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, 2016
Commission File Number 001-10315

HealthSouth Corporation
(Exact Name of Registrant as Specified in its Charter)

Delaware	**63-0860407**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
3660 Grandview Parkway, Suite 200 Birmingham, Alabama	**35243**
(Address of Principal Executive Offices)	**(Zip Code)**

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

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

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

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

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 and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒ Accelerated filer ☐ Non-Accelerated filer ☐ Smaller reporting company ☐

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 $3.3 billion . For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 89,052,284 shares of common stock of the registrant outstanding, net of treasury shares, as of February 15, 2017 .

DOCUMENTS INCORPORATED BY REFERENCE

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

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NOTE TO READERS

As used in this report, the terms "HealthSouth," "we," "us," "our," and the "Company" refer to HealthSouth Corporation and 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 HealthSouth Corporation, the publicly traded parent company, owns or operates any specific asset, business, or property. The hospitals, operations, and businesses described in this filing are primarily owned and operated by subsidiaries of the parent company. In addition, we use the term "HealthSouth Corporation" to refer to HealthSouth Corporation alone wherever a distinction between HealthSouth Corporation and its subsidiaries is required or aids in the understanding of this filing. We use the term "Encompass," depending on the context, to refer to our consolidated subsidiary, EHHI Holdings, Inc. ("EHHI"), and its subsidiaries as well as the home health and hospice business operated through various subsidiaries of EHHI.

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 discussed elsewhere in this Form 10-K, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;
- changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction such as the reinstatement of the “75% Rule” or the introduction of site neutral payments with skilled nursing facilities for certain conditions, payment system reforms, and related increases in the costs of complying with such changes;
- reductions or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors;
- restrictive interpretations of the regulations governing the claims that are reimbursable by Medicare;
- delays in the administrative appeals process associated with denied Medicare reimbursement claims, including from various Medicare audit programs, and our exposure to the related delay or reduction in the receipt of the reimbursement amounts for services previously provided;
- the ongoing evolution of the healthcare delivery system, including alternative payment models and value-based purchasing initiatives, which may decrease our reimbursement rate or increase costs associated with our operations;
- our ability to comply with extensive and changing healthcare regulations as well as the increased costs of regulatory compliance and compliance monitoring in the healthcare industry, including the costs of investigating and defending asserted claims, whether meritorious or not;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on our labor expenses from potential union activity and staffing recruitment and retention;
- competitive pressures in the healthcare industry, including from other providers that may be participating in integrated delivery payment arrangements in which we do not participate, and our response to those pressures;
- changes in our payor mix or the acuity of our patients affecting reimbursement rates;
- our ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with our growth strategy, including realization of anticipated revenues, cost savings, productivity improvements arising from the related operations and avoidance of unanticipated difficulties, costs or liabilities that could arise from acquisitions or integrations;
- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including the ongoing investigations initiated by the U.S. Department of Health and Human Services, Office of the Inspector General;
- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to claims;

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

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

PART I

Item 1. Business.

Overview of the Company

General

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

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

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

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

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

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

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

Inpatient Rehabilitation

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

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

Home Health and Hospice

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

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

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

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

Competitive Strengths

As one of the nation's largest providers of post-acute healthcare services and with our experience in and focus on those services, we believe we differentiate ourselves from our competitors based on, among other things, our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of technology. We also believe our competitive strengths discussed below give us the ability to adapt and succeed in a healthcare industry facing the uncertainty associated with the efforts to identify and implement workable integrated delivery payment models. For example, we are positioned to treat all types of post-acute patients by leveraging our operational expertise across our network of facility- and home-based assets in the event multiple or all post-acute settings (long-term acute care, inpatient rehabilitation, skilled nursing, and home health) face site neutral reimbursement for care provided in the future. Our hospitals have the physical construct (including therapy gym and training areas), clinical staffing, and operating expertise to address the full spectrum of needs for higher acuity post-acute patients needing inpatient care. Encompass can then often treat patients leaving our or other inpatient facilities who need additional post-acute care services in lieu of skilled nursing facility-based care. Additionally, Encompass can serve the lower acuity patients that do not require more intensive facility-based care.

- People . We believe our approximately 35,710 employees, in particular our highly skilled clinical staff, share a steadfast commitment to providing outstanding care to our patients. We undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality care in the most cost-effective manner. We also have hospital staff trained for all patient acuity levels faced in the post-acute setting.

- Quality . We have an extensive base of facility-based and home-based clinical experience from which we have developed best practices and protocols. We believe these clinical best practices and protocols, particularly as leveraged with industry leading technology, help ensure the delivery of consistently high-quality rehabilitative healthcare services. We have developed a program called “TeamWorks,” which is a series of operations-focused initiatives using identified best practices to reduce inefficiencies and improve performance across a wide spectrum of operational areas. We believe these initiatives have enhanced, and will continue to enhance, patient-employee interactions and coordination of care and communication among the patient, the patient’s family, the hospital’s treatment team, other care providers, and payors, which, in turn, improves outcomes and patient satisfaction. One of our primary operational initiatives in 2017 will be a TeamWorks program focused on enhancing clinical collaboration between our hospitals and home health agencies.

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

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

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

- Efficiency and Cost Effectiveness . Our size, technology-enabled business practices, and culture help us provide facility-based and home-based healthcare services on a cost-effective basis. For example, our inpatient rehabilitation hospitals have historically received, on average, a lower per discharge payment from Medicare than the industry average payment while also treating patients with higher average acuity. Our hospitals have also historically averaged significantly less Medicare reimbursement for high cost outlier patients than other inpatient rehabilitation facility (“IRF”) providers have averaged. Specifically, we can leverage our centralized administrative functions, identify best practices, utilize proven staffing models, and take advantage of supply chain efficiencies across our extensive platform of operations. At the location level, we also enjoy economies of scale as our hospitals are often larger (more beds) than industry average. Also, Encompass targets a certain patient density in the markets it serves which contributes to a lower cost per visit than competing publicly-held home health providers. In addition, our proprietary information systems, discussed below, aggregate data from our business into a comprehensive reporting package and database used by the management teams in our hospitals as well as executive management. Our information systems allow users to analyze data and trends and create custom reports on a timely basis. Likewise, Encompass utilizes Homecare Homebase ^{SM} , an industry-leading information system originally developed by the Encompass management team, to provide home-based care with an emphasis on efficiency and cost effectiveness.

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

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

- Strong Cash Flow Generation and Balance Sheet . We have a proven track record of generating strong cash flows from operations that have allowed us to successfully implement our growth strategy, reduce our financial leverage, and make significant shareholder distributions. As of December 31, 2016, we have a flexible balance sheet, no significant debt maturities prior to 2020, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide sufficient support for our business strategy.

- Technology-Enabled Processes . As a market leader in post-acute healthcare services, we have devoted substantial effort and expertise to leveraging technology to improve patient care and operating efficiencies. We have developed and implemented information technology, such as our rehabilitation-specific electronic clinical information system that we have branded as ACE-IT and our internally developed management reporting system described above that we have branded as BEACON, which we then leverage to enhance our clinical and business processes. For example, part of our clinical data analytics strategy has been the development of a predictive model for identifying patients at risk for acute care transfers. As of December 31, 2016, we have installed ACE-IT in 101 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. We believe ACE-IT will improve patient care and safety, streamline operating efficiencies, and enhance staff recruitment and retention, making it a key competitive differentiator.

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

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

Patients and Demographic Trends

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

Strategy

Our 2016 strategy focused on the following priorities:

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

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

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

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

Employees

As of December 31, 2016 , we employed approximately 27,968 individuals, of whom approximately 17,187 were full-time employees, in our inpatient rehabilitation business and approximately 7,742 individuals, of whom approximately 5,698 were full-time employees, in the Encompass home health and hospice business. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 63 employees at one hospital (about 17% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2016 . Like most healthcare providers, our labor costs are rising faster than the general inflation rate. In some markets, the lack of availability of medical personnel is a significant operating issue facing healthcare providers. To address this challenge, we will continue to focus on maintaining the competitiveness of our compensation and benefit programs and improving our recruitment, retention, and productivity. Shortages of nurses and other medical personnel, including therapists, may, from time to time, require us to increase utilization of more expensive temporary personnel, which we refer to as “contract labor,” and other types of premium pay programs.

Competition

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

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

Regulatory and Reimbursement Challenges

Healthcare has always been a highly regulated industry. Currently, the industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the Patient Protection and Affordable Care Act (as subsequently amended, the “2010 Healthcare Reform Laws”), to identify and implement workable coordinated care and integrated delivery payment models. In January 2015, the United States Department of Health and Human Services (“HHS”) announced it had set various goals with respect to tying Medicare reimbursements to alternative payment models and value-based purchasing. Specifically, HHS set a goal of tying 50 percent of traditional, or fee-for-service, Medicare payments to quality or value through integrated delivery payment models, such as ACOs or bundled payment arrangements, by the end of 2018. HHS also set a goal of tying 90 percent of traditional Medicare payments to quality or value by the end of 2018 through programs such as those that include financial incentives for reducing acute care hospital readmissions. While we do not expect the drive toward integrated delivery payment models, value-based purchasing, and post-acute site neutrality in Medicare reimbursement to reverse, there remains significant uncertainty around the future of healthcare regulation in general.

The election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. On January 20, 2017, President Trump issued his first executive order titled “Minimizing the Economic Burden of the Patient Protection And Affordable Care Act Pending Repeal,” that directs federal regulators to begin dismantling those laws through regulatory and policy-making processes and procedures, “to the maximum extent permitted by law." Any changes may ultimately affect, among other things, reimbursement of healthcare providers and consumers' access to coverage of health services, including among non-Medicare aged population segments within commercial insurance markets and Medicaid enrollees. Changes may also affect the delivery of healthcare services to patients by providers and the regulatory compliance obligations associated with those services.

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

Sources of Revenues

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

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

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

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

Inpatient Rehabilitation

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

Home Health and Hospice (1)

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

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

Medicare Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare facilities and services. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"), the home health prospective payment system ("HH-PPS") and the hospice prospective payment system (the "Hospice-PPS"). Congress is not obligated to adopt MedPAC recommendations, and in recent years Congress has not adopted any of the recommendations on the annual market basket update to Medicare payment rates under the IRF-PPS, which updates are discussed in greater detail below. However, MedPAC's recommendations have, and could in the future, become the basis for subsequent legislative or regulatory action.

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

From time to time, Medicare reimbursement methodologies and rates can be further modified by HHS's Centers for Medicare & Medicaid Services ("CMS"). In some instances, these modifications can have a substantial impact on existing healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems, including the IRF-PPS and HH-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS requires IRFs to submit data on certain quality of care measures for the IRF Quality Reporting Program. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in a subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions for fiscal years 2015, 2016 and 2017. Similarly, home health and hospice agencies are also required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update. To date, only one of Encompass' home health and hospice agencies has incurred a reduction in its reimbursement rate.

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

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

Likewise, Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable and necessary. For example, current CMS coverage rules require inpatient rehabilitation services to be ordered by a physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide the rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services that may be needed. For individual claims, Medicare contractors make coverage determinations regarding medical necessity which can represent more restrictive interpretations of the CMS coverage rules. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

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

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

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

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

Inpatient Rehabilitation . As discussed above, our hospitals receive a fixed payment reimbursement amount per discharge under IRF-PPS based on the patient's rehabilitation impairment category established by HHS and other characteristics and conditions identified by the attending clinicians. In order to qualify for reimbursement under IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, pre-admission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. For example, a physician must admit each patient and in doing so determine that the patient's IRF treatment is reasonable and necessary. Also, each patient admitted to an IRF must be able to tolerate a minimum of three hours of therapy per day. Once in an IRF, patients must have nursing care available 24 hours, each day of the week.

Under IRF-PPS, CMS is required to adjust the payment rates based on a market basket index. Beginning in fiscal year 2016, CMS began implementing an inpatient IRF-specific market basket. The annual market basket update is designed to reflect changes over time in the prices of a mix of goods and services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units. In setting annual market basket updates, CMS uses data furnished by the Bureau of Labor Statistics for price proxy purposes, primarily in three categories: Producer Price Indexes, Consumer Price Indexes, and Employment Cost Indexes. With IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers.

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for inpatient rehabilitation providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to healthcare providers. For example, in 2004, CMS narrowed its rule, known as the "75% Rule," stipulating that to qualify as an inpatient rehabilitation hospital under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any inpatient rehabilitation hospital that failed to meet its requirements would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. On December 29, 2007, the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") was signed, setting the compliance threshold at 60% instead of 75% and allowing hospitals to continue using a patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitative care under the rule. The modification of the compliance threshold in 2004 significantly reduced the total number of Medicare IRF discharges, but since setting the 60% threshold, the number of discharges has grown. In another example, the 2007 Medicare Act included an elimination of the IRF-PPS market basket adjustment for the period from April 1, 2008 through September 30, 2009 causing a reduction in the pricing of services eligible for Medicare reimbursement, or a Medicare pricing "roll-back," which resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs.

