations	(0.01)	—	—	0.02	0.01
Net income	$ 0.85	$ 0.93	$ 0.90	$ 0.29	$ 2.98
Diluted earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.85	$ 0.92	$ 0.89	$ 0.26	$ 2.92
Discontinued operations	(0.01)	—	—	0.02	0.01
Net income	$ 0.84	$ 0.92	$ 0.89	$ 0.28	$ 2.93

(a) We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

21. 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 *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 10, *Long-term Debt*.

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*, *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.

The "Holdings" column in the condensed consolidating financial statements below represents Holdings and its wholly-owned subsidiaries. As discussed in Note 12, *Redeemable Noncontrolling Interests*, Holdings had 5.5% noncontrolling interest as of December 31, 2019, and accordingly, Holdings and its wholly-owned subsidiaries were not guarantors of our debt. In February 2020, we acquired for cash all but 1.2% of the remaining noncontrolling interest in Holdings following the most recent exercise of the put option by the management investors. On February 20, 2020, Encompass Health Corporation and each of the two remaining management investors agreed to exchange the remaining shares representing the noncontrolling interest for an equal value of shares of common stock of Encompass Health Corporation. We expect to settle the exchanges in March 2020.

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2019					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net operating revenues	$ 20.7	$ 2,425.5	$ 1,221.7	$ 1,074.1	$ (137.0)	$ 4,605.0
Operating expenses:						
Salaries and benefits	59.6	1,176.5	608.7	748.9	(20.7)	2,573.0
Other operating expenses	45.0	351.8	189.3	88.4	(50.9)	623.6
Occupancy costs	2.1	100.8	27.5	17.3	(65.4)	82.3
Supplies	—	98.0	49.3	20.6	—	167.9
General and administrative expenses	160.0	—	—	87.0	—	247.0
Depreciation and amortization	19.9	106.8	54.9	37.1	—	218.7
Total operating expenses	286.6	1,833.9	929.7	999.3	(137.0)	3,912.5
Loss on early extinguishment of debt	7.7	—	—	—	—	7.7
Interest expense and amortization of debt discounts and fees	131.0	24.7	5.6	28.4	(30.0)	159.7
Other income	(32.3)	(21.1)	(7.1)	—	30.0	(30.5)
Equity in net income of nonconsolidated affiliates	—	(5.1)	(0.4)	(1.2)	—	(6.7)
Equity in net income of consolidated affiliates	(492.6)	(67.0)	—	—	559.6	—
Management fees	(160.8)	117.8	43.0	—	—	—
Income from continuing operations before income tax (benefit) expense	281.1	542.3	250.9	47.6	(559.6)	562.3
Provision for income tax (benefit) expense	(78.2)	140.3	40.3	13.5	—	115.9
Income from continuing operations	359.3	402.0	210.6	34.1	(559.6)	446.4
Loss from discontinued operations, net of tax	(0.6)	—	—	—	—	(0.6)
Net income	358.7	402.0	210.6	34.1	(559.6)	445.8
Less: Net income attributable to noncontrolling interests	—	—	(83.3)	(3.8)	—	(87.1)
Net income attributable to Encompass Health	$ 358.7	$ 402.0	$ 127.3	$ 30.3	$ (559.6)	$ 358.7
Comprehensive income	$ 358.7	$ 402.0	$ 210.6	$ 34.1	$ (559.6)	$ 445.8
Comprehensive income attributable to Encompass Health	$ 358.7	$ 402.0	$ 127.3	$ 30.3	$ (559.6)	$ 358.7

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2018					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net operating revenues	$ 21.0	$ 2,351.8	$ 1,118.9	$ 915.9	$ (130.3)	$ 4,277.3
Operating expenses:						
Salaries and benefits	49.5	1,132.2	550.4	643.3	(21.4)	2,354.0
Other operating expenses	37.9	344.3	177.4	75.3	(49.8)	585.1
Occupancy costs	1.9	95.7	25.4	14.1	(59.1)	78.0
Supplies	—	95.8	44.9	18.0	—	158.7
General and administrative expenses	161.0	—	—	59.2	—	220.2
Depreciation and amortization	14.3	108.2	47.6	29.6	—	199.7
Government, class action, and related settlements	52.0	—	—	—	—	52.0
Total operating expenses	316.6	1,776.2	845.7	839.5	(130.3)	3,647.7
Interest expense and amortization of debt discounts and fees	124.2	22.6	2.2	23.5	(25.2)	147.3
Other income	(22.4)	(1.0)	(3.5)	(0.5)	25.2	(2.2)
Equity in net income of nonconsolidated affiliates	—	(7.1)	(0.4)	(1.2)	—	(8.7)
Equity in net income of consolidated affiliates	(465.6)	(63.4)	—	—	529.0	—
Management fees	(153.1)	114.0	39.1	—	—	—
Income from continuing operations before income tax (benefit) expense	221.3	510.5	235.8	54.6	(529.0)	493.2
Provision for income tax (benefit) expense	(69.9)	136.6	38.4	13.8	—	118.9
Income from continuing operations	291.2	373.9	197.4	40.8	(529.0)	374.3
Income from discontinued operations, net of tax	1.1	—	—	—	—	1.1
Net income	292.3	373.9	197.4	40.8	(529.0)	375.4
Less: Net income attributable to noncontrolling interests	—	—	(77.8)	(5.3)	—	(83.1)
Net income attributable to Encompass Health	$ 292.3	$ 373.9	$ 119.6	$ 35.5	$ (529.0)	$ 292.3
Comprehensive income	$ 292.3	$ 373.9	$ 197.4	$ 40.8	$ (529.0)	$ 375.4
Comprehensive income attributable to Encompass Health	$ 292.3	$ 373.9	$ 119.6	$ 35.5	$ (529.0)	$ 292.3

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2017					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net operating revenues	$ 21.3	$ 2,252.5	$ 1,006.4	$ 759.8	$ (126.1)	$ 3,913.9
Operating expenses:						
Salaries and benefits	34.7	1,088.7	508.9	543.3	(21.0)	2,154.6
Other operating expenses	32.8	324.8	160.2	62.4	(48.6)	531.6
Occupancy costs	1.9	93.7	23.0	11.4	(56.5)	73.5
Supplies	—	94.2	41.7	13.4	—	149.3
General and administrative	143.7	—	—	28.0	—	171.7
Depreciation and amortization	8.8	106.6	44.7	23.7	—	183.8
Total operating expenses	221.9	1,708.0	778.5	682.2	(126.1)	3,264.5
Loss on early extinguishment of debt	10.7	—	—	—	—	10.7
Interest expense and amortization of debt discounts and fees	130.5	23.2	2.5	19.2	(21.0)	154.4
Other (income) loss	(21.7)	0.2	(3.6)	—	21.0	(4.1)
Equity in net income of nonconsolidated affiliates	—	(6.9)	(0.4)	(0.7)	—	(8.0)
Equity in net income of consolidated affiliates	(342.1)	(39.0)	—	—	381.1	—
Management fees	(145.0)	109.5	35.5	—	—	—
Income from continuing operations before income tax (benefit) expense	167.0	457.5	193.9	59.1	(381.1)	496.4
Provision for income tax (benefit) expense	(104.5)	182.6	66.8	0.9	—	145.8
Income from continuing operations	271.5	274.9	127.1	58.2	(381.1)	350.6
Loss from discontinued operations, net of tax	(0.4)	—	—	—	—	(0.4)
Net income	271.1	274.9	127.1	58.2	(381.1)	350.2
Less: Net income attributable to noncontrolling interests	—	—	(68.7)	(10.4)	—	(79.1)
Net income attributable to Encompass Health	$ 271.1	$ 274.9	$ 58.4	$ 47.8	$ (381.1)	$ 271.1
Comprehensive income	$ 271.0	$ 274.9	$ 127.1	$ 58.2	$ (381.1)	$ 350.1
Comprehensive income attributable to Encompass Health	$ 271.0	$ 274.9	$ 58.4	$ 47.8	$ (381.1)	$ 271.0

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2019					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Assets						
Current assets:						
Cash and cash equivalents	$ 53.7	$ 5.2	$ 6.0	$ 29.9	$ —	$ 94.8
Restricted cash	—	—	57.4	—	—	57.4
Accounts receivable	—	280.4	125.6	100.1	—	506.1
Prepaid expenses and other current assets	64.3	35.4	9.3	7.8	(19.3)	97.5
Total current assets	118.0	321.0	198.3	137.8	(19.3)	755.8
Property and equipment, net	133.4	1,246.0	551.2	28.7	—	1,959.3
Operating lease right-of-use assets	10.1	171.5	86.5	43.7	(35.3)	276.5
Goodwill	—	912.2	323.0	1,070.0	—	2,305.2
Intangible assets, net	17.7	101.7	65.3	291.6	—	476.3
Deferred income tax assets	27.2	11.1	0.1	—	(35.5)	2.9
Other long-term assets	53.6	85.4	151.6	14.1	—	304.7
Intercompany notes receivable	737.8	—	—	—	(737.8)	—
Intercompany receivable and investments in consolidated affiliates	3,155.4	523.6	—	—	(3,679.0)	—
Total assets	$ 4,253.2	$ 3,372.5	$ 1,376.0	$ 1,585.9	$ (4,506.9)	$ 6,080.7
Liabilities and Shareholders' Equity						
Current liabilities:						
Current portion of long-term debt	$ 17.0	$ 10.4	$ 3.8	$ 8.1	$ —	$ 39.3
Current operating lease liabilities	1.3	21.9	16.0	12.1	(10.9)	40.4
Accounts payable	9.8	56.5	24.3	4.0	—	94.6
Accrued payroll	34.8	76.2	40.4	59.1	—	210.5
Accrued interest payable	30.4	2.0	—	—	—	32.4
Other current liabilities	82.2	30.5	68.8	141.6	(19.3)	303.8
Total current liabilities	175.5	197.5	153.3	224.9	(30.2)	721.0
Long-term debt, net of current portion	2,670.6	305.4	41.6	5.7	—	3,023.3
Long-term operating lease liabilities	9.0	153.9	73.6	31.9	(24.6)	243.8
Intercompany notes payable	—	—	—	737.8	(737.8)	—
Self-insured risks	19.3	—	97.9	—	—	117.2
Other long-term liabilities	26.6	12.2	2.4	37.0	(35.5)	42.7
Intercompany payable	—	—	66.0	4.4	(70.4)	—
	2,901.0	669.0	434.8	1,041.7	(898.5)	4,148.0
Commitments and contingencies						
Redeemable noncontrolling interests	—	—	31.4	208.2	—	239.6
Shareholders' equity:						
Encompass Health shareholders' equity	1,352.2	2,703.5	568.9	336.0	(3,608.4)	1,352.2
Noncontrolling interests	—	—	340.9	—	—	340.9
Total shareholders' equity	1,352.2	2,703.5	909.8	336.0	(3,608.4)	1,693.1
Total liabilities and shareholders' equity	$ 4,253.2	$ 3,372.5	$ 1,376.0	$ 1,585.9	$ (4,506.9)	$ 6,080.7

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2018					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Assets						
Current assets:						
Cash and cash equivalents	$ 41.5	$ 3.0	$ 5.1	$ 19.6	$ —	$ 69.2
Restricted cash	—	—	59.0	—	—	59.0
Accounts receivable	—	270.7	121.6	75.4	—	467.7
Prepaid expenses and other current assets	36.3	17.6	26.2	4.9	(18.8)	66.2
Total current assets	77.8	291.3	211.9	99.9	(18.8)	662.1
Property and equipment, net	123.9	1,041.5	445.2	24.2	—	1,634.8
Goodwill	—	912.2	293.3	895.3	—	2,100.8
Intangible assets, net	21.4	96.6	67.5	257.9	—	443.4
Deferred income tax assets	47.9	28.9	0.1	—	(34.0)	42.9
Other long-term assets	47.9	100.4	130.9	11.8	—	291.0
Intercompany notes receivable	535.3	—	—	—	(535.3)	—
Intercompany receivable and investments in consolidated affiliates	2,904.4	457.6	—	—	(3,362.0)	—
Total assets	$ 3,758.6	$ 2,928.5	$ 1,148.9	$ 1,289.1	$ (3,950.1)	$ 5,175.0
Liabilities and Shareholders' Equity						
Current liabilities:						
Current portion of long-term debt	$ 35.0	$ 7.5	$ 4.4	$ 6.4	$ (17.5)	$ 35.8
Accounts payable	8.9	46.4	30.4	4.3	—	90.0
Accrued payroll	35.0	69.1	35.4	48.9	—	188.4
Accrued interest payable	22.3	2.4	—	—	(0.3)	24.4
Other current liabilities	154.5	5.1	85.7	89.6	(1.0)	333.9
Total current liabilities	255.7	130.5	155.9	149.2	(18.8)	672.5
Long-term debt, net of current portion	2,188.7	262.1	20.0	7.8	—	2,478.6
Intercompany notes payable	—	—	—	535.3	(535.3)	—
Self-insured risks	16.1	—	103.5	—	—	119.6
Other long-term liabilities	21.4	17.1	5.0	76.0	(33.9)	85.6
Intercompany payable	—	—	48.9	4.2	(53.1)	—
	2,481.9	409.7	333.3	772.5	(641.1)	3,356.3
Commitments and contingencies						
Redeemable noncontrolling interests	—	—	38.3	223.4	—	261.7
Shareholders' equity						
Encompass Health shareholders' equity	1,276.7	2,518.8	497.0	293.2	(3,309.0)	1,276.7
Noncontrolling interests	—	—	280.3	—	—	280.3
Total shareholders' equity	1,276.7	2,518.8	777.3	293.2	(3,309.0)	1,557.0
Total liabilities and shareholders' equity	$ 3,758.6	$ 2,928.5	$ 1,148.9	$ 1,289.1	$ (3,950.1)	$ 5,175.0

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2019					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net cash (used in) provided by operating activities	$ (110.8)	$ 450.3	$ 247.9	$ 47.9	$ —	$ 635.3
Cash flows from investing activities:						
Acquisition of businesses, net of cash acquired	(217.8)	—	—	(13.7)	—	(231.5)
Purchases of property and equipment	(38.6)	(207.3)	(117.9)	(8.6)	—	(372.4)
Additions to capitalized software costs	(7.4)	(0.7)	(1.4)	(3.5)	—	(13.0)
Purchases of intangible assets	—	(18.0)	—	(0.7)	—	(18.7)
Proceeds from sale of restricted investments	—	—	17.6	—	—	17.6
Purchases of restricted investments	—	—	(30.9)	(2.0)	—	(32.9)
Funding of intercompany note receivable	(64.0)	—	—	—	64.0	—
Proceeds from repayment of intercompany note receivable	93.0	—	17.5	—	(110.5)	—
Other, net	(8.3)	8.2	(6.7)	0.3	—	(6.5)
Net cash provided used in investing activities	(243.1)	(217.8)	(121.8)	(28.2)	(46.5)	(657.4)
Cash flows from financing activities:						
Proceeds from bond issuance	1,000.0	—	—	—	—	1,000.0
Principal payments on debt, including pre-payments	(517.8)	—	(1.7)	—	—	(519.5)
Principal borrowings on intercompany note payable	—	—	—	64.0	(64.0)	—
Principal payments on intercompany note payable	(17.5)	—	—	(93.0)	110.5	—
Borrowings on revolving credit facility	635.0	—	—	—	—	635.0
Payments on revolving credit facility	(620.0)	—	—	—	—	(620.0)
Principal payments under finance lease obligations	(0.7)	(8.3)	(2.6)	(7.9)	—	(19.5)
Debt amendment and issuance costs	(21.5)	—	—	—	—	(21.5)
Repurchases of common stock, including fees and expenses	(45.9)	—	—	—	—	(45.9)
Dividends paid on common stock	(108.6)	—	—	(0.1)	—	(108.7)
Purchase of equity interests in consolidated affiliates	(162.9)	—	—	—	—	(162.9)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(79.8)	—	—	(79.8)
Taxes paid on behalf of employees for shares withheld	(15.4)	—	—	(1.2)	—	(16.6)
Contributions from consolidated affiliates	—	—	15.9	—	—	15.9
Other, net	(4.4)	—	—	(3.9)	—	(8.3)
Change in intercompany advances	245.8	(222.0)	(56.5)	32.7	—	—
Net cash provided by (used in) financing activities	366.1	(230.3)	(124.7)	(9.4)	46.5	48.2
Increase in cash, cash equivalents, and restricted cash	12.2	2.2	1.4	10.3	—	26.1
Cash, cash equivalents, and restricted cash at beginning of year	41.5	3.0	69.4	19.6	—	133.5
Cash, cash equivalents and restricted cash at end of year	$ 53.7	$ 5.2	$ 70.8	$ 29.9	$ —	$ 159.6
Reconciliation of Cash, Cash Equivalents, and Restricted Cash						
Cash and cash equivalents at beginning of period	$ 41.5	$ 3.0	$ 5.1	$ 19.6	$ —	$ 69.2
Restricted cash at beginning of period	—	—	59.0	—	—	59.0
Restricted cash included in other long-term assets at beginning of period	—	—	5.3	—	—	5.3
Cash, cash equivalents, and restricted cash at beginning of period	$ 41.5	$ 3.0	$ 69.4	$ 19.6	$ —	$ 133.5
Cash and cash equivalents at end of period	$ 53.7	$ 5.2	$ 6.0	$ 29.9	$ —	$ 94.8
Restricted cash at end of period	—	—	57.4	—	—	57.4
Restricted cash included in other long-term assets at end of period	—	—	7.4	—	—	7.4
Cash, cash equivalents, and restricted cash at end of period	$ 53.7	$ 5.2	$ 70.8	$ 29.9	$ —	$ 159.6
Supplemental schedule of noncash financing activity:						
Intercompany note activity	$ (232.9)	$ —	$ —	$ 232.9	$ —	$ —

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2018					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net cash (used in) provided by operating activities	$ (11.3)	$ 422.2	$ 259.0	$ 92.5	$ —	$ 762.4
Cash flows from investing activities:						
Acquisition of businesses, net of cash acquired	(131.4)	—	—	(12.5)	—	(143.9)
Purchases of property and equipment	(34.1)	(133.9)	(79.9)	(6.6)	—	(254.5)
Additions to capitalized software costs	(14.1)	(0.1)	—	(1.8)	—	(16.0)
Purchases of intangible assets	(2.5)	—	(0.1)	(3.1)	—	(5.7)
Proceeds from sale of restricted investments	—	—	11.6	—	—	11.6
Purchases of restricted investments	—	—	(13.3)	—	—	(13.3)
Proceeds from repayment of intercompany note receivable	87.0	—	—	—	(87.0)	—
Other, net	(6.0)	2.8	—	0.5	—	(2.7)
Net cash used in investing activities	(101.1)	(131.2)	(81.7)	(23.5)	(87.0)	(424.5)
Cash flows from financing activities:						
Principal payments on debt, including pre-payments	(17.6)	—	(3.0)	—	—	(20.6)
Principal payments on intercompany notes payable	—	—	—	(87.0)	87.0	—
Borrowings on revolving credit facility	325.0	—	—	—	—	325.0
Payments on revolving credit facility	(390.0)	—	—	—	—	(390.0)
Principal payments under finance lease obligations	—	(8.4)	(4.2)	(5.3)	—	(17.9)
Debt amendment and issuance costs	—	—	(0.1)	—	—	(0.1)
Dividends paid on common stock	(100.7)	—	—	(0.1)	—	(100.8)
Purchase of equity interests in consolidated affiliates	(65.1)	—	—	—	—	(65.1)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(75.4)	—	—	(75.4)
Taxes paid on behalf of employees for shares withheld	(7.4)	—	—	(0.9)	—	(8.3)
Contributions from consolidated affiliates	—	—	12.6	—	—	12.6
Other, net	3.0	—	13.2	3.2	—	19.4
Change in intercompany advances	372.4	(282.5)	(118.9)	29.0	—	—
Net cash provided by (used in) financing activities	119.6	(290.9)	(175.8)	(61.1)	87.0	(321.2)
Increase in cash, cash equivalents, and restricted cash	7.2	0.1	1.5	7.9	—	16.7
Cash, cash equivalents, and restricted cash at beginning of year	34.3	2.9	67.9	11.7	—	116.8
Cash, cash equivalents, and restricted cash at end of year	$ 41.5	$ 3.0	$ 69.4	$ 19.6	$ —	$ 133.5
Reconciliation of Cash, Cash Equivalents, and Restricted Cash						
Cash and cash equivalents at beginning of period	$ 34.3	$ 2.9	$ 5.5	$ 11.7	$ —	$ 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	$ 67.9	$ 11.7	$ —	$ 116.8
Cash and cash equivalents at end of period	$ 41.5	$ 3.0	$ 5.1	$ 19.6	$ —	$ 69.2
Restricted cash at end of period	—	—	59.0	—	—	59.0
Restricted cash included in other long-term assets at end of period	—	—	5.3	—	—	5.3
Cash, cash equivalents, and restricted cash at end of period	$ 41.5	$ 3.0	$ 69.4	$ 19.6	$ —	$ 133.5
Supplemental schedule of noncash investing activities:						
Intercompany note activity	$ (136.8)	$ —	$ —	$ 136.8	$ —	$ —

Encompass Health Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2017					
	Encompass Health Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Holdings	Eliminating Entries	Encompass Health Consolidated
	(In Millions)					
Net cash provided by operating activities	$ 28.2	$ 385.9	$ 181.2	$ 63.0	$ —	$ 658.3
Cash flows from investing activities:						
Acquisition of businesses, net of cash acquired	(10.9)	—	—	(27.9)	—	(38.8)
Purchases of property and equipment	(39.4)	(106.5)	(75.4)	(4.5)	—	(225.8)
Additions to capitalized software costs	(16.3)	(0.3)	(0.1)	(2.5)	—	(19.2)
Purchases of intangible assets	—	—	—	(3.7)	—	(3.7)
Proceeds from sale of restricted investments	—	—	4.2	—	—	4.2
Purchases of restricted investments	—	—	(8.5)	—	—	(8.5)
Proceeds from repayment of intercompany note receivable	51.0	—	—	—	(51.0)	—
Other, net	(3.7)	11.7	0.2	0.6	—	8.8
Net cash used in investing activities	(19.3)	(95.1)	(79.6)	(38.0)	(51.0)	(283.0)
Cash flows from financing activities:						
Principal payments on debt, including pre-payments	(126.9)	—	(3.0)	—	—	(129.9)
Principal payments on intercompany notes payable	—	—	—	(51.0)	51.0	—
Borrowings on revolving credit facility	273.3	—	—	—	—	273.3
Payments on revolving credit facility	(330.3)	—	—	—	—	(330.3)
Principal payments under finance lease obligations	—	(7.3)	(3.9)	(4.1)	—	(15.3)
Debt amendment and issuance costs	(4.1)	—	—	—	—	(4.1)
Repurchases of common stock, including fees and expenses	(38.1)	—	—	—	—	(38.1)
Dividends paid on common stock	(91.5)	—	—	—	—	(91.5)
Proceeds from exercising stock warrants	26.6	—	—	—	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(51.9)	—	—	(51.9)
Taxes paid on behalf of employees for shares withheld	(19.5)	—	—	(0.3)	—	(19.8)
Contributions from consolidated affiliates	—	—	20.8	—	—	20.8
Other, net	1.0	—	—	(0.7)	—	0.3
Change in intercompany advances	314.3	(282.2)	(62.0)	29.9	—	—
Net cash provided by (used in) financing activities	4.8	(289.5)	(100.0)	(26.2)	51.0	(359.9)
Increase in cash, cash equivalents, and restricted cash	13.7	1.3	1.6	(1.2)	—	15.4
Cash, cash equivalents, and restricted cash at beginning of year	20.6	1.6	66.3	12.9	—	101.4
Cash, cash equivalents, and restricted cash at end of year	$ 34.3	$ 2.9	$ 67.9	$ 11.7	$ —	$ 116.8
Reconciliation of Cash, Cash Equivalents, and Restricted Cash						
Cash and cash equivalents at beginning of period	$ 20.6	$ 1.6	$ 5.4	$ 12.9	$ —	$ 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	$ 66.3	$ 12.9	$ —	$ 101.4
Cash and cash equivalents at end of period	$ 34.3	$ 2.9	$ 5.5	$ 11.7	$ —	$ 54.4
Restricted cash at end of period	—	—	62.4	—	—	62.4
Cash, cash equivalents, and restricted cash at end of period	$ 34.3	$ 2.9	$ 67.9	$ 11.7	$ —	$ 116.8
Supplemental schedule of noncash financing activities:						
Intercompany note activity	$ (8.8)	$ —	$ —	$ 8.8	$ —	$ —
Conversion of convertible debt	319.4	—	—	—	—	319.4

EXHIBIT LIST

Effective as of January 1, 2018, we changed our name to Encompass Health Corporation. By operation of law, any reference to "HealthSouth" in these exhibits should be read as "Encompass Health" as set forth in the Exhibit List below.

No.	Description
3.1.1	Amended and Restated Certificate of Incorporation of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.1 to Encompass Health's Current Report on Form 8-K filed on October 25, 2017).
3.1.2	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to Encompass Health's Current Report on Form 8-K filed on March 9, 2006).
3.2	Amended and Restated Bylaws of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.2 to Encompass Health's Current Report on Form 8-K filed on October 25, 2017).
4.1.1	Indenture, dated as of December 1, 2009, between Encompass Health Corporation and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.125% Senior Notes due 2023, 5.75% Senior Notes due 2024, and 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.7.1 to Encompass Health's Annual Report on Form 10-K filed on February 23, 2010).
4.1.2	First Supplemental Indenture, dated December 1, 2009, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.7.2 to Encompass Health's Annual Report on Form 10-K filed on February 23, 2010).
4.1.3	Second Supplemental Indenture, dated as of October 7, 2010, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on October 12, 2010).
4.1.4	Third Supplemental Indenture, dated October 7, 2010, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.3 to Encompass Health's Current Report on Form 8-K filed on October 12, 2010).
4.1.5	Fourth Supplemental Indenture, dated September 11, 2012, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on September 11, 2012).
4.1.6	Fifth Supplemental Indenture, dated as of March 12, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to Encompass Health's 5.125% Senior Notes due 2023 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on March 12, 2015).
4.1.7	Sixth Supplemental Indenture, dated as of August 7, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to Encompass Health's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.4 to Encompass Health's Current Report on Form 8-K filed on August 12, 2015).
4.1.8	Seventh Supplemental Indenture, dated as of September 16, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health's 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.2 to Encompass Health's Current Report on Form 8-K filed on September 21, 2015).
4.1.9	Eighth Supplemental Indenture dated as of September 18, 2019, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.500% Notes due 2028 (incorporated by referenced to Exhibit 4.2 to the Encompass Health's Current Report on Form 8-K filed on September 18, 2019).