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

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

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

The 2017 IRF Rule also includes other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index values, changes to designations between rural and urban facilities, and updates to the outlier fixed-loss threshold. The final rule also continues the freeze to the update to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, and teaching status adjustment factors. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the 2017 IRF Rule, we believe the 2017 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2016, prior to the impact of sequestration. Additionally, the 2017 IRF Rule requires us to report five new quality measures, the reporting of which will require additional time and expense and could affect reimbursement beginning October 1, 2017.

Unlike our inpatient services, our outpatient services are primarily reimbursed under the physician fee schedule of Medicare Part B. Medicare reimbursement for outpatient services are subject to an annual outpatient therapy cap and a therapy cap exception process. On November 2, 2016, CMS released its final notice of rulemaking for the payment policies under the physician fee schedule and other revisions to Part B for calendar year 2017. The provisions of this rule, including the updates to the fee schedule, are not material to us.

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

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

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

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

On October 31, 2016, CMS released its notice of final rulemaking for calendar year 2017 for home health agencies under the HH-PPS (the "2017 HH Rule"). Specifically, while the rule provides for a market basket update of 2.8%, that update is offset by a 2.3% rebasing adjustment reduction (the final year of a four-year phase-in), a productivity adjustment reduction of 30 basis points, and a nominal case-mix coding intensity reduction of 90 basis points. The 2017 HH Rule also includes other pricing changes, such as a reduction to the case-mix weights for certain cases and a change in the outlier payment calculation, that impact our Medicare reimbursement. Based on our analysis, we believe the 2017 HH Rule will result in a net decrease to our Medicare home health payment rates of approximately 3.6% effective for episodes ending in calendar year 2017, prior to the impact of sequestration. Additionally, the 2017 HH Rule requires us to report four new quality measures, the reporting of which will require additional time and expense and could affect reimbursement beginning in 2018.

Hospice . Medicare pays hospice benefits for patients with life expectancies of six months or less, as documented by the patient's physician(s). Under Medicare rules, patients seeking hospice benefits must agree to forgo curative treatment for their terminal medical conditions. For each day a patient elects hospice benefits, Medicare pays an adjusted daily rate based on patient location, and payments represent a prospective per diem amount tied to one of four different categories or levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Medicare hospice reimbursements to each provider are also subject to two annual caps, one limiting total hospice payments based on the average annual payment per beneficiary and another limiting payments based on the number of days of inpatient care billed by the hospice provider. There are currently no limits to the number of hospice benefit periods an eligible Medicare patient may receive, and a patient may revoke the benefit at any time.

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

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

Managed Care and Other Discount Plans

We offer discounts from established charges to certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms between one and three years, although we have a number of managed care contracts that automatically renew each year (with pre-defined rate increases) unless a party elects to terminate the contract. In 2016 , typical rate increases for our inpatient rehabilitation contracts ranged from 2-4% and for our home health and hospice contracts ranged from 0-2%. We cannot provide any assurance we will continue to receive increases in the future. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed unable to afford healthcare. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of certain services. Continuing downward pressure on Medicaid payment rates could cause a decline in that portion of our *Net operating revenues* . However, for the year ended December 31, 2016, Medicaid payments represented only 3.2% of our consolidated *Net operating revenues* . In certain states in which we operate, we are experiencing an increase in Medicaid patients, likely the result of expanded coverage consistent with the intent of the 2010 Healthcare Reform Laws. Changes to these laws and regulations implemented by Congress, the Trump Administration, or both, could impact expanded Medicaid coverage, including the number of Medicaid patients with access to our services. For additional discussion, see Item 1A, *Risk Factors* , "Changes in our payor mix or the acuity of our patients could adversely impact our revenues or our profitability."

Cost Reports

Because of our participation in Medicare, Medicaid, and certain Blue Cross and Blue Shield plans, we are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenue, costs, and expenses associated with the services provided by inpatient hospital, home health, and hospice providers to Medicare beneficiaries and Medicaid recipients. These annual cost reports are subject to routine audits which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. These audits are used for determining if any under- or over-payments were made to these programs and to set payment levels for future years. Medicare also makes retroactive adjustments to payments for certain low-income patients after comparing subsequently published statistical data from CMS to the cost report data. We cannot predict what retroactive adjustments, if any, will be made, but we do not anticipate such adjustments would have a material impact on us.

Regulation

The healthcare industry is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our operations, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth. We are also subject to the broader federal and state regulations that prohibit fraud and abuse in the delivery of healthcare services. As a healthcare provider, we are subject to periodic audits, examinations and investigations conducted by, or at the direction of, government investigative and oversight agencies. Violations of the applicable federal and state healthcare regulations can result in a provider's exclusion from participation in government reimbursement programs and in substantial civil and criminal penalties.

We undertake significant effort and expense to provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as, for most facilities, accreditation standards of The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) and, for some facilities, the Commission on Accreditation of Rehabilitation Facilities.

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

Licensure and Certification

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

In addition, hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. Certification and participation in these programs involve numerous regulatory obligations. For example, hospitals must treat at least 30 patients free-of-charge prior to certification and eligibility for Medicare reimbursement. Once certified by Medicare, hospitals undergo periodic on-site surveys and revalidations in order to maintain their certification. All of our inpatient hospitals participate in the Medicare program.

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

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

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

We have developed operational systems to oversee compliance with the various standards and requirements of the Medicare program and have established ongoing quality assurance activities; however, given the complex nature of governmental healthcare regulations, there can be no assurance Medicare, Medicaid, or other regulatory authorities will not allege instances of noncompliance. A determination by a regulatory authority that a facility is not in compliance with applicable requirements could also lead to the assessment of fines or other penalties, loss of licensure, exclusion from participation in Medicare and Medicaid, and the imposition of requirements that an offending facility takes corrective action.

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities or agencies, or the introduction of new beds or inpatient, home health, and hospice services may be subject to review by and prior approval of state regulatory bodies under a "certificate of need," or "CON," law. As of December 31, 2016, approximately 51% of our licensed beds and 20% of our home health and hospice locations are located in states or U.S. territories that have CON laws. CON laws often require a reviewing agency to determine the public need for additional or expanded healthcare facilities and services. These laws also generally require approvals for capital expenditures involving inpatient rehabilitation hospitals, if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any time a CON is required, we must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility, starting a new healthcare program, or opening a new home health or hospice agency.

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

False Claims

The federal False Claims Act (the "FCA") prohibits the knowing presentation of a false claim to the United States government and provides for penalties equal to three times the actual amount of any overpayments plus up to approximately $22,000 per claim. Beginning no later than August 1, 2016, federal civil penalties will be adjusted to account for inflation each year. In addition, the FCA allows private persons, known as "relators," to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. The government and relators may also allege violations of the FCA for the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. This is known as a "reverse false claim." The government deems identification of the overpayment to occur when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

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

Relationships with Physicians and Other Providers

Anti-Kickback Law . Various state and federal laws regulate relationships between providers of healthcare services, including management or service contracts and investment relationships. Among the most important of these restrictions is a federal law prohibiting the offer, payment, solicitation, or receipt of remuneration by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs (the "Anti-Kickback Law"). The 2010 Healthcare Reform Laws amended the federal Anti-Kickback Law to provide that proving violations of this law does not require proving actual knowledge or specific intent to commit a violation. Another amendment made it clear that Anti-Kickback Law violations can be the basis for claims under the FCA. These changes and those described above related to the FCA, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. In addition to standard federal criminal and civil sanctions, including imprisonment and penalties of up to $50,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. In 1991, the HHS-OIG issued regulations describing compensation arrangements that are not viewed as illegal remuneration under the Anti-Kickback Law. Those regulations provide for certain safe harbors for identified types of compensation arrangements that, if fully complied with, assure participants in the particular arrangement that the HHS-OIG will not treat that participation as a criminal offense under the Anti-Kickback Law or as the basis for an exclusion from the Medicare and Medicaid programs or the imposition of civil sanctions. Failure to fall within a safe harbor does not constitute a violation of the Anti-Kickback Law, but the HHS-OIG has indicated failure to fall within a safe harbor may subject an arrangement to increased scrutiny. A violation of the Anti-Kickback Law by us or one or more of our joint ventures could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

Some of our rehabilitation hospitals are owned through joint ventures with institutional healthcare providers that may be in a position to make or influence referrals to our hospitals. In addition, we have a number of relationships with physicians and other healthcare providers, including management or service contracts. Some of these investment relationships and contractual relationships may not fall within the protection offered by a safe harbor. Despite our compliance and monitoring efforts, there can be no assurance violations of the Anti-Kickback Law will not be asserted in the future, nor can there be any assurance our defense against any such assertion would be successful.

For example, we have entered into agreements to manage our hospitals that are owned by joint ventures. Most of these agreements incorporate a percentage-based management fee. Although there is a safe harbor for personal services and management contracts, this safe harbor requires, among other things, the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, the fee arrangement may not meet this requirement. However, we believe our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and comply with the Anti-Kickback Law.

Physician Self-Referral Law . The federal law commonly known as the “Stark law” and CMS regulations promulgated under the Stark law prohibit physicians from making referrals for “designated health services” including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, and home health services, to an entity in which the physician (or an immediate family member) has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing Medicare for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $15,000 for each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.

Under the 2010 Healthcare Reform Laws, the exception to the Stark law that currently permits physicians to refer patients to hospitals in which they have an investment or ownership interest has been dramatically limited by providing that only physician-owned hospitals with a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the physician ownership percentage in the hospital after March 23, 2010. Additionally, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, except when certain market and regulatory approval conditions are met. Currently, we have no hospitals that would be considered physician-owned under this law, except for one hospital acquired in 2015 which has an outside limited partner with a 0.5% equity interest.

CMS has issued several phases of final regulations implementing the Stark law. On November 16, 2015, CMS issued a new rule revising, clarifying, and adding two exceptions in order to accommodate delivery and payment system reform, reduce burdens on physicians and other providers, and promote compliance. While the changes are generally expected to help providers comply with the Stark law requirements, the complexity of the law and the associated regulations will remain a challenge for healthcare providers, who do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet one or more exceptions to the Stark law, but the regulations implementing the exceptions are detailed and complex. Accordingly, we cannot assure that every relationship complies fully with the Stark law.

Additionally, no assurances can be given that any agency charged with enforcement of the Stark law and regulations might not assert a violation under the Stark law, nor can there be any assurance our defense against any such assertion would be successful or that new federal or state laws governing physician relationships, or new interpretations of existing laws governing such relationships, might not adversely affect relationships we have established with physicians or result in the imposition of penalties on us or on particular HealthSouth hospitals or another of our providers. A violation of the Stark law by us could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA,” broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare or Medicaid beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties. The HHS Office of Civil Rights ("HHS-OCR") implemented a permanent HIPAA audit program for healthcare providers nationwide in 2016. As of December 31, 2016, we have not been selected for audit.

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

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

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

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

Available Information

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

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and the reader should take such risks into account in evaluating HealthSouth or any investment decision involving HealthSouth.

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

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

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

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

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

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

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

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

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

Other federal legislation can also have a significant direct impact on our Medicare reimbursement. On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2% reduction of Medicare program payments. This automatic reduction, known as "sequestration," which began affecting payments received after April 1, 2013, reduced the payments we receive under the inpatient rehabilitation facility prospective payment system (the "IRF-PPS") resulting in a net year-over-year decrease in our *Net operating revenues* of approximately $9 million in 2014. The effect of sequestration on year-over-year comparisons of *Net operating revenues* ceased on April 1, 2014. However, each year through 2025, the reimbursement we receive from Medicare, after first taking into account all annual payment adjustments including the market basket update, will be reduced by sequestration unless it is repealed before then.

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

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

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

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

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

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

In addition, there are increasing pressures, including as a result of the 2010 Healthcare Reform Laws, from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors, such as health maintenance organizations and preferred provider organizations, are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

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

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

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

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

Similarly, CMS has established per the 2010 Healthcare Reform Laws several separate ACO programs, the largest of which is the Medicare Shared Savings Program (“MSSP”), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Under the MSSP, there are two different ACO tracks from which participants can choose. The first track allows ACOs to share only in the savings. The second track requires ACOs to share in any savings and losses but offers ACOs a greater share of any savings realized than the first track offers. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. According to CMS, 562 ACOs will be serving patients in 2017. We continue to evaluate, on a case-by-case basis, appropriate ACO participation opportunities for our hospitals, home health agencies, and patients. To date, we have signed two ACO participation agreements for our hospitals. Encompass has also partnered as the exclusive preferred home health provider with Premier PHC™, an ACO serving approximately 22,000 Medicare patients.

In January 2015, HHS announced it set various goals with respect to tying Medicare reimbursements to alternative payment models and value-based purchasing. Specifically, HHS set goals of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016 and tying 50 percent of payments to those models by the end of 2018. HHS also set goals of tying 85 and 90 percent of traditional Medicare payments to quality or value by the end of 2016 and 2018, respectively, through programs such as those that include financial incentives for reducing acute care hospital readmissions. Given the results of the 2016 elections in the United States, the future of these goals and the means by which CMS attempts to achieve them, such as continued proliferation of mandatory bundled payment models, are uncertain.

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

On January 3, 2017, CMS published its final rule providing for the creation and testing of three new episode payment models ("EPMs") as well as modification of the CJR model. The three new Medicare EPMs are: (1) acute myocardial infarction model, (2) coronary artery bypass graft ("CABG") model, and (3) surgical hip/femur fracture treatment excluding lower extremity joint replacement ("SHFFT") model. Most relevant to us are the mandatory CABG and SHFFT models which are set to begin July 1, 2017 and continue through the end of 2021. Under these models, as with the CJR model, acute care hospitals are financially accountable for the quality and cost of an episode of care, which is intended to incentivize increased coordination of care among hospitals, physicians, and post-acute care providers.

The SHFFT model covers the same 67 markets as the CJR model, and the CABG model covers 98 markets, 40 of which include at least one of our IRFs. Hospitals subject to these models will earn a composite quality of care score based on performance in comparison to that of other hospitals. Following completion of a model performance year, hospitals that achieve actual episode spending below the target cost and achieve an acceptable or better quality score will be eligible to earn an incentive payment for the difference between the target and actual cost, up to a specified limit. Hospitals will have no downside financial risk for the first year, optional downside risk in the second year, and mandatory downside risk beginning in the third year.

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

Additionally, as the number and types of bundling and ACO models increase, the number of Medicare beneficiaries who are treated in one of the models increases. Our willingness and ability to participate in integrated delivery payment and other alternative payment models and the referral patterns of other providers participating in those models may limit our access to Medicare patients who would benefit from treatment in inpatient rehabilitation hospitals or from the services Encompass offers. To the extent that acute care hospitals participating in those models do not perceive our quality of care or cost efficiency favorably compared to alternative post-acute providers, we may experience a decrease in volumes and *Net operating revenues* , which could adversely affect our financial position, results of operations, and cash flows. For further discussion of new coordinated care and integrated delivery payment models and value-based purchasing initiatives, the associated challenges, and our efforts to respond to them, see the "Executive Overview—Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations* .

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

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

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

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

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

For home health agencies, the proposed rule includes several new requirements. The discharge planning process would require the regular re - evaluation of patients to identify changes requiring modification of the discharge plan. The physician responsible for a patient's plan of care would have to be involved in the ongoing establishment of the discharge plan. Home health agencies must also send certain specified medical and other information to the post-discharge facility or health care practitioner. The proposed rule would likely require the modification of existing discharge forms and reports, and patient visits may need to be extended in order to accommodate patient education. If adopted as proposed, we would expect to incur additional one-time and recurring expenses to comply, but at this time, we cannot predict what the final requirements will be or the timing or effect of those requirements.

In accordance with requirements adopted pursuant to the IMPACT Act, CMS implemented the new Medicare spending per beneficiary measures for each inpatient rehabilitation hospital in October 2016 and each home health agency in January 2017. The intent of tracking and publishing this data is to evaluate a given provider's payment efficiency relative to the efficiency of the national median provider in that provider's post-acute segment. CMS believes this measure will encourage improved efficiency and coordination of care in the post-acute setting by holding providers accountable for Medicare resource use during an episode of care. However, the measures do not take into account patient outcomes. CMS has not proposed to compare payment efficiency across provider segments.

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

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

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

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

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

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

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

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

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

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

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

Healthcare providers are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under the 2007 Medicare Act;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

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

In addition to specific compliance-related laws and regulations, examples of regulatory changes that can affect our business, beyond direct changes to Medicare reimbursement rates, can be found from time to time in CMS's annual rulemaking. For example, the final rule for the fiscal year 2010 IRF-PPS implemented new coverage requirements which provided in part that a patient medical record must document a reasonable expectation that, at the time of admission to an IRF, the patient generally required and was able to participate in the intensive rehabilitation therapy services uniquely provided at IRFs. CMS has also taken the position that a patient's medical file must appropriately document the rationale for the use of group therapies, as opposed to one-on-one therapy. Beginning on October 1, 2015, CMS instituted a new data collection requirement pursuant to which IRFs must capture the minutes and mode (individual, group, concurrent, or co-treatment) of therapy by specialty. CMS plans to use this data to potentially support future rulemaking in this area. Additionally, the final rules for the fiscal years 2014 and 2015 IRF-PPS included a reduction in the number of medical conditions that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

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

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

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

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

Although we have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, we could be required to return portions of reimbursements for discharges alleged after the fact to have not been appropriate under the applicable reimbursement rules. We could also be subjected to other liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs, which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement.

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

Reductions in reimbursements, substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

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

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

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

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

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

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

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

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

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

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

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

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

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

In May 2014, the American Hospital Association and others filed a lawsuit seeking to compel HHS to meet the statutorily required deadlines for adjudication of denied Medicare claims. In December 2016, the presiding federal district court judge in the lawsuit ordered HHS to reduce the backlog of appeals by 30% by the end of 2017, by 60% by the end of 2018, by 90% by the end of 2019, and completely by the end of 2020. HHS has appealed the federal district court decision. On January 17, 2017, CMS published a rule implementing procedural and administrative changes to the appeals process, but it is unclear what, if any, impact these changes will have on the backlog. However, these changes may limit or otherwise negatively affect provider appeal rights. This new rule may be subject to legal challenge by healthcare providers as well. We cannot predict what, if any, further action CMS will take to reduce the backlog.

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

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

We face intense competition for patients from other healthcare providers.

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

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

There can be no assurance this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, from time to time, there are efforts in states with certificate of need ("CON") laws to weaken those laws, which could potentially increase competition in those states. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, *Properties* .

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

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

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

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

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

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

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

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

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

We may undertake strategic acquisitions from time to time. For example, we completed the acquisitions of Encompass in 2014, the operations of Reliant Hospital Partners, LLC and affiliated entities in 2015, and the home care operations of CareSouth Health System, Inc. in 2015. Prior to consummation of any acquisition, the acquired business will have operated independently of us, with its own procedures, corporate culture, locations, employees and systems. We will fold those businesses into our existing business as one combined organization, for example utilizing certain common information systems, operating procedures, administrative functions, financial and internal controls and human resources practices. There may be substantial difficulties, costs and delays involved in the integration of an acquired business with our business. Additionally, an acquisition could cause disruption to our business and operations and our relationships with customers, employees and other parties. In some cases, the acquired business has itself grown through acquisitions, as was the case with Encompass, Reliant and CareSouth, and there may be legacy systems, operating policies and procedures, financial and administrative practices yet to be fully integrated. To the extent we are attempting to integrate multiple businesses at the same time, we may not be able to do so as efficiently or effectively as we would prefer. The failure to successfully integrate on a timely basis any acquired business with our existing business could have an adverse effect on our business, financial position, results of operations, and cash flows.

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

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

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This issue may be exacerbated if immigration is limited in the future. A shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

If our labor costs increase, we may not experience reimbursement rate or pricing increases to offset these additional costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual market basket update from Medicare or we continue to experience a shift in our payor mix to lower rate payors such as Medicaid, our results of operations and cash flows will be adversely affected. Conversely, decreases in reimbursement revenues, such as with sequestration, may limit our ability to increase compensation or benefits to the extent necessary to retain key employees, in turn increasing our turnover and associated costs. Union activity is another factor that may contribute to increased labor costs. We currently have a minimal number of union employees, so an increase in labor union activity could have a significant impact on our labor costs. Our failure to recruit and retain qualified medical personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our indebtedness could have important consequences, including:

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

We are subject to contingent liabilities, prevailing economic conditions, and financial, business, and other factors beyond our control. Although we expect to make scheduled interest payments and principal reductions, we cannot provide assurance that changes in our business or other factors will not occur that may have the effect of preventing us from satisfying obligations under our debt instruments. If we are unable to generate sufficient cash flow from operations in the future to service our debt and meet our other needs or have an unanticipated cash payment obligation, we may have to refinance all or a portion of our debt, obtain additional financing or reduce expenditures or sell assets we deem necessary to our business. We cannot provide assurance these measures would be possible or any additional financing could be obtained.

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

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

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

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

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

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

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

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

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

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

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

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

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

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

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

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

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

Item 3. Legal Proceedings

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

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market Information

Shares of our common stock trade on the New York Stock Exchange under the ticker symbol "HLS." The following table sets forth the high and low sales prices per share for our common stock as reported on the NYSE from January 1, 2015 through December 31, 2016 :

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

Holders

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

Dividends

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

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

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

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

Purchases of Equity Securities

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

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

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

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

Company Stock Performance

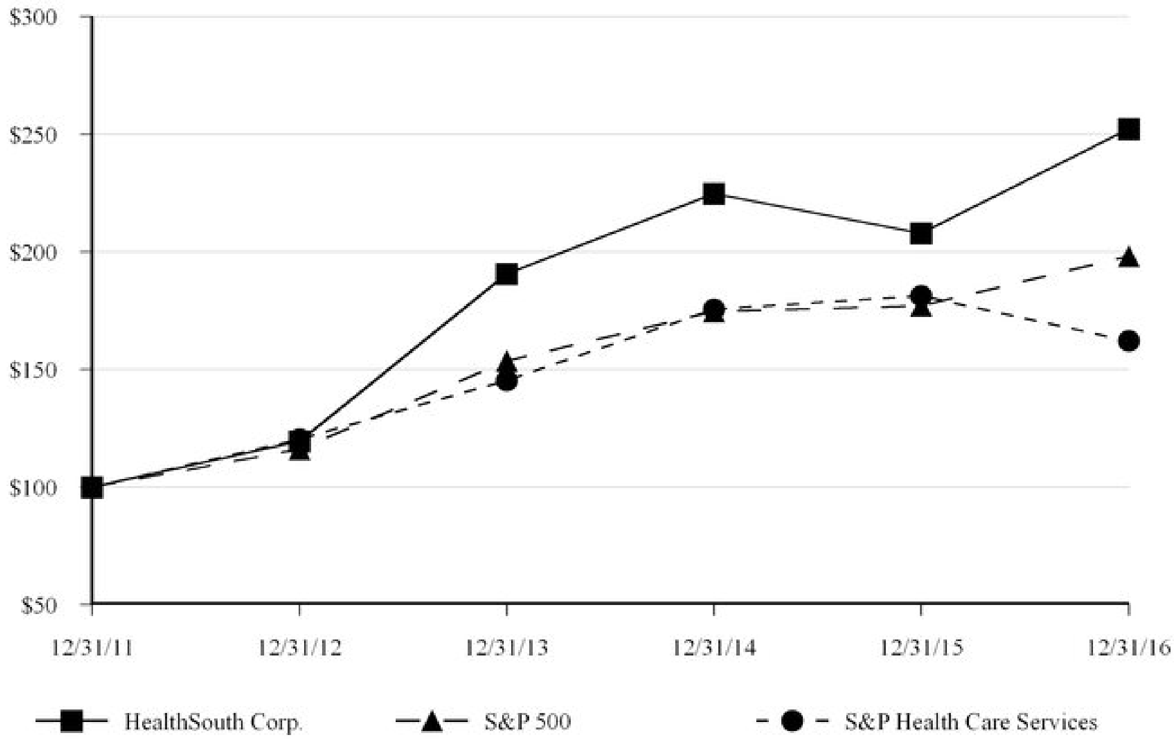
Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor’s 500 Index (“S&P 500”), and the S&P Health Care Services Select Industry Index (“SPSIHP”), an equal-weighted index of at least 35 companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2011 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock. We have paid a quarterly cash dividend on our common stock since October 2013.

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

The comparisons in the graph below are based upon historical data and are not indicative of, nor intended to forecast, future performance of HealthSouth's common stock. Research Data Group, Inc. provided the data for the indices presented below. We assume no responsibility for the accuracy of the indices' data, but we are not aware of any reason to doubt its accuracy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

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



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

Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2016 , 2015 , and 2014 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below for the years ended December 31, 2013 and 2012 from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2013 . Refer to Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* and the notes to the accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations.

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

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

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

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

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

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

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

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

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

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

The following Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying consolidated financial statements and related notes. This MD&A is designed to provide the reader with information that will assist in understanding our consolidated financial statements, the changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes, as well as how certain accounting principles affect our consolidated financial statements. See "Cautionary Statement Regarding Forward-Looking Statements" on page ii of this report for a description of important factors that could cause actual results to differ from expected results. See also Item 1A, *Risk Factors* .