4.1.10	Ninth Supplemental Indenture dated as of September 18, 2019, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.750% Notes due 2030 (incorporated by referenced to Exhibit 4.3 to the Encompass Health's Current Report on Form 8-K filed on September 18, 2019).
4.2	Description of Securities Registered under Section 12 of the Securities Exchange Act of 1934 (Common Stock).
10.1.1	Encompass Health Corporation Amended and Restated 2004 Director Incentive Plan (incorporated by reference to Exhibit 10.12.1 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+
10.1.2	Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan)(incorporated by reference to Exhibit 10.12.2 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+
10.2	Form of Indemnity Agreement entered into between Encompass Health Corporation and the directors of Encompass Health (incorporated by reference to Exhibit 10.31 to Encompass Health's Annual Report on Form 10-K filed on June 27, 2005).+
10.3	Encompass Health Corporation Fourth Amended and Restated Change in Control Benefits Plan (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2018).+
10.4	Description of the Encompass Health Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, "Other Matters," in Encompass Health's Quarterly Report on Form 10-Q filed on November 4, 2009).+
10.5	Description of the Encompass Health Corporation Senior Management Bonus and Long-Term Incentive Plans (incorporated by reference to the section captioned "Executive Compensation – Compensation Discussion and Analysis – Elements of Executive Compensation" in Encompass Health's Definitive Proxy Statement on Schedule 14A filed on March 21, 2019).+
10.6	Description of the annual compensation arrangement for non-employee directors of Encompass Health Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in Encompass Health's Definitive Proxy Statement on Schedule 14A, filed on March 21, 2019).+
10.7	Encompass Health Corporation Fifth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.2 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2018).+
10.8	Encompass Health Corporation Nonqualified 401(k) Plan.+
10.9.1	Encompass Health Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to Encompass Health's Registration Statement on Form S-8 filed on August 2, 2011).+
10.9.2	Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.2 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.3	Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.3 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.4	Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Encompass Health's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.10	Encompass Health Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to Exhibit 10.15 to Encompass Health's Annual Report on Form 10-K filed on February 19, 2013).+
10.11.1	Encompass Health Corporation 2016 Omnibus Performance Incentive Plan (incorporated by reference to Exhibit 10.1.1 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.2	Form of Non-Qualified Stock Option Agreement (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed on December 12, 2016).+
10.11.3	Form of Restricted Stock Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.3 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.4	Form of Performance Share Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.4 to Quarterly Report on Form 10-Q filed on July 29, 2016).+

10.11.5	Form of Restricted Stock Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.12	Second Amended and Restated Collateral and Guarantee Agreement, dated November 25, 2019, by and among Encompass Health Corporation, certain of its subsidiaries, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.2 to Encompass Health's Current Report on Form 8-K filed on December 2, 2019).
10.13	Fifth Amended and Restated Credit Agreement, dated November 25, 2019, by and among Encompass Health Corporation, certain of its subsidiaries, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Bank USA, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to Encompass Health's Current Report on Form 8-K filed on December 2, 2019).
10.14	Homecare Homebase, L.L.C. Restated Client Service and License Agreement, dated December 31, 2014, by and between Homecare Homebase, L.L.C. and EHHI Holdings, Inc. (incorporated by reference to Exhibit 10.19 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).*
10.15	Second Amended and Restated Senior Management Agreement, dated as of October 7, 2019, by and among EHHI Holdings, Inc., April Anthony, and Encompass Health Corporation.+
10.16	Stockholders' Agreement relating to Encompass Health Home Health Holdings, Inc., dated as of December 31, 2014, by and among Encompass Health Corporation, Encompass Health Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein (incorporated by reference to Exhibit 10.15 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
21.1	Subsidiaries of Encompass Health Corporation.
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.
24.1	Power of Attorney (included as part of signature page).
31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	Sections of the Encompass Health Corporation Annual Report on Form 10-K for the year ended December 31, 2019, formatted in XBRL (eXtensible Business Reporting Language), submitted in the following files:
	101.INS XBRL Instance Document
	101.SCH XBRL Taxonomy Extension Schema Document
	101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
	101.DEF XBRL Taxonomy Extension Definition Linkbase Document
	101.LAB XBRL Taxonomy Extension Label Linkbase Document
	101.PRE XBRL Taxonomy Extension Presentation Linkbase Document
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)

+ Management contract or compensatory plan or arrangement.

* Certain portions of this exhibit have been omitted pursuant to a request for confidential treatment. The nonpublic information has been filed separately with the Securities and Exchange Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

Exhibit 4.2

DESCRIPTION OF THE REGISTRANT'S SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

Encompass Health Corporation (the "Company," "we," "our" and "us") has one class of securities registered under Section 12 of the Securities Exchange Act of 1934, as amended: our common stock, par value $0.01 per share.

General

The following description of our capital stock is intended as a summary only. This description is based on our amended and restated certificate of incorporation (the "Certificate of Incorporation"), our amended and restated bylaws (the "Bylaws"), and applicable provisions of the Delaware General Corporation Law (the "DGCL"). This summary is not complete and is qualified in its entirety by reference to the Certificate of Incorporation and the Bylaws, each of which is filed as an exhibit to this Annual Report on Form 10-K. We encourage you to read the Certificate of Incorporation, the Bylaws and the applicable provisions of the DGCL for additional information.

Authorized Capital Stock

Our authorized capital stock consists of 200,000,000 shares of common stock, par value $0.01 per share (the "common stock"), and 1,500,000 shares of preferred stock, par value $0.10 per share. Our board of directors established a series of preferred stock, designated as 6.50% Series A Convertible Perpetual Preferred Stock, par value $0.10 per share (the "Series A Preferred Stock"), consisting of up to 400,000 shares, pursuant to a Certificate of Designations dated March 7, 2006; however, no shares of Series A Preferred Stock are outstanding.

Common Stock

The common stock of the Company has the following rights, preferences and privileges:

Voting rights. Each outstanding share of common stock entitles its holder to one vote on all matters submitted to a vote of the Company's stockholders, including the election of directors. There are no cumulative voting rights.

The Bylaws provide that directors of the Company shall be elected by a vote of the majority of the votes cast at a meeting of stockholders for the election of directors, except that directors are to be elected by a plurality of the votes cast in any contested election (as described in the Bylaws). The DGCL provides generally that the Certificate of Incorporation may be amended by the affirmative vote of a majority of the shares entitled to vote thereon; however, pursuant to the terms of the Certificate of Incorporation and as permitted by the DGCL, certain votes as described below require a supermajority. The Bylaws provide that they may be amended, altered or repealed at a meeting of stockholders by the vote of the holders of not less than a majority of the outstanding shares of stock entitled to vote thereat. Except as otherwise provided in the DGCL or other applicable law or regulation or stock exchange listing standard, all other matters to be voted on by stockholders must be approved by a majority of the shares present in person or represented by proxy at a meeting of stockholders and entitled to vote on the subject matter.

Dividends. Holders of common stock are entitled to receive dividends when, as and if declared by the Company's board of directors out of assets legally available for the payment of dividends.

Liquidation. In the event of a liquidation, dissolution or winding up of the Company's affairs, whether voluntary or involuntary, after payment of our liabilities and obligations to creditors, the Company's remaining assets will be distributed ratably among the holders of the common stock on a per share basis. If there is any preferred stock outstanding at such time, holders of the preferred stock may be entitled to distribution and/or liquidation preferences. In either case, the Company will need to pay the applicable distribution to the holders of any preferred stock before distributions are paid to the holders of common stock.

Rights and preferences. The common stock has no preemptive, redemption, conversion or subscription rights. The rights, powers, preferences and privileges of holders of the common stock are subject to, and may be adversely affected by, the rights of the holders of shares of any series of preferred stock that the Company may designate and issue in the future.

Provisions of the Certificate of Incorporation and the DGCL That May Have Anti-Takeover Effects

Our Certificate of Incorporation and the DGCL contain certain provisions that may have anti-takeover effects and may delay, defer or prevent a change in control of the Company.

Authorized but Unissued Common Stock. The authorized but unissued shares of our common stock are available for future issuance without stockholder approval, subject to any limitations imposed by the rules of any stock exchange on which our securities may be listed. These additional shares may be used for a variety of corporate finance transactions, acquisitions and employee benefit plans. The existence of authorized but unissued and unreserved shares of our common stock could make more difficult or discourage an attempt to obtain control of us by means of a proxy contest, tender offer, merger or otherwise.

Delaware Business Combination Statute. We are subject to Section 203 of the DGCL. Subject to certain exceptions, Section 203 prevents a publicly held Delaware corporation from engaging in a "business combination" with any "interested stockholder" for three years following the date that the person became an interested stockholder, unless the interested stockholder attained such status with the approval of our board of directors or unless the business combination is approved in a prescribed manner. A "business combination" includes, among other things, a merger or consolidation involving us and the "interested stockholder" and the sale of more than 10% of our assets. In general, an "interested stockholder" is any entity or person beneficially owning 15% or more of our outstanding voting stock and any entity or person affiliated with or controlling or controlled by such entity or person.

Approval of Certain Business Combinations; Supermajority Voting. Pursuant to the Certificate of Incorporation, the affirmative vote of the holders of 66-2/3% of all shares of the Company entitled to vote in elections of directors, considered as one class, is required for the adoption or authorization of a business combination (as hereinafter defined) with any other entity if, as of the record date for the determination of stockholders entitled to notice thereof and to vote thereon, the other entity is the beneficial owner, directly or indirectly, of more than 20% of the outstanding shares of the Company entitled to vote in elections of directors, considered as one class. The term "business combination" includes (A) the sale, exchange, lease, transfer or other disposition by the Company of all, or substantially all, of its assets or business to any other entity, (B) the consolidation of the Company with or its merger into any other entity, (C) the merger into the Company of any other entity, or (D) a combination or majority share acquisition in which the Company is the acquiring corporation and its voting shares are issued or transferred to any other entity or to stockholders of any other entity, and the term "business combination" shall also include any agreement, contract or other arrangement with another entity providing for any of the transactions described in (A) through (D) above. The supermajority voting provision for business combinations has an exception based on the value of the consideration to be paid by the other entity and the other entity's conduct after acquiring its 20% holdings, as described in the Certificate of Incorporation.

Preferred Stock. Under the terms of the Certificate of Incorporation, our board of directors is authorized to direct us to issue shares of preferred stock in one or more series without stockholder approval. Our board of directors has the discretion to determine the rights, preferences, privileges and restrictions, including voting powers, dividend rights, conversion rights, and liquidation preferences, of each series of preferred stock. Our board of directors also may from time to time increase the number of shares of any series already created by providing that any unissued shares of preferred stock shall constitute part of such series. The issuance of preferred stock, while providing flexibility in connection with possible acquisitions, future financings and other corporate purposes, could have the effect of making it more difficult for a third party to acquire, or could discourage a third party from seeking to acquire, a majority of our outstanding voting stock. No shares of preferred stock are outstanding.

Transfer Agent and Registrar

Computershare Trust Company, N.A., is the transfer agent and registrar for our common stock.

Exchange Listing

Our common stock is traded on The New York Stock Exchange under the symbol “EHC.”

Exhibit 10.8

ENCOMPASS HEALTH CORPORATION

NONQUALIFIED 401(K) PLAN

As Amended and Restated January 2, 2018

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ENCOMPASS HEALTH CORPORATION NON-QUALIFIED 401(K) PLAN

PREAMBLE

Encompass Health Corporation (the "**Company**") has adopted the Encompass Health Corporation Nonqualified 401(k) Plan (the "**Plan**") to benefit certain senior executives of the Company. The Plan is intended to operate both in connection with and independent from the Company's qualified section 401(k) plan and will be administered accordingly. However, although participation in the two plans may be coordinated, an election to participate or not participate in the qualified 401(k) plan will satisfy the requirements of section 409A of the Code and the regulations issued thereunder since such a decision will not result in the increase or decrease in elective deferrals to this Plan in excess of the limitations set forth by section 402(g) of the Code and will not create a corresponding increase or reduction in employer matching contributions in excess of such limitation or in excess of the amount of employer matching contributions the participant would have received under the qualified 401(k) plan determined without regard to the limits on such contributions under the Internal Revenue Code.

HISTORY

The Benefits Committee amended and restated the Plan, generally effective December 31, 2008, except as otherwise provided therein, to (i) make certain clarifying amendments to reflect current administrative practices with respect to the benefit election and distribution provisions of the Plan and any changes required to ensure compliance with section 409A of the Code and (ii) expand the Plan's eligibility provisions to include Chief Executive Officers and Chief Financial Officers of each of the Company's hospitals, provided that such officers earn more than the compensation limit set forth in section 414(q) of the Code, effective January 1, 2009. The provisions of this amended and restated Plan were effective December 31, 2008, except as specifically provided therein, in order to comply with applicable law or prior design decisions adopted by the Company.

The Benefits Committee subsequently amended and restated the Plan generally effective March 1, 2013, to (i) amend the Plan to add a definition of “Spouse” to conform to the recent Supreme Court decision on the constitutionality of the Defense of Marriage Act and (ii) make additional clarifying amendments to reflect current plan provisions set forth in the terms of the Plan’s election forms and administrative practices with respect to the benefit election and distribution provisions of the Plan.

The Benefits Committee again amended and restated the Plan, generally effective June 1, 2014 to expand the subsequent deferral election provisions to include Termination of Employment distributions.

By this instrument, the Benefits Committee desires to amend and restate the Plan, generally effective January 1, 2018, to reflect that the name of the Company has changed from HealthSouth Corporation to Encompass Health Corporation and update references to the Company and the name of the Plan accordingly and make certain administrative clarifications.

The Company may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefits under this Plan.

End of Preamble

PURPOSE AND NATURE OF PLAN

1.1 Purpose of Plan

The objective and purpose of this Plan is to attract and retain competent officers and key executives by providing flexible compensation opportunities to officers and key executives of the Company and its affiliates to offer them an opportunity to build an estate or supplement income for use after retirement. In addition to this Plan, the Company sponsors certain broad-based employee benefit plans covering its employees.

1.2 Nature of Plan

Through this Plan, the Company intends to permit the deferral of compensation and to provide additional benefits to a select group of management or highly compensated employees. Accordingly, it is intended that this Plan will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Internal Revenue Code of 1986, as amended (the "**Code**"), nor will it constitute a "funded plan", for purposes of such requirements. It is also intended that this Plan will be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), the funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans which are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 Definitions

When a word or phrase will appear in this Plan with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) "**Account**" means one or more of the bookkeeping accounts maintained by the Company or its agent on behalf of a Participant, as described in more detail in Section 4.5.

(b) "**Affiliate**" means a corporation that is (i) a member of a controlled group of corporations (as defined in section 414(b) of the Code) which includes the Company, (ii) any trade or business (whether or not incorporated) which is in common control (as defined in section 414(c) of the Code) with the Company, or (iii) any entity that

is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company. In addition, the term Affiliate will also include any related entity (regardless of whether in the Company's controlled group of corporations, as defined above) that the Company has designated for participation in the Plan.

"**Beneficiary**" means the person designated by the Participant to receive a distribution of his benefits under the Plan upon the death of the Participant. In the event that a Participant fails to designate a Beneficiary, or if the Participant's Beneficiary does not survive the Participant, the Participant's Beneficiary will be his surviving Spouse, if any, or if the Participant does not have a surviving Spouse, his estate. The term "Beneficiary" also will mean a Participant's Spouse or former Spouse who is entitled to all or a portion of a Participant's benefit pursuant to Section 6.2. Solely for purposes of identifying a Participant's beneficiary, the term "Spouse" as used in this definition will include a same or opposite sex domestic partner of the Participant, provided the domestic partner satisfies the requirements for domestic partner benefits under the Employer's Domestic Partner Guidelines set forth in Appendix B. Appendix B may be revised from time-to-time by the Daily Administrator without the need for a formal amendment to the Plan.

(c) "**Benefits Committee**" means the administrative committee responsible for the administration of the Plan in accordance with Article VIII.

(d) "**Board**" means the Board of Directors of the Company.

(e) "**Claimant**" means a Participant or Beneficiary who files a claim for benefits pursuant to Section 8.5.

(f) "**Code**" means the Internal Revenue Code of 1986, as amended from time to time, and any regulations or rulings issued thereunder.

(g) "**Company**" means Encompass Health Corporation or any successor thereto.

(h) "**Compensation**" means the total of all amounts paid by the Employer to or for the benefit of an Employee for services rendered or labor performed for the Employer while a Participant and while an Employee, which are required to be reported on the Employee's Federal Wage and Tax Statement, Form W-2 or its successor; provided, however, that Compensation will not include: (i) mileage reimbursements; (ii) severance pay; (iii) termination vacation payouts; (iv) termination paid time-off payouts; (v) relocation reimbursements; (vi) income from the exercise or award of any stock options or stock grants; (vii) imputed income from life insurance; (viii) car allowances; (ix) club dues; (x) housing allowances; (xi) any stock purchase plan match monies, (xii) dividends on Company stock paid in connection with the exercise or award of stock options or stock grants or (xiii) Scheduled In-Service Withdrawals. Further, Compensation excludes:

(i) elective contributions made on the Employee's behalf by the Employer that are not includible in income under sections 125, 132(f)(4), 402(e)(3), 402(h), or 403(b) of the Code;

(ii) compensation deferred under an eligible deferred compensation plan within the meaning of section 457(b) of the Code; and

(iii) employee contributions described in section 414(h) of the Code that are picked up by the employing unit and treated as employer contributions.

Compensation will include all of the Employee's Form W-2 earnings defined in the preceding sentences accrued and paid by the last day of the Plan Year; provided, that bonus compensation will include all amounts earned during the Plan Year even if paid during the next Plan Year.

(i) "**Compensation Committee**" means the Compensation Committee of the Board of Directors of the Company.

(j) "**Compensation Deferral**" means the deferral described in Section 4.1 made by a Participant who has elected to defer all or a portion of his Compensation under the Plan including a deferral of Compensation classified as a bonus that is subject to a separate and distinct deferral election.

(k) "**Daily Administrator**" means the individuals, entity or department designated by the Compensation Committee or the Benefits Committee to handle the day to day administration of the Plan and to make initial claim determinations pursuant to Section 8.5. In the event the Compensation Committee or the Benefits Committee fails to appoint a Daily Administrator, the Benefits Committee will be the Daily Administrator.

(l) "**Disability**" means that due to a physical or mental condition, the Participant has been determined to be totally and permanently disabled by the Social Security Administration and is eligible to receive Social Security disability benefits.

(m) "**Effective Date**" means January 2, 2018, except as expressly provided otherwise herein.

(n) "**Election Process**" means the written forms or on-line processes provided by the Daily Administrator, or delegate thereof, pursuant to which the Participant consents to participation in the Plan, elects to defer Compensation as a Compensation Deferral and specifies the time and form in which such Compensation Deferrals, Employer Matching Contributions attributable to such Compensation Deferrals and any Employer Discretionary Contributions will be paid as provided in Article V. Such Participant consent and elections may be done either in writing or on-line through an electronic signature as determine by the Daily Administrator.

(o) "**Eligible Employee**" means each Employee who holds the position of an Executive Officer, Senior Vice President, Vice President or Director or is the Chief Executive Officer or Chief Financial Officer of one of the Company's hospitals; provided, however, that each such individual must earn more than the compensation limit set forth in section 414(q) of the Code (*i.e.*, one hundred twenty thousand dollars ($120,000) for 2018 (as adjusted under section 414(q)(1) of the Code)).

(p) "**Employee**" means any person employed by the Employer in the capacity of a common law employee and not in the capacity of an Leased Employee or independent contractor, even if such Leased Employee or independent contractor is subsequently determined by the Employer, the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of the Employer. Each such Employee who is currently employed by the Employer or an Affiliate will be referred to herein as an "Active Employee" and each such Employee who is no longer employed by the Employer or an Affiliate but has an Account balance under the Plan will be referred to herein as an "Inactive Employee."

(q) "**Employer**" means the Company and any other Affiliate which adopts the Plan. An Affiliate may evidence its adoption of the Plan either by a formal action of its governing body or by commencing deferrals and taking other administrative actions with respect to this Plan on behalf of its employees.

(r) "**Employer Discretionary Contribution**" means discretionary profit sharing contributions made to the Plan on behalf of a Participant.

(s) "**Employer Matching Contribution**" means the matching contributions made to the Plan on behalf of a Participant.

(t) "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulations or rulings issued thereunder.

(u) "**Hour of Service**" means each hour for which an Employee is directly or indirectly paid, or is entitled to payment, by the Employer (including any predecessor business of an Employer conducted as a corporation, partnership or proprietorship) or Affiliate for the performance of duties or reasons other than the performance of duties, including but not limited to vacation, holidays, sickness, disability, paid layoff, jury duty, military duty, leave of absence and similar paid periods of nonworking time. An Hour of Service also includes each hour, not credited above, for which back pay, irrespective of mitigation of damages, has been either awarded or agreed to by the Employer or an Affiliate. For all purposes of the Plan, Hours of Service will be credited for any individual considered to be a Leased Employee and for any individual considered an Employee under section 414(o) of the Code and the final regulations thereunder.

(i) **Acquired Entities**. Service or employment completed by an Employee of an acquired facility or an acquired employee group before such facility became an Affiliate or before the employees of such employee group become Employees will not be credited except to the extent provided in the acquisition agreement, a resolution by the Board of Directors or other governing body of the Employer. Any such prior vesting service credit will be described in Appendix A attached hereto. Appendix A may be revised from time-to-time by the Daily Administrator without the need for a formal amendment to the Plan.

(ii) **Licensed Professionals**. Service or employment completed by licensed professionals on behalf of professional corporations for which the Company provides payroll services who become Employees will be taken into account for purposes of determining Hours of Service under this Plan.

(v) "**Investment Options**" means the investment options used under the Plan to measure the investment returns attributable to each Participant's Account. As of the Effective Date, any investment fund offered through the Charles Schwab Trust Company may be selected as an Investment Option under the Plan. The Benefits Committee may revise the Investment Options provided under the Plan from time to time without the need for a formal Plan amendment, in which case the new Investment Options will be communicated to Participants.

(w) "**Key Employee**" means a key employee within the meaning of section 416(i) of the Code. Specifically, an individual who is:

(i) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code) (*i.e.*, one hundred seventy-five thousand dollars ($175,000) for 2018);

(ii) a five percent (5%) owner of the Company or an Affiliate as defined in section 416 of the Code; or

(iii) a one percent (1%) owner of the Company or an Affiliate as defined in section 416 of the Code having compensation of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or one percent owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (*i.e.*, W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections), section 132(f) of the Code (regarding qualified transportation fringe benefits), or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2(e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.*, the identification date). Employees who are Key Employees during such twelve (12) month period will be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.*, since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a five percent owner or a one percent owner, the Company and each Affiliate will be treated as a separate employer (*i.e.*, the controlled group rules of sections 414(b),

(c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(x)(i), compensation from the Company and all Affiliates will be taken into account (*i.e.*, the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(x)(1), no more than fifty (50) employees of the Company or its Affiliates (*i.e.*, the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former employees are officers will be determined based on who had the largest annual compensation from the Company and Affiliates for the Plan Year.

(x) "**Leased Employee**" means each person who is not an employee of the Employer or an Affiliate but who performs services for the Employer or an Affiliate pursuant to an agreement (oral or written) between the Employer or an Affiliate and any leasing organization, provided that such person has performed such services for the Employer or an Affiliate or for related persons (within the meaning of section 144(a)(3) of the Code) on a substantially full-time basis for a period of at least one (1) year and such services are performed under primary direction or control by the Employer or an Affiliate. In the case of any person who is a Leased Employee before or after a Period of Service as an Employee, the entire period during which he has performed services as a Leased Employee will be counted as Service as an Employee for all purposes of the Plan, except that he will not, by reason of that status, become a Member of the Plan.

(y) "**Normal Retirement Age**" means the date the Participant reaches age sixty-five (65).

(z) "**Participant**" means each Eligible Employee who has elected to participate in the Plan by timely completing the Election Process and whose participation in this Plan has not terminated. Each such Participant who is currently employed by the Employer will be referred to herein as an "Active Participant" and each such Employee who is no longer employed by the Employer or is employed by an Affiliate who has not adopted the Plan but has an Account balance under the Plan will be referred to herein as an "Inactive Participant."

(aa) "**Plan**" means the Encompass Health Corporation Nonqualified 401(k) Plan, as described in this document, and as it may hereafter be amended.

(bb) "**Plan Year**" means the fiscal year of this Plan, which will commence on January 1 each year and end on December 31 of such year, except that the initial Plan Year will commence on March 1 and end on December 31.

(cc) "**Rabbi Trust**" means the grantor trust established by the Company to assist with the payment of benefits under the Plan. The Rabbi Trust will be unfunded within the meaning of ERISA and its assets will be subject to the claims of the Employer's and Affiliate's general creditors. Such Rabbi Trust and its assets will conform to the terms of the model trust, as described in Revenue Procedure 92- 64.

(dd) "**Scheduled In-Service Withdrawal**" means a distribution elected by the Participant pursuant to Section 5.1 for an in-service withdrawal of amounts of Compensation Deferrals, Employer Matching Contributions attributable to such Compensation Deferrals and any Employer Discretionary Contributions made in a given Plan Year, and earnings or losses attributable thereto, as set forth in the Election Process for such Plan Year.

(ee) "**Scheduled In-Service Withdrawal Date**" means the distribution date elected by the Participant for a Scheduled In-Service Withdrawal.

(ff) "**Spouse**" means the legal spouse (including a same sex spouse) of an Eligible Employee, except that such term will not include a common law spouse unless all documentation of the common law marriage required by the Plan Administrator has been received by the Plan Administrator.

(gg) "**Termination of Employment**" means the date that such Employee ceases performing services for the Employer and its Affiliates in the capacity of an Employee. For this purpose an Employee who is on a leave of absence that exceeds six (6) months and who does not have statutory or contractual reemployment rights with respect to such leave, will be deemed to have incurred a Termination of Employment on the first day of the seventh (7th) month of such leave, An Employee who transfers employment from an Employer to an Affiliate, regardless of whether such Affiliate has adopted the Plan as a participating employer, will not incur a Termination of Employment.

(hh) "**Trustee**" means the individual or entity appointed to serve as trustee of any trust established as a possible source of funds for the payment of benefits under the Plan as provided in Section 7.1.

(ii) "**Unforeseeable Emergency**" means a severe financial hardship to the Participant resulting from (i) an illness or accident of the Participant, his Spouse, his beneficiary, or his dependent (as defined under section 152(a) of the Code), (ii) a loss of the Participant's property due to casualty, or (iii) any other similar extraordinary and unforeseeable loss arising from events beyond the control of the Participant, as determined by the Daily Administrator in its sole and absolute discretion in accordance with the requirements of section 409A of the Code.

A distribution on account of Unforeseeable Emergency may only be made to the extent that the Participant's need cannot be relieved through reimbursement or compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent that liquidation of such assets would not cause a severe financial hardship or by cessation of Compensation Deferrals under the Plan. The amount of the distribution cannot exceed the amount necessary to meet the need (plus any taxes resulting from the distribution).

(jj) "**Year of Vesting Service**" means a Plan year in which an Employee is credited with no less than one thousand (1,000) Hours of Service.

2.2 Construction

If any provision of this Plan is determined to be for any reason invalid or unenforceable, the remaining provisions of this Plan will continue in full force and effect. All of the provisions of this Plan will be construed and enforced in accordance with the laws of the State of Alabama and will be administered according to the laws of such state, except as otherwise required by ERISA, the Code or other applicable federal law. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of the Plan. The masculine gender, where appearing in this Plan, will include the feminine gender, the singular may include the plural; and vice versa, unless the context clearly indicates to the contrary.