Executive Overview

Our Business

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

Inpatient Rehabilitation

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

Home Health and Hospice

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

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

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

2016 Overview

Our 2016 strategy focused on the following priorities:

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

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

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

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

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

Many of our quality and outcome measures remained above both inpatient rehabilitation and home health industry averages, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), the United States Centers for Medicare and Medicaid Services ("CMS"), and Avalere Health and the Alliance for Home Health Quality and Innovation. Not only did we treat more patients and enhance outcomes, we did so in a cost-effective manner.

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

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

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

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

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

(1) In March 2016, we secured land and began the design and permitting process.

(2) In June 2016, we were awarded a CON, acquired land, and began the design and permitting process.

(3) In August 2016, we were awarded a CON, acquired land, and began the zoning, design, and permitting process.

(4) In August 2014, we acquired land and began the design and permitting process.

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

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

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

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

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

Business Outlook

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

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

We have invested considerable resources into clinical and management systems and protocols that have allowed us to consistently produce high-quality outcomes for our patients while continuing to contain cost growth. Our proprietary hospital management reporting system aggregates data from each of our key business systems into a comprehensive reporting package used by the management teams in our hospitals, as well as executive management, and allows them to analyze data and trends and create custom reports on a timely basis. Our commitment to technology also includes the on-going implementation of ACE-IT. As of December 31, 2016, we had installed this system in 101 of our 123 hospitals, and we expect to complete installation in substantially all of our existing hospitals by the end of 2017. We believe this system will improve patient care and safety, enhance staff recruitment and retention, and set the stage for connectivity with other providers and health information exchanges. Our home health and hospice segment also uses information technology to enhance patient care and manage the business by utilizing Homecare Homebase SM , a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. This allows our home health segment to manage the entire patient work flow and provide valuable data for health systems, payors, and ACO partners. We are currently the home health provider to one ACO serving approximately 22,000 patients and are exploring several other participation opportunities.

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

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

For these and other reasons, we believe we will be able to adapt to changes in reimbursement, sustain our business model, and grow through acquisition and consolidation opportunities as they arise.

Key Challenges

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

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

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

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

  Concerns held by federal policymakers about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both, in 2017 and beyond. Additionally, many legislators in the United States House of Representatives and the United States Senate continue to express the policy objective of modifying or repealing the 2010 Healthcare Reform Laws. The election of President Donald Trump, along with Republican majorities in the United States Senate and House of Representatives, increase the likelihood of changes to or repeal of provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. At this time, it is unclear what, if any, of the Medicare-related changes may ultimately be enacted and signed into law by the President, but it is possible that any reductions in Medicare spending will have a material impact on reimbursements for healthcare providers generally and post-acute providers specifically. We cannot predict what, if any, changes in Medicare spending or modifications to the healthcare laws and regulations will result from future budget and other legislative initiatives.

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

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

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

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

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

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

The final rule also includes other changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index values, changes to designations between rural and urban facilities, and updates to the outlier fixed loss threshold. The final rule also continues the freeze to the update to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, and teaching status adjustment factors. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the final rule's release and incorporates other adjustments included in the final rule, we believe the 2017 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2016, prior to the impact of sequestration.

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

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

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

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

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

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

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

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

- Changes to Our Operating Environment Resulting from Healthcare Reform . Our challenges related to healthcare reform are discussed in Item 1, *Business* , "Sources of Revenues," and Item 1A, *Risk Factors* . Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notably for us are the reductions to our hospitals' annual market basket updates, including productivity adjustments, mandated reductions to home health and hospice Medicare reimbursements, and future payment reforms such as ACOs and bundled payments.

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

  - We have a track record of successful partnerships with acute care providers. Thirty-seven of our hospitals already operate as joint ventures with acute care hospitals, and we continue to pursue joint ventures as one of our growth initiatives. These joint ventures create an immediate link to an acute care system and position us to quickly and efficiently integrate our services in a coordinated care model.

- Our commitment to coordinated care is demonstrated and enhanced by the utilization of technology. Our hospital electronic clinical information system is capable of interfaces with all major acute care electronic medical record systems and health information exchanges making communication easier across the continuum of healthcare providers. Our home health and hospice clinical information system utilizes a leading home care technology that manages the entire patient work flow. Importantly, we have the ability to use data from both systems to develop clinical protocol best practices.

- Our balance sheet is strong, and we have consistently strong free cash flows. We have no significant debt maturities prior to 2020, and we have significant liquidity under our revolving credit facility. In addition, we own the real estate associated with approximately 69% of our hospitals.

- We have a proven track record of being a high-quality, cost-effective provider. The FIM ® Gains (a tool based on an 18-point assessment used to measure functional independence from admission to discharge) at our inpatient rehabilitation hospitals consistently exceed industry results, and the 30-day readmission rates at our home health agencies are lower than the national average. In addition, we have the scale and operating leverage to generate a low cost per discharge/visit.

- The combination of home health and hospice with our existing inpatient rehabilitative healthcare services provides us with an increased opportunity to succeed in value-based purchasing programs and to participate in more coordinated care and integrated delivery payment models, such as ACOs and bundled payment arrangements. We believe enhanced clinical collaboration between our hospitals and home health agencies offers an excellent means to deliver the quality of care and the cost effectiveness that these new models require to be successful. Since partnering with Encompass, we have focused, and will continue to focus, on increasing this collaboration. We are currently participating in several coordinated care delivery model initiatives and are exploring ACO participation in several others. Eight of our IRFs began participating in Phase 2, the “at-risk” phase, of Model 3 of CMS’ Bundled Payments for Care Improvement (“BPCI”) initiative in 2015. We also have several IRFs that have signed participation agreements with acute care providers participating in Model 2 of the BPCI initiative. Ten of our home health agencies began participating in Phase 2 of Model 3 of the BPCI initiative in 2014. As of December 31, 2016, 38 home health agencies participate in Phase 2. In addition, we have partnered as the home health provider with Premier PHC™, an ACO serving approximately 22,000 Medicare patients.

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

Additionally, in October 2014, President Obama signed into law the IMPACT Act. The IMPACT Act was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees’ solicitation of post-acute payment reform ideas and proposals. It directs the United States Department of Health and Human Services (“HHS”), in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the development of a new post-acute payment system, we believe this act will lay the foundation for possible future post-acute payment policies that would be based on patients’ medical conditions and other clinical factors rather than the setting where the care is provided, also referred to as “site neutral” reimbursement. It will also create additional data reporting requirements for our hospitals and home health agencies, and we expect to fully comply with these requirements. The precise details of these new reporting requirements, including timing and content, will be developed and implemented by CMS through the regulatory process that we expect will take place over the next several years. While we cannot quantify the potential financial effects of the IMPACT Act on HealthSouth, we believe any post-acute payment system that is data-driven and focuses on the needs and underlying medical conditions of post-acute patients ultimately will be a net positive for providers who offer high-quality, cost-effective care. However, it will likely take years for the related quality measures to be established, quality data to be gathered, standardized patient assessment data to be assembled and disseminated, and potential payment policies to be developed, tested, and promulgated. As the nation's largest owner and operator of inpatient rehabilitation hospitals and fourth largest provider of Medicare-certified skilled home health services, we will work with HHS, MedPAC, and other healthcare stakeholders on these initiatives.

- Maintaining Strong Volume Growth . Various factors, including competition and increasing regulatory and administrative burdens, may impact our ability to maintain and grow our hospital, home health, and hospice volumes. In any particular market, we may encounter competition from local or national entities with longer operating histories or other competitive advantages, such as acute care hospitals who provide post-acute services similar to ours or other post-acute providers with relationships with referring acute care hospitals or physicians. Aggressive payment review practices by Medicare contractors, aggressive enforcement of regulatory policies by government agencies, and restrictive or burdensome rules, regulations or statutes governing admissions practices may lead us to not accept patients who would be appropriate for and would benefit from the services we provide. In addition, from time to time, we must get regulatory approval to expand our services and locations in states with certificate of need laws. This approval may be withheld or take longer than expected. In the case of new-store volume growth, the addition of hospitals, home health agencies, and hospice agencies to our portfolio also may be difficult and take longer than expected.

- Recruiting and Retaining High-Quality Personnel . See Item 1A, *Risk Factors* , for a discussion of competition for staffing, shortages of qualified personnel, and other factors that may increase our labor costs. Recruiting and retaining qualified personnel for our inpatient hospitals and home health and hospice agencies remain a high priority for us. We attempt to maintain a comprehensive compensation and benefits package that allows us to remain competitive in this challenging staffing environment while remaining consistent with our goal of being a high-quality, cost-effective provider of inpatient rehabilitative services.

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

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

Results of Operations

Payor Mix

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

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

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

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

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

Our Results

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

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

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

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

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

2016 Compared to 2015

Net Operating Revenues

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

Provision for Doubtful Accounts

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

Salaries and Benefits

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

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

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

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

Other Operating Expenses

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

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

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

Occupancy costs

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

Supplies

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

General and Administrative Expenses

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

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

Depreciation and Amortization

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

Government, Class Action, and Related Settlements

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

Professional Fees — Accounting, Tax, and Legal

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

Loss on Early Extinguishment of Debt

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

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

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

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

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

Interest Expense and Amortization of Debt Discounts and Fees

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

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

Other Income

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

Income from Continuing Operations Before Income Tax Expense

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

Provision for Income Tax Expense

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

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

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

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

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

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

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

2015 Compared to 2014

Net Operating Revenues

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

Provision for Doubtful Accounts

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

Salaries and Benefits

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

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

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

Other Operating Expenses

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

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

Occupancy costs

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

Supplies

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

General and Administrative Expenses

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

Depreciation and Amortization

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

Government, Class Action, and Related Settlements

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

Professional Fees — Accounting, Tax, and Legal

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

Loss on Early Extinguishment of Debt

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

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

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

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

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

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* in 2015 compared to 2014 resulted from an increase in average borrowings offset by a lower average cash interest rate. Average borrowings increased due to our use of debt to fund the acquisitions of Encompass, Reliant, and CareSouth. Our average cash interest rate decreased from 6.3% in 2014 to 5.3% in 2015 due to the redemption of our 7.25% Senior Notes due 2018 in October 2014, the redemption of approximately $25 million of our 7.75% Senior Notes due 2022 in December 2014, and the redemption of our 8.125% Senior Notes due 2020 in April 2015. Cash paid for interest approximated $121 million and $101 million in 2015 and 2014, respectively. See Note 9 , *Long-term Debt* , to the accompanying consolidated financial statements.

Other Income

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

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

Income from Continuing Operations Before Income Tax Expense

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

Provision for Income Tax Expense

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

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

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

Net Income Attributable to Noncontrolling Interests

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

Impact of Inflation

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

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

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

Relationships and Transactions with Related Parties

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

Segment Results of Operations

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

Inpatient Rehabilitation

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

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

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

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

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

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

2016 Compared to 2015

Net Operating Revenues

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

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

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

Adjusted EBITDA

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

2015 Compared to 2014

Net Operating Revenues

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

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

Adjusted EBITDA

The increase in Adjusted EBITDA in 2015 compared to 2014 primarily resulted from revenue growth, as discussed above. Adjusted EBITDA in 2015 was also impacted by (1) an increase in salaries and benefits as a percent of revenue due to increases in group medical costs, an increase in our licensed skills mix, and an increase in volume-related "premium" pay, (2) increased bad debt expense from continued pre-payment claims denials predominately by one of our MACs, (3) SSI ratio adjustments, as discussed above (4) a settlement of an employee sexual harassment matter that was not covered by insurance, and (5) incremental investments in our operating platform, including a contractual increase in costs associated with the ongoing implementation of our electronic clinical information system, the addition of staff at our hospitals to ensure compliance with new CMS quality reporting requirements, the creation of a new medical services department, and costs associated with our participation in CMS' Model 3 bundling pilot initiative. Increases in group medical costs resulted from an increase in the number and size of large claims (claims greater than $100,000) and an increase in the cost and use of specialty pharmaceuticals.

Home Health and Hospice

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

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

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

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

2016 Compared to 2015

Net Operating Revenues

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

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

Adjusted EBITDA

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

2015 Compared to 2014

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

Liquidity and Capital Resources

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

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

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

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

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

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

Current Liquidity

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

In addition to *Cash and cash equivalents* , as of December 31, 2016 , we had approximately $415 million available to us under our revolving credit facility. Our credit agreement governs the substantial majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $75 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. In calculating the leverage ratio under our credit agreement, we are permitted to use pro forma Adjusted EBITDA, the calculation of which includes historical income statement items and pro forma adjustments resulting from (1) the dispositions and repayments or incurrence of debt and (2) the investments, acquisitions, mergers, amalgamations, consolidations and operational changes from acquisitions to the extent such items or effects are not yet reflected in our trailing four-quarter financial statements. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2016 , the maximum leverage ratio requirement per our credit agreement was 4.50x and the minimum interest coverage ratio requirement was 3.0x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2016 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2016 , if we had drawn on the first day and maintained the maximum amount of outstanding draws under our revolving credit facility for the entire year, we would still be in compliance with the maximum leverage ratio and minimum interest coverage ratio requirements.

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

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

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

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

Sources and Uses of Cash

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

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

2016 Compared to 2015

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

Investing activities . The decrease in *Net cash used in investing activities* during 2016 compared to 2015 resulted primarily from the decrease in cash used in the acquisition of businesses offset by the proceeds received from the divestiture of our home health pediatric assets in 2016. Cash outflows were significantly higher in 2015 due to the acquisitions of Reliant and CareSouth described in Note 2, *Business Combinations* , to the accompanying consolidated financial statements.

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

2015 Compared to 2014

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

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

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

Contractual Obligations

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

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

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

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

(c) Amounts include interest portion of future minimum capital lease payments.

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

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

(e) Future operating lease obligations and purchase obligations are not recognized in our consolidated balance sheet.

(f) Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on HealthSouth and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, 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.

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

(h) The table above does not include *Redeemable noncontrolling interests* of $138.3 million because of the uncertainty surrounding the timing and amounts of any related cash outflows. See Note 11, *Redeemable Noncontrolling Interests* , to the accompanying consolidated financial statements.

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

Authorizations for Returning Capital to Stakeholders

In October 2015, February 2016, and May 2016, our board of directors declared cash dividends of $0.23 per share that were paid in January 2016, April 2016, and July 2016, respectively. On July 21, 2016, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.24 per share, payable on October 17, 2016 to stockholders of record on October 3, 2016. On October 20, 2016, our board of directors declared a cash dividend of $0.24 per share, payable on January 17, 2017 to stockholders of record on January 3, 2017. We expect quarterly dividends to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board of directors after consideration of various factors, including our capital position and alternative uses of funds. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our credit agreement.

The payment of cash dividends on our common stock triggers antidilution adjustments, except in instances when such adjustments are deemed *de minimis,* under our convertible notes. See Note 9 , *Long-term Debt* , to the accompanying consolidated financial statements.

On February 14, 2014, our board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million. As of December 31, 2016, approximately $96 million remained under this authorization. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. During 2016, we repurchased 1.7 million shares of our common stock in the open market for $64.1 million under this repurchase authorization using cash on hand. Future repurchases under this authorization generally are expected to be funded using a combination of cash on hand and availability under our $600 million revolving credit facility.

Adjusted EBITDA

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

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

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

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

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

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

Reconciliation of Net Income to Adjusted EBITDA

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

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

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

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

Off-Balance Sheet Arrangements

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

- any obligation under certain guarantees or contracts;

- a retained or contingent interest in assets transferred to an unconsolidated entity or similar entity or similar arrangement that serves as credit, liquidity, or market risk support to that entity for such assets;

- any obligation under certain derivative instruments; and

- any obligation under a material variable interest held by the registrant in an unconsolidated entity that provides financing, liquidity, market risk, or credit risk support to the registrant, or engages in leasing, hedging, or research and development services with the registrant.

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

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

Critical Accounting Estimates

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

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

Revenue Recognition

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

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

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

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation and review, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. However, we continually review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective.

Allowance for Doubtful Accounts

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

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

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

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

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

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers’ compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers’ compensation risks are insured through a wholly owned insurance subsidiary. See Note 10, *Self-Insured Risks* , to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

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

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

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

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

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

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

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

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

Goodwill

Absent any impairment indicators, we evaluate goodwill for impairment as of October 1st of each year. We test goodwill for impairment at the reporting unit level and are required to make certain subjective and complex judgments on a number of matters, including assumptions and estimates used to determine the fair value of our inpatient rehabilitation and home health and hospice reporting units. We assess qualitative factors in each reporting unit to determine whether it is necessary to perform the first step of the two-step quantitative goodwill impairment test. The quantitative impairment test is required only if we conclude it is more likely than not a reporting unit's fair value is less than its carrying amount.

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

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

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

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

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

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

Income Taxes

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

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

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

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

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

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

Assessment of Loss Contingencies

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

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

Recent Accounting Pronouncements

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

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use sensitivity analysis models to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2016, our primary variable rate debt outstanding related to $152.0 million in advances under our revolving credit facility and $421.2 million outstanding under our term loan facilities. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $5.1 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $4.1 million over the next 12 months, assuming floating rate indices are floored at 0%.

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

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

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

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

Item 8. Financial Statements and Supplementary Data

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

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

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

Management's Report on Internal Control Over Financial Reporting

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

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

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

Changes in Internal Control Over Financial Reporting

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

Item 9B. Other Information

None.

PART III

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

Item 10. Directors and Executive Officers of the Registrant

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

Item 11. Executive Compensation

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

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

Equity Compensation Plans

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

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

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

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

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

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

2004 Amended and Restated Director Incentive Plan

The 2004 Amended and Restated Director Incentive Plan (the "2004 Plan") provided for the grant of common stock, awards of restricted common stock, and the right to receive awards of common stock, which we refer to as "restricted stock units," to our non-employee directors. The 2004 Plan expired in March 2008 and was replaced by the 2008 Equity Incentive Plan. Some awards remain outstanding. Awards granted under the 2004 Plan at the time of its termination will continue in effect in accordance with their terms. Awards of restricted stock units were fully vested when awarded and will be settled in shares of common stock on the earlier of the six-month anniversary of the date on which the director ceases to serve on the board of directors or certain change in control events. The restricted stock units generally cannot be transferred. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

2005 Equity Incentive Plan

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

Security Ownership of Certain Beneficial Owners and Management

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

Item 13. Certain Relationships and Related Transactions and Director Independence

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

Item 14. Principal Accountant Fees and Services

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

PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

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

Financial Statement Schedules

None.

Exhibits

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

Item 16. Form 10-K Summary

Not applicable.

SIGNATURES

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

HEALTHSOUTH CORPORATION

By: /s/ MARK J. TARR

Mark J. Tarr
President and Chief Executive Officer

Date: February 22, 2017

[Signatures continue on the following page]

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POWER OF ATTORNEY

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

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

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

Item 15. Financial Statements

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of HealthSouth Corporation:

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

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

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

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

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Operations

	For the Year Ended December 31,		
	2016	2015	2014
	(In Millions, Except Per Share Data)		
Net operating revenues	**$ 3,707.2**	$ 3,162.9	$ 2,405.9
Less: Provision for doubtful accounts	**(61.2)**	(47.2)	(31.6)
Net operating revenues less provision for doubtful accounts	**3,646.0**	3,115.7	2,374.3
Operating expenses:			
Salaries and benefits	**1,985.9**	1,670.8	1,161.7
Other operating expenses	**492.1**	432.1	351.6
Occupancy costs	**71.3**	53.9	41.6
Supplies	**140.0**	128.7	111.9
General and administrative expenses	**133.4**	133.3	124.8
Depreciation and amortization	**172.6**	139.7	107.7
Government, class action, and related settlements	**—**	7.5	(1.7)
Professional fees—accounting, tax, and legal	**1.9**	3.0	9.3
Total operating expenses	**2,997.2**	2,569.0	1,906.9
Loss on early extinguishment of debt	**7.4**	22.4	13.2
Interest expense and amortization of debt discounts and fees	**172.1**	142.9	109.2
Other income	**(2.9)**	(5.5)	(31.2)
Equity in net income of nonconsolidated affiliates	**(9.8)**	(8.7)	(10.7)
Income from continuing operations before income tax expense	**482.0**	395.6	386.9
Provision for income tax expense	**163.9**	141.9	110.7
Income from continuing operations	**318.1**	253.7	276.2
(Loss) income from discontinued operations, net of tax	**—**	(0.9)	5.5
Net income	**318.1**	252.8	281.7
Less: Net income attributable to noncontrolling interests	**(70.5)**	(69.7)	(59.7)
Net income attributable to HealthSouth	**247.6**	183.1	222.0
Less: Convertible perpetual preferred stock dividends	**—**	(1.6)	(6.3)
Net income attributable to HealthSouth common shareholders	**$ 247.6**	$ 181.5	$ 215.7
Weighted average common shares outstanding:			
Basic	**89.1**	89.4	86.8
Diluted	**99.5**	101.0	100.7
Earnings per common share:			
Basic earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	**$ 2.77**	$ 2.03	$ 2.40
Discontinued operations	**—**	(0.01)	0.06
Net income	**$ 2.77**	$ 2.02	$ 2.46
Diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	**$ 2.59**	$ 1.92	$ 2.24
Discontinued operations	**—**	(0.01)	0.05
Net income	**$ 2.59**	$ 1.91	$ 2.29
Cash dividends per common share	**$ 0.94**	$ 0.88	$ 0.78
Amounts attributable to HealthSouth common shareholders:			
Income from continuing operations	**$ 247.6**	$ 184.0	$ 216.5
(Loss) income from discontinued operations, net of tax	**—**	(0.9)	5.5
Net income attributable to HealthSouth	**$ 247.6**	$ 183.1	$ 222.0

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

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2016	**2015**	**2014**
	(In Millions)		
COMPREHENSIVE INCOME			
Net income	**$ 318.1**	$ 252.8	$ 281.7
Other comprehensive loss, net of tax:			
Net change in unrealized gain (loss) on available-for-sale securities:			
Unrealized net holding gain (loss) arising during the period	**0.1**	(0.1)	(0.2)
Reclassifications to net income	**—**	(1.2)	(0.5)
Other comprehensive (income) loss before income taxes	**0.1**	(1.3)	(0.7)
Provision for income tax (expense) benefit related to other comprehensive loss items	**(0.1)**	0.6	0.3
Other comprehensive loss, net of tax:	**—**	(0.7)	(0.4)
Comprehensive income	**318.1**	252.1	281.3
Comprehensive income attributable to noncontrolling interests	**(70.5)**	(69.7)	(59.7)
Comprehensive income attributable to HealthSouth	**$ 247.6**	$ 182.4	$ 221.6

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

HealthSouth Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31,	
	2016	**2015**
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 40.5**	$ 61.6
Restricted cash	**60.9**	45.9
Accounts receivable, net of allowance for doubtful accounts of $53.9 in 2016; $39.3 in 2015	**443.8**	410.5
Prepaid expenses and other current assets	**109.3**	80.7
Total current assets	**654.5**	598.7
Property and equipment, net	**1,391.8**	1,310.1
Goodwill	**1,927.2**	1,890.1
Intangible assets, net	**411.3**	419.4
Deferred income tax assets	**75.8**	190.8
Other long-term assets	**221.3**	197.0
Total assets [(1)]	**$ 4,681.9**	$ 4,606.1
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	**$ 37.1**	$ 36.8
Accounts payable	**68.3**	61.6
Accrued payroll	**147.3**	126.2
Accrued interest payable	**25.8**	29.7
Other current liabilities	**197.1**	172.1
Total current liabilities	**475.6**	426.4
Long-term debt, net of current portion	**2,979.3**	3,134.7
Self-insured risks	**110.4**	101.6
Other long-term liabilities	**49.6**	43.0
	3,614.9	3,705.7
Commitments and contingencies		
Redeemable noncontrolling interests	**138.3**	121.1
Shareholders' equity:		
HealthSouth shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 109,381,283 in 2016; 108,275,900 in 2015	**1.1**	1.1
Capital in excess of par value	**2,799.1**	2,834.9
Accumulated deficit	**(1,448.4)**	(1,696.0)
Accumulated other comprehensive loss	**(1.2)**	(1.2)
Treasury stock, at cost (20,451,458 shares in 2016 and 18,145,822 shares in 2015)	**(614.7)**	(527.4)
Total HealthSouth shareholders' equity	**735.9**	611.4
Noncontrolling interests	**192.8**	167.9
Total shareholders' equity	**928.7**	779.3
Total liabilities [(1)] and shareholders' equity	**$ 4,681.9**	$ 4,606.1

(1) Our consolidated assets as of December 31, 2016 include total assets of variable interest entities of $262.3 million , which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2016 include total liabilities of the variable interest entities of $50.3 million . See Note 3, *Variable Interest Entities* .