2.3 409A Compliance

The provisions of the Plan will be construed and administered in a manner that enables the Plan to comply with the provisions of section 409A of the Code.

End of Article II

ARTICLE III
PARTICIPATION AND VESTING

3.1 Eligibility and Participation

An Employee who is a Participant as of January 2, 2018, will continue as an Active Participant as of such date if such Eligible Employee has timely completed the required Election Process pursuant to Section 4.1. An Employee who becomes an Eligible Employee during a Plan Year, or an Employee hired during a Plan Year who is an Eligible Employee as of his hire date, will become a Participant as of the January 1st of the Plan Year following his initial eligibility to participate in the Plan if such Eligible Employee has timely completed the required Election Process prior to the beginning of such Plan Year. Prior to the beginning of each subsequent Plan Year, each Eligible Employee may elect to defer portions of his Compensation by completing the required Election Process prior to the beginning of the Plan Year.

3.2 Continued Eligibility and Participation

Any Eligible Employee who does not elect to make Compensation Deferrals when he is first eligible, may elect to do so in a subsequent Plan Year by completing the required Election Process prior to the beginning of the Plan Year. Such Eligible Employee will become a Participant as of January 1st of the Plan Year for which he first elects to make Compensation Deferrals. Eligibility to become a Participant for any Plan Year will not entitle an Eligible Person to continue as an Active Participant for any subsequent Plan Year.

ARTICLE IV
CONTRIBUTIONS AND ACCOUNTING

4.1 Deferral Elections

An Eligible Employee may become a Participant by electing to defer Compensation pursuant to the required Election Process. Such Election Process will be completed prior to the first day of the Plan Year for which the election is effective. A Participant's deferral election will only be effective with respect to a single Plan Year and will be irrevocable for the duration of such Plan Year, except as provided in Article V regarding Unforeseeable Emergency distributions. Deferral elections for each subsequent Plan Year of participation will be made pursuant to a new election for such Plan Year.

An Eligible Employee who is an Active Employee may elect to have a sum equal to at least one percent (1%) but not more than one hundred percent (100%) of his Compensation which otherwise would have been paid to him by the Employer deferred under the Plan as a Compensation Deferral. The Daily Administrator may allow such Employee to make a separate and distinct deferral election with regard to any amounts of Compensation classified by the Employer as a bonus if such election is completed prior to the first day of the Plan Year during which the services are performed that give rise to the bonus, regardless of when the bonus would otherwise be paid but for such deferral election. In addition, a bonus election once made remains in effect even if the Participant incurs a Termination of Employment before the bonus is paid. An Eligible Employee's deferral election (including his separate and distinct deferral election with respect to his bonus, if any) must specify, in the format adopted by the Company as part of its Election Process, the time and manner in which his Compensation Deferral for each Plan Year will be paid, in accordance with the benefit distribution options set forth in Article V. An Eligible Employee may make a separate and distinct distribution election with respect to each Plan Year in which he elects to make a Compensation Deferral to the Plan. The Eligible Employee may not modify his election as to the manner in which a Compensation Deferral will be paid.

Compensation Deferrals will be made pursuant to administrative procedures established by the Plan Administrator. Such procedures will provide that Compensation Deferrals will be subject to a "withholding hierarchy" for purposes of determining the amount of such contributions that may be contributed on behalf of a Participant. The Plan Administrator (or its delegates) will determine the order of withholdings taken from a Participant's Compensation (*e.g.*, for federal, state and local taxes, social security, wage garnishments, welfare plan contributions, 401(k) deferrals, and similar withholdings) and Compensation Deferrals will be subject to such withholding hierarchy. As a result, Compensation Deferrals may be effectively limited to Compensation available after the application of such withholding hierarchy (*i.e.*, the Participant may not be able to defer one hundred percent (100% of his Compensation).

4.2 Company Contributions

(a) **Employer Matching Contribution**. Each Plan Year, the Employer will make an Employer Matching Contribution to the Plan for each Participant who makes Compensation Deferrals pursuant to Section 4.1 above. Such Employer Matching Contribution will equal fifty percent (50%) of the first six percent (6%) of the

Participant's Compensation contributed to the Plan as a Compensation Deferral offset by any Employer Matching Contributions made to the Encompass Health Corporation Retirement Investment Plan (the "**Retirement Plan**") on behalf of such Participant (*i.e.*, the total of Employer Matching Contributions that a Participant may receive between this Plan and the Retirement Plan will equal fifty percent (50%) of the first six percent (6%) of the Participant's Compensation contributed to both this Plan as Compensation Deferrals and the Retirement Plan as Salary Deferral Contributions (as defined in the Retirement Plan).

(b) **Employer Discretionary Contribution**. The Employer may elect to make an Employer Discretionary Contribution to the Plan at such time and in such amount as may be determined by the Compensation Committee.

4.3 Vesting

(a) **Participant Deferrals**. A Participant will be one hundred percent (100%) vested in the Compensation Deferrals credited to his Account, including the earnings and losses thereon.

(b) **Employer Matching Contributions**. A Participant will become vested in Employer Matching Contributions made on his behalf to the Plan in accordance with the following schedule:

Years of Vesting Service	Percentage Vested
2 or fewer years	0%
3 or more years	100%

Notwithstanding the foregoing, a Participant will become fully vested in his Employer Matching Contributions when he reaches his Normal Retirement Age, dies or incurs a Disability (in each such case while an Employee), without regard to his Years of Vesting Service. Any portion of a Participant's Account that has not become vested, as herein provided, will be forfeited.

(c) **Employer Discretionary Contributions**. Each Employer Discretionary Contribution may be subject to a vesting schedule, as determined by the Compensation Committee, in its sole discretion, at the time such Employer Discretionary Compensation is elected to be made to the Plan.

Notwithstanding the foregoing, as provided in Section 7.2, each Participant will be only a general creditor of the Company and/or Employer with respect to the payment of any benefit under this Plan.

4.4 Plan Benefits

The benefits to which a Participant and, if applicable, his Beneficiary are entitled under the Plan will consist of the Compensation Deferrals, Employer Matching Contributions and any

Employer Discretionary Contributions credited to such Participant's Account, plus earnings thereon and less losses allocable thereto, if any, attributable to the investment of such amounts pursuant to Section 4.5(c) hereof. Distribution of benefits attributable to a Participant's Account(s) will be made pursuant to the provisions of Article V.

4.5 Accounting for Deferred Compensation.

(a) **Establishment of Accounts**. The Daily Administrator will establish and maintain an individual Account under the name of each Participant under the Plan. Further, in the sole discretion of the Daily Administrator, additional Accounts may be established for each Participant to facilitate record keeping convenience and accuracy. Each such Account will be credited and adjusted as provided in this Plan. Such Account will be maintained until all amounts credited to such Account have been distributed in accordance with the terms and provisions of this Plan. The establishment and maintenance of a separate Account or Accounts for each Participant will not be construed as giving any person any interest in assets of the Company or an Affiliate, or a right to payment other than as provided hereunder. Amounts credited to such Accounts will be held with the general assets of the Employer.

(b) **Crediting Accounts**. All amounts deferred under the Plan as Compensation Deferrals will be credited to the Participant's Account at the end of the pay period during which such Compensation would have otherwise been paid to the Participant. The amount of Employer Matching Contributions to be contributed to the Plan on the Participant's behalf will be computed on the last day of each month and will be contributed as soon as administratively practicable after such computation. Any Employer Discretionary Contributions made to the Plan will be credited to the Participant's Account at the time such contributions are made.

(c) **Adjustment of Accounts**. Each Account will be adjusted on each business day that the New York Stock Exchange is open to reflect the Compensation Deferrals, Employer Matching Contributions and any Employer Discretionary Contributions made to the Plan, any earnings credited on such Compensation Deferrals, Employer Matching Contributions and Employer Discretionary Contributions pursuant to this Section 4.5(c), and any payment of such Compensation Deferrals, Employer Matching Contributions and Employer Discretionary Contributions under the Plan.

(i) **Participant Investment Recommendations**. For purposes of measuring the investment returns of the Participant's Account(s), the Participant may select the Investment Options in which all or part of his Account(s) will be deemed to be invested. The Participant will make his initial investment designation in the Enrollment Process and such an investment designation will remain effective until it is subsequently changed by the Participant pursuant to this Section 4.5(c). The Participant may change his investment designation each Plan Year at the time and manner specified by the Daily Administrator. The Participant may change the investment allocation of his existing Account(s) at the time and manner specified by the Daily Administrator. During the Plan Year, a Participant may elect to make transfers

of his Account(s) among the Investment Options by written, telephonic or electronic means at the time and manner specified by the Daily Administrator.

(ii) **Benefits Committee Investment Designation**. Notwithstanding the foregoing, the Benefits Committee in its sole and absolute discretion may direct the Daily Administrator to disregard the Participant's investment designation and determine that all interests in the Account(s) will be deemed to be invested in one particular or a mixture of the Investment Options. Likewise, if a Participant fails to make any investment recommendations, the Daily Administrator will invest the Participant's Account(s) in any default investment fund established under the Plan by the Benefits Committee or in such other manner as the Benefits Committee deems appropriate in its sole and absolute discretion.

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End of Article IV

ARTICLE V
DISTRIBUTION OF BENEFITS

5.1 General Rule Regarding Payment of Account

Subject to Section 5.6, Compensation Deferrals made in accordance with Section 4.1 and Employer Matching Contributions and Employer Discretionary Contributions made in accordance with Section 4.2 will be distributed to a Participant (i) upon the Participant's Termination of Employment or (ii) in a future year in which the Participant is still employed by the Employer and that is at least three (3) calendar years after the end of the Plan Year in which the Compensation would have otherwise been paid, but within forty (40) calendar years of the first day of the Plan Year in which such Compensation would have otherwise been paid (*i.e.*, as a Scheduled In-Service Withdrawal), subject in each case to the provisions of Section 5.2. Amounts paid by reason of a Termination of Employment will be subject to the six (6) month delay applicable to Key Employees under Section 5.6.

Prior to the Plan Year commencing in 2014, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment before his Scheduled In-Service Withdrawal date, his Scheduled In-Service Withdrawal election will be cancelled and of no effect and such amounts will be paid according to the Participant’s distribution election with respect to his Employer Matching Contributions and Employer Discretionary Contributions, if any, for the Plan Year in which his related Compensation Deferrals were made (*i.e.*, in accordance with the Participant's Termination of Employment distribution election with respect to such Employer Matching Contributions or Employer Discretionary Contributions), subject to the six (6) month delay applicable to Key Employees under Section 5.6 and the subsequent deferral election rules of Section 5.2. If a Participant does not have a Termination of Employment distribution election on file with respect to the Plan Year in which Employer Matching Contributions and any Employer Discretionary Contributions were made, such amounts will be paid in a single lump sum distribution upon

his Termination of Employment (subject to the six (6) month delay applicable to Key Employees under Section 5.6).

Commencing for the 2014 Plan Year and thereafter, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment before his Scheduled In-Service Withdrawal date, his Scheduled In-Service Withdrawal election will be cancelled and of no effect and such amounts will be paid in a single lump sum distribution upon his Termination of Employment (subject to the six (6) month delay applicable to Key Employees under Section 5.6) and the subsequent deferral election rules of Section 5.2.

5.2 Subsequent Deferrals

An Active Participant who elects a Scheduled In-Service Withdrawal or Termination of Employment distribution pursuant to Section 5.1 may subsequently elect to delay such distribution, provided that:

(a) such distribution is deferred for a period of at least five (5) years from the date such amounts would otherwise be paid,

(b) in the case of a Scheduled In-Service Withdrawal, such distribution election does not defer such distribution more than forty (40) calendar years from the first day of the Plan Year in which such Compensation would have otherwise been paid,

(c) in the case of a Termination of Employment Distribution, such election may also modify the form of payment (e.g., a lump sum to installments or visa versa); provided, that the lump sum payment or first installment, as applicable, satisfies the five (5) year deferral requirement of Section 5.2(a); and

(d) the Active Participant makes such subsequent deferral election at least twelve (12) months before the date such amounts would otherwise be paid (*i.e.*, in the case of the first subsequent deferral election for a Scheduled In-Service Withdrawal before the date certain and in the case of the first subsequent deferral election for a Termination of Employment distribution before the date of his Termination of Employment).

An Active Participant may elect to postpone his distribution date up to two (2) times pursuant to this Section 5.2. An Active Participant may not modify the form of his Scheduled In-Service Withdrawal pursuant to an election made under this Section 5.2.

If an Active Participant makes a subsequent deferral election within twelve (12) months from the date such amounts would otherwise be paid (*i.e.*, within twelve (12) months of the date certain on which such distribution would otherwise be made or within twelve (12) months of his Termination of Employment), such subsequent deferral election will be of no effect and the Participant's Compensation Deferrals subject to such election will be paid according to the Participant's initial deferral election.

5.3 Distributions on Death

In the event of a Participant's death prior to the distribution of all amounts credited to his Account, the Participant's Account balance will be paid in a single lump sum to his

Beneficiary within ninety (90) days following the date of the Participant's death. If the Participant had been receiving annual installments from amounts credited to his Account under the Plan, the remainder of such annual installments will continue to be paid to the Participant's Beneficiary. This six (6) month restriction applicable to Key Employees under Section 5.6 will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

5.4 Distributions on Disability

In the event of the Participant's Disability prior to the receipt of his entire Account, he will receive amounts credited to such Account in accordance with the terms of Section 5.1 (*i.e.*, at Termination of Employment or as a Scheduled In-Service Withdrawal). Alternatively, if the Participant elects, he may apply to the Daily Administrator for an Unforeseeable Emergency distribution pursuant to Section 5.5 of the Plan.

5.5 Unforeseeable Emergency

A Participant who is an Active Employee or who has incurred a Disability may submit a written application to the Daily Administrator for an earlier distribution of amounts credited to his Account on account of an Unforeseeable Emergency. The existence of an Unforeseeable Emergency will be determined by the Daily Administrator in its sole and absolute discretion. In the event that the Daily Administrator determines an Unforeseeable Emergency exists, it may permit the Participant to receive a distribution of all or a portion of his Account as necessary to satisfy such Unforeseeable Emergency as provided under the final regulations issued under section 409A. Specifically, the amount distributable on account of an Unforeseeable Emergency must be limited to the amount reasonably necessary to satisfy the emergency need (which may include amounts necessary to pay any Federal, state or local income taxes or penalties reasonably anticipated to result from the distribution). The determination of an Unforeseeable Emergency must take into account any additional compensation that is available by reason of the cessation of the Participant's Compensation Deferrals to the Plan pursuant to this Section 5.5. However, such determination is not required to take into account additional compensation that could be paid to the Participant, but which has not actually been paid, under any other nonqualified deferred compensation plan in which the Participant is a member or pursuant to the provisions of Article V of this Plan. An Unforeseeable Emergency distribution to an Active Employee will result in the suspension of his Compensation Deferrals to the Plan for the remainder of the Plan Year in which the Unforeseeable Emergency distribution occurs.

5.6 Time and Form of Payment

Prior to the Plan Year commencing in 2014, any Scheduled In-Service Withdrawal distribution will be paid in the form of a single lump sum in March of the year specified by the Participant in accordance with Section 5.1. Effective for the 2014 Plan Year and thereafter, such Scheduled In-Service Withdrawal distribution will be paid in the form of a single lump sum in January of the year specified by the Participant in accordance with Section 5.1

Upon Termination of Employment, the Participant's entire Account balance will be distributed in the form of either (i) a single lump sum or (ii) in a series of between two (2) and fifteen

(15) equal annual installments with the final payment being a distribution of one hundred percent (100%) of the Account balance, as elected by the Participant in accordance with Section 4.1 and Section 5.1, subject to the subsequent deferral election rules of Section 5.2..

To the extent that a Participant has elected to receive installment distributions upon his Termination of Employment, such installment distributions will only be paid if the value of the Participant's Accounts upon Termination of Employment exceeds Ten Thousand Dollars ($10,000). If such Accounts equal Ten Thousand Dollars ($10,000) or less, such Accounts will be paid in the form of a lump sum payment. Further, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment prior to the Scheduled In-Service Withdrawal Date, the Participant's Scheduled In-Service Withdrawal election will be cancelled and payable in accordance with Section 5.1 of the Plan, subject to the subsequent deferral election rules of section 5.2.

A lump sum payment of amounts credited to a Participant's Account will be made as soon as administratively possible following the date the Participant is entitled to a distribution under this Article V but in no event more than sixty (60) days following the date entitling the Participant to such distribution. The first annual installment payment of amounts credited to a Participant's Account will be made as soon as administratively possible following the date the Participant is entitled to a distribution under this Article V but in no event more than (60) days following the date entitling the Participant to such distribution. Subsequent installment payments of the Participant's Account will be made in March or, effective January 1, 2014, January of each year thereafter.

As provided in Section 4.1, if the Participant does not specify the time and form of payment with respect to his Account under the Plan, such Account balance will be distributed to the Participant upon his Termination of Employment in a single lump sum.

Notwithstanding the foregoing, distributions under this Plan that are payable to a Key Employee on account of a Termination of Employment will be delayed for a period of six (6) months and one (1) day following such Participant's Termination of Employment. This six (6) month restriction will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Payment Due an Incompetent

If a person entitled to any payment under this Plan is, in the sole judgment of the Daily Administrator, under a legal disability, or is otherwise unable to apply such payment to his own interest and advantage, the Daily Administrator, in the exercise of its discretion, may direct the Employer or payor of the benefit to make any such payment in any one (1) or more of the following ways:

(a) Directly to such person;

(b) To his legal guardian or conservator; or

(c) To his Spouse or to any person charged with the duty of his support, to be expended for his benefit and/or that of his dependents.

The decision of the Daily Administrator will in each case be final and binding upon all persons in interest.

6.2 Nonalienation of Benefits

To the extent permitted by law, benefits payable under this Plan will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary except that the Plan will recognize the division of benefits between the Participant and his Spouse in connection with a divorce. However, no benefit awarded to the Spouse pursuant to such divorce will be payable to such Spouse until the time the Participant is entitled to receive a distribution of benefits from the Plan. The benefit payable to the Spouse will be paid in the form of a lump sum cash payment as soon as practicable following the event entitling the Participant to a distribution but in no event more than ninety (90) days after such distribution event.

Any unauthorized attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder will be void. No part of the assets of the Employer will be subject to seizure by legal process resulting from any attempt by creditors of or claimants against any Participant (or beneficiary), or any person claiming under or through the foregoing, to attach his interest under the Plan.

End of Article VI

ARTICLE VII
FUNDING

7.1 Funding

Benefits under the Plan will constitute general unfunded obligations of the Employer in accordance with the terms of the Plan. No amounts in respect of such benefits will be set aside or held in trust, and no recipient of any benefit under this Plan will have any right to have the benefit paid out of any particular assets of the Employer; provided, however, that the Company may establish a Rabbi Trust to assist with the payment of benefits under the Plan. The assets of any such Rabbi Trust will be subject to the claims of the Employer's and the Affiliate's general creditors. Such Rabbi Trust and its assets will conform to the terms of the model trust, as described in Revenue Procedure 92-64.

7.2 Creditor Status

Participants have the status of general unsecured creditors of the Employer and this Plan constitutes the Employer's promise to make benefit payments as described herein. It is the intention of the parties to this Plan and any companion Rabbi Trust that benefits under this Plan be unfunded for tax purposes and for purposes of Title I of ERISA.

End of Article VII

ARTICLE VIII
ADMINISTRATION

8.1 Appointment of Benefits Committee

Responsibility for administration of this Plan will be with the Benefits Committee who will be the named Plan Administrator. The Benefits Committee will be appointed by the Compensation Committee. If the Compensation Committee fails to appoint a Benefits Committee, it will serve as the Benefits Committee. The members of the Benefits Committee will not receive compensation with respect to their services for the Benefits Committee. The members of the Benefits Committee will serve without bond or security for the performance of their duties under the Plan unless the applicable law makes the furnishing of such bond or security mandatory or unless required by the Compensation Committee.

8.2 Committee Powers and Duties

The Benefits Committee will have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. Such powers and duties will include, but not be limited to, the following powers and duties as may be necessary to discharge its responsibilities under the Plan:

(a) to appoint a Daily Administrator to handle the day-to-day administration of the Plan pursuant to Section 8.3, and, if applicable, to appoint the Trustee of the Rabbi Trust;

(b) to construe and interpret the Plan, decide all questions of eligibility, determine the amount, manner and time of payment of any benefits under the Plan and make final determinations regarding all benefit claims;

(c) to prescribe rules for the operation of the Plan;

(d) to receive from the Employer and from Employees such information as will be necessary for the proper administration of the Plan;

(e) to make any necessary filings with the appropriate government agency;

(f) to furnish any Employee or Beneficiary, who requests in writing, statements indicating such Employee's or Beneficiary's total Account balances;

(g) to maintain all records necessary for the administration of the Plan;

(h) to select the Investment Options under the Plan;

(i) to report to the Trustee of the Rabbi Trust all available information regarding the amount of benefits payable to each Employee, the computations with respect to the allocation of assets, and any other information which the Trustee may require;

(j) to delegate to one or more of the members of the Benefits Committee the right to act in its behalf in all matters connected with the administration of the Plan and Rabbi Trust;

(k) to delegate to any individual such of the powers and duties as the Benefits Committee deems appropriate; and

(l) to appoint or employ for the Plan any agents it deems advisable, including, but not limited to, legal counsel.

Except as provided in Section 10.1, the Benefits Committee will have no power to add to, subtract from or modify any of the terms of the Plan, nor to change or add to any benefits provided by the Plan, nor to waive or fail to apply any requirements of eligibility for benefits under the Plan. All rules and decisions of the Benefits Committee will be uniformly and consistently applied to all Employees in similar circumstances.

A majority of the members of the Benefits Committee will constitute a quorum for the transaction of business. No action will be taken except upon a majority vote of the Benefits Committee members. An individual will not vote or decide upon any matter relating solely to himself or vote in any case in which his individual right or claim to any benefit under the Plan is particularly involved.

8.3 Appointment of Daily Administrator

The Compensation Committee or the Benefits Committee will appoint the Daily Administrator who will have the responsibility and duty to administer the Plan on a daily basis in a nondiscretionary manner. The Compensation Committee or the Benefits Committee may remove the Daily Administrator with or without cause at any time. The Daily Administrator may resign upon written notice to the Benefits Committee.

8.4 Daily Administrator Powers and Duties

The Daily Administrator will have the following duties:

(a) to direct the administration of the Plan in accordance with its terms;

(b) to adopt rules of procedure and regulations necessary for the administration of the Plan, provided such rules are not inconsistent with the terms of the Plan;

(c) to determine all questions with regard to rights of Employees, Participants, and Beneficiaries under the Plan including, but not limited to, questions involving

eligibility of an Employee to participate in the Plan and the value of the Participant's vested Account;

(d) to enforce the terms of the Plan and any rules and regulations adopted by the Benefits Committee;

(e) to review and render decisions respecting an initial claim for a benefit under the Plan;

(f) to furnish the Employer with information which the Employer may require for tax or other purposes;

(g) to engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) to prescribe procedures to be followed by distributees in obtaining benefits;

(i) to receive from the Employer and from Employees such information as is necessary for the proper administration of the Plan;

(j) to receive and review reports from the Trustee of the financial condition and receipts of disbursements from the Rabbi Trust;

(k) to establish and maintain, or cause to be maintained, the individual Account(s) described in Section 2.1(a);

(l) to create and maintain such records and forms as are required for the efficient administration of the Plan;

(m) to make all determinations and computations concerning the benefits, credits and debits to which any Participant, or other Beneficiary, is entitled under the Plan;

(n) to give the Trustee specific directions in writing with respect to:

    (i) the making of distribution payments, giving the names of the payees, the amounts to be paid and the time or times when payments will be made; and

    (ii) the making of any other payments which the Trustee is not by the terms of the Trustee Agreement authorized to make without a direction in writing by the Daily Administrator;

(o) to prepare, or cause to be prepared, an annual report for the Employer, as of the last day of each Plan Year, in such form as may be required by the Employer;

(p) to determine and maintain records of the age and amount of Compensation, Hours of Service, and Service of each Employee;

(q) to comply (or transfer responsibility for compliance to the Trustee) with all applicable Federal income tax withholding requirements for benefit distributions; and

(r) to construe the Plan, in its sole and absolute discretion, and make equitable adjustments for any mistakes and errors made in the administration of the Plan.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Daily Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

8.5 Claim Procedures

(a) **Initial Claim**. In the event that an Employee, Eligible Employee, Participant or his Beneficiary claims to be eligible for benefits, or claims any rights under this Plan, such Claimant must complete and submit such claim forms and supporting documentation as will be required by the Daily Administrator, in its sole and absolute discretion. Likewise, any Participant or Beneficiary who feels unfairly treated as a result of the administration of the Plan must file a written claim, setting forth the basis of the claim, with the Daily Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the Claimant may examine this Plan, and any other pertinent documents generally available to Participants that are specifically related to the claim.

A written or electronic notice of the disposition of any such claim will be furnished to the Claimant within ninety (90) days after the claim is filed with the Daily Administrator. Such notice will refer, if appropriate, to pertinent provisions of this Plan, will set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of this Plan) and, where appropriate, will describe any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the Claimant will also be notified of the Plan's claim review procedure, including the Claimant's right to file an action under section 502(a) of ERISA, and the time limits applicable to such procedures following an adverse decision regarding his claim on review as provided below. All benefits provided in this Plan as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review**. Within ninety (90) days after receiving the notice of the Daily Administrator's disposition of the claim, the Claimant may file with the Benefits Committee a written request for review of his claim. In connection with the request for review, the Claimant will be entitled to be represented by counsel and will be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the Claimant does not file a written request for review within ninety (90) days after receiving notice of the Daily Administrator's disposition of the claim, the Claimant will be deemed to have accepted the Daily Administrator's written or electronic disposition, unless the Claimant was physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review**. After receipt by the Benefits Committee of a written application for review of his claim, the Benefits Committee will review the claim taking into

account all comments, documents, records and other information submitted by the Claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The Benefits Committee will notify the Claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on review of the claim will be made by the Benefits Committee within sixty (60) days following receipt of the written application for review. If special circumstances require an extension of the sixty (60) day period, the Benefits Committee will so notify the Claimant and a decision will be rendered within one hundred-twenty (120) days of receipt of the request for review. In any event, if a claim is not determined by the Benefits Committee within one hundred-twenty (120) days of receipt of written submission for review, it will be deemed to be denied.

The decision of the Benefits Committee will be provided to the Claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing or electronic and will include the specific reasons for the decision presented in a manner calculated to be understood by the Claimant and will contain references to all relevant Plan provisions on which the decision was based. Such decision will also advise the Claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and that he may file an action under section 502(a) of ERISA in the case of an adverse decision regarding his claim on review. The decision of the Benefits Committee will be final and conclusive.

8.6 Benefits Committee Procedures

The Benefits Committee may adopt such bylaws as it deems desirable. The Benefits Committee will elect one of its members as chairman and will elect a secretary who may, but need not, be a member of the Benefits Committee.

End of Article VIII

ARTICLE IX
OTHER BENEFIT PLANS OF THE COMPANY

9.1 Other Plans

Nothing contained in this Plan will prevent a Participant prior to his death, or his Spouse or other Beneficiary after his death, from receiving, in addition to any payments provided for under this Plan, any payments provided for under any other plan or benefit program of the Company or an Affiliate, or which would otherwise be payable or distributable to him, his surviving Spouse or Beneficiary under any plan or policy of the Company or an Affiliate or otherwise. Nothing in this Plan will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees. Unless specifically provided otherwise in any plan of the

Company intended to "qualify" under section 401 of the Code, Compensation deferrals made under this Plan will not constitute earnings or compensation for purposes of determining contributions or benefits under such qualified plan.

End of Article IX

ARTICLE X
MISCELLANEOUS

10.1 Amendment

The Compensation Committee may, by resolution, in its absolute discretion, from time to time, amend, any or all of the provisions of the Plan. In addition, the Benefits Committee may amend the Plan to comply with changes in the law or to implement administrative or design changes that will not materially increase the cost of the Plan to the Company. No such amendment may adversely impact the amount of benefits a Participant has accrued under the Plan at such time except to the extent required by applicable law.

10.2 Termination

The Compensation Committee may, by resolution, in its absolute discretion, terminate the Plan in whole or part at any time; provided, that no such termination may adversely impact the amount of benefits a Participant has accrued under the Plan at such time except to the extent required by applicable law. Any termination of the Plan will comply with the provisions of section 409A of the Code as set forth in this Section 10.2.

The Plan may be terminated and liquidated under the following circumstances:

(a) **Corporate Dissolution or Bankruptcy**. The Compensation Committee may terminate and liquidate the Plan within twelve (12) months of a corporate dissolution taxed under section 331 of the Code or with the approval of a bankruptcy court pursuant to 11 U.S.C. § 503(b)(1)(A), provided that the amounts deferred under the Plan are included in Participants; gross incomes in the latest of the following years (or if earlier, the taxable year in which the amount is actually or constructively received):

(i) The calendar year in which the Plan termination and liquidation occurs.

(ii) The first calendar year in which the amount is no longer subject to a substantial risk of forfeiture.

(iii) The first calendar year in which the payment is administratively practicable.

(b) **Change in Control**. The Compensation Committee may terminate and liquidate the Plan within the thirty (30) days preceding or the twelve (12) months following a change in control event, as defined in Treasury Regulation section 1.409A-3(i)(5)),

provided that all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated with respect to each Participant that experienced the change in control event so that under the terms of the Plan and all such arrangements the Participant is required to receive all amounts of compensation deferred under such arrangements within twelve (12) months of the termination of the Plan or arrangement, as applicable. In the case of a change of control event which constitutes a sale of assets, the termination of the Plan pursuant to this Section 10.2(b) may be made with respect to the Employer that is primarily liable immediately after the change of control transaction for the payment of benefits under the Plan.

(c) **Termination of Plan**. The Compensation Committee may terminate and liquidate the Plan provided that (i) the termination and liquidation does not occur by reason of a downturn of the financial health of the Company or an Employer, (ii) all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated, (iii) no payments in liquidation of the Plan are made within twelve (12) months of the date of termination of the Plan other than payments that would be made in the ordinary course operation of the Plan, (iv) all payments are made within twenty-four (24) months of the date the Plan is terminated and (v) the Company or the Employer, as applicable depending on whether the Plan is terminated with respect to such entity, do not adopt a new plan that would be aggregated with the Plan within three (3) years of the date of the termination of the Plan.

10.3 Nonguarantee of Employment

Nothing contained in this Plan will be construed as a contract of employment between the Employer and any Employee, or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

10.4 Indemnification

The Company will indemnify each of its Compensation Committee members and Benefits Committee members against any and all claims, loss, damages, expense (including reasonable counsel fees), and liability arising from any action, failure to act, or other conduct in the member's official capacity, except when due to such Compensation Committee or Benefits Committee's member's own gross negligence or willful misconduct.

10.5 Withholding

The Employer or its designee will withhold from any benefit payments made under this Plan, the required amounts of federal, state or local income or other applicable taxes.

10.6 Expenses

The Employer will pay all costs and expenses incurred in operating and administering the Plan. Such costs and expenses will be paid by the Employer from its general assets or the Rabbi Trust.

End of Article X

IN WITNESS WHEREOF, the Company has executed this Plan as of this _____ day of _____, 2018.

ENCOMPASS HEALTH CORPORATION

By: _____

Its: _____

APPENDIX A

SERVICE CREDITING

Participant Vesting for Certain Acquisitions or Business Transactions

An individual who becomes an Employee of the Employer or an Affiliate and a Participant in the Plan in connection with an acquisition (either stock, partnership interest or assets) or a similar business transaction (such as an outsourcing or employee leasing arrangement) will be given credit for his prior service with the seller, outsourcing entity or leasing company, as applicable, for vesting purposes under the Plan if the terms of the acquisition agreement, business transaction documents or an action of the Employer or an Affiliate so provides. This prior vesting service credit applies with respect to the following acquisitions and business transactions:

Acquisition or Transaction	Effective Date

No further action except amending this schedule under Appendix A by the Daily Administrator will be necessary to reflect prior service granted to employees of acquired entities or groups by the Company.

This Appendix A may be updated from time to time without the need for formal amendment to the Plan in which case an updated appendix A will be attached hereto.

APPENDIX B

DOMESTIC PARTNER GUIDELINES FOR THE ENCOMPASS HEALTH CORPORATION GROUP LIFE, AD&D, DISABILITY AND MEDICAL PLAN AND THE ENCOMPASS HEALTH CORPORATION RETIREMENT INVESTMENT PLAN

Encompass Health Corporation ("**EHC"**) adopts this Domestic Partner Guidelines (the "**Guidelines**") to extend group health, dental and vision coverage under the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan (the "**Group Health Plan" or "GHP**") to the "**Domestic Partner**" (as defined below) of an eligible employee of EHC ("**Employee**") and to the children of a Domestic Partner up to age 26.

The Guidelines also provide that a participant's Domestic Partner will be the default beneficiary for purposes of the Encompass Health Corporation Retirement Investment Plan (the "**401(k) Plan**") and the Encompass Health Corporation Nonqualified 401(k) Plan (the "**Nonqualified 401(k) Plan**") in situations where the participant dies without designating a beneficiary in accordance with the requirements of the 401(k) Plan and the Nonqualified 401(k) Plan.

The applicable requirements of the Guidelines are outlined below. Together, the GHP, the 401(k) Plan and the Nonqualified 401(k) Plan are referred to herein as the "**Plans**".

PART A - DOMESTIC PARTNERSHIP DEFINED

1 A Domestic Partnership is defined as follows:

For purposes of the Plans, a domestic partner consists of an eligible Employee and one other person of the same or opposite sex (a "**Domestic Partner**").

A Domestic Partnership must satisfy the following requirements:

Each partner must be the other's sole domestic partner and must intend to remain so indefinitely. The partners must have an exclusive mutual commitment similar to that of marriage and:

(a) Each partner must be at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;
(b) The partners must share the same permanent residence and have done so for at least 12 months;
(c) The partners cannot be related by blood to a degree that would prohibit marriage;

(d) The partners cannot be legally married to each other or anyone else or in a domestic partnership with another individual nor have had another domestic partner within the prior six months;
(e) The partners must share the same permanent address and must be able to provide their driver's licenses listing the common address;
(f) The partners must share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;
(g) The partners must each be mentally competent to consent to contract; and
(h) The partners must be financially interdependent, demonstrated by at least two of the following:
   i. Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;
   ii. Common ownership of a motor vehicle;
   iii. Joint ownership of a residence; or evidence of a joint mortgage or lease;
   iv. Evidence of common household expenses, e.g. utility, phone;

v. Execution of wills naming each other as executor and/or beneficiary;
vi. Granting each other durable powers of attorney; or
vii. Designation of each other as beneficiary under a retirement benefit account.

Notwithstanding the foregoing, the Plans will recognize an individual as a Domestic Partner of an Employee if the Domestic Partnership has been registered with any state or local government registry recognizing domestic partnerships and the Domestic Partnership meets the requirements of such registry or if the domestic partners have entered into a legal civil union in any state recognizing such civil union.

2 Dependent Children of Domestic Partners include the following individuals:

For purposes of the GHP, children of a Domestic Partner ("**Dependent Children**") are eligible for coverage under any GHP that provides dependent coverage when they are:

(a) A "child" as defined in the GHP (e.g., a natural child of the Domestic Partner, step child of the Domestic Partner or adopted child of the Domestic Partner);
(b) Unmarried; and
(c) Under the age of 26.

3 Obtaining Domestic Partner Coverage:

In order to obtain Domestic Partner status for purposes of the Plans, the Employee and Domestic Partner must complete and file with Human Resources, the **Affidavit Declaring Domestic Partnership** (the "**Affidavit**"), attached hereto. *For purposes of the GHP*, such Affidavit must be filed at annual enrollment. *For purposes of the 401(k) Plan and the Nonqualified 401(k) Plan*, such Affidavit may be filed at any time. However, if the Affidavit is not filed during an annual enrollment period, GHP coverage for the Domestic Partner will not begin until after the next annual enrollment period, unless the Domestic Partner loses other group health coverage during the plan year and is entitled to a mid-year entry under the plan's HIPAA special enrollment provisions that apply in the case of a loss of other group health coverage. Note, due to federal law, a same sex Domestic Partner may not be enrolled in a GHP mid-year under the HIPAA special enrollment provisions that apply in the case of acquisition of dependent. Likewise, mid-year enrollment of a same sex Domestic Partner as a "change in status" (as defined in the GHP) is also not permitted by federal law. In the case of an opposite sex Domestic Partner, mid-year enrollment on account of an acquisition of dependent or as a "change in status" is only possible if the Domestic Partner qualifies as the Employee's Spouse.

To the extent that the Domestic Partner has Dependent Children, such children may be enrolled pursuant to the terms of the GHP at the same time the Domestic Partner is enrolled; provided, the children satisfy the definition of Dependent Children above. Dependent Children may also be entitled to mid-year enrollment under the plan's HIPAA special enrollment provisions that apply in the case of acquisition of a child or a loss of other group health coverage. Dependent Children may also be entitled to mid-year enrollment on account of a "change in status."

4 Termination of a Domestic Partnership:

(a) Each Employee with a Domestic Partner has an obligation to notify "change in status", by filing the **Declaration of Termination of Domestic Partnership** (attached hereto), if there is any change in the Domestic Partnership status as attested to in the Affidavit that would terminate such partnership (such as the death of a Domestic Partner, a change in residence of one partner, termination of the relationship, etc.). **The Employee must notify Human Resources within thirty-one (31) days of such change in the Domestic Partnership for purposes of the GHP.**
(b) Upon termination of the Domestic Partnership, the GHP coverage of the Domestic Partner who is not an employee as well as coverage of any Dependent Children of such Domestic Partner will cease, unless the Dependent Children continue to satisfy the definition of Dependent Children under the GHP (i.e., are unmarried and under the age

of 26). Termination of such coverage (obtained as a result of completion of the **Declaration of Termination of Domestic Partnership**) will be effective on the date the relationship ends as indicated on such form.

(c) In the event a Domestic Partnership is terminated for reasons other than death of a Domestic Partner, an Employee cannot re-enroll for Domestic Partnership coverage under the GHP until six months from the date the Domestic Partnership ended.

(d) A Domestic Partner will no longer be the Participant's default beneficiary under the 401(k) Plan and the Nonqualified 401(k) Plan following the filing of a Declaration of Termination of Domestic Partnership.

5 COBRA coverage upon termination of Domestic Partnership:

(a) **Domestic Partner**. Under federal law, COBRA is only available to qualifying employees and their qualifying spouses and dependent children. Thus, under the law a Domestic Partner may not elect COBRA in his or her own right. However, an Employee on COBRA may add a Domestic Partner to the GHP in the same manner as is permitted for active employees. In the event an Employee who is a COBRA beneficiary dies or becomes Medicare entitled, or the Domestic Partnership is terminated, the Employee's Domestic Partner (or former Domestic Partner) may not make an election under the GHP pursuant to COBRA as a second qualifying event.

(b) **Dependent Children**. If dependent coverage of the Dependent Child of the Domestic Partner ends under the GHP because such a child or children cease to satisfy the definition of Dependent Children under such plan, such children will be eligible to elect COBRA.

PART B - TAX CONSEQUENCES OF GHP COVERAGE

1 Possible Tax Implications of Domestic Partner:

There may be federal income tax implications associated with providing coverage under the GHP to Domestic Partners (i.e., if the Domestic Partner does not qualify as your dependent under section 152 of the Internal Revenue Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)), the fair market value of the Domestic Partner coverage will be includible in your income as wages for federal income tax purposes). Similar tax implications apply for state income tax purposes. However, GHP coverage provided to your Domestic Partner may qualify for exclusion from income for state income tax purposes based on state law. Exemption from state income tax is often conditioned on the relationship being registered or the parties having entered into a civil union or marriage. It is your responsibility to determine the requirements of your state. The Employee and Domestic Partner should consult with their tax advisor prior to making a declaration of Domestic Partnership.

In addition, an Employee may not obtain reimbursement for medical expenses incurred by the Domestic Partner under the Health Care Flexible Spending Account Program unless the Domestic Partner qualifies as the Employee's federal tax dependent as described above. The same rules regarding the after-tax treatment of the cost of coverage and premiums under the Plan and the reimbursement of medical expenses under the health care flexible spending account will also apply to the Domestic Partner's Dependent Child(ren) unless such Dependent Child(ren) are adopted by the Employee. The Employee and Domestic Partner should consult with their tax advisor prior to making a declaration of Domestic Partnership.

2 Proof of Tax-Qualified Status of Domestic Partnership:

Domestic Partner coverage under the GHP (including coverage of the Domestic Partner's Child(ren)) will be provided on an after-tax basis for both federal and state income tax purposes **unless** the Employee certifies on the Affidavit Declaring Domestic Partnership Status that such coverage may be provided on a pre-tax basis for federal or state (or both) income tax purposes. The Employee will be required to provide proof of dependent status by submitting a copy of his or her redacted tax return or similar documentation.

PART C- CONSEQUENCES OF COVERAGE ON 401(k) PLAN AND NONQUALIFIED 401(k) PLAN DEFAULT BENEFICIARY

For purposes of the 401(k) Plan and the Nonqualified 401(k) Plan, a Domestic Partner will be the default death beneficiary for an Employee's account balances under the 401(k) Plan and the Nonqualified 401(k) Plan if the Employee has not completed a beneficiary designation in accordance with the policies and procedures under such plan at the time of the Employee's death. Any beneficiary designation made by the Employee under the 401(k) Plan and the Nonqualified 401(k) Plan is revoked upon the execution of the Affidavit. A Domestic Partner will cease to be such default beneficiary upon the filing of a Declaration of Termination of Domestic Partnership with EHC.

ENCOMPASS HEALTH CORPORATION

Return this Form to Human Resources

AFFIDAVIT DECLARING DOMESTIC PARTNER STATUS

We, _____, (the "**Employee**") and _____, (the "**Domestic Partner**"), are "**Domestic Partners**" within the meaning of the Encompass Health Corporation Domestic Partner Benefit Guidelines (the "**Guidelines**"). Capitalized terms not defined in this Affidavit Declaring Domestic Partner Status (this "**Affidavit**") will have the meaning set forth in the Guidelines. We execute this Affidavit as of the date set forth below as part of the requirements for (i) coverage of the Domestic Partner under the medical, dental and vision coverages under the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan (the "**GHP**") provided by Encompass Health Corporation or one of its affiliates ("**EHC**") and (ii) recognition of the Domestic Partner as the default beneficiary for the Employee's accounts under the Encompass Health Corporation Retirement Income Plan (the "**401(k) Plan**") and the Encompass Health Corporation Nonqualified 401(k) Plan (the "**Nonqualified 401(k) Plan**"), in accordance with the terms set forth in the Guidelines. We hereby certify as follows:

1. We acknowledge that we have read and understand the Guidelines, which summarize the eligibility criteria, termination provisions, available benefits, employee responsibilities, taxation, and notification requirements pertaining to Domestic Partner status.
2. We declare that we meet the eligibility requirements for Domestic Partner status as set forth below: [Check a., b. and c. below as applicable]

____ a. We are currently registered as domestic partners with a state or local government (and we meet the requirements of such registry);

____ b. We have entered into a legally binding civil union; or

____ c. We meet the alternative criteria for establishing Domestic Partner status as set forth below:

i. We are both at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;

ii. We have lived together for at least the last 12 consecutive months prior to the date of this Affidavit;

iii. The Employee has not had another person enrolled as a Domestic Partner or as a Spouse in any benefit program offered by EHC in the six months prior to the date on this Affidavit;

iv. Neither of us is legally married to another person;

v. We are not related by blood or adoption to a degree that would prohibit marriage in our state of residence;

vi. The Domestic Partner is not eligible for GHP coverage as an employee or as a retiree in any benefit program offered by EHC.

vii. We share the same permanent address and each has a driver's license listing the common address;

viii. We share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;

ix. We each are mentally competent to consent to contract; and

x. We are financially interdependent, demonstrated by at least two of the following: [Check at least two items below as applicable]

____ A. Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;

____ B. Common ownership of a motor vehicle;

____ C. Joint ownership of a residence; or evidence of a joint mortgage or lease;

____ D. Evidence of common household expenses, e.g. utility, phone;

____ E. Execution of wills naming each other as executor and/or beneficiary;

____ F. Granting each other durable powers of attorney; or

____ G. Designation of each other as beneficiary under a retirement benefit account.

3. We acknowledge that the Plan Administrator reserves the right, at its discretion, to require that we supply copies of appropriate documentation supporting any of the certifications made in this Affidavit, including certification of Domestic Partner status, Dependent Children status or federal tax dependent status.
4. We understand that obtaining Domestic Partner recognition and coverage and the execution of this Affidavit may affect our liability to each other, to taxing authorities, and to third parties. We understand that we should consult with our respective tax and/or legal advisors regarding these and other potential consequences, and we acknowledge that we have been advised to do so.
5. We understand that EHC may take disciplinary action against us if we misrepresent or falsify any of the information in this Affidavit. Disciplinary action may include termination of employment by EHC and appropriate legal action, such as reimbursement of EHC for the contributions and benefits that were improperly obtained and costs incurred related to such misrepresentation or falsification.
6. We acknowledge that we have read and understand this Affidavit and that all information set forth in this Affidavit is true and correct. We further acknowledge that EHC will rely on this Affidavit and that EHC will not be liable for a false or inaccurate Affidavit.

(Declarations Relating Solely to GHP)

7. We seek to obtain Domestic Partner coverage in the following GHP plans or programs offered by EHC: [Check below as applicable]
   __ Medical Benefit Program
   __ Dental Benefit Program
   __ Vision Benefit Program

We understand that EHC is not legally required to offer the GHP to Domestic Partners and that due to insurer or other constraints, Domestic Partner coverage may not be available under all health programs offered by EHC.

8. We seek to obtain coverage for the Dependent Children of the Domestic Partner in the following GHP plans or programs offered by EHC: [Check below as applicable]
   __ Medical Benefit Program
   __ Dental Benefit Program
   __ Vision Benefit Program

We understand that EHC is not legally required to offer the GHP to Dependent Children of Domestic Partners and that due to insurer or other constraints, Dependent Children of Domestic Partner coverage may not be available under all health programs offered by EHC.

9. We understand the GHP coverage for the Domestic Partner and the Dependent Children of Domestic Partners (as applicable) will not take effect until the dates set forth in the Guidelines.
10. We further understand that the benefits under the GHP will be provided to the Domestic Partner on an after-tax basis for federal income tax purposes **unless** the Domestic Partner qualifies as a dependent (within the meaning of section 152 (without regard to sections 152(b)(1), (b)(2), or (d)(1)(B)) of the Internal Revenue Code such that benefits under the GHP may be provided on a pre-tax basis for purposes of federal law. We hereby certify that the Domestic Partner ___ is ___ is not (***select one***) the Employee's federal tax dependent within the meaning of Code section 152 (determined without regard to Code sections 152(b)(1), (b)(2), and (d)(1)(B)).
11. We further understand that the benefits under the GHP will be provided on an after-tax basis for state income tax purposes, unless such benefits qualify for pre-tax payment or an income tax exclusion under state tax law. We hereby certify that we ___ are___ are not (***select one***) eligible to pay for Domestic Partner health benefits on a pre-tax basis for state tax purposes.
12. We, understand that the benefits under the GHP for the Domestic Partner's Child(ren) who do not qualify as the Employee's Child(ren) as defined under the Plan will be provided on an after-tax basis for federal and state law purposes. I certify that we ___ are ___ are not (***select one***) eligible to pay for the Domestic Partner's children's health benefits on a pre-tax basis for __ federal and/or __ state tax (***select as appropriate***) purposes.
13. We agree that each year during the annual open enrollment period, or at such time as there is a material change in GHP benefits (or at other times, at the discretion of the Plan Administrator), we will certify to the status of the Domestic Partner (and any enrolled Dependent Children of the Domestic Partner).
14. We agree to notify EHC within 31 days after the termination of the Domestic Partner relationship for any reason, including death. We understand that, except in cases of death, the Employee will not be eligible to cover another Domestic Partner under the GHP or recognize until six months after notification to EHC of termination of this Domestic Partner relationship.

(Declaration Relating to 401(k) Plan and Nonqualified 401(k) Plan)

15. We acknowledge that solely for purposes of the 401(k) Plan and the Nonqualified 401(k) Plan, pursuant to this Affidavit, the Domestic Partner will be the default death beneficiary for the Employee's account balances under the 401(k) Plan and the Nonqualified 401(k) Plan if the Employee has not completed a beneficiary designation in accordance with the policies and procedures under the 401(k) Plan at the time of the Employee's death. We

further acknowledge that this Affidavit revokes any beneficiary designation made by the Employee under the 401(k) Plan before this Affidavit is signed. We further acknowledge that the Domestic Partner will cease to be such default beneficiary upon the filing of a Declaration of Termination of Domestic Partnership with EHC.

EMPLOYEE: **DOMESTIC PARTNER:**

Signed: Signed:
Printed Name: Printed Name:
Date: Date:

Subscribed and sworn to me this _____day of _____, 20____.

Witness my hand and official seal.

_____

[Seal]

My Commission expires:
Notary Public:_

Subscribed and sworn to me this _____day of _____, 20____.

Witness my hand and official seal.

_____

[Seal]

My Commission expires:
Notary Public:_

Return this Form to Human Resources

ENCOMPASS HEALTH CORPORATION

Return this Form to Human Resources

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP FORM

I, _____ (the "**Employee**"), certify and declare that _____ (the "**Former Domestic Partner**") and I are no longer domestic partners as of __/__/__ (the "**Termination Date**").

I understand that medical, dental and vision coverage under the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan (the "**GHP**") for the Former Domestic Partner (and Dependent Children of the Former Domestic Partner) will terminate effective as of the Termination Date.

I further understand that the Former Domestic Partner Domestic Partner will cease to be my default beneficiary under the under the Encompass Health Corporation Retirement Income Plan (the "**401(k) Plan**") and the Encompass Health Corporation Nonqualified 401(k) Plan (the "**Nonqualified 401(k) Plan**") as of the Termination Date.

1. I make and file this Declaration of Termination of Domestic Partnership in order to cancel the Affidavit Declaring Domestic Partnership filed with EHC on __/__/__.

2. Termination of the Affidavit Declaring Domestic Partnership is due to: [Check below as applicable]

   __ Termination of domestic partnership
   __ No longer jointly responsible for each other's common welfare and living expenses
   __ Death of domestic partner

I understand that with respect to the GHP another **Affidavit Declaring Domestic Partnership** cannot be filed until **six months** from the date the relationship ends (as indicated above) except with respect to death of my Former Domestic Partner.

In the event that termination of this relationship is not due to the death of my Former Domestic Partner, I will mail my Former Domestic Partner a copy of this notice to the following address:

_____
_____
_____
(Former Domestic Partner new address)

I affirm, under penalty of perjury, that the above statements are true and correct.

_____ ___/__/_____ __/__/__

Signature of Employee Date of Birth Date

_____

Printed name

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Exhibit 10.15

SECOND AMENDED AND RESTATED SENIOR MANAGEMENT AGREEMENT

THIS SECOND AMENDED AND RESTATED SENIOR MANAGEMENT AGREEMENT ("***Agreement***") made and entered into as of October 7, 2019, by and among EHHI Holdings, Inc., a Delaware corporation (the "***Company***"), April Anthony ("***Executive***"), and Encompass Health Corporation, a Delaware corporation ("***EHC***" and, together with Executive and the Company, the "***Parties***").

RECITALS:

WHEREAS, Executive is presently employed by the Company pursuant to the Amended and Restated Senior Management Agreement, dated as of November 23, 2014, by and among the Company, Executive, EHC (formerly known as HealthSouth Corporation), and, solely for purposes of Sections 6(b) and 6(j) thereof, Thoma Cressey Fund VIII, L.P. (the "***Existing Employment Agreement***");

WHEREAS, upon the closing of the acquisition of the Company by a subsidiary of EHC, Thoma Cressey Fund VIII, L.P. ceased having any rights or obligations under the Existing Employment Agreement;

WHEREAS, as of the date hereof, the Parties desire to amend and restate the Existing Employment Agreement in order to extend Executive's employment pursuant to the terms of this Agreement; and

WHEREAS, the Parties intend that this Agreement shall become effective as of January 1, 2020 (the "***Effective Date***") and that Executive's employment shall continue on terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

PROVISIONS RELATING TO EMPLOYMENT

1. Employment. The Company agrees to employ Executive and she accepts such employment for the period beginning as of the Effective Date and ending upon her termination of employment pursuant to Section 1(e) hereof (the "***Employment Period***").

(a) Duties. During the Employment Period, Executive shall serve as the Chief Executive Officer ("***CEO***") of the Company and shall have such duties and responsibilities as are typically commensurate with such position. Executive shall have powers and perform such duties as may from time to time reasonably be prescribed by the Chief Executive Officer of EHC (the "***EHCCEO***") which are consistent with the position of CEO of the Company, including serving without additional compensation as an officer or director of the Company's Subsidiaries.

(b) Reporting and Devotion to Duties. Executive shall report to the EHCCEO, and she shall devote substantially all of her working time and efforts to the business and affairs of the Company and the Subsidiaries; provided, however, (i) Executive may serve as director or trustee of an unaffiliated entity as may be approved from time to time by the Board of Directors of EHC or applicable committee thereof (the "***Board***") pursuant the EHC Corporate Governance Guidelines; and (ii) Executive may continue to provide services to Homecare Homebase LLC as an officer or chairman in a manner consistent with those positions, so long as

Executive's time commitment to such services is no greater than the time commitment in effect immediately prior to the Effective Date; provided, further, however, that in the case of clauses (i) and (ii) such activities do not materially interfere with Executive's duties and responsibilities to the Company and its Subsidiaries. Notwithstanding the foregoing, the Company acknowledges that Executive may continue to serve on the board of directors of First Financial Bankshares, on the board of directors of the Encompass Cares Foundation, and on the board of trustees, in the role of Chair or otherwise, of Abilene Christian University (together with any roles approved pursuant to the foregoing clause (i), the "***Board Roles***").