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

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HealthSouth Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	HealthSouth 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, 2013	88.0	$ 1.0	$ 2,849.4	$ (2,101.1)	$ (0.1)	$ (404.6)	$ 124.1	$ 468.7
Net income	—	—	—	222.0	—	—	53.1	275.1
Receipt of treasury stock	(0.3)	—	—	—	—	(9.7)	—	(9.7)
Dividends declared on common stock	—	—	(69.0)	—	—	—	—	(69.0)
Dividends declared on convertible perpetual preferred stock	—	—	(6.3)	—	—	—	—	(6.3)
Stock-based compensation	—	—	23.9	—	—	—	—	23.9
Stock options exercised	0.3	—	7.5	—	—	(0.1)	—	7.4
Stock warrants exercised	0.2	—	6.3	—	—	—	—	6.3
Distributions declared	—	—	—	—	—	—	(44.9)	(44.9)
Repurchases of common stock in open market	(1.3)	—	—	—	—	(43.1)	—	(43.1)
Consolidation of Fairlawn Rehabilitation Hospital	—	—	—	—	—	—	14.0	14.0
Other	0.9	—	(1.3)	—	(0.4)	(1.2)	—	(2.9)
December 31, 2014	87.8	1.0	2,810.5	(1,879.1)	(0.5)	(458.7)	146.3	619.5
Net income	—	—	—	183.1	—	—	55.9	239.0
Conversion of preferred stock	3.3	—	93.2	—	—	—	—	93.2
Receipt of treasury stock	(0.5)	—	—	—	—	(17.2)	—	(17.2)
Dividends declared on common stock	—	—	(79.9)	—	—	—	—	(79.9)
Dividends declared on convertible perpetual preferred stock	—	—	(1.6)	—	—	—	—	(1.6)
Stock-based compensation	—	—	22.4	—	—	—	—	22.4
Stock options exercised	0.2	—	6.7	—	—	(4.4)	—	2.3
Distributions declared	—	—	—	—	—	—	(49.0)	(49.0)
Repurchases of common stock in open market	(1.3)	—	—	—	—	(45.3)	—	(45.3)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	14.8	14.8
Fair value adjustments to redeemable noncontrolling interests, net of tax	—	—	(18.2)	—	—	—	—	(18.2)
Other	0.6	0.1	1.8	—	(0.7)	(1.8)	(0.1)	(0.7)
December 31, 2015	90.1	1.1	2,834.9	(1,696.0)	(1.2)	(527.4)	167.9	779.3
Net income	**—**	**—**	**—**	**247.6**	**—**	**—**	**56.4**	**304.0**
Receipt of treasury stock	**(0.5)**	**—**	**—**	**—**	**—**	**(11.6)**	**—**	**(11.6)**
Dividends declared on common stock	**—**	**—**	**(84.9)**	**—**	**—**	**—**	**—**	**(84.9)**
Stock-based compensation	**—**	**—**	**21.4**	**—**	**—**	**—**	**—**	**21.4**
Stock options exercised	**0.6**	**—**	**13.1**	**—**	**—**	**(7.8)**	**—**	**5.3**
Distributions declared	**—**	**—**	**—**	**—**	**—**	**—**	**(54.2)**	**(54.2)**
Repurchases of common stock in open market	**(1.7)**	**—**	**—**	**—**	**—**	**(65.6)**	**—**	**(65.6)**
Capital contributions from consolidated affiliates	**—**	**—**	**—**	**—**	**—**	**—**	**19.6**	**19.6**
Fair value adjustments to redeemable noncontrolling interests, net of tax	**—**	**—**	**(6.7)**	**—**	**—**	**—**	**—**	**(6.7)**
Windfall tax benefits from share-based compensation	**—**	**—**	**17.3**	**—**	**—**	**—**	**—**	**17.3**
Other	**0.4**	**—**	**4.0**	**—**	**—**	**(2.3)**	**3.1**	**4.8**
December 31, 2016	**88.9**	**$ 1.1**	**$ 2,799.1**	**$ (1,448.4)**	**$ (1.2)**	**$ (614.7)**	**$ 192.8**	**$ 928.7**

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

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2016	2015	2014
	(In Millions)		
Cash flows from operating activities:			
Net income	**$ 318.1**	$ 252.8	$ 281.7
Loss (income) from discontinued operations, net of tax	**—**	0.9	(5.5)
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for doubtful accounts	**61.2**	47.2	31.6
Provision for government, class action, and related settlements	**—**	7.5	(1.7)
Depreciation and amortization	**172.6**	139.7	107.7
Amortization of debt-related items	**13.8**	14.3	12.7
Loss on early extinguishment of debt	**7.4**	22.4	13.2
Equity in net income of nonconsolidated affiliates	**(9.8)**	(8.7)	(10.7)
Distributions from nonconsolidated affiliates	**8.5**	7.7	12.6
Stock-based compensation	**27.4**	26.2	23.9
Deferred tax expense	**132.9**	127.1	97.4
Gain on consolidation of Fairlawn	**—**	—	(27.2)
Other, net	**0.1**	(0.6)	4.8
Changes in assets and liabilities, net of acquisitions—			
Accounts receivable	**(127.5)**	(134.1)	(91.6)
Prepaid expenses and other assets	**(3.3)**	(9.6)	6.5
Accounts payable	**6.3**	0.9	5.4
Accrued payroll	**9.8**	(18.1)	(4.9)
Other liabilities	**11.8**	13.8	(5.5)
Premium received on bond issuance	**—**	9.8	6.3
Premium paid on redemption of bonds	**(5.8)**	(13.7)	(10.6)
Windfall tax benefits from share-based compensation	**(17.3)**	—	—
Net cash used in operating activities of discontinued operations	**(0.7)**	(0.7)	(1.2)
Total adjustments	**287.4**	231.1	168.7
Net cash provided by operating activities	**605.5**	484.8	444.9
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	**(48.1)**	(985.1)	(694.8)
Purchases of property and equipment	**(177.7)**	(128.4)	(170.9)
Additions to capitalized software costs	**(25.2)**	(28.1)	(17.0)
Proceeds from disposal of assets	**23.9**	4.0	0.2
Proceeds from sale of marketable securities	**—**	12.8	—
Purchases of restricted investments	**(1.3)**	(7.1)	(3.5)
Net change in restricted cash	**(15.1)**	2.7	6.8
Other, net	**(1.6)**	(1.1)	2.3
Net cash provided by investing activities of discontinued operations	**0.1**	0.5	—
Net cash used in investing activities	**(245.0)**	**(1,129.8)**	**(876.9)**

(Continued)

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2016	**2015**	**2014**
	(In Millions)		
Cash flows from financing activities:			
Principal borrowings on term loan facilities	—	250.0	450.0
Proceeds from bond issuance	—	1,400.0	175.0
Principal payments on debt, including pre-payments	**(202.1)**	(597.4)	(302.6)
Borrowings on revolving credit facility	**335.0**	540.0	440.0
Payments on revolving credit facility	**(313.0)**	(735.0)	(160.0)
Principal payments under capital lease obligations	**(13.3)**	(11.0)	(6.1)
Debt amendment and issuance costs	—	(31.9)	(6.5)
Repurchases of common stock, including fees and expenses	**(65.6)**	(45.3)	(43.1)
Dividends paid on common stock	**(83.8)**	(77.2)	(65.8)
Dividends paid on convertible perpetual preferred stock	—	(3.1)	(6.3)
Distributions paid to noncontrolling interests of consolidated affiliates	**(64.9)**	(54.4)	(54.1)
Windfall tax benefits from share-based compensation	**17.3**	—	—
Other, net	**8.8**	5.2	13.7
Net cash (used in) provided by financing activities	**(381.6)**	639.9	434.2
(Decrease) increase in cash and cash equivalents	**(21.1)**	(5.1)	2.2
Cash and cash equivalents at beginning of year	**61.6**	66.7	64.5
Cash and cash equivalents at end of year	**$ 40.5**	$ 61.6	$ 66.7
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	**$ (164.3)**	$ (121.4)	$ (100.6)
Income tax refunds	**1.4**	7.4	1.3
Income tax payments	**(33.3)**	(16.8)	(17.7)
Supplemental schedule of noncash investing and financing activities:			
Equity rollover from Encompass management	—	—	64.5
Preferred stock conversion	—	93.2	—

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—

HealthSouth 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 35 states and Puerto Rico through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As a result of the December 31, 2014 acquisition of Encompass Home Health and Hospice ("Encompass"), management changed the way it manages and operates the consolidated reporting entity and modified the reports used by its chief operating decision maker to assess performance and allocate resources. These changes required us to revise our segment reporting from our historic presentation of only one reportable segment. We now manage our operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. See Note 18 , *Segment Reporting* .

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of HealthSouth 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 HealthSouth* 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 —

Effective January 1, 2016, in connection with our adoption of ASU 2015-02, we updated our evaluation of all jointly held legal entities to determine whether they are now variable interest entities ("VIEs") under the new guidance. Any entity considered a 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) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) asset impairments, including goodwill; (5) depreciable lives of assets; (6) useful lives of intangible assets; (7) economic lives and fair value of leased assets; (8) income tax valuation allowances; (9) uncertain tax positions; (10) fair value of stock options and restricted stock containing a market condition; (11) fair value of redeemable noncontrolling interests; (12) reserves for self-insured healthcare plans; (13) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (14) 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* , it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. 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.

Pursuant to legislative directives and authorizations from Congress, the United States Centers for Medicare and Medicaid Services ("CMS") developed and instituted various Medicare audit programs. We undertake significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules. Despite our belief that our coding and assessment of patients is 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 programs will affect us.

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 17, *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—

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

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

We record gross service charges in our accounting records on an accrual basis using our established rates for the type of service provided to the patient. We recognize an estimated contractual allowance and an estimate of potential subsequent adjustments that may arise from post-payment and other reviews to reduce gross patient charges to the amount we estimate we will actually realize for the service rendered based upon previously agreed to rates with a payor. Our accounting systems calculate contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor.

Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. 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 HealthSouth 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.

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

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. As a matter of course, we undertake significant efforts through training and education to ensure compliance with Medicare requirements. However, audits may lead to assertions we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these audit programs will affect us.

Inpatient Rehabilitation Revenues

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

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

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 that are considered and could influence the level of our reserves 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, and additional reserves are provided to account for these factors.

In connection with CMS approved and announced Recovery Audit Contractors (“RACs”) audits related to inpatient rehabilitation facilities (“IRFs”), we received requests from 2013 to 2016 to review certain patient files for discharges occurring from 2010 to 2016 . These RAC audits are post-payment reviews focused on identifying Medicare claims that may contain improper payments. RAC contractors must have CMS approval before conducting these focused reviews 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.

To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2016 , and not all of these patient file requests have resulted in payment denial determinations by the RACs. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of their patients, we have appealed substantially all RAC denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by Medicare Administrative Contractors ("MACs") (see "Accounts Receivable and Allowance for Doubtful Accounts" below). Due to the delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of three years. In addition, because we have limited experience with RACs in the context of post-payment reviews of this nature, we cannot provide assurance as to the future success of these disputes. As such, we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs. As the ultimate results of these audits impact our estimates of amounts determined to be due to HealthSouth under these reimbursement programs, our provision for claims that are part of this post-payment review process are recorded to *Net operating revenues* . During 2016 , 2015 , and 2014 , our adjustment to *Net operating revenues* for post-payment claims that are part of this review process was not material.

Home Health and Hospice Revenues

The results of operations for our home health and hospice segment in 2014 included only the results of HealthSouth's legacy hospital-based home health agencies. Our home health and hospice segment derived its *Net operating revenues* from the following payor sources:

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

Home health and hospice revenues are earned as services are performed either on an episode of care basis, on a per visit basis, or on a daily basis, depending upon the payment terms and conditions established with each payor for services provided.

Home Health

Under the Medicare home health prospective payment system, we are paid by Medicare based on episodes 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 legislation. 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.

A portion of reimbursement from each Medicare episode is billed near the start of each episode, and cash is typically received before all services are rendered. 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, 2016 , the difference between the cash received from Medicare for a request for anticipated payment on episodes in progress and the associated estimated revenue was not material and was recorded in *Other current liabilities* in our condensed consolidated balance sheets.

We are subject to certain Medicare regulations affecting outlier revenue if our patient's care was unusually costly. Regulations require a cap on all outlier revenue at 10% of total Medicare revenue received by each provider during a cost reporting year. Management has reviewed the potential cap. Reserves recorded for the outlier cap were not material as of December 31, 2016 .

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, gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates. Contractual allowances are recorded for the differences between our standard rates and the applicable contracted rates.

Hospice

Medicare revenues for hospice are recorded on an accrual basis based on the number of days a patient has been on service at amounts equal to an estimated daily or hourly payment rate. The payment rate is dependent on whether a patient is receiving routine home care, general inpatient care, continuous home care or respite care. Adjustments to Medicare revenues are recorded based on an inability to obtain appropriate billing documentation or authorizations acceptable to the payor or other reasons unrelated to credit risk. Hospice companies are subject to two specific payment limit caps under the Medicare program. One limit relates to inpatient care days that exceed 20% of the total days of hospice care provided for the year. The second limit relates to an aggregate Medicare reimbursement cap calculated by the Medicare fiscal intermediary. Currently, we do not believe we are at risk for exceeding these caps and have not recorded a reserve for these caps as of December 31, 2016 .