(c) Compensation.

(i) Commencing upon the Effective Date and thereafter, during the Employment Period, Executive's base salary shall be $550,000 per annum or such higher rate as the Board may designate from time to time, based upon the Company's achievement of budgetary and other objectives set by the Board (as in effect from time to time, the "***Base Salary***"). Executive's Base Salary shall be payable in regular installments in accordance with the Company's general payroll practices (but no less frequently than monthly) and shall be subject to customary withholding for income tax, social security or other such taxes. Executive's Base Salary for any partial year will be prorated based upon the number of days elapsed in such year.

(ii) In addition to the Base Salary, Executive shall be eligible for an annual bonus (an "***Annual Bonus***") as a participant in EHC's senior management bonus plan at the following percentages of the Base Salary: 37.5% (threshold); 75% (target); and 150% (maximum). The Annual Bonus shall be paid by no later than March 1 of the year following the year in which it was earned and shall be subject to customary withholding for income tax, social security or other such taxes. Except as provided in Section 1(e), Executive shall receive an Annual Bonus payable for a calendar year only if she is employed by the Company or its Subsidiaries as of the date of payment of the Annual Bonus.

(iii) Each year during the Employment Period, Executive shall be entitled to participate in and receive equity awards with a target value of 150% of her Base Salary under the EHC 2016 Omnibus Incentive Plan (or any successor thereto (the "***EHC EIP***")) as approved by the Board from time to time (collectively, the "***Equity Grants***").

(d) Benefits. In addition to the Base Salary, the Annual Bonus and the Equity Grants payable to Executive pursuant to this Agreement, she shall be entitled to the following benefits during the Employment Period:

(i) paid time off per the Company's policy;

(ii) reimbursement for reasonable business expenses incurred by Executive on the Company's behalf and within EHC's stated policies and procedures for expense reimbursement, subject to providing appropriate documentation thereof to the Company (including reimbursement for the cost of professional representation and consultation in connection with the negotiation of this Agreement);

(iii) participation in all health, disability, welfare and benefit plans available to the Company's senior executives, all subject to plan terms and generally applicable policies;

(iv) participation in all retirement plans available to the Company's senior executives; and

(v) any other benefits and perquisites approved by the Board.

(e) Termination.

(i) The Employment Period shall continue for three years commencing on the Effective Date (the "***Initial Term***") and shall be automatically renewed for successive one year terms unless the Company or Executive receives written notice from the other at least ninety (90) days prior to the termination of either the Initial Term or a successive term then in effect, unless earlier terminated as provided herein. Executive or the Company may terminate Executive's employment prior to the end of the term set forth in the preceding sentence, as set forth in this Section 1(e); provided, that written notice to Executive shall be required ninety (90) days prior to termination by the Company without Cause and written notice to the Board shall be required ninety (90) days prior to termination by Executive without Good Reason. The Parties' rights and duties in the event of a termination of employment during Employment Period will be as set forth below.

(ii) If the Company terminates Executive's employment without Cause or Executive terminates her employment for Good Reason, the Company will:

(A) continue to pay Executive's Base Salary at the rate in effect on the Date of Termination until the date that is twelve months after the Date of Termination in accordance with the Company's payroll practices (but not less frequently than monthly);

(B) pay to Executive any Annual Bonus for any fiscal year that has ended prior to the Date of Termination, if such Annual Bonus has not yet been paid as of the Date of Termination (payable on the later of the date that annual bonuses are paid generally, in accordance with Section 1(c)(ii) hereof, and the next regular payday following the effective date of the release of claims referenced below in this Section 1(e));

(C) pay to Executive an amount equal to the amount of the COBRA premium required to continue health coverage for Executive and her dependents under the Company's group health plan to the extent permitted by the plan (provided that such amount shall not exceed the Company's cost of coverage prior to termination) until the earliest of (i) the date that is twelve months after the Date of Termination, (ii) the date of commencement of health coverage for the benefit of Executive and her dependents under any other plan, and (iii) the date of Executive's eligibility for health coverage as a result of her employment with another entity; and

(D) pay to Executive a ratable amount (based on Executive's Base Salary) with respect to accrued and unused paid time off as of the Date of Termination.

The right to receive the benefits set forth above is expressly conditioned on Executive's execution and delivery to the Company of a release of claims arising out of Executive's employment with the Company or termination thereof, in a form reasonably acceptable to the Company, as of the Date of Termination. Additionally, if Executive materially breaches her obligations under Sections 2 or 3 of this Agreement during the period in which Executive is entitled to such benefits, Executive no longer shall be entitled to receive such benefits and the Company will have no further obligation to provide such benefits to Executive. In any event, the Company will reimburse Executive for any unreimbursed business expenses pursuant to Section 1(d)(ii) of this Agreement.

(iii) If (A) the Company terminates Executive's employment for Cause or (B) Executive terminates her employment without Good Reason, the Company will pay Executive's Base Salary through the Date of Termination, at the rate then in effect, plus reimbursement of business expenses pursuant to Section 1(d)(ii) of this Agreement, without any obligation to pay any other amounts hereunder.

(iv) If Executive terminates or the Company terminates Executive's employment because of Executive's death or

Disability for a period of ninety (90) consecutive days or one hundred eighty (180) total days during any period of three hundred sixty five (365) consecutive days, the Company will continue to pay Executive's Base Salary through the Date of Termination at the rate then in effect, without any obligation to pay any other amounts hereunder in cash or otherwise.

(v) Payments under Section 1(e)(ii) shall be made without regard to Sections 280G or 4999 of the Internal Revenue Code of 1986, as amended (the "***Code***"), except that if Executive's total after-tax payments would be increased by a reduction of payments or benefits under Section 1(e)(ii), or by the adjustment to the vesting of any equity-based or other awards that would otherwise be an "excess parachute payment" within the meaning of Section 280G of the Code, such reduction and/or adjustment shall be made to the extent necessary to maximize Executive's total after-tax payments. After-tax payments shall be determined after reduction for federal taxes, including the excise tax under Section 4999 of the Code. The calculations described in this Section 1(e)(v) shall be made by such certified public accounting firm as the Company may designate prior to the applicable change in ownership or effective control, or in the ownership of a substantial portion of the assets, of the applicable corporation under Section 280G of the Code.

2. Confidential Information and Inventions and Patents.

(a) Confidential Information. Executive acknowledges that the information, observations and data prepared by or for her or obtained by her concerning the business and affairs of the Company and its Affiliates and its and their predecessors during the course of her performance of services for, or employment with, any of the foregoing Persons (whether or not compensated for such services) are the property of the Company and its Affiliates, including information concerning acquisition opportunities in or reasonably related to the Company's business or industry of which Executive becomes aware during such period. Therefore, Executive agrees that she will not (and shall cause each of her Affiliates not to) at any time (whether during or after employment) disclose to any unauthorized Person or, directly or indirectly, use for her own account, any of such information, observations or data without the Board's consent, unless and to the extent that the aforementioned matters become generally known to and available for use by the public other than as a direct or indirect result of Executive's acts or omissions to act. Executive agrees to deliver to the Company at the termination of her employment with the Company, or at any other time the Company may request in writing (whether during or after the employment), all memoranda, notes, plans, records, reports and other documents and copies thereof, regardless of the format or media, of the Company and its Affiliates (including, without limitation, all acquisition prospects, lists and contact information) which she may then possess or have under her control, except any information relating to her employment terms and benefits, her performance, or the circumstances of her departure from the Company.

(b) Inventions and Patents. Executive acknowledges that all inventions, innovations, improvements, developments, methods, designs, analyses, drawings, trade secrets, copyrightable subject matter, reports, and all similar or related information (whether or not patentable) that relate to the Company's or any of its Affiliates' actual or anticipated business, research and development or existing or future products or services and that are conceived, developed, made or reduced to practice by Executive while employed by the Company and its Affiliates or any of its and their predecessors ("***Work Product***") belong to the Company or such Affiliate and Executive hereby assigns, and agrees to assign (and to the extent to which she already has assigned pursuant to the Existing Employment Agreement, hereby confirms such assignment of), all right, title, and interest in and to the Work Product to the Company or such Affiliate; provided that the foregoing shall not apply to any inventions, innovations, improvements, developments, methods, designs, analyses, drawings, reports and all similar or related information (whether or not patentable) of the information technology systems and software licenses from Homecare Homebase, LLC, and provided further, that as between Homecare Homebase, LLC and Advanced Homecare Management, Inc. d/b/a Encompass Health Home Health & Hospice (an Affiliate of the Company and EHC), the Innovation Project Development Agreement entered into on February 8, 2019, and the Client Service and License Agreement dated December 1, 2004, establish the rights and obligations of Homecare Homebase, LLC and that certain Affiliate of the Company and EHC with respect to the intellectual property that is the subject of those agreements. Any Work Product comprising copyrightable subject matter prepared in whole or in part by Executive in the course of her work for any of the foregoing entities shall be deemed a "work made for hire" under the copyright laws, and the Company or such Affiliate shall own all rights therein. To the extent that any such copyrightable subject matter is not a "work made for hire," Executive hereby assigns and agrees to assign to Company or such Affiliate all right, title, and interest, including without limitation, copyright in and to such

copyrightable subject matter. Executive shall promptly disclose all such Work Product to the Board and perform all actions reasonably requested by the Board (whether during or after the Employment Period) to establish and confirm the Company's or its Affiliate's ownership (including, without limitation, assignments, consents, powers of attorney and other instruments).

3. Noncompetition and Nonsolicitation.

(a) Noncompetition. In further consideration of the compensation to be paid to Executive hereunder, she acknowledges that during the course of her employment with the Company and its Affiliates (including, without limitation, any predecessors thereof) she has become familiar with, and during the course of her employment with the Company and its Affiliates she will become familiar with, EHC's and its Subsidiaries' trade secrets and with other Confidential Information. Executive acknowledges that her services shall be of special, unique and extraordinary value to EHC and its Subsidiaries and that EHC's and its Subsidiaries' ability to accomplish their purposes and to successfully pursue their business plan and compete in the marketplace depends substantially on the skills and expertise of Executive. Therefore, and in further consideration of the compensation being paid to Executive hereunder, she agrees that, during the Noncompete Period (as defined below), she shall not directly or indirectly engage, whether as an owner, general partner, member, officer, employee, consultant, director, stockholder or otherwise (other than passive ownership of less than ten percent (10%) of any class of securities of an entity, without otherwise participating in or advising on the activities of such entity), any business of which the primary activity is the provision of products or services within the Restricted Territory (as defined below) that, as of the Date of Termination, are competitive with (i) the business of operating or managing inpatient rehabilitation, home health or hospice services within the Restricted Territory, or (ii) any business line of EHC or its Subsidiaries that has generated revenue in excess of $500,000 (the "***Revenue Threshold***") during the twelve months prior to the Date of Termination (each, an "***EHC Competitive Business***"); provided that (y) revenues generated by business lines that are not substantially related shall not be aggregated for purposes of determining whether any EHC Competitive Business has met the Revenue Threshold; and (z) EHC shall, within 30 days of the Date of Termination, provide Executive with, and certify the accuracy of, a schedule identifying each EHC Competitive Business. The "***Noncompete Period***" shall mean the period during which she is employed by EHC or any of its Subsidiaries and the period beginning on the Date of Termination and ending on the later of 12 months from the Date of Termination and April 1, 2022. "***Restricted Territory***" shall mean any state or territory of the United States in which EHC or any of its Subsidiaries is located or operates, or is in the process of actively planning to conduct or conducting operations, as of the Date of Termination. Notwithstanding the foregoing provisions of this Section 3(a), this Agreement shall not preclude or limit Executive's activities relating to (i) Executive's provision of services to Homecare Homebase, LLC as an officer or chairman in a manner consistent with those positions, so long as Executive's time commitment to such services is no greater than the time commitment in effect immediately prior to the Effective Date, (ii) any activities approved by the written consent of the Board after the Effective Date or (iii) any other Board Roles; provided, that in the case of clauses (i) and (ii) such activities do not materially interfere with Executive's duties and responsibilities to the Company and its Subsidiaries. Executive acknowledges that the geographic boundaries, scope of prohibited activities and the time duration are reasonable and are no broader than are necessary to protect legitimate business interests.

(b) Nonsolicitation. In addition, Executive agrees that, during the period during which she is employed by the Company or any of its Affiliates and for two years thereafter (the "***Nonsolicitation Period***"), she shall not (and shall cause all of her Affiliates not to), directly or indirectly through another Person (i) induce or attempt to induce any employee of the Company or any of its Subsidiaries to leave the employ of the Company or any of its Subsidiaries, or in any way interfere with the relationship between the Company or any of its Subsidiaries and any employee thereof, (ii) hire (in any capacity) any Person who was an employee of the Company or any of its Subsidiaries at any time during the six month period immediately prior to the date on which such hiring would take place (it being conclusively presumed by the Parties so as to avoid any disputes under this Section 3(b) that any such hiring within such six month period is in violation of clause (a) above), (iii) for so long as Executive has any obligations under Section 3(a) above, call on, solicit or service any customer, supplier, licensee, licensor or other business relation of the Company or any of its Subsidiaries in order to induce or attempt to induce such Person to cease doing business with the Company or any of its Subsidiaries, (including making any negative statements or communications about the Company or any of its Subsidiaries) or (iv) initiate or engage in any discussions regarding an acquisition of, or Executive's employment (whether as an employee, an independent contractor or otherwise) by, any businesses in which the Company or any of its Subsidiaries within the two (2) year

period prior to the Date of Termination has had or is engaged in discussions, or has requested or received information, relating to the acquisition of such business by the Company or any of its Subsidiaries. This paragraph shall not preclude or limit (X) Executive's provision of services to Homecare Homebase as an officer or executive chairman in a manner consistent with those positions, so long as Executive's time commitment to such services is no greater than the time commitment in effect immediately prior to the Effective Date, (Y) any activities approved by written consent of the Board or any other Board Roles, or (Z) any solicitation, hiring or engagement of Misty Nelson.

(c) Enforcement. If, at the time of enforcement of Sections 2 or 3 of this Agreement, a court holds that the restrictions stated herein are unreasonable under circumstances then existing, the Parties agree that the maximum duration, scope or geographical area reasonable under such circumstances shall be substituted for the stated duration, scope or area and that the court shall be allowed to revise the restrictions contained herein to cover the maximum duration, scope and area permitted by law. Because Executive's services are unique and because Executive has access to Confidential Information, the Parties agree that money damages would not be an adequate remedy for any breach of this Agreement. Therefore, in the event a breach or threatened breach of this Agreement, EHC, the Company or their successors or assigns may, in addition to other rights and remedies existing in their favor, apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief in order to enforce, or prevent any violations of, the provisions hereof (without posting a bond or other security and without proving damages).

GENERAL PROVISIONS

4. Definitions. For purposes of this Agreement:

"***Affiliate***" means, as to any Person, any other Person, which directly or indirectly controls, or is under common control with, or is controlled by, such Person. As used in this definition, "control" (including, with its correlative meanings, "controlled by" and "under common control with") shall mean possession, directly or indirectly, of power to direct or cause the direction of management or policies (whether through ownership of securities or partnership or other ownership interests, by contract or otherwise).

"***Cause***" shall mean (i) dishonesty, fraud, or any act involving moral turpitude on Executive's part in connection with the performance of her duties which is materially detrimental to the Company or any of its Affiliates, (ii) being charged (by indictment, information or otherwise) with any criminal violation of any law or regulation pertaining to health care and/or pharmaceutical services and products (including, without limitation, laws and regulations pertaining to reimbursement or coverage by the Medicare program, any state Medicaid program or any other governmental health care program or by third-party payors, laws prohibiting kickbacks or false claims, and laws prohibiting fraud or abuse or fraudulent or abusive activities), (iii) Executive's refusal to follow lawful directives of the Board in a manner that is materially detrimental to EHC, (iv) Executive's intentional or gross neglect of the performance of her duties as Chief Executive Officer of the Company, (v) Executive's misappropriation of any corporate opportunity, provided Executive's pursuit or referral of an opportunity shall not be improper or misappropriation if (A) Executive first presents an opportunity to the EHCCEO in writing and the EHCCEO does not express an interest in pursuing it within thirty (30) days or (B) the Board authorizes Executive to pursue or refer an opportunity to another Person or entity, (vi) Executive's conviction of, or plea of guilty or no contest to, any felony, (vii) a material breach by Executive of this Agreement, including but not limited to Sections 2 and 3; provided, Cause shall not exist unless and until (1) Executive receives written notice from the Board stating the Board's intent to terminate Executive's employment and such written notice includes a reasonably detailed explanation of the reasons for such intent and states the subsection of the Cause definition that the Board believes to be present, (2) in the circumstances described in clauses (iii), (iv), (v) and (vii), Executive shall have fifteen (15) days to cure the alleged default after written notice by the Board, (3) Executive may address the Board at a duly-scheduled meeting of the Board, and shall be able to bring counsel if the Board chooses to have counsel present at such meeting, at which Company counsel shall be present at such meeting and (4) the Board votes to authorize a termination for Cause.

"***Confidential Information***" means all information of a confidential or proprietary nature (whether or not specifically labeled or identified as "confidential"), in any form or medium that relates to EHC, the Company or any of their Affiliates or their business

relations and their respective business activities. Confidential Information includes, but is not limited to, the following: (i) internal business information (including information relating to strategic and staffing plans and practices, business, training, marketing, promotional and sales plans and practices, cost, rate and pricing structures and accounting and business methods); (ii) identities and individual requirements of, and specific contractual arrangements with, EHC's, the Company's or any of their Affiliates' joint venture partners, vendors or customers and other business relations and their confidential information; (iii) trade secrets, know-how, compilations of data and analyses, techniques, systems, formulae, research, records, reports, manuals, documentation, models, data and data bases relating thereto; (iv) inventions, innovations, improvements, developments, methods, designs, analyses, drawings, reports and all similar or related information (whether or not patentable), (v) intellectual property rights, and (vi) financial information.

"***Date of Termination***" shall mean the date Executive's employment with the Company terminates regardless of the reason.

"***Disability***" shall have the meaning defined in the long-term disability insurance plan of the Company or its Affiliates in which Executive participates.

"***Good Reason***" shall mean (i) any material reduction in Executive's pay or benefits or failure to provide any compensation or benefit to which Executive is entitled other than in connection with a Company-wide reduction in pay or benefits, or any reduction in Base Salary below $550,000, regardless of the circumstances, (ii) any relocation of Executive's primary work site by more than twenty (20) miles from both Executive's prior primary work site and Executive's primary residence, (iii) a material diminution of Executive's duties, responsibilities or title, or (iv) a material breach by the Company of this Agreement; provided, that in the circumstances described in (i), (ii), (iii) and (iv) the Company shall have fifteen (15) days to cure the default after delivery written notice by Executive, such written notice to state the nature of the issue and subsection of the Good Reason definition that Executive believes to be present.

"***Person***" means an individual, a partnership, a limited liability company, a corporation, an association, a joint stock company, a trust, a joint venture, an unincorporated organization and a governmental entity or any department, agency or political subdivision thereof.

"***Subsidiary***" means any corporation or other entity of which the Company owns securities having a majority of the ordinary voting power in electing the board of directors or other body having direction over the affairs of such entity either directly or through one or more subsidiaries.

5. Notices. All notices, demands or other communications to be given or delivered under or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given when delivered personally to the recipient, one day after being sent to the recipient by reputable overnight courier service (charges prepaid), upon machine-generated acknowledgement of receipt after transmittal by facsimile or five days after being mailed to the recipient by certified or registered mail, return receipt requested and postage prepaid. Such notices, demands and other communications shall be sent to the Company and Executive at the address set forth below, or at such address or to the attention of such other Person as the recipient Party has specified by prior written notice to the sending Party.

Notices to Executive:

At the most recent contact information on file in the Company's payroll records.

Notices to the Company and EHC:

Encompass Health Corporation

9001 Liberty Parkway

Birmingham, Alabama 35242

Facsimile number: (205) 262-3948

Attention: General Counsel

6. General Provisions.

(a) Severability. Whenever possible, each provision of this Agreement will be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under any applicable law or rule in any jurisdiction, such invalidity, illegality or unenforceability will not affect any other provision or any other jurisdiction, but this Agreement will be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable provision had never been contained herein.

(b) Complete Agreement. This Agreement and those other documents expressly referred to herein and therein embody the complete agreement and understanding among the Parties and supersede and preempt any prior understandings, agreements or representations by or among the Parties, written or oral, which may have related to the subject matter hereof in any way (including, without limitation, the Existing Employment Agreement).

(c) Counterparts. This Agreement may be executed in separate counterparts, each of which is deemed to be an original and all of which taken together constitute one and the same agreement. In the event that any signature of this Agreement is delivered by facsimile or by email delivery of a "PDF" or other electronic format, such signature shall create a valid and binding obligation of the executing Party and shall be considered as if it were the original thereof.

(d) Successors and Assigns. Except as otherwise provided herein, this Agreement shall bind and inure to the benefit of and be enforceable by Executive, the Company and EHC and their respective successors and assigns; provided that the rights and obligations of Executive under this Agreement shall not be assignable. There are no third-party beneficiaries of or to this Agreement.

(e) Choice of Law. The corporate law of the State of Delaware will govern all issues and questions concerning the relative rights of the Company and its stockholders. All other issues and questions concerning the construction, validity and interpretation of this Agreement will be governed by, and construed in accordance with, the internal laws of the State of Delaware, without giving effect to any choice of law or conflict of law provision or rule (whether of the State of Delaware or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Delaware. All actions or proceedings arising out of or from or related to this Agreement shall be litigated in courts having situs in Dallas, Texas. Executive and the Company hereby consent and submit to the jurisdiction of any local, state or federal courts located within such county. Executive and the Company hereby waive any right either may have to transfer or change the venue of any litigation brought by the other in accordance with the terms of this Section.

(f) Remedies. Each of Executive, EHC and the Company will be entitled to enforce its rights under this Agreement specifically, to recover damages and costs (including attorney's fees) caused by any breach of any provision of this Agreement and

to exercise all other rights existing in its favor. Executive, EHC and the Company agree and acknowledge that money damages may not be an adequate remedy for any breach of the provisions of this Agreement and that any Party may in its sole discretion apply to any court of law or equity of competent jurisdiction (without posting any bond or deposit) for specific performance and/or other injunctive relief in order to enforce or prevent any violations of the provisions of this Agreement.

(g) Recoupment. Nothing in the this Agreement should be interpreted to alter or supersede the terms or requirements of EHC's Compensation Recoupment Policy, as it may be amended from time to time, which policy is hereby incorporated in this Agreement by reference.

(h) Amendment and Waiver. The provisions of this Agreement may be amended only with the prior written consent of the Company, EHC and Executive, and any provision of this Agreement may be waived only by the Party waiving compliance.

(i) Business Days. If any time period for giving notice or taking action hereunder expires on a day which is a Saturday, Sunday or holiday in the state in which the Company's chief executive office is located, the time period shall be automatically extended to the business day immediately following such Saturday, Sunday or holiday.

(j) Indemnification and Reimbursement of Payments on Behalf of Executive. Executive shall be solely responsible for all taxes, if any, associated with the amounts payable or value delivered to Executive under this Agreement. The Company and its Affiliates shall be entitled to deduct or withhold from any amounts owing from the Company or any of its Affiliates to Executive any federal, state, local or foreign withholding taxes, excise taxes, or employment taxes ("***Taxes***") imposed on Executive with respect to Executive's compensation or other payments from the Company or any of its Affiliates or Executive's ownership interest in Encompass Health Home Health Holdings, Inc. or EHC, including, but not limited to, wages, bonuses, dividends, the receipt or exercise of stock appreciation rights and/or the receipt or vesting of restricted stock.

(k) Effectiveness of Agreement and Replacement of Prior Agreements. At 12:01 a.m. central time on the Effective Date, (i) this Agreement shall supersede and replace the Existing Employment Agreement and (ii) the Existing Employment Agreement shall thereupon be terminated and without any further force or effect, with no penalty or severance payable to any Person as a result of such termination. For the avoidance of doubt, from the date that this Agreement is executed until the Effective Date, the Existing Employment Agreement shall continue in full force and effect in accordance with its terms.

(l) Termination. Except as otherwise provided herein, this Agreement shall survive the termination of Executive's employment with the Company and shall remain in full force and effect after such termination.

(m) Generally Accepted Accounting Principles; Adjustments of Numbers. Where any accounting determination or calculation is required to be made under this Agreement, such determination or calculation (unless otherwise provided) shall be made in accordance with generally accepted accounting principles, consistently applied, except that if because of a change in generally accepted accounting principles the Company would have to alter a previously utilized accounting method or policy in order to remain in compliance with generally accepted accounting principles, such determination or calculation shall continue to be made in accordance with the Company's previous accounting methods and policies. All numbers set forth herein which refer to share prices or amounts will be appropriately adjusted to reflect stock splits, stock dividends, combinations of shares and other recapitalizations affecting the subject class of stock.

(n) Reformation; Specified Employee. Executive, EHC and the Company agree that if any provision of this Agreement is deemed unenforceable or invalid, it may be reformed to permit enforcement of the objectionable provision to the fullest permissible extent. Any provision of this Agreement deemed unenforceable after modification shall be deemed stricken from this Agreement, with the remainder of the Agreement being given its full force and effect. Notwithstanding any other provision with respect to the timing of payments under this Agreement, if, at the time of Executive's termination of employment, Executive is deemed to be a

"specified employee" (within the meaning of Section 409A(a)(2)(B) of the Code), and any successor statute, regulation and guidance thereto) of the Company, then only to the extent necessary to comply with the requirements of Section 409A of the Code, any payments to which Executive may become entitled under this Agreement as a result of Executive's termination of employment which are subject to Section 409A of the Code (and not otherwise exempt from its application) will be withheld until the first business day of the seventh month following the Date of Termination, at which time Executive shall be paid an aggregate amount equal to six months of payments otherwise due to Executive under the terms of or a full lump sum if otherwise due. For purposes of Section 409A of the Code, each payment made under this Agreement shall be treated as a separate payment. Further, notwithstanding anything herein, to the extent that Executive or the Company reasonably believes that Section 409A of the Code will result in adverse tax consequences to Executive as a result of this Agreement, then Executive and the Company shall renegotiate this Agreement in good faith in order to minimize or eliminate such tax consequences and retain the basic after-tax economics of this Agreement for Executive to the extent reasonably possible.

(o) No Strict Construction. The Parties have participated jointly in the negotiation and drafting of this Agreement. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the Parties, and no presumption or burden of proof shall arise favoring or disfavoring any Party by virtue of the authorship of any of the provisions of this Agreement.

(p) Descriptive Headings; Interpretation. The descriptive headings of this Agreement are inserted for convenience only and do not constitute a part of this Agreement. The use of the word "including" in this Agreement shall be by way of example rather than by limitation. Definitions are equally applicable to both the singular and plural forms of the terms defined, and references to the masculine, feminine or neuter gender include each other gender.

(q) Resolution of Disputes.

(i) Mediation. No Party shall initiate arbitration or other legal proceedings against any other Party arising out of or relating in any way to this Agreement, except that any Party may seek injunctive relief at any time. No such arbitration or proceeding shall be initiated in respect of Executive's employment with the Company or any and all claims that one Party may have against another Party or its Affiliates until thirty (30) days after written notice has been given of the specific nature of any purported claim and the amount of any purported damages. The Parties further agree that if any Party submits the claim to the American Arbitration Association for nonbinding mediation prior to the expiration of such thirty (30) day period, no other Party may institute arbitration or other legal proceedings against the claimant Party until the earlier of: (i) completion of nonbinding mediation efforts, or (ii) forty-five (45) days after the date on which the non-claimant Party receives notice of the claimant Party's claim. The mediation shall be conducted in Dallas, Texas or such other location to which the applicable Parties may agree.

(ii) Arbitration. Except as provided in Section 6(f) or Section 6(p)(iii), any dispute or controversy between or among the Parties, whether arising out of or relating to this Agreement, the breach of this Agreement, or otherwise, shall be settled by arbitration in Dallas, Texas or such other location to which the applicable Parties may agree administered by the American Arbitration Association, with any such dispute or controversy arising under this Agreement being so administered in accordance with its Employment Rules then in effect, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The arbitrator shall have the authority to award any remedy or relief that a court of competent jurisdiction could order or grant, including, without limitation, the issuance of an injunction. Except as necessary in court proceedings to enforce this arbitration provision or an award rendered hereunder, or to obtain interim relief, neither a Party nor an arbitrator may disclose the existence, content or results of any arbitration hereunder without the prior written consent of EHC, the Company and Executive. The Parties acknowledge that this Agreement evidences a transaction involving interstate commerce. Notwithstanding any choice of law provision included in this Agreement, the United States Federal Arbitration Act shall govern the interpretation and enforcement of this arbitration provision.

(iii) Enforcement. The Parties agree that EHC, the Company and their Affiliates would be damaged irreparably in the event that any provision of Section 2 or 3 of this Agreement were not performed in accordance with its terms or were otherwise breached, and that Executive would be damaged irreparably in the event of certain conduct by EHC, the Company and their Affiliates, and that money damages would be an inadequate remedy for any such nonperformance or breach. Accordingly, Executive, EHC, and the Company and its successors and permitted assigns shall be entitled, in addition to other rights and remedies existing in its favor, to seek an injunction or injunctions to prevent any breach or threatened breach of any of such provisions and to enforce such provisions specifically (without posting a bond or other security). Executive, EHC, and the Company agree to submit to the personal jurisdiction of the courts of the State of Texas in any action by EHC or the Company to enforce an arbitration award against Executive or to obtain interim injunctive or other relief pending an arbitration decision.

Remainder of page intentionally left blank.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their respective duly authorized officers (as applicable) as of the day and year first written above.

EHHI HOLDINGS, INC.

By: /s/ Patrick Darby
Name: Partick Darby
Title: Vice President and Secretary

ENCOMPASS HEALTH CORPORATION

By: /s/ Mark J. Tarr
Name: Mark J. Tarr
Title: President and Chief Executive Officer

/s/ April Anthony

April Anthony

[2019 Amended and Restated Senior Management Agreement]

Exhibit 21

Subsidiary Name	Jurisdiction of Incorporation	DBA
A & B Home Health Solutions, LLC	CT	Encompass Health Home Health
Abba Home Health, L.P.	TX	Encompass Health Home Health Encompass Health Hospice
Advanced Homecare Management, Inc.	DE	Encompass Health Encompass Health Home Health & Hospice
AHM Action Home Health, LP	TX	Encompass Health Home Health
AnMed Encompass Health Rehabilitation Hospital, LLC	SC	AnMed Health Rehabilitation Hospital
Apex Hospice LLC	TX	Encompass Health Hospice
Best Home Care LP	TX	Encompass Health Home Health
Camellia Home Health of East Tennessee, LLC	TN	Encompass Health Home Health
Camellia Home Health of the Gulf Coast, LLC	MS	Encompass Health - Home Health of the Gulf Coast
Camellia Hospice of East Louisiana, LLC	LA	Encompass Health Hospice of Vidalia
Camellia Hospice of Louisiana, LLC	LA	Encompass Health Hospice of Bogalusa
Camellia Hospice of North Mississippi, LLC	MS	Encompass Health - Hospice of North Mississippi
Camellia Hospice of Northeast Alabama, LLC	AL	Encompass Health Hospice - Rainbow City
Camellia Hospice of Northeast Mississippi, LLC	MS	Encompass Health - Hospice of Northeast Mississippi
Camellia Hospice of South Alabama, LLC	MS	Encompass Health Hospice - Dothan Encompass Health Hospice - Prattville
Camellia Hospice of the Gulf Coast, LLC	MS	Encompass Health - Hospice of the Gulf Coast
CareServices of Bethesda, LLC	FL	Encompass Health Home Health of Bethesda
CareSouth HHA Holdings of Columbus, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Dothan, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Gainesville, LLC	GA	Encompass Health Home Health Encompass Health Hospice
CareSouth HHA Holdings of Greensboro, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Lexington, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Middle Georgia, LLC	GA	Encompass Health Home Health

CareSouth HHA Holdings of North Florida, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Panama City, LLC	FL	Encompass Health Home Health
CareSouth HHA Holdings of Richmond, LLC	VA	Encompass Health Home Health
CareSouth HHA Holdings of Tallahassee, LLC	FL	Encompass Health Home Health
CareSouth HHA Holdings of the Bay Area, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of the Treasure Coast, LLC	GA	Encompass Health Home Health of Jupiter Medical Center
CareSouth HHA Holdings of Valley, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Virginia, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Washington, LLC	GA	Encompass Health Home Health
CareSouth HHA Holdings of Western Carolina, LLC	GA	Encompass Health Home Health
CareSouth Hospice, LLC	GA	Encompass Health Hospice
Central Arkansas Rehabilitation Associates, L.P.	DE	CHI St. Vincent Sherwood Rehabilitation Hospital, a partner of Encompass Health CHI St. Vincent Hot Springs Rehabilitation Hospital, a partner of Encompass Health
Central Louisiana Rehab Associates, L.P.	DE	Encompass Health Rehabilitation Hospital of Alexandria
CMS Rehab of WF, L.P.	DE	Encompass Health Rehabilitation Hospital of Wichita Falls
Continental Home Care, Inc.	OK	Encompass Health Home Health of Eastern Oklahoma
Day-By-Day Staff Relief, Inc.	OK	Encompass Health Home Health Encompass Health Home Health of Northeast Oklahoma Encompass Health Hospice
Dosik, Inc.	TX	Encompass Health Home Health
DRC Health Systems, L.P.	TX	Encompass Health Home Health Encompass Health Hospice
Encompass Health Alabama Real Estate, LLC	DE	
Encompass Health Arizona Real Estate, LLC	DE	
Encompass Health Arkansas Real Estate, LLC	DE	
Encompass Health California Real Estate, LLC	DE	
Encompass Health Deaconess Rehabilitation Hospital, LLC	IN	Encompass Health Deaconess Rehabilitation Hospital
Encompass Health Fairlawn Holdings, LLC	DE	
Encompass Health Home Health of Alabama, LLC	DE	Encompass Health Home Health
Encompass Health Home Health of Birmingham, LLC	DE	Encompass Health Home Health

Encompass Health Home Health of Florida, LLC	DE	Encompass Health Home Health
Encompass Health Home Health of Kentucky, LLC	DE	Encompass Health Home Health of Kentucky
Encompass Health Home Health of Talladega, LLC	DE	Encompass Health Home Health
Encompass Health Hospice of Alabama, LLC	DE	Encompass Health Hospice
Encompass Health Hospice of Pennsylvania, LLC	DE	Encompass Health Hospice
Encompass Health Hospice of Talladega, LLC	DE	Encompass Health Hospice Talladega
Encompass Health Iowa Real Estate, LLC	DE	
Encompass Health Jonesboro Holdings, Inc.	DE	
Encompass Health Kansas Real Estate, LLC	DE	
Encompass Health Kentucky Real Estate, LLC	DE	
Encompass Health Maryland Real Estate, LLC	DE	
Encompass Health Massachusetts Real Estate, LLC	DE	
Encompass Health Methodist Rehabilitation Hospital, LP	TN	Encompass Health Rehabilitation Hospital of Memphis, a partner of Methodist Healthcare Encompass Health Rehabilitation Hospital of North Memphis, a partner of Methodist Healthcare
Encompass Health Nevada Real Estate, LLC	DE	
Encompass Health New Mexico Real Estate, LLC	DE	
Encompass Health Ohio Real Estate, LLC	DE	
Encompass Health Pennsylvania Real Estate, LLC	DE	
Encompass Health Rehabilitation Hospital of Abilene, LLC	DE	Encompass Health Rehabilitation Hospital of Abilene
Encompass Health Rehabilitation Hospital of Albuquerque, LLC	DE	Encompass Health Rehabilitation Hospital of Albuquerque
Encompass Health Rehabilitation Hospital of Altamonte Springs, LLC	DE	Encompass Health Rehabilitation Hospital of Altamonte Springs
Encompass Health Rehabilitation Hospital of Altoona, LLC	DE	Encompass Health Rehabilitation Hospital of Altoona
Encompass Health Rehabilitation Hospital of Arlington, LLC	DE	Encompass Health Rehabilitation Hospital of Arlington
Encompass Health Rehabilitation Hospital of Austin, LLC	DE	Encompass Health Rehabilitation Hospital of Austin

Encompass Health Rehabilitation Hospital of Bakersfield, LLC	DE	Encompass Health Rehabilitation Hospital of Bakersfield
Encompass Health Rehabilitation Hospital of Bluffton, LLC	DE	Encompass Health Rehabilitation Hospital of Bluffton
Encompass Health Rehabilitation Hospital of Braintree, LLC	DE	Encompass Health Rehabilitation Hospital of Braintree
Encompass Health Rehabilitation Hospital of Cardinal Hill, LLC	DE	Cardinal Hill Rehabilitation Hospital
Encompass Health Rehabilitation Hospital of Charleston, LLC	SC	Encompass Health Rehabilitation Hospital of Charleston
Encompass Health Rehabilitation Hospital of Cincinnati, LLC	DE	Encompass Health Rehabilitation Hospital of Cincinnati
Encompass Health Rehabilitation Hospital of City View, Inc.	DE	Encompass Health Rehabilitation Hospital of City View
Encompass Health Rehabilitation Hospital of Colorado Springs, Inc.	DE	Encompass Health Rehabilitation Hospital of Colorado Springs
Encompass Health Rehabilitation Hospital of Columbia, Inc.	DE	Encompass Health Rehabilitation Hospital of Columbia
Encompass Health Rehabilitation Hospital of Concord, Inc.	DE	Encompass Health Rehabilitation Hospital of Concord
Encompass Health Rehabilitation Hospital of Cypress, LLC	DE	Encompass Health Rehabilitation Hospital of Cypress
Encompass Health Rehabilitation Hospital of Dallas, LLC	DE	Encompass Health Rehabilitation Hospital of Dallas
Encompass Health Rehabilitation Hospital of Dayton, LLC	DE	Encompass Health Rehabilitation Hospital of Dayton
Encompass Health Rehabilitation Hospital of Desert Canyon, LLC	DE	Encompass Health Rehabilitation Hospital of Desert Canyon
Encompass Health Rehabilitation Hospital of Dothan, Inc.	AL	Encompass Health Rehabilitation Hospital of Dothan
Encompass Health Rehabilitation Hospital of East Valley, LLC	DE	Encompass Health Rehabilitation Hospital of East Valley
Encompass Health Rehabilitation Hospital of Erie, LLC	DE	Encompass Health Rehabilitation Hospital of Erie
Encompass Health Rehabilitation Hospital of Florence, Inc.	SC	Encompass Health Rehabilitation Hospital of Florence
Encompass Health Rehabilitation Hospital of Fort Smith, LLC	DE	Encompass Health Rehabilitation Hospital of Fort Smith

Encompass Health Rehabilitation Hospital of Franklin, LLC	TN	Encompass Health Rehabilitation Hospital of Franklin
Encompass Health Rehabilitation Hospital of Fredericksburg, LLC	DE	Encompass Health Rehabilitation Hospital of Fredericksburg
Encompass Health Rehabilitation Hospital of Gadsden, LLC	DE	Encompass Health Rehabilitation Hospital of Gadsden
Encompass Health Rehabilitation Hospital of Gulfport, LLC	DE	Encompass Health Rehabilitation Hospital, a partner of Memorial Hospital at Gulfport
Encompass Health Rehabilitation Hospital of Harmarville, LLC	DE	Encompass Health Rehabilitation Hospital of Harmarville
Encompass Health Rehabilitation Hospital of Henderson, LLC	DE	Encompass Health Rehabilitation Hospital of Henderson
Encompass Health Rehabilitation Hospital of Humble, LLC	DE	Encompass Health Rehabilitation Hospital of Humble
Encompass Health Rehabilitation Hospital of Jonesboro, LLC	AR	Encompass Health Rehabilitation Hospital of Jonesboro
Encompass Health Rehabilitation Hospital of Katy, LLC	DE	Encompass Health Rehabilitation Hospital of Katy
Encompass Health Rehabilitation Hospital of Kingsport, LLC	DE	Encompass Health Rehabilitation Hospital of Kingsport
Encompass Health Rehabilitation Hospital of Lakeview, LLC	DE	Encompass Health Rehabilitation Hospital of Lakeview
Encompass Health Rehabilitation Hospital of Largo, LLC	DE	Encompass Health Rehabilitation Hospital of Largo
Encompass Health Rehabilitation Hospital of Las Vegas, LLC	DE	Encompass Health Rehabilitation Hospital of Las Vegas
Encompass Health Rehabilitation Hospital of Manati, Inc.	DE	Encompass Health Rehabilitation Hospital of Manati
Encompass Health Rehabilitation Hospital of Martin County, LLC	DE	Encompass Health Rehabilitation Hospital, an affiliate of Martin Health
Encompass Health Rehabilitation Hospital of Mechanicsburg, LLC	DE	Encompass Health Rehabilitation Hospital of Mechanicsburg
Encompass Health Rehabilitation Hospital of Miami, LLC	DE	Encompass Health Rehabilitation Hospital of Miami
Encompass Health Rehabilitation Hospital of Middletown, LLC	DE	Encompass Health Rehabilitation Hospital of Middletown
Encompass Health Rehabilitation Hospital of Midland Odessa, LLC	DE	Encompass Health Rehabilitation Hospital of Midland Odessa

Encompass Health Rehabilitation Hospital of Modesto, LLC	DE	Encompass Health Rehabilitation Hospital of Modesto
Encompass Health Rehabilitation Hospital of Montgomery, Inc.	AL	Encompass Health Rehabilitation Hospital of Montgomery
Encompass Health Rehabilitation Hospital of New England, LLC	DE	Encompass Health Rehabilitation Hospital of New England
Encompass Health Rehabilitation Hospital of Newnan, LLC	DE	Encompass Health Rehabilitation Hospital of Newnan
Encompass Health Rehabilitation Hospital of Nittany Valley, Inc.	DE	Encompass Health Rehabilitation Hospital of Nittany Valley
Encompass Health Rehabilitation Hospital of Northern Kentucky, LLC	DE	Encompass Health Rehabilitation Hospital of Northern Kentucky
Encompass Health Rehabilitation Hospital of Northern Virginia, LLC	DE	Encompass Health Rehabilitation Hospital of Northern Virginia
Encompass Health Rehabilitation Hospital of Northwest Tucson, L.P.	DE	Encompass Health Rehabilitation Hospital of Northwest Tucson
Encompass Health Rehabilitation Hospital of Ocala, LLC	DE	Encompass Health Rehabilitation Hospital of Ocala
Encompass Health Rehabilitation Hospital of Panama City, Inc.	FL	Encompass Health Rehabilitation Hospital of Panama City
Encompass Health Rehabilitation Hospital of Pearland, LLC	DE	Encompass Health Rehabilitation Hospital of Pearland
Encompass Health Rehabilitation Hospital of Petersburg, LLC	DE	Encompass Health Rehabilitation Hospital of Petersburg
Encompass Health Rehabilitation Hospital of Plano, LLC	DE	Encompass Health Rehabilitation Hospital of Plano
Encompass Health Rehabilitation Hospital of Reading, LLC	DE	Encompass Health Rehabilitation Hospital of Reading
Encompass Health Rehabilitation Hospital of Richardson, LLC	DE	Encompass Health Rehabilitation Hospital of Richardson
Encompass Health Rehabilitation Hospital of Rock Hill, LLC	SC	Encompass Health Rehabilitation Hospital of Rock Hill
Encompass Health Rehabilitation Hospital of Round Rock, LLC	DE	Encompass Health Rehabilitation Hospital of Round Rock
Encompass Health Rehabilitation Hospital of San Antonio, Inc.	DE	Encompass Health Rehabilitation Hospital of San Antonio
Encompass Health Rehabilitation Hospital of San Juan, Inc.	DE	Encompass Health Rehabilitation Hospital of San Juan

Encompass Health Rehabilitation Hospital of Sarasota, LLC	DE	Encompass Health Rehabilitation Hospital of Sarasota
Encompass Health Rehabilitation Hospital of Savannah, LLC	DE	Encompass Health Rehabilitation Hospital of Savannah
Encompass Health Rehabilitation Hospital of Scottsdale, LLC	DE	Encompass Health Rehabilitation Hospital of Scottsdale
Encompass Health Rehabilitation Hospital of Sewickley, LLC	DE	Encompass Health Rehabilitation Hospital of Sewickley
Encompass Health Rehabilitation Hospital of Shelby County, LLC	DE	Encompass Health Rehabilitation Hospital of Shelby County
Encompass Health Rehabilitation Hospital of Spring Hill, Inc.	DE	Encompass Health Rehabilitation Hospital of Spring Hill
Encompass Health Rehabilitation Hospital of Sugar Land, LLC	DE	Encompass Health Rehabilitation Hospital of Sugar Land
Encompass Health Rehabilitation Hospital of Sunrise, LLC	DE	Encompass Health Rehabilitation Hospital of Sunrise
Encompass Health Rehabilitation Hospital of Tallahassee, LLC	DE	Encompass Health Rehabilitation Hospital of Tallahassee
Encompass Health Rehabilitation Hospital of Texarkana, Inc.	DE	Encompass Health Rehabilitation Hospital of Texarkana
Encompass Health Rehabilitation Hospital of the Mid-Cities, LLC	DE	Encompass Health Rehabilitation Hospital of the Mid-Cities
Encompass Health Rehabilitation Hospital of The Woodlands, Inc.	DE	Encompass Health Rehabilitation Hospital of The Woodlands
Encompass Health Rehabilitation Hospital of Toms River, LLC	DE	Encompass Health Rehabilitation Hospital of Toms River
Encompass Health Rehabilitation Hospital of Treasure Coast, Inc.	DE	Encompass Health Rehabilitation Hospital of Treasure Coast
Encompass Health Rehabilitation Hospital of Tustin, L.P.	DE	Encompass Health Rehabilitation Hospital of Tustin
Encompass Health Rehabilitation Hospital of Utah, LLC	DE	Encompass Health Rehabilitation Hospital of Utah
Encompass Health Rehabilitation Hospital of Vineland, LLC	DE	Encompass Health Rehabilitation Hospital of Vineland
Encompass Health Rehabilitation Hospital of Western Massachusetts, LLC	MA	Encompass Health Rehabilitation Hospital of Western Massachusetts
Encompass Health Rehabilitation Hospital of Westerville, LLC	DE	Mount Carmel Rehabilitation Hospital, an affiliate of Encompass Health

Encompass Health Rehabilitation Hospital of York, LLC	DE	Encompass Health Rehabilitation Hospital of York
Encompass Health Rehabilitation Hospital The Vintage, LLC	DE	Encompass Health Rehabilitation Hospital The Vintage
Encompass Health Rehabilitation Hospital Vision Park, LLC	DE	Encompass Health Rehabilitation Hospital Vision Park
Encompass Health Rehabilitation Institute of Tucson, LLC	AL	Encompass Health Rehabilitation Institute of Tucson
Encompass Health Sewickley Holdings, LLC	DE	
Encompass Health South Carolina Real Estate, LLC	DE	
Encompass Health South Dakota Real Estate, LLC	DE	
Encompass Health Texas Real Estate, LLC	DE	
Encompass Health Utah Real Estate, LLC	DE	
Encompass Health ValleyofTheSun Rehabilitation Hospital, LLC	DE	Encompass Health Valley of The Sun Rehabilitation Hospital
Encompass Health Virginia Real Estate, LLC	DE	
Encompass Health Walton Rehabilitation Hospital, LLC	DE	Walton Rehabilitation Hospital, an affiliate of Encompass Health
Encompass Health West Virginia Real Estate, LLC	DE	
Encompass Home Health of Austin, LLC	TX	Encompass Health Home Health Encompass Health Hospice
Encompass Home Health of Colorado, LLC	CO	Encompass Health Home Health Encompass Health Hospice
Encompass Home Health of DFW, LLC	TX	Encompass Health Home Health
Encompass Home Health of East Texas, LLC	DE	Encompass Health Home Health Encompass Health Hospice
Encompass Home Health of Roanoke, LLC	DE	Encompass Health Home Health
Encompass Home Health of the Mid Atlantic, LLC	VA	Encompass Health Home Health Encompass Health Hospice
Encompass Home Health of the Midwest, LLC	DE	Encompass Health Home Health
Encompass Home Health of the Southeast, LLC	FL	Encompass Health Home Health
Encompass Home Health of the West, LLC	ID	Encompass Health Home Health Encompass Health Home Health of Eastern Idaho

		Encompass Health Home Health of Southern Utah Encompass Health Hospice of Southern Utah
Encompass Hospice of the West, LLC	ID	Encompass Health Hospice Encompass Health Hospice of Eastern Idaho
Encompass of Fort Worth, LP	TX	Encompass Health Home Health
Encompass of West Texas, LP	TX	Encompass Health Home Health
Encompass PAHS Rehabilitation Hospital, LLC	CO	Encompass Health Rehabilitation Hospital of Littleton
Geisinger Encompass Health Limited Liability Company	PA	Geisinger Encompass Health Rehabilitation Hospital
Guardian Home Care, Inc.	ID	Encompass Health Home Health Encompass Health Home Health of Idaho
Hallmark Homecare, L.P.	TX	Encompass Health Home Health Encompass Health Hospice
HCA Wesley Rehabilitation Hospital, Inc.	DE	Wesley Rehabilitation Hospital, an affiliate of Encompass Health
HealthCare Innovations of Oklahoma, L.L.C.	TX	Encompass Health Home Health of Southeast Oklahoma Encompass Health Hospice
HealthCare Innovations of Western Oklahoma, L.L.C.	TX	Encompass Health Home Health of Western Oklahoma
HealthCare Innovations-Travertine Health Services, L.L.C.	TX	Encompass Health Home Health of Central Oklahoma
Home Health Care of Bogalusa, Inc.	LA	Encompass Health Home Health of Bogalusa
Home Health Care Systems, Inc.	MS	Encompass Health - Home Health & Hospice
Hospice Care of Mississippi, LLC	MS	Encompass Health - Hospice
K.C. Rehabilitation Hospital, Inc.	DE	MidAmerica Rehabilitation Hospital
Kansas Rehabilitation Hospital, Inc.	DE	Kansas Rehabilitation Hospital, a joint venture of Encompass Health and Stormont Vail Health
MMC Encompass Health Rehabilitation Hospital, LLC	NJ	Encompass Health Rehabilitation Hospital of Tinton Falls, a Joint Venture with Monmouth Medical Center
Myrtle Beach Rehabilitation Hospital, LLC	DE	Tidelands Health Rehabilitation Hospital, an affiliate of Encompass Health
New England Rehabilitation Hospital of Portland, LLC	ME	New England Rehabilitation Hospital of Portland, a Joint Venture of Maine Medical Center and Encompass Health
New England Rehabilitation Services of Central Massachusetts, Inc.	MA	Fairlawn Rehabilitation Hospital, an affiliate of Encompass Health
Northwest Arkansas Rehabilitation Associates	AR	Encompass Health Rehabilitation Hospital, a partner of Washington Regional
Novant Health Rehabilitation Hospital of Winston-Salem, LLC	DE	Novant Health Rehabilitation Hospital, an affiliate of Encompass Health
Orion Homecare, LLC	ID	Encompass Health Home Health Encompass Health Home Health of Western Idaho Encompass Health Hospice

Preferred Home Health, L.P.	TX	Encompass Health Home Health
Quillen Rehabilitation Hospital of Johnson City, LLC	DE	Quillen Rehabilitation Hospital, a joint venture of Ballad Health and Encompass Health
Rebound, LLC	DE	Encompass Health Lakeshore Rehabilitation Hospital Encompass Health Rehabilitation Hospital of Chattanooga Encompass Health Rehabilitation Hospital of Huntington
Rehabilitation Hospital Corporation of America, LLC	DE	Encompass Health Rehabilitation Hospital of Salisbury Encompass Health Rehabilitation Hospital of Richmond Encompass Health Rehabilitation Hospital of Parkersburg Encompass Health Rehabilitation Hospital of Princeton
Rehabilitation Hospital of Bristol, LLC	DE	Rehabilitation Hospital of Bristol, a joint venture of Ballad Health and Encompass Health
Rehabilitation Hospital of North Alabama, LLC	DE	Encompass Health Rehabilitation Hospital of North Alabama
Rehabilitation Hospital of Phenix City, L.L.C.	AL	Regional Rehabilitation Hospital
Rusk Rehabilitation Center, L.L.C.	MO	Rusk Rehabilitation Hospital, an affiliation of Encompass Health and MU Health Care
Saint Alphonsus Regional Rehabilitation Hospital, LLC	ID	Saint Alphonsus Regional Rehabilitation Hospital, an affiliate of Encompass Health
Sea Pines Rehabilitation Hospital Limited Partnership	AL	Sea Pines Rehabilitation Hospital, an affiliate of Encompass Health
South Plains Rehabilitation Hospital, LLC	TX	South Plains Rehabilitation Hospital, an affiliate of UMC and Encompass Health
St. John Encompass Health Rehabilitation Hospital, LLC	DE	St. John Rehabilitation Hospital, an affiliate of Encompass Health
St. Joseph Encompass Health Rehabilitation Hospital, LLC	DE	CHI St. Joseph Health Rehabilitation Hospital, an affiliate of Encompass Health
Texas Senior Care, L.P.	TX	Encompass Health Home Health
TH of San Antonio LLC	TX	Encompass Health Hospice
The Rehabilitation Institute of St. Louis, LLC	MO	The Rehabilitation Institute of St. Louis, an affiliation of BJC HealthCare and Encompass Health
Tyler Rehab Associates, L.P.	DE	Christus Trinity Mother Frances Rehabilitation Hospital, a partner of Encompass Health
UVA Encompass Health Rehabilitation Hospital, LLC	VA	UVA Encompass Health Rehabilitation Hospital
Van Matre Encompass Health Rehabilitation Hospital, LLC	IL	Van Matre Encompass Health Rehabilitation Hospital
Vanderbilt Stallworth Rehabilitation Hospital, L.P.	TN	Vanderbilt Stallworth Rehabilitation Hospital
WellCare, Inc.	NM	Encompass Health Home Health Encompass Health Hospice
Wellmark Healthcare Services of El Paso, Inc.	TX	Encompass Health Home Health Encompass Health Hospice
West Mississippi Home Health Services, Inc.	MS	Encompass Health - Home Health
West Tennessee Rehabilitation Hospital, LLC	DE	West Tennessee Healthcare Rehabilitation Hospital Jackson, a partnership with Encompass Health West Tennessee Healthcare Rehabilitation Hospital Cane Creek, a partnership with Encompass Health

West Virginia Rehabilitation Hospital, Inc.	WV	Encompass Health Rehabilitation Hospital of Morgantown
Yuma Rehabilitation Hospital, L.L.C.	AZ	Yuma Rehabilitation Hospital, an affiliation of Encompass Health and Yuma Regional Medical Center

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-157445, 333-175981, and 333-212840) and Form S-3 (No. 333-220519) of Encompass Health Corporation of our report dated February 27, 2020 relating to the financial statements and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 27, 2020

Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Mark J. Tarr, certify that:

1. I have reviewed this Annual Report on Form 10-K of Encompass Health Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2020

By: /s/ MARK J. TARR

Name: Mark J. Tarr

Title: President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Douglas E. Coltharp, certify that:

1. I have reviewed this Annual Report on Form 10-K of Encompass Health Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2020

By: /s/ Douglas E. Coltharp

Name: Douglas E. Coltharp

Title: Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATE OF CHIEF EXECUTIVE OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED
PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Encompass Health Corporation on Form 10-K for the period ended December 31, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Mark J. Tarr, President and Chief Executive Officer of Encompass Health Corporation, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (the "2002 Act"), that to the best of my knowledge and belief:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Encompass Health Corporation.