For non-Medicare hospice revenues, we record gross revenue on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per day rates, as applicable. Contractual adjustments are recorded for the difference between our established rates and the amounts estimated to be realizable from patients and third parties for services provided and are deducted from gross revenue to determine our net service revenue.

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.

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 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 is 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 and Allowance for Doubtful Accounts—

We report accounts receivable at estimated net realizable amounts from services rendered 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 geographically dispersed, but a significant portion of our revenues are concentrated by type of payors. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, is as follows:

	As of December 31,	
	2016	2015
Medicare	73.0%	70.5%
Managed care and other discount plans, including Medicare Advantage	18.5%	19.7%
Medicaid	2.7%	2.9%
Other third-party payors	3.3%	4.1%
Workers' compensation	1.6%	1.9%
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.

We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Additions to the allowance for doubtful accounts are made by means of the *Provision for doubtful accounts* . We write off uncollectible accounts (after exhausting collection efforts) against the allowance for doubtful accounts. Subsequent recoveries are recorded via the *Provision for doubtful accounts* .

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. 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. Accounts are written off after all collection efforts (internal and external) have been exhausted.

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 pre-payment claim reviews conducted by MACs. 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.

For several years, under programs designated as “widespread probes,” certain of our MACs have conducted pre-payment claim reviews of supporting documentation in patient medical files and have denied payment based on the assertion that the IRF admission lacked medical necessity, including one MACs denial of all claims under certain diagnosis codes. We dispute, or “appeal,” most of these denials, and for claims we choose to take to administrative law judge hearings, we have historically experienced an approxim ate 70% success rate. The resolution of these disputes can take in excess of three years, and we cannot provide assurance as to our ongoing and future success of these disputes. As such, we make provisions against these receivables in accordance with our accounting policy that necessarily considers historical collection trends of the receivables in this review process as part of our *Provision for doubtful accounts* . Because we do not write-off receivables until all collection efforts have been exhausted, we do not write off receivables related to denied claims while they are in this review process. When the amount collected related to denied claims differs from the net amount previously recorded, these collection differences are recorded in the *Provision for doubtful accounts* . As a result, the timing of these denials by MACs and their subsequent collection can create volatility in our *Provision for doubtful accounts* .

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 report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. 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
Assets under capital lease obligations:	
Real estate	15 to 25
Vehicles	3
Equipment	3 to 5

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.

We account for operating leases by recognizing rents, including any rent holidays, on a straight-line basis over the term of the lease.

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 first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, 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 first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, 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, 2016 , 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 is 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 available-for-sale restricted marketable securities at fair value. The fair values of our available-for-sale 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.

Convertible Perpetual Preferred Stock—

Our *Convertible perpetual preferred stock* contained fundamental change provisions that allowed the holder to require us to redeem the preferred stock for cash if certain events occurred. As redemption under these provisions was not solely within our control, we classified our *Convertible perpetual preferred stock* as temporary equity.

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, and as discussed in Note 2, *Business Combinations* , certain members of Encompass management hold similar put rights regarding their interests in our home health and hospice business. 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 twelve-month specified performance measure and a specified median market price multiple based on a basket of public health companies. 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—

HealthSouth 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, 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 $7.5 million , $7.3 million , and $5.3 million in each of the years ended December 31, 2016 , 2015 , and 2014 , respectively.

Professional Fees—Accounting, Tax, and Legal—

In 2016 , 2015 , and 2014 *, Professional fees—accounting, tax, and legal* related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 17, *Contingencies and Other Commitments* .

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. Under this method in 2016, we recognized these excess tax benefits only after we fully realized the tax benefits of net operating losses.

HealthSouth 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 HealthSouth facility no longer qualifies as a discontinued operation. This accounting change was made prospectively. No new components were recognized as discontinued operations during 2015 or 2016.

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 nonvested restricted stock awards granted before 2014 and 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 use the if-converted method to include our convertible senior subordinated notes in our computation of 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 Accounting Pronouncements —

In May 2014, the FASB issued ASU 2014-09, “Revenue from Contracts with Customers” and has subsequently issued supplemental and/or clarifying ASUs (collectively “ASC 606”). ASC 606 outlines a five-step framework that intends to clarify the principles for recognizing revenue and eliminate industry-specific guidance. In addition, ASC 606 revises current disclosure requirements in an effort to help financial statement users better understand the nature, amount, timing, and uncertainty of revenue that is recognized. ASC 606 will be effective for our annual reporting period beginning on January 1, 2018, including interim periods within that year. Early adoption beginning on January 1, 2017 is permitted. ASC 606 may be applied retrospectively to each period presented or on a modified retrospective basis with the cumulative effect recognized as of the date of adoption. We are currently assessing the impact this guidance may have on our consolidated financial statements by analyzing our current portfolio of third-party payor contracts, including a review of historical accounting policies and practices to identify potential differences in applying the new guidance. We are also evaluating the nature and amount of data available to us in assessing implementation of ASC 606. Under ASC 606, substantially all amounts that were previously presented as *Provision for doubtful accounts* will be considered an implicit price concession in determining *Net operating revenues* . Amounts considered to be doubtful accounts under ASC 606 will be presented as a component of *Total operating expenses* within the consolidated statements of operations. We expect to adopt ASC 606 retrospectively effective January 1, 2018.

In February 2015, the FASB issued ASU 2015-02, “Consolidations (Topic 810) - Amendments to the Consolidation Analysis,” which provided guidance on evaluating whether a reporting entity should consolidate certain legal entities.

Specifically, the amendments modified the evaluation of whether limited partnerships and similar legal entities are VIEs. Under this analysis, limited partnerships and other similar entities are considered a VIE unless the limited partners hold substantive kick-out rights or participating rights. Further, the amendments eliminated the presumption that a general partner should consolidate a limited partnership under the voting interest model, as well as affect the consolidation analysis of reporting entities that are involved with VIEs, particularly those that have fee arrangements and related party relationships. This standard was effective for annual periods beginning after December 15, 2015 and interim periods within those annual periods. We elected to adopt this guidance using the modified retrospective approach. Our adoption of this guidance resulted in certain limited partnership-like entities that were previously consolidated as voting interest entities to now be consolidated as VIEs, for which additional disclosures are required. Our adoption of ASU 2015-02 did not have a material impact on our financial position, results of operations, or cash flows. See Note 3, *Variable Interest Entities* .

In January 2016, the FASB issued ASU No. 2016-01, "Financial Instruments - Overall (Topic 825): Recognition and Measurement of Financial Assets and Financial Liabilities." This standard revises the classification and measurement of investments in certain equity investments and the presentation of certain fair value changes for certain financial liabilities measured at fair value. This revised standard requires the change in fair value of many equity investments to be recognized in net income. This revised standard is effective for our interim and annual periods beginning January 1, 2018. While we are currently assessing the impact this guidance may have on our consolidated financial statements, we expect to recognize mark to market gains and losses associated with our available-for-sale equity securities through *Net income* instead of *Accumulated other comprehensive income* . We continue to review the requirements of this revised standard and any potential impact it may have on our consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)," in order to increase transparency and comparability by recognizing lease assets and liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the new standard, lessees will recognize a right-of-use asset and a corresponding lease liability for all leases other than leases that meet the definition of a short-term lease. The liability will be equal to the present value of future minimum lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, the FASB retained a dual model, requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense while finance leases will result in an expense pattern similar to current capital leases. Classification will be based on criteria that are similar to those applied in current lease accounting. This standard will be effective for our annual reporting period beginning on January 1, 2019. Early adoption is permitted. In transition, we will be required to recognize and measure leases beginning in the earliest period presented using a modified retrospective approach; therefore, we anticipate restating our consolidated financial statements for the two fiscal years prior to the year of adoption. While we are currently assessing the impact this guidance may have on our consolidated financial statements, we expect that virtually all of our existing operating leases will be reflected as right of use assets and liabilities on our consolidated balance sheets under the new standard. We do not expect to early adopt this standard. See Note 6, *Property and Equipment* , for disclosure related to our operating leases.

In March 2016, the FASB issued ASU 2016-09, "Improvements to Employee Share-Based Payment Accounting (Topic 718)," to simplify various aspects of share-based payment accounting and presentation. The new standard requires entities to record all of the tax effects related to share-based payments at settlement (or expiration) through the income statement. This will require us to reclassify tax benefits in excess of compensation cost ("windfalls") and tax deficiencies ("shortfalls") to the extent of previous windfalls from *Capital in excess of par value* to *Provision for income tax expense* . This change is required to be applied prospectively to all excess tax benefits and tax deficiencies resulting from settlements after the date of adoption of the ASU. The standard eliminates the requirement to delay recognition of a windfall tax benefit until it reduces current taxes payable. This change is required to be applied on a modified retrospective basis, with a cumulative-effect adjustment to opening retained earnings. In addition, all income tax-related cash flows resulting from share-based windfall tax benefits are required to be reported as operating activities on the statement of cash flows as opposed to the current presentation as an inflow from financing activities and an outflow from operating activities. Either prospective or retrospective transition of this provision is permitted. Finally, the standard clarifies that all cash payments made to taxing authorities on the employees' behalf for withheld shares should be presented as financing activities on the statement of cash flows. This change will be applied retrospectively. For HealthSouth, this guidance is effective for its annual reporting period beginning January 1, 2017, including interim periods within that reporting period. Early adoption was permitted, with any adjustments reflected as of the beginning of the fiscal year of adoption. Upon our adoption in the first quarter of 2017, the historical and future amount of cash flows resulting from share-based windfall benefits and cash payments made to taxing authorities on the employees' behalf for withheld shares will result in an increase to our historical and future *Cash flows from operating activities* and a decrease to *Cash flows from financing activities* .

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 HealthSouth for the annual period beginning January 1, 2020, including interim periods within that reporting period. Early adoption is permitted for HealthSouth beginning January 1, 2019. We continue to review the requirements of this standard and any potential impact it may have on our consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230), Classification of Certain Cash Receipts and Cash Payments," to reduce diversity in practice in how certain transactions are classified in the statement of cash flows. In addition, the standard clarifies when cash receipts and cash payments have aspects of more than one class of cash flows and cannot be separated, classification will depend on the predominant source or use. The new guidance requires retrospective application and is effective for HealthSouth for the annual reporting period beginning January, 1 2018, 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.

In November 2016, the FASB issued ASU 2016-18, "Statement of Cash Flows (Topic 230), Restricted Cash," to clarify how entities should present restricted cash and restricted cash equivalents in the statement of cash flows. The new guidance requires amounts generally described as restricted cash and restricted cash equivalents be included with cash and cash equivalents when reconciling the total beginning and ending amounts for the periods shown on the statement of cash flows. The new guidance requires retrospective application and is effective for our annual reporting period beginning January 1, 2018, including interim periods within that reporting period. Early adoption is permitted. We continue to review the requirements of this revised 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 :

2016 Acquisitions

Inpatient Rehabilitation

During 2016, we completed the following inpatient rehabilitation hospital 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. Each acquisition was funded through a contribution to the respective consolidated joint venture.

- In February 2016, we acquired 50% of the inpatient rehabilitation hospital at CHI St. Vincent Hot Springs ("Hot Springs"), a 20 -bed inpatient rehabilitation hospital in Hot Springs, Arkansas, through a joint venture with St. Vincent Community Health Services, Inc.
- In August 2016, we acquired 50% of the inpatient rehabilitation hospital at St. Joseph Regional Health Center ("Bryan"), a 19 -bed inpatient rehabilitation hospital in Bryan, Texas, through a joint venture with St. Joseph Health System.
- In August 2016, we also acquired 51% of the inpatient rehabilitation hospital at The Bernsen Rehabilitation Center at St. John ("Broken Arrow"), a 24 -bed inpatient rehabilitation hospital in Broken Arrow, Oklahoma, through a joint venture with St. John Health System.