Date: February 27, 2020

By: /s/ MARK J. TARR

Name: Mark J. Tarr

Title: President and Chief Executive Officer

A signed original of this written statement has been provided to Encompass Health Corporation and will be retained by Encompass Health Corporation and furnished to the Securities and Exchange Commission or its staff upon request. This written statement shall not, except to the extent required by the 2002 Act, be deemed filed by Encompass Health Corporation for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and will not be deemed to be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act, except to the extent that Encompass Health Corporation specifically incorporates it by reference.

Exhibit 32.2

CERTIFICATE OF CHIEF FINANCIAL OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED
PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Encompass Health Corporation on Form 10-K for the period ended December 31, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Douglas E. Coltharp, Executive Vice President and Chief Financial Officer of Encompass Health Corporation, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (the "2002 Act"), that to the best of my knowledge and belief:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Encompass Health Corporation.

Date: February 27, 2020

By: /s/ DOUGLAS E. COLTHARP

Name: Douglas E. Coltharp

Title: Executive Vice President and Chief Financial Officer

A signed original of this written statement has been provided to Encompass Health Corporation and will be retained by Encompass Health Corporation and furnished to the Securities and Exchange Commission or its staff upon request. This written statement shall not, except to the extent required by the 2002 Act, be deemed filed by Encompass Health Corporation for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and will not be deemed to be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act, except to the extent that Encompass Health Corporation specifically incorporates it by reference.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

Mike Richardson, being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Tennessee Health Services and Development Agency and T.C.A. § 68-11-1601, *et seq.*, and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

Signature/Title

Sworn to and subscribed before me this the 14 day of July, 2020, a Notary Public in and for the County of Knox, State of Tennessee.

NOTARY PUBLIC

My Commission expires 09-05-2022.

SUZANNE F MOUNGER
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY
My Commission Expires 09-05-2022

HF-0056
Revised 7/02 - All forms prior to this date are obsolete

Supplemental 1
July 28, 2020

July 28, 2020

Mr. Phillip Earhart
HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC ("WEST") – CN2007-023

Dear Mr. Earhart:

Please find enclosed our responses to the supplemental questions you sent regarding the above-referenced CON application which seeks approval for the establishment of an Inpatient Rehabilitation Hospital utilizing 51 existing licensed IRF beds in the service area.

Should you need further clarification regarding the CON application, please let me know at your earliest convenience.

Respectfully,

Mike Richardson
Vice President, Strategic Planning and Development
Covenant Health

Enclosures

Covenant Health: Strategic Planning Department
280 Fort Sanders West Boulevard, Building 4, Suite 218 – Knoxville, Tennessee 37922
Office: (865) 531-5123

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1. **Section A, Executive Summary, Overview, A.1. - Description**

   If approved, what are the plans for the area vacated by the currently licensed 51 beds at Fort Sanders Medical Center's Patricia Neal Rehabilitation Center?

Response:

This "West" CON project involves the utilization of only 51 of the existing 73 licensed Inpatient Rehabilitation beds currently operated under the hospital license of Fort Sanders Regional Medical Center (FSRMC). Rather than fully-vacating the existing area, the relocation and utilization of these existing 51 IRF beds by the "West" project for a new freestanding IRF to be independently licensed will allow significant space decompression needed to create a modern IRF suite in the same area of FSRMC's main building where the Patricia Neal Rehabilitation Center (PNRC), FSRMC's current IFR unit, has been operated since 1978.

Plans for most of the existing FSRMC building space currently utilized by PRNC involve the proposed development of the companion CON project: Rehabilitation Hospital of Knox County, LLC "Downtown" – which is for a modern 22-bed IRF, utilizing the other 22 licensed IRF beds of FSRMC, which will be independently licensed and operated at the same location within FSRMC. Most of the current PNRC area, including all space on the vertically adjacent and operationally connected 4-East and 5-East floors of FSRMC utilized by PRNC, will be leased by the applicant for the "Downtown" project – and renovated and improved as appropriate to create a modern 22-bed IRF with all private rooms, all private and complete bathrooms, and many other features to benefit patients as required to meet or exceed all relevant requirements for a new IRF. Additional detail regarding the plans for these area improvements (including drawings, letters, and construction summaries) are provided in the companion CON application ("Downtown") and are summarized where appropriate within this CON application ("West"). The area to be used by the "Downtown" CON project was initially developed to support PNRC operations in 1978. There is a smaller and much older portion of the FSRMC area currently used by PNRC as needed (i.e. within the 4-West building area of FSRMC created in 1962) that will not be required for the "Downtown" 22-bed IRF project (and is not subject to that companion project's lease option). This smaller and older area of FSRMC includes some administrative office space, conference rooms, a theater room for patients, a recreation room for patients, space utilized to accommodate some inpatient and outpatient rehabilitation needs of FSRMC patients, and some outdated rooms. This additional space made available in the smaller 4-West area after completion of the companion CON projects is anticipated to be used by FSRMC for similar purposes to support various hospital service lines and provide some future flexibility for evolving administrative and patient care needs.

It is noted the Patricia Neal Rehabilitation Center is located within Fort Sanders Medical Center. Please discuss the advantages and disadvantages of a freestanding rehabilitation hospital that is not physically located within an existing licensed hospital.

Response:

Both "freestanding rehabilitation hospitals" and "inpatient rehabilitation hospitals (or units) physically located within a licensed hospital" are suitable and appropriate care settings for providing high quality, safe, and accessible comprehensive inpatient rehabilitation services for patients.

A few advantages of the proposed freestanding rehabilitation hospital include the following:

- **The ability of the proposed "West" rehabilitation hospital to focus solely on the needs of inpatient rehabilitation patients and dedicate all facility space, staff, and resources to this specialized type of service.**
- **A modern facility design that is focused exclusively on inpatient rehabilitation services, including large rehabilitation therapy areas with specialized equipment and technology, an extensive outdoor therapy area, dedicated bariatric rehabilitation rooms, a dedicated dialysis unit, and other features.**
- **The proposed freestanding hospital will provide easy access to a one-story building with adequate surface parking and ease of entry for visitors and caregivers as they are able to directly access the rehabilitation hospital building.**
- **The freestanding hospital will have improved space for educational programs and family-focused services to enhance the patient's rehabilitation and transition back into the community.**

The applicant sees no significant disadvantages to a freestanding rehabilitation hospital that is not physically located within an existing licensed hospital. However, in addition to the proximity to other hospital services, one of the advantages of a rehabilitation hospital located within an existing licensed hospital is the potential for shared services that can be utilized by both the rehabilitation hospital and the general acute care hospital.

What is the distance of the location to the proposed site from Fort Sanders Medical Center's Patricia Neal Rehabilitation Center?

Response:

The proposed site for the 51-bed freestanding IRF is approximately 12 miles from FSRMC.

Please clarify if the proposed project will have a dedicated outpatient physical rehabilitation unit. If not, where will discharged patients be referred for outpatient physical rehabilitation services?

Response:

The proposed project will not have (or need) a dedicated outpatient physical rehabilitation unit.

Rather than creating unnecessary duplication of services and capacity, the project will benefit from the comprehensive network of outpatient rehabilitation services and providers already established by Covenant Health within the service area and across the East Tennessee region. Consistent with other IRF partnerships in Tennessee and nationally, this proven model of care integration will allow clinical collaboration and referral coordination across geographically dispersed care settings to optimize patient care and experience. Additionally, the proposed project will work with other providers as appropriate to address patient needs and preferences – and to ensure post-discharge care in appropriate settings close to where patients live and work (i.e. within the service area, across the broader region, and with out-of-state providers when required).

For informational purposes, current examples of the fully-integrated services and programs provided by Covenant Health's comprehensive outpatient rehabilitation network in the region are provided below:

- **Physical Therapy: Orthopedics; Sports Medicine; Post-Surgical Rehabilitation (joint replacement, orthopedic surgery, amputees, etc.); Back Pain/Rehabilitation; Manual Therapy; Arthritis, Headache and TMJ; Chronic Pain Management and Fibromyalgia; Performance Screenings (runners, cyclists and musicians); Aquatic Therapy; Certified McKenzie Therapy; Certified Hand Therapy; Neurological Rehabilitation (stroke, head injury, Parkinson's, etc.); Balance and Vestibular Rehabilitation; Pelvic Floor Dysfunction; Lymphedema Therapy; and others.**

- **Occupational Therapy: Functional Task Training for Activities of Daily Living (ADL); Neurological Rehabilitation (stroke, head injury, Parkinson's, etc.); and others.**

- **Speech Therapy:** Speech, Language and Cognitive abilities; Auditory & Reading Comprehension; Reasoning, Memory, Attention and Concentration Skills; Tumor and Cancer Rehabilitation; Swallowing Disorders; and others.

- **Workplace Solutions:** Industrial Rehabilitation; Functional Capacity Evaluations; Ergonomic Evaluations; Post-Offer/Pre-Placement Screens; Employee Rehabilitation; Work Conditioning Programs; and others.

If needed, additional information regarding Covenant Health's established network of outpatient therapy centers in the region – including core services, specialty programs, patient accessibility, patient success stories, and key locations – is available on the following website: https://www.covenanthealth.com/therapy-centers/.

Please provide an overview of the number of licensed semi-private and private inpatient rehabilitation patient rooms that are located at Fort Sanders Medical Center's Patricia Neal Rehabilitation Center.

Response:

Number of Existing Licensed IRF Beds at FSRMC/PNRC:

FSRMC is currently licensed to operate 73 IRF beds – which will be split as appropriate to support both companion CON projects (51 licensed IRF beds to be utilized for the proposed "West" project + 22 licensed IRF beds to be utilized for the proposed "Downtown" project) and then relinquished by FSRMC following completion of both proposed projects to be independently licensed if the two CONs are approved.

Number (and Nature) of Patient Rooms available in the existing FSRMC/PNRC IRF Unit:

Currently, FSRMC maintains and utilizes 48 older patient rooms that were originally developed (1962-1978) for use by inpatients based upon semi-private occupancy. These rooms do not meet all current architectural, space, and design requirements for a modern IRF; cannot be modified as required to support all 73 of FSRMC's licensed IRF beds and critical support functions at the same location; and do not meet the evolving expectations of many patients, patient families, referring providers, and other stakeholders for a modern IRF. As a result, all 48 rooms have been staffed and utilized as private rooms by FSRMC/PNRC for many years to optimize patient care and experience as well as possible until an appropriate and comprehensive plan for improvement could be created and implemented. As outlined within the two companion CON projects ("West" and "Downtown"), the proposed projects seek to address these specific issues in an optimal manner, improve all aspects of patient care and experience moving forward, and increase the functional accessibility and operations of all 73 existing licensed IRF beds in the service area.

Executive Summary, Item 3 Need (Rationale for Approval)

Why is there need for a 51-bed licensed rehabilitation hospital since the Patricia Neal Rehabilitation Center only staffed 48 of their 73 licensed inpatient rehabilitation beds and operated at 41% licensed occupancy in 2019?

Response:

PNRC's 73 licensed inpatient rehabilitation beds have been underutilized historically due to space, operational, and other admission constraints addressed throughout the CON application.

As an initial matter, the existing PNRC unit does not have adequate suitable space to accommodate its 73 licensed beds and meet relevant requirements and stakeholder expectations for a modern IRF. Because PNRC does not staff its 73 licensed beds, this results in an artificially suppressed occupancy percentage if calculated based on total licensed beds (*e.g.*, 41% of licensed occupancy in 2019). The space constraints that limit PNRC's ability to utilize its full complement of licensed beds is one of the many reasons that the proposed 51-bed project is needed.

The historic occupancy of the existing PNRC unit - whether calculated as a percentage of licensed or staffed beds - is indicative of the need for this 51-bed "West" project and the companion "Downtown" project. The operational challenges caused by space constraints and dated clinical support infrastructure have limited PNRC's ability to fully utilize even the 48 staffed beds in an optimal manner. The relocation of 51 IRF beds from PNRC to the proposed "West" project is critical to allow space renovations and infrastructure enhancements necessary to improve the existing PNRC unit space for the "Downtown" project to increase efficiency, practical capacity, and utilization.

This project will create additional space required to accommodate all private rooms with private bathrooms. The project will allow significant improvements over the historical "status quo" at PNRC – marked by bed capacity limitations and other operational challenges caused by space constraints and dated clinical support infrastructure. The companion projects will allow PNRC to be more effectively utilize the licensed beds that will remain at the downtown location while providing a new state-of-the-art freestanding hospital where the remainder of the licensed IRF beds can serve patients in need of rehabilitation services. The creation of modern IRF space at PNRC combined with the "West" hospital will provide the ability to support patient care more effectively and will greatly increase the accessibility and benefits of needed IRF resources in the service area.

These companion projects will enable more effective utilization of inpatient rehabilitation services in this area in the future. The projected utilization contained within the CON application for the project is primarily based upon a few interrelated factors:

- **The current Tennessee Department of Health Guidelines for Growth regarding IRF services confirm that all of the existing licensed beds in the service area are needed – and that additional licensed beds will likely be needed to address growing patient**

needs for IRF services in the future. However, the project does not seek to add licensed beds – representing a bed neutral project in the service area for CON consideration.

- Anticipated IRF discharge volume increases over historical baseline volumes at PNRC are based on unmet need for, and utilization of, the existing licensed IRF bed capacity in the project's primary service area. PNRC beds have historically been underutilized due to space, operational, and other admission constraints addressed elsewhere in the CON application.
- The projected volumes for the project, and its companion CON project, primarily represent patients discharged from Covenant Health hospitals who are eligible for IRF services. Historically, many of these patients, who otherwise could have benefited from admission to PNRC, stayed in an acute care hospital setting due to limited accessibility to PNRC because of capacity and intersystem referral processes across major service lines (i.e. orthopedic, neuroscience, rehabilitation, cardiac, surgery, pulmonary, ICU, and others). With the planned modernization of PNRC bed capacity, these IRF-qualified patients will benefit from improved accessibility to focused multidisciplinary IRF services that will prepare a broader spectrum of patients for optimal functionality post discharge. In addition to being fully integrated with the acute care hospitals and inpatient service lines of Covenant Health, the project will be closely aligned with outpatient rehabilitation, homecare, skilled nursing, and physician services – both within the Covenant Health network and with other providers across the region. The project will be accessible to all consumers – and to other referring providers across the region.
- It is expected that significant growth of both the total population and the elderly (65+) population across the project's primary service area, as well as across secondary and tertiary areas, will further increase utilization of all IRF services in the region over time.
- As cited within an attachment included with the original CON application, the applicant is confident that the projected utilization and occupancy for the project is both realistic and conservative.

2. **Section A, Executive Summary, Overview, 3.C., Consent Calendar Justification**

Please clarify the statement on page 9 "the proposed project does not seek to initiate any new services for which a CON is required in Tennessee". The applicant is establishing a new inpatient rehabilitation facility at a new site that will be independently licensed that requires a Certificate of Need.

Response:

The proposed CON project seeks HSDA approval to create a new institution – an independently licensed Inpatient Rehabilitation Hospital (or Inpatient Rehabilitation Facility, i.e. "IRF") that will provide comprehensive inpatient rehabilitation services. To provide requested clarification and context regarding the statement in that section of the CON application, the proposed project does not seek to initiate any other new services for which a CON is required beyond the clear intent (i.e. implied scope of services) of the CON application under consideration for a new Inpatient Rehabilitation Hospital (or "IRF") to be developed at the proposed site and independently licensed.

Please briefly address the request for Consent Calendar using the criteria for review: need, economic feasibility, quality measures, and contribution of orderly development health care.

Response:

The applicant respectfully requests consideration for CON review as a Consent Calendar agenda item. As required, written communication regarding this Consent Calendar request was provided with the original CON application via an attached cover letter to the Agency's Executive Director.

The rationale for an expedited review of the CON application is summarized below:

- **Approval of the CON will result in a bed neutral project for the service area.**
  - **Although the CON project seeks to establish a new inpatient rehabilitation facility (IRF) to be independently licensed, the project does not seek to add any new licensed beds to the service area.**
  - **Rather, the project involves the conversion, upgrade, and partial relocation of existing healthcare resources at another suitable location.**
- **The proposed project does not seek to initiate any other new services for which a CON is required beyond the clear intent (i.e. implied scope of services) of the CON application under consideration for a new Inpatient Rehabilitation Hospital (or "IRF") to be developed at the proposed site and independently licensed.**

- **The proposed project seeks to better serve patients (in the same service area currently served by the existing IRF beds) through a collaborative partnership to modernize existing healthcare resources to address evolving needs and expectations of many stakeholders in the region.**
- **The project meets applicable criteria for IRF CON approval as addressed within various sections of the application.**
- **The project supports the core tenets of the Tennessee State Health Plan.**
- **The project meets the general criteria for CON approval as outlined below:**

Need:

The proposed project will not add any new licensed beds or healthcare services to the region. Rather, the project supports an important continuation and modernization of existing inpatient rehabilitation resources at a different location within Knox County. Approval of the CON will result in a bed neutral project for the service area. The project meets applicable criteria for IRF CON approval as addressed within various sections of the application.

The proposed project will address both unmet current demand for IRF services and increasing demand for inpatient rehabilitation services in the service area related to a growing and aging population as well as other factors. The project will upgrade existing healthcare resources in Knox County to better serve patients and referring providers across the service area. Additionally, the proposed IRF will complement both Covenant Health and Encompass Health care networks in Tennessee through a partnership to enhance care and access for all patients in East Tennessee.

The Tennessee Department of Health's new *Determination of Need* guideline formula for comprehensive inpatient rehabilitation beds in a service area is met for this proposed project.

Economic Feasibility:

The costs anticipated for the project are reasonable. Adequate funding is available to support the project as needed through the cash reserves of Covenant Health and Encompass Health. Projected revenue and expenses for the project indicate the IRF will create positive free cash flow within the first two years of operations, achieve positive net income by Year 2, and maintain operational viability over time.

Quality Standards:

The applicant is committed to ensuring high-quality care for all patients at the proposed IRF. All services at the new IRF will be provided under the oversight of experienced clinical leaders and physicians affiliated with Covenant Health and Encompass Health. The applicant will maintain compliance with all applicable quality, safety, licensure, and other

regulatory standards – and will ensure that all relevant clinical standards for both patient care and patient experience performance are met or exceeded within the new facility.

The applicant will ensure that all State, Federal, CMS, and other requirements for inpatient rehabilitation care environments are met – and will seek accreditation by the Joint Commission and explore accreditation by other organizations as appropriate during the initial years of operation. Additionally, patients to be cared for within the proposed IRF will benefit from the significant clinical collaboration and care management resources available through the integrated care networks of Covenant Health and Encompass Health.

Orderly Development of Adequate and Effective Health Care:

The proposed project will have a positive effect on the overall health care system in the service area and will promote the orderly achievement of the Tennessee State Health Plan's core tenets. Modernization efforts planned for the project will create a state-of-the-art care environment that will be more attractive, accessible, and beneficial to inpatient rehabilitation patients through the proposed conversion of existing licensed beds and related healthcare resources. Approval of the CON will result in a bed neutral project for the service area.

3. **Section A, Project Details, Item 6B.1 Plot Plan**

   It is noted the proposed site consists of 8.1 acres. However, the site documentation notes the site is 10.28 acres (one lot 5.71 acres, and an adjoining lot of 4.59 acres). What currently occupies, or will occupy the remaining 2.18 acres?

Response:

The proposed "West" IRF project will require use of 8.10 acres of land contributed by Covenant Health, to be made available via appropriate allocation of the two contiguous parcels documented as required in the original CON application and attachments.

To clarify: use of the entire "larger parcel" (Parcel 131NCO18) of land will be required to complete the project; however, only a portion of the second and "smaller parcel" (Parcel 131LA00105) of land will be required to develop the "West" IRF project. The remaining (unused) acreage is currently, and will remain, open green space (i.e. grass with a few trees) adjacent to Fort Sanders West Boulevard just south of Kingston Pike at the main entrance to the Fort Sanders West medical campus – this open green space to remain unused will continue to serve as an attractive buffer between Fort Sanders West Boulevard and the busy access ramp to Pellissippi Parkway (i.e. East of the parcel) from Kingston Pike (i.e. North of the parcel).

4. **Section A., Item 8, Purpose of Review**

   The applicant will not be relocating and/or replacement existing licensed beds since this application will be licensed under a different entity. Please uncheck item 8.A. under Purpose of Review on page 14 and submit a replacement page 14 (labeled as 14R).

Response:

See Supplemental Attachment: Replacement Page 14R

5. **Section A, Item 10, Bed Complement Data Chart**

The bed complement data chart for Fort Sanders Regional Medical Center is noted. However, please complete the Bed complement chart for the proposed project and submit a replacement page 15 (labeled as 15R)

Response:

See Supplemental Attachment: Replacement Pages 15R and 16R

Please provide the Fort Sanders Regional Medical Center bed complement chart that was submitted on page 15 of the original application as an attachment to this supplemental response. This is being requested since it is separately licensed.

Response:

See Supplemental Attachment: Bed Complement Chart for FSRMC

6. **Section A. Item 12, Item A**

   What is a "HIH" unit?

Response:

CMS defines a "hospital within a hospital" or "HIH" as "a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital." 42 CFR § 412.22(e).

7. **Section B, Need, Item A. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services (1))**

   Please note this criterion is applicable to this application. Please remove "not applicable" in the first line of your response on page 24 and submit a replacement page.

Response:

See Supplemental Attachment: Replacement Page 24R

8. **Section B, Need, Item A. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services (4))**

   This criterion applies to this proposed project. Please address in full.

Response:

See Supplemental Attachment: Replacement Page 28R

9. **Section B, Need Item B., Item 3**

Please provide a source for the historical patient chart data on page 39.

Response:

The internal data and patient care statistics of Fort Sanders Regional Medical Center (FSRMC) are the source of the information used to complete the chart titled "Patricia Neal Rehabilitation Center (at Fort Sanders Regional Medical Center)" on page 39 of the original CON application.

10. **Section B, Need, Item 5.**

Please complete the following table:

Proposed Five County Inpatient Rehabilitation UtilizationTrends-2016-2018

Facility	Licensed Beds	2016 Pt Days	2017 Pt Days	2018 Pt Days	'16- '18% change	2016 % Occupancy	2017 % Occupancy	2018% Occupancy
Fort Sanders Reg Medical Center	73							
Tennova Lakeway Regional Medical Center	27							
Tennova Healthcare-PRMC	30							
Total	**130**							

Response:

Proposed Five County Inpatient Rehabilitation UtilizationTrends-2016-2018

Facility	Licensed Beds	2016 Pt Days	2017 Pt Days	2018 Pt Days	'16- '18% change	2016 % Occupancy	2017 % Occupancy	2018 % Occupancy
Fort Sanders Reg Medical Center (+)	73	11,966	11,319	10,010	-16%	45%	43%	38%
Tennova Lakeway Regional Medical Center***	27	2,150	1,978	*N/A*	*N/A*	22%	20%	*N/A*
Tennova Healthcare-PRMC***	30	4,994	7,220	*N/A*	*N/A*	45%	66%	*N/A*
Total	**130**	**19,060**	**20,517**	*N/A*	*N/A*	**40 %**	**43%**	*N/A*

Data Sources: HSDA Staff Summary for CN1903-007, June 26, 2019, page 8; Tennessee Annual Reports 2016-2018; and internal data from FSRMC/PNRC.

(+) Note: FSRMC/PNRC is only able to staff 48 of the 73 licensed beds typically as addressed in the CON applications; for informational purposes, the occupancy % based upon "staffed beds" was approximately 57-75% in recent years.

**** Note: these two Tennova hospitals closed in late 2018 and are currently in an "inactive status"; additionally, the requested information for the 2018 Inpatient Rehabilitation Days (and needed for related calculations) is not publically available (N/A) via the 2018 Hospital Joint Annual Reports and was not found in the final CON materials associated with CN1903-007 from June 2019.*

Section B, Need, Item 6.

Please complete the following chart for Year 1 and Year 2 of the proposed project.

Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
51 beds	Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.

Response:

Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
51 beds	Admits (Discharges)	Pat. Days	ALOS	%Occ.	Admits (Discharges)	Pat. Days	ALOS	%Occ.
	665	**8,046**	**12.1**	**43 %**	**997**	**12,064**	**12.1**	**65 %**

11. Section B, Economic Feasibility, Item 3 – Projected Data Chart

The Projected Data Chart for the total facility on page 59 is noted. However, earnings before interest. Taxes, and depreciation for Year 2023 in the amount of $2,225,000 is incorrect. Please correct and submit a replacement page 59 (labeled as 59R).

Response:

See Supplemental Attachment: Replacement Pages 59R and 60R

12. Section B, Economic Feasibility, Item 6.A.2

The financial chart on page 66 is noted. However, Year 2 figures may need to be corrected if there are revisions to be Projected Data Chart. If needed, please submit a corrected page 66.

Response:

See Supplemental Attachment: Replacement Page 66R

13. Section B, Economic Feasibility, Item 7, Payor Source Table

The total of the payor source table located on page 70 is incorrect. Please correct and submit a replacement page 71 (labeled as 71R).

Response:

See Supplemental Attachment: Replacement Page 71R

14. Section B, Orderly Development, Item 1

What is the closest inpatient medical center to the proposed project? Please clarify if the applicant will have a transfer agreement with that hospital.

Response:

The two closest acute care medical centers to the proposed project location are Parkwest Medical Center (a Covenant Health network affiliate) which is almost 4 miles away – and Turkey Creek Medical Center (a Tennova network affiliate) which is about 2.5 miles away. Both of these hospitals operating in west Knoxville are an estimated drive time of 7-9 minutes from the project site via various primary routes.

The proposed "West" IRF anticipates maintaining appropriate transfer agreements, for both receiving and sending inpatient rehabilitation patients, with any hospital in the region that has interest. This will include hospitals within the service area and others located in outlying geographies – including both Covenant Health network affiliates and other hospitals regardless of affiliation. Perhaps most notably for CON purposes, the project will have transfer agreements in place with Parkwest Medical Center (approximately 4 miles away in Knox County) and Fort Sanders Regional Medical Center (approximately 12 miles away in Knox County where the companion 22-bed "Downtown" IRF will be operated). Both Parkwest Medical Center and Fort Sanders Regional Medical Center are tertiary medical centers and wholly-owned affiliates of Covenant Health.

15. Section B. Quality Measures, Item 2.C.1

It is noted the applicant will be Joint Commission Accredited. However, the current Fort Sanders Regional Medical Center Patricia Neal Rehabilitation Center is CARF accredited per the 2018 Joint Annual Report. Please explain why the applicant will pursue Joint Commission accreditation for the proposed project rather than the historical CARF accreditation.

Response:

All of Encompass Health's hospitals are accredited by The Joint Commission. Approximately 124 of Encompass Health's hospitals have disease-specific certifications awarded by The Joint Commission that recognize the specialized programs available at these rehabilitation hospitals, including stroke, brain injury, cardiac, oncology, pulmonary, spine injury, and other types of rehabilitation. In specific markets, some hospitals are also accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF"). The applicant will seek accreditation by The Joint Commission and also evaluate whether to seek additional accreditation by CARF within its first few years of operation.

16. Section B. Quality Measures, Item 2.D

It is noted on page 84 the applicant will retain or recruit a physiatrist. However, a physiatrist is not listed in the proposed project's staffing chart for Year One. Please clarify.

Response:

It is anticipated that the applicant will enter a contract with a qualified physician (physiatrist) to serve as Medical Director of the proposed inpatient rehabilitation hospital. The physician will not be directly employed by the applicant – and is not considered part of the non-physician staffing plan typically included on the FTE chart for CON purposes. Therefore, no projected physician salary or wages are shown. However, the stipend for the Medical Director was included in the "Other" category of "Other Operating Expenses Categories" found on page 60 of the application. The anticipated expense relating to the medical directorship stipend for Year 2022 is $176,943. The anticipated expense relating to the medical directorship stipend for Year 2023 is $180,482.

Required AFFIDAVIT: Supplemental Materials

See Supplemental Attachment, Signed and Notarized Affidavit

Supplemental 1
July 28, 2020

Supplemental Attachments

Rehabilitation Hospital of Knox County, LLC "WEST"

(CN2007-023)

Supplemental Attachment, Replacement Page 14R

Supplemental Attachment, Replacement Pages 15R and 16R

Supplemental Attachment, Bed Complement Chart for FSRMC

Supplemental Attachment, Replacement Page 24R

Supplemental Attachment, Replacement Page 28R

Supplemental Attachment, Replacement Pages 59R and 60R

Supplemental Attachment, Replacement Page 66R

Supplemental Attachment, Replacement Page 71R

Supplemental Attachment, Signed and Notarized Affidavit

7. *Type of Institution* *(Check as appropriate--more than one response may apply)*

A.	**Hospital *(Inpatient Rehabilitation)***	X	H	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	I.	Outpatient Diagnostic Center	_____
C.	ASTC, Single Specialty	_____	J.	**Rehabilitation Facility**	X
D.	Home Health Agency	_____	K.	Residential Hospice	_____
E.	Hospice	_____	L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	_____
F.	Mental Health Hospital	_____	M.	Other (Specify)_____ _____	
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID	_____			

8. Purpose of Review *(Check appropriate lines(s) – more than one response may apply)*

A.	**Establish New Health Care Institution *(Inpatient Rehabilitation Facility)***	X	G.	MRI Unit Increase	_____
B.	Change in Bed Complement	_____	H.	Satellite Emergency Department	_____
C.	Initiation of Health Care Service as Defined in TCA 68-11-1607(4) (Specify) _____	_____	I.	Addition of ASTC Specialty	_____
D.	Relocation and/or Replacement	_____	J.	Addition of Therapeutic Catheterization	_____
E.	Initiation of MRI	_____	K.	Other (Specify)_____ _____	_____
F.	Initiation of Pediatric MRI	_____			

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan X BlueCare X TennCare Select

Medicare Provider Number *Applicant will apply for a Medicare Provider Number*

Medicaid Provider Number *Applicant will apply for a Medicaid Provider Number*

Certification Type *Inpatient Rehabilitation Facility (Hospital)*

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare X Yes __ No __ N/A **Medicaid/TennCare X Yes** __ No __ N/A

10. Bed Complement Data ("WEST")

A.

Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation *(See Note)*	0	0	51			51
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL *(IRF Beds)*	0	0	51			51

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

***Note*: if this proposed "West" IRF CON project is approved, FSRMC will relinquish 51 of its 73 Inpatient Rehabilitation Beds available under its current license upon project completion. Likewise, the other 22 licensed IRF beds of FSRMC will be relinquished upon project completion if a contemporaneously filed CON application ("Downtown") is approved (which would allow operation of the other 22 IRF beds at the FSRMC campus as a new and independently licensed IRF).**

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

Response:

Not Applicable. The CON is for a new IRF institution to be independently licensed.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

Response:

Not Applicable.

1. **Healthy Lives:** The purpose of the State Health Plan is to improve the health of Tennesseans.
2. **Access:** Every citizen should have reasonable access to health care.
3. **Economic Efficiencies:** The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.
4. **Quality of Care:** Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.
5. **Workforce:** The state should support the development, recruitment and retention of a sufficient and quality health care workforce.

Standards and Criteria

1. **Determination of Need:** The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of one bed per 1,000 applied to the age 65+ population in the service area of the proposal.

   The need shall be based upon the current year's population and projected four years forward. Population statistics from the Department of Health should be used for the calculation.

   In accordance with Tennessee Code Annotated 68-11-14607 (g), "no more frequently than one time every three years, a hospital, rehabilitation facility, or mental health hospital may increase its total number of licensed beds in any category by ten percent or less of its licensed capacity at any one campus over any period of one year for any services it purposes it is licensed to perform without obtaining a certificate of need. These licensed beds that were added without a certificate of need should be considered as part of the determination of need formula by the agency.

   Response:

   This CON application is for the establishment of a new freestanding Inpatient Rehabilitation Facility ("IRF"), or Rehabilitation Hospital, using only existing licensed inpatient rehabilitation facility (hospital) beds in Knoxville, Tennessee (Knox County). The proposed project will not add any new licensed beds or healthcare services to the region. All licensed beds to be relocated and utilized for the proposed project existed prior to any outstanding or unimplemented certificates of need in the service area. Approval of the CON will result in a bed neutral project for the service area.

   The proposed IRF to be independently licensed will be created by relocating and utilizing 51 of the 73 existing licensed IRF beds that are licensed currently as part of Fort Sanders Regional Medical Center ("FSRMC"), an Acute Care Hospital that has been operating in Knox County, Tennessee since early 1920. The inpatient rehabilitation beds to be used for the proposed project have been operated by FSRMC under the well-known name "Patricia Neal

4. Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the latest reported three-year trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed increase in rehabilitation beds on existing providers in the proposed service area and shall include how the applicant's services may differ from these existing services. The agency should consider if the approval of additional beds in the service area will result in unnecessary, costly duplication of services.

Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA unless all existing units or facilities in the proposed service area are utilized at the following levels:

10-30 bed unit ~ 75%
31-50 bed unit/facility ~ 80%
51 bed plus unit/facility ~ 85%

Response:

The proposed project does not involve the addition of new beds in the service area and will result in a bed neutral project. The project represents an important continuation and modernization of inpatient rehabilitation services utilizing existing licensed beds in Knox County. The proposed project represents a partnership between Covenant Health and Encompass Health to better serve patients in the region – through creation of an optimal solution to improve patient care environments, patient access, and operational effectiveness.

The proposed project will not have a negative impact upon other providers since the project does not seek to increase the licensed beds available in the service area or add new services to the region. Projected utilization of the facility is based primarily on discharges and growing demand from Covenant Health hospitals, although it will be open to referrals from any hospital or other providers. All other existing inpatient rehabilitation beds in the community (i.e. 57 beds associated with Tennova that were once operated as part of two hospitals which closed in late 2018) will be consolidated, relocated, and operated within a new facility as well upon completion of another CON project that was approved in 2019 (CN1903-007). The CON application for that project projected 82.5% occupancy of their 57 licensed IRF beds by Year 2 (2022) – and the projected utilization for that project is based upon discharges and demand from Tennova hospitals in the area and the University of Tennessee Medical Center. Additionally, the current *Guidelines for Growth* for Inpatient Rehabilitation Beds indicate that there is a clear need for all existing and approved licensed beds in the service area to address growing demand (including all IRF beds involved with this project, its companion CON project, and all beds associated with CN1903-007).

A summary of the recent utilization and occupancy for each IRF provider in the service area is provided below:

Facility	Licensed Beds	2015 PT Days	2016 Pt Days	2017 Pt Days	2018 Pt Days	2015 % Occupancy	2016 % Occupancy	2017 % Occupancy	2018 % Occupancy
Fort Sanders Regional Medical Center *(+)*	**73**	11,912	11,966	11,319	10,010	45 %	45%	43%	38%
Tennova Lakeway Regional Medical Center***	**27**	1,997	2,150	1,978	*N/A*	20 %	22%	20%	*N/A*
Tennova Healthcare-PRMC***	**30**	4,708	4,994	7,220	*N/A*	43 %	45%	66%	*N/A*
Total	**130**	**18,617**	**19,060**	**20,517**	*N/A*	**39 %**	**40 %**	**43%**	*N/A*

Data Sources: HSDA Staff Summary for CN1903-007, June 26, 2019, page 8; Tennessee JARs 2015-2018; internal data from FSRMC/PNRC.
(+) Note: FSRMC/PNRC is only able to staff 48 of the 73 licensed beds typically as addressed in the CON applications; for informational purposes, the occupancy % based upon "staffed beds" at PNRC was approximately 57-75% in recent years.
**** Note: these two Tennova hospitals closed in late 2018 and are currently in an "inactive status"; additionally, information for the 2018 Inpatient Rehabilitation Patient Days (and needed for related calculations) is not publically available (N/A) via the 2018 Hospital Joint Annual Reports and was not found in the final CON materials associated with CN1903-007 from 2019.*

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□ Project Only
X Total Facility

PROJECTED DATA CHART ("WEST")

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **July** for CON purposes.

		Year 2022	Year 2023
A.	Utilization Data		
	Specify Unit of Measure **IRF Discharges**	665	997
B.	Revenue from Services to Patients		
	1. Inpatient Services	$16,333,000	$26,131,000
	2. Outpatient Services		
	3. Emergency Services		
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$ 16,333,000**	**$ 26,131,000**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$5,566,000	$8,905,000
	2. Provision for Charity Care	$430,000	$687,000
	3. Provisions for Bad Debt	$136,000	$217,000
	Total Deductions	**$ 6,132,000**	**$ 9,809,000**
NET OPERATING REVENUE		**$ 10,201,000**	**$ 16,322,000**
D.	Operating Expenses		
	1. Salaries and Wages	$7,412,000	$9,585,000
	a. Direct Patient Care	$4,595,440	$5,942,700
	b. Non-Patient Care	$2,816,560	$3,642,300
	2. Physician's Salaries and Wages		
	3. Supplies	$486,000	$744,000
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	5. Management Fees:		
	a. Paid to Affiliates	$510,000	$816,000
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses (D6)	$2,573,000	$2,951,000
	Total Operating Expenses	$ 10,981,000	$ 14,096,000
E.	**Earnings Before Interest, Taxes and Depreciation**	**$ (780,000)**	**$ 2,226,000**
F.	Non-Operating Expenses		
	1. Taxes	$(592,000)	$188,000
	2. Depreciation	$1,495,000	$1,502,000
	3. Interest		
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	$ 903,000	$ 1,690,000
NET INCOME (LOSS)		**$ (1,683,000)**	**$ 536,000**

Chart Continues Onto Next Page

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NET INCOME (LOSS)	**$ (1,683,000)**	**$ 536,000**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$ _____	$ _____
2. Annual Capital Expenditure	$51,000	$102,000
Total Other Deductions	$51,000	$102,000
NET BALANCE	**$ (1,734,000)**	**$ 434,000**
DEPRECIATION	$ 1,495,000	$ 1,502,000
FREE CASH FLOW (Net Balance + Depreciation)	**$ (239,000)**	**$ 1,936,000**

□ Project Only
X Total Facility

PROJECTED DATA CHART-OTHER EXPENSES

OTHER OPERATING EXPENSES CATEGORIES (D6)	**Year 2022**	**Year 2023**
1. Equipment Rental & Maintenance	$366,000	$409,000
2. Utilities/Telephone	$296,000	$302,000
3. Contract Services	$451,000	$691,000
4. Insurance/Bonding	$378,000	$386,000
5. Other	$1,082,000	$1,163,000
6. _____	_____	_____
7. _____	_____	_____
***Total Other Expenses**	**$ 2,573,000**	**$ 2,951,000**

**Total other expenses should equal Line D.6. In the Projected Data Chart*

6. A. Discuss how projected utilization rates will be sufficient to support financial performance.

1) Noting when the project's financial breakeven is expected, and

2) Demonstrating the availability of sufficient cash flow until financial viability is achieved.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-6A**

Response:

Anticipated utilization rates are sufficient to produce positive Free Cash Flow for the IRF project by Year 2 of operations – and will be sufficient to maintain operations over time.

Projected Annual Utilization	**Year 1**	**Year 2**
IRF Discharges	**665**	**997**
Financial Feasibility	**Year 1**	**Year 2**
Net Operating Revenue	**$ 10,201,000**	**$ 16,322,000**
Earnings Before Interest, Taxes, & Depreciation	**($ 780,000)**	**$ 2,226,000**
Net Income (Loss)	**($ 1,683,000)**	**$ 536,000**
Free Cash Flow ***(Net Balance + Depreciation)***	**($ 239,000)**	**$ 1,936,000**

Beyond initial projections for Year 1 and Year 2, it is expected that the proposed IRF's utilization will grow modestly over time due to demographic factors and increasing demand.

The project is for a new IRF, thus financial statements for the proposed facility are not available at this time. However, relevant information to document adequate funding to support the project, which is available via Covenant Health and Encompass Health, is provided via attachment.

See Attachments, Economic Feasibility: Project Funding Sources

Covenant Health and Encompass Health

Response:

Historically, the affiliates of both Covenant Health and Encompass Health have provided a significant level of care to patients participating in both Medicare and TennCare funded programs. The proposed new IRF project will participate in these government sponsored programs. Additionally, the proposed IRF project will implement an appropriate charity care policy and be accessible to uninsured (and underinsured) individuals.

The following chart provides the estimated dollar amount of Gross Revenue associated with patients covered by each key payer category.

Applicant's Projected Payor Mix, Year 1 ("West")
Total Facility Chart

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$10,334,000	63.3%
TennCare/Medicaid	$316,000	1.9%
Commercial/Other Managed Care	$4,861,000	29.8%
Self-Pay		
Other *(including Self-Pay & Charity)*	$822,000	5%
Total *	$16,333,000	100%
Charity Care	$430,000	2.6%

** Matches Gross Operating Revenue Year One on Projected Data Chart*

10. Bed Complement Data ***Chart provided regarding Fort Sanders Regional Medical Center***

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical	317	191				317
2) Surgical	45	44				45
3) ICU/CCU	50	50				50
4) Obstetrical	32	32				32
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation *(See Note)*	73	48	0			0
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)	24	24				24
19) ICF/IID						
20) Residential Hospice						
TOTAL	541	389	0			468

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

***Note:** if this proposed "West" CON project is approved, FSRMC will relinquish 51 inpatient rehabilitation beds available under its current license upon project completion. Likewise, the other 22 licensed IRF beds of FSRMC will be relinquished upon project completion if a contemporaneously filed CON application ("Downtown") is approved (which would allow operation of the other 22 IRF beds at the FSRMC campus as a new and independently licensed IRF).*

Supplemental Attachment: Bed Complement Chart for FSRMC

Supplemental 2
July 30, 2020

July 30, 2020

Mr. Phillip Earhart
HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Rehabilitation Hospital of Knox County, LLC ("WEST") – CN2007-023

Dear Mr. Earhart:

Please find enclosed our responses to the second set of supplemental questions you sent regarding the above-referenced CON application which seeks approval for the establishment of an Inpatient Rehabilitation Hospital utilizing 51 existing licensed IRF beds in the service area.

Should you need further clarification regarding the CON application, please let me know at your earliest convenience.

Respectfully,

Mike Richardson
Vice President, Strategic Planning and Development
Covenant Health

Enclosures

Covenant Health: Strategic Planning Department
280 Fort Sanders West Boulevard, Building 4, Suite 218 – Knoxville, Tennessee 37922
Office: (865) 531-5123

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1. Section B, Need, Item A. (Service Specific Criteria-Comprehensive Inpatient Rehabilitation Services (4))

The utilization chart on page 28R is noted. However, the 2016 total patient days in the chart are incorrect. Please correct and submit a replacement page 28 (labeled as 28R2).

Response:

See Supplemental 2 Attachment: Replacement Page 28R2

2. Section B, Need, Item 5.

It is noted the applicant complete the following table. However, the total 2016 patient days are incorrect. Please correct.

Proposed Five County Inpatient Rehabilitation UtilizationTrends-2016-2018

Facility	Licensed Beds	2016 Pt Days	2017 Pt Days	2018 Pt Days	'16-'18% change	2016 % Occupancy	2017 % Occupancy	2018% Occupancy
Fort Sanders Reg Medical Center	73							
Tennova Lakeway Regional Medical Center	27							
Tennova Healthcare-PRMC	30							
Total	**130**							

Response:

Proposed Five County Inpatient Rehabilitation UtilizationTrends-2016-2018

Facility	Licensed Beds	2016 Pt Days	2017 Pt Days	2018 Pt Days	'16- '18% change	2016 % Occupancy	2017 % Occupancy	2018 % Occupancy
Fort Sanders Reg Medical Center (+)	73	11,966	11,319	10,010	-16%	45%	43%	38%
Tennova Lakeway Regional Medical Center***	27	2,150	1,978	*N/A*	*N/A*	22%	20%	*N/A*
Tennova Healthcare-PRMC***	30	4,994	7,220	*N/A*	*N/A*	45%	66%	*N/A*
Total	**130**	**19,110**	**20,517**	*N/A*	*N/A*	**40 %**	**43%**	*N/A*

Data Sources: HSDA Staff Summary for CN1903-007, June 26, 2019, page 8; Tennessee Annual Reports 2016-2018; and internal data from FSRMC/PNRC.

(+) Note: FSRMC/PNRC is only able to staff 48 of the 73 licensed beds typically as addressed in the CON applications; for informational purposes, the occupancy % based upon "staffed beds" was approximately 57-75% in recent years.

**** Note: these two Tennova hospitals closed in late 2018 and are currently in an "inactive status"; additionally, the requested information for the 2018 Inpatient Rehabilitation Days (and needed for related calculations) is not publically available (N/A) via the 2018 Hospital Joint Annual Reports and was not found in the final CON materials associated with CN1903-007 from June 2019.*

3. Section B, Economic Feasibility, Item 3 – Projected Data Chart

It is noted the applicant correctly completed the lines under the Salaries and Wages Heading: D.1a--Direct Patient Care, and D.2.a Non-Patient Care. However, please note there is not a line in the Projected Data Chart for total salaries and wages. Please remove $7,412,000 in Year One and $9,585,000 in Year 2 for salaries and wages and submit a replacement page 59 (labeled as 59R2).

Response:

See Supplemental 2 Attachment: Replacement Pages 59R2

4. **Section B. Quality Measures, Item 2.D**

It is noted a salary expense for a physiatrist in Year One in the amount of $176,943 is included in the "other category" of operating expenses. What other type expenses are included in the remaining $905,057?

Response:

The remaining $ 905,000 (i.e. $ 905,057 rounded to the nearest thousand) is comprised mainly of legal & professional fees, CIS expenses, other fixed expenses (including property fees and other annual fees or non-income taxes), and miscellaneous variable expenses (housekeeping, security, printing, travel, and other miscellaneous expenses). Provided below is a more detailed breakdown of the "Other Operating Expenses" for Years 1 and 2 of the "West" IRF project:

Other Operating Expenses	**Year 1: 2022**	**Year 2: 2023**
Equipment Rental & Maintenance	**$366,000**	**$409,000**
Utilities/Telephone	**$296,000**	**$302,000**
Contract Services	**$451,000**	**$691,000**
Insurance/Bonding	**$378,000**	**$386,000**
Others:	***$1,082,000:*** • $17,000 (Legal & Professional Fees) • $81,000 (CIS Expense) • *$177,000 (Medical Director Fees)* • $226,000 (other fixed expenses, including property fees and other annual fees or non-income taxes) • $581,000 (other variable expenses, including housekeeping, security, printing, travel, and other miscellaneous expenses)	***$1,163,000:*** • $17,000 (Legal & Professional Fees) • $83,000 (CIS Expense) • *$180,000 (Medical Director Fees)* • $230,000 (other fixed expenses, including property fees and other annual fees or non-income taxes) • $653,000 (other variable expenses, including housekeeping, security, printing, travel, and other miscellaneous expenses)
TOTAL Other Operating Expenses (D.6. in the Projected Data Chart)	**$2,573,000**	**$2,951,000**

Required AFFIDAVIT: Supplemental 2 Materials

See Supplemental Attachment, Signed and Notarized Affidavit

4. Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the latest reported three-year trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed increase in rehabilitation beds on existing providers in the proposed service area and shall include how the applicant's services may differ from these existing services. The agency should consider if the approval of additional beds in the service area will result in unnecessary, costly duplication of services.

Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HSDA unless all existing units or facilities in the proposed service area are utilized at the following levels:

10-30 bed unit ~ 75%
31-50 bed unit/facility ~ 80%
51 bed plus unit/facility ~ 85%

Response:

The proposed project does not involve the addition of new beds in the service area and will result in a bed neutral project. The project represents an important continuation and modernization of inpatient rehabilitation services utilizing existing licensed beds in Knox County. The proposed project represents a partnership between Covenant Health and Encompass Health to better serve patients in the region – through creation of an optimal solution to improve patient care environments, patient access, and operational effectiveness.

The proposed project will not have a negative impact upon other providers since the project does not seek to increase the licensed beds available in the service area or add new services to the region. Projected utilization of the facility is based primarily on discharges and growing demand from Covenant Health hospitals, although it will be open to referrals from any hospital or other providers. All other existing inpatient rehabilitation beds in the community (i.e. 57 beds associated with Tennova that were once operated as part of two hospitals which closed in late 2018) will be consolidated, relocated, and operated within a new facility as well upon completion of another CON project that was approved in 2019 (CN1903-007). The CON application for that project projected 82.5% occupancy of their 57 licensed IRF beds by Year 2 (2022) – and the projected utilization for that project is based upon discharges and demand from Tennova hospitals in the area and the University of Tennessee Medical Center. Additionally, the current *Guidelines for Growth* for Inpatient Rehabilitation Beds indicate that there is a clear need for all existing and approved licensed beds in the service area to address growing demand (including all IRF beds involved with this project, its companion CON project, and all beds associated with CN1903-007).

A summary of the recent utilization and occupancy for each IRF provider in the service area is provided below:

Facility	Licensed Beds	2015 PT Days	2016 Pt Days	2017 Pt Days	2018 Pt Days	2015 % Occupancy	2016 % Occupancy	2017 % Occupancy	2018 % Occupancy
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Tennova Healthcare-PRMC***	**30**	4,708	4,994	7,220	*N/A*	43 %	45%	66%	*N/A*
Total	**130**	**18,617**	**19,110**	**20,517**	*N/A*	**39 %**	**40 %**	**43%**	*N/A*

Data Sources: HSDA Staff Summary for CN1903-007, June 26, 2019, page 8; Tennessee JARs 2015-2018; internal data from FSRMC/PNRC.
(+) Note: FSRMC/PNRC is only able to staff 48 of the 73 licensed beds typically as addressed in the CON applications; for informational purposes, the occupancy % based upon "staffed beds" at PNRC was approximately 57-75% in recent years.
**** Note: these two Tennova hospitals closed in late 2018 and are currently in an "inactive status"; additionally, information for the 2018 Inpatient Rehabilitation Patient Days (and needed for related calculations) is not publically available (N/A) via the 2018 Hospital Joint Annual Reports and was not found in the final CON materials associated with CN1903-007 from 2019.*

Supplemental 2
July 30, 2020

☐ Project Only
X Total Facility

PROJECTED DATA CHART ("WEST")

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **July** for CON purposes.

	Year 2022	Year 2023
A. Utilization Data		
Specify Unit of Measure **IRF Discharges**	665	997
B. Revenue from Services to Patients		
1. Inpatient Services	$16,333,000	$26,131,000
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify)_____		
Gross Operating Revenue	**$ 16,333,000**	**$ 26,131,000**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$5,566,000	$8,905,000
2. Provision for Charity Care	$430,000	$687,000
3. Provisions for Bad Debt	$136,000	$217,000
Total Deductions	**$ 6,132,000**	**$ 9,809,000**
NET OPERATING REVENUE	**$ 10,201,000**	**$ 16,322,000**
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	$4,595,440	$5,942,700
b. Non-Patient Care	$2,816,560	$3,642,300
2. Physician's Salaries and Wages		
3. Supplies	$486,000	$744,000
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates	$510,000	$816,000
b. Paid to Non-Affiliates		
6. Other Operating Expenses (D6)	$2,573,000	$2,951,000
Total Operating Expenses	$ 10,981,000	$ 14,096,000
E. **Earnings Before Interest, Taxes and Depreciation**	**$ (780,000)**	**$ 2,226,000**
F. Non-Operating Expenses		
1. Taxes	$(592,000)	$188,000
2. Depreciation	$1,495,000	$1,502,000
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$ 903,000	$ 1,690,000
NET INCOME (LOSS)	**$ (1,683,000)**	**$ 536,000**

Chart Continues Onto Next Page

Supplemental 2
July 30, 2020

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

NAME OF FACILITY: Rehabilitation Hospital of Knox County - West

I, MIKE RICHARDSON, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

VP

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of July, 2020, witness my hand at office in the County of Knox, State of Tennessee.

Suzanne F. Mounger

NOTARY PUBLIC

My commission expires September 5, 2022.

HF-0043

Revised 7/02

SUZANNE F MOUNGER
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY
My Commission Expires 09-05-2022

Supplemental 2
July 28, 2020

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

NAME OF FACILITY: Rehabilitation Hospital of Knox County - 1st

I, Mike Richardson, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

VP
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28 day of July, 2020 witness my hand at office in the County of Knox, State of Tennessee.

Suzanne F. Mounger
NOTARY PUBLIC

My commission expires September 5, 2022.

HF-0043

Revised 7/02

SUZANNE F MOUNGER
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY
My Commission Expires 09-05-2022