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 and liabilities assumed, if any, 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	$	5.3
Identifiable intangible assets:		
Noncompete agreements (useful lives of 1 to 3 years)		0.4
Trade names (useful lives of 20 years)		1.0
Goodwill		9.4
Total assets acquired	$	16.1

Information regarding the net cash paid for all inpatient rehabilitation acquisitions during 2016 is as follows (in millions):

Fair value of assets acquired	$	6.7
Goodwill		9.4
Fair value of noncontrolling interest owned by joint venture partner		(16.1)
Net cash paid for acquisition	$	—

See also Note 8, *Investments in and Advances to Nonconsolidated Affiliates*

Home Health and Hospice

During 2016, 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 May, 2016, we acquired Home Health Agency of Georgia, LLC ("Camellia"), a home health and hospice provider with two home health locations and two hospice locations in the Greater Atlanta area.
- In July 2016, we acquired Advantage Health Inc. ("Advantage"), a home health provider with one location in Yuma, Arizona.
- In September, 2016, we acquired three hospice agencies from Sotto International, Inc. ("Serenity") located in Texarkana, Arkansas, Magnolia, Arkansas, and Texarkana, Texas.
- In October 2016, we acquired two home health agencies from Summit Home Health Care, Inc. ("Summit") located in Cheyenne, Wyoming and Laramie, Wyoming.
- In October 2016, we also acquired LightHouse Health Care, Inc. ("LightHouse"), a home health provider with one location in Springfield, Virginia.
- In November 2016, we acquired Gulf City Home Care, Inc. ("Gulf City"), a home health provider with one location in Sarasota, Florida.

- In November 2016, we also acquired Honor Hospice, LLC ("Honor"), a hospice provider with one location in Wheat Ridge, Colorado.

We accounted for all of 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 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 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):

Identifiable intangible asset:	
Noncompete agreements (useful lives of 5 years)	$ 1.1
Trade names (useful lives of 1 year)	0.7
Certificate of needs (useful lives of 10 years)	1.9
Licenses (useful lives of 10 years)	3.4
Goodwill	41.4
Total assets acquired	48.5
Total liabilities assumed	(0.4)
Net assets acquired	$ 48.1

Information regarding the net cash paid for home health and hospice acquisitions during 2016 is as follows (in millions):

Fair value of assets acquired	$ 7.1
Goodwill	41.4
Fair value of liabilities assumed	(0.4)
Net cash paid for acquisitions	$ 48.1

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, 2015 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to HealthSouth
Acquired entities only: Actual from acquisition date to December 31, 2016*	$ 27.4	$ (2.2)
Combined entity: Supplemental pro forma from 1/01/2016-12/31/2016 (unaudited)	3,745.6	252.2
Combined entity: Supplemental pro forma from 1/01/2015-12/31/2015 (unaudited)	3,217.1	187.3

* Hot Springs - includes operating results from February 1, 2016 through December 31, 2016
Camellia - includes operating results from May 1, 2016 through December 31, 2016
Advantage - includes operating results from July 1, 2016 through December 31, 2016
Bryan - includes operating results from August 1, 2016 through December 31, 2016
Broken Arrow - includes operating results from August 1, 2016 through December 31, 2016
Serenity - includes operating results from September 1, 2016 through December 31, 2016
Summit - includes operating results from October 1, 2016 through December 31, 2016
LightHouse - includes operating results from October 1, 2016 through December 31, 2016
Gulf City - includes operating results from November 1, 2016 through December 31, 2016
Honor - includes operating results from November 1, 2016 through December 31, 2016

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 2015 reporting period.

2015 Acquisitions

Inpatient Rehabilitation

Reliant Acquisition

In October 2015, we completed the previously announced acquisition of the operations of Reliant Hospital Partners, LLC and affiliated entities (“Reliant”). Reliant operates a portfolio of 11 inpatient rehabilitation hospitals in Texas, Massachusetts, and Ohio with a total of 902 beds. All of the Reliant hospitals are leased, and seven of the leases are treated as capital leases for accounting purposes. We assumed all of these lease obligations. The amount of the capital lease obligation initially recognized on our balance sheet was approximately $210 million . At closing, one Reliant hospital entity had a remaining minority limited partner interest of 0.5% . The cash purchase price was reduced by the estimated fair value of this interest. We funded the cash purchase price in the acquisition with proceeds from our August and September 2015 senior notes issuances and borrowings under our senior secured credit facility. See Note 9, *Long-term Debt* .

With this acquisition, we are able to offer comprehensive, high-quality and cost-effective facility-based care across new and existing service areas. We expect approximately 86% of the goodwill resulting from this transaction to be deductible for federal income tax purposes. The goodwill reflects our expectations of our ability to gain access to and penetrate each 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.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Reliant from its date of acquisition. Assets acquired, liabilities assumed, and noncontrolling interests 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 license intangible assets and capital lease liabilities; an income approach utilizing the relief-from-royalty method for the trade name intangible assets; an income approach utilizing the excess earnings method for the certificate of need intangible assets; and an estimated realizable value approach using historical trends and other relevant information for accounts receivable and certain accrued liabilities. 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.

The fair value of the assets acquired and liabilities assumed at the acquisition date for Reliant were as follows (in millions):

Cash and cash equivalents	$ 42.6
Accounts receivable	25.7
Prepaid expenses and other current assets	2.8
Property and equipment	220.6
Identifiable intangible assets:	
Noncompete agreements (useful lives of 1 to 2 years)	9.7
Trade names (useful lives of 20 years)	8.9
Certificates of need (useful lives of 20 years)	36.6
Licenses (useful lives of 20 years)	11.4
Goodwill	642.6
Other long-term assets	0.9
Total assets acquired	1,001.8
Liabilities assumed:	
Current portion of long-term debt	4.1
Accounts payable	1.7
Accrued payroll	3.7
Other current liabilities	10.8
Long-term debt, net of current portion	205.8
Deferred tax liabilities	3.9
Total liabilities assumed	230.0
Noncontrolling interests	0.4
Net assets acquired	$ 771.4

Information regarding the net cash paid for the acquisition of Reliant is as follows (in millions):

Fair value of assets acquired, net of $42.6 million of cash acquired	$ 316.6
Goodwill	642.6
Fair value of liabilities assumed	(230.0)
Noncontrolling interests	(0.4)
Net cash paid for acquisition	$ 728.8

Other Inpatient Rehabilitation Acquisitions

In April 2015, we acquired 83% of the inpatient rehabilitation hospital at Memorial University Medical Center ("Memorial"), a 50 -bed inpatient rehabilitation hospital in Savannah, Georgia, through a joint venture with Memorial Health.

The joint venture, which was funded using cash on hand, was not material to our financial position, results of operations, or cash flows. The Memorial transaction was made to enhance our position and ability to provide inpatient rehabilitative services to patients in Savannah and its surrounding areas. As a result of this transaction, *Goodwill* increased by $0.7 million , none of which is deductible for federal income tax purposes.

In May 2015, we acquired Cardinal Hill Rehabilitation Hospital ("Cardinal Hill"), comprised of 158 licensed inpatient rehabilitation beds, 74 licensed skilled nursing beds, and one home health location, in Lexington, Kentucky. This acquisition was made to enhance our position and ability to provide inpatient rehabilitative and home health services to patients in Lexington, Kentucky and its surrounding areas. The acquisition, which was funded using availability under our revolving credit facility, was not material to our financial position, results of operations, or cash flows. Goodwill did not increase as a result of this transaction.

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, liabilities assumed, and noncontrolling interests, if any, 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, which was also used to estimate the fair value of any noncontrolling interest, 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, if any, was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired or consolidated hospitals' 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.

The fair value of the assets acquired and liabilities assumed at the acquisition dates for the other inpatient rehabilitation transactions completed in 2015 were as follows (in millions):

Total current assets	$	10.1
Property and equipment		42.7
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		0.1
Trade names (useful lives of 20 years)		0.8
Certificates of need (useful lives of 20 years)		8.8
Licenses (useful lives of 20 years)		0.2
Goodwill		0.7
Total assets acquired		63.4
Total liabilities assumed		(2.7)
Net assets acquired	$	60.7

Information regarding the net cash paid for other inpatient rehabilitation acquisitions during 2015 is as follows (in millions):

Fair value of assets acquired	$	62.8
Goodwill		0.7
Fair value of liabilities assumed		(2.7)
Fair value of noncontrolling interest owned by joint venture partner		(4.2)
Net cash paid for acquisitions	$	56.6

See also Note 8, *Investments in and Advances to Nonconsolidated Affiliates* .

Home Health and Hospice

CareSouth Acquisition

In November 2015, Encompass, a subsidiary of HealthSouth, completed its previously announced acquisition of the home health agency operations of CareSouth Health System, Inc. ("CareSouth"). CareSouth operates a portfolio of 44 home health agencies and 3 hospice agencies in Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee, and Virginia. In addition, two of these home health agencies operate as joint ventures which we account for using the equity method of accounting. We funded the cash purchase price in the acquisition with our term loan facility capacity and cash on hand. See Note 9, *Long-term Debt* .

With this acquisition, we are able to offer comprehensive, high-quality and cost-effective home-based care across new and existing service areas. We expect approximately 6.5% of the goodwill resulting from this transaction to be 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.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of CareSouth from its date of acquisition. Assets acquired, liabilities assumed, and noncontrolling interests 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 license intangible assets and capital lease liabilities; 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 certificate of need intangible assets; and an estimated realizable value approach using historical trends and other relevant information for accounts receivable and certain accrued liabilities. 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.

The fair value of the assets acquired and liabilities assumed at the acquisition date for CareSouth were as follows (in millions):

Cash and cash equivalents	$	0.4
Accounts receivable		10.5
Prepaid expenses and other current assets		2.0
Property and equipment		0.7
Identifiable intangible assets:		
Noncompete agreements (useful lives of 3 years)		0.8
Trade name (useful life of 5 years)		2.8
Certificates of need (useful lives of 10 years)		15.6
Licenses (useful lives of 10 years)		13.0
Internal-use software		0.4
Goodwill		143.3
Investment in nonconsolidated subsidiaries		2.2
Total assets acquired		191.7
Liabilities assumed:		
Current portion of long-term debt		0.1
Accounts payable		2.7
Accrued payroll		2.4
Other current liabilities		2.8
Long-term debt, net of current portion		0.2
Deferred tax liabilties		9.5
Total liabilities assumed		17.7
Noncontrolling interests		4.3
Net assets acquired	$	169.7

Information regarding the net cash paid for the acquisition of CareSouth is as follows (in millions):

Fair value of assets acquired, net of $0.4 million of cash acquired	$	48.0
Goodwill		143.3
Fair value of liabilities assumed		(17.7)
Fair value of noncontrolling interest owned by joint venture partner		(4.3)
Net cash paid for acquisitions	$	169.3

Other Home Health and Hospice Acquisitions

Other than the CareSouth acquisition discussed above, 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 with cash on hand.

- In March 2015, we acquired Integrity Home Health Care, Inc. (“Integrity”), a home health company with two locations in the Las Vegas, Nevada area.

- In April 2015, we acquired Harvey Home Health Services, Inc. ("Harvey"), a home health company in Houston, Texas.
- In May 2015, we acquired Heritage Home Health Care, LLC ("Heritage"), a home health company in Texarkana, Arkansas.
- In June 2015, we acquired Washington County Home Health Care, Inc. and Benton County Home Health, Inc., doing business as Alliance Home Health ("Alliance"), a home health company with two locations in the Fayetteville, Arkansas area.
- In July 2015, we acquired Southern Utah Home Health, Inc. ("Southern Utah"), a home health and hospice company with two home health locations and two hospice locations in southern Utah.
- In July 2015, we acquired Orthopedic Rehab Specialist, LLC ("ORS"), a home health company in Ocala, Florida.

We accounted for all of 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 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 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 dates for the other home health and hospice transactions completed in 2015 were as follows (in millions):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 5 years)		1.3
Trade names (useful lives of 1 year)		0.5
Certificates of need (useful lives of 10 years)		4.9
Licenses (useful lives of 10 years)		3.6
Goodwill		20.3
Total assets acquired		30.7
Total liabilities assumed		(0.2)
Net assets acquired	$	30.5

Information regarding the net cash paid for the other home health and hospice acquisitions during 2015 is as follows (in millions):

Fair value of assets acquired	$	10.4
Goodwill		20.3
Fair value of liabilities assumed		(0.2)
Net cash paid for acquisitions	$	30.5

2015 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned transactions 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, 2014 (in millions):

	Net Operating Revenues	Net Income Attributable to HealthSouth
Acquired entities only: Actual from acquisition date to December 31, 2015:*		
Reliant	$ 63.7	$ 11.2
All Other Inpatient	54.7	1.7
CareSouth	19.2	2.5
All Other Home Health and Hospice	17.8	1.2
Combined entity: Supplemental pro forma from 1/01/2015-12/31/2015 (unaudited)	3,479.9	234.0
Combined entity: Supplemental pro forma from 1/01/2014-12/31/2014 (unaudited)	2,851.0	276.9

* Memorial - includes operating results from April 1, 2015 through December 31, 2015
Cardinal Hill - includes operating results from May 1, 2015 through December 31, 2015
Integrity - includes operating results from March 3, 2015 through December 31, 2015
Harvey - includes operating results from April 15, 2015 through December 31, 2015
Heritage - includes operating results from May 1, 2015 through December 31, 2015
Alliance - includes operating results from June 4, 2015 through December 31, 2015
Southern Utah - includes operating results from July 1, 2015 through December 31, 2015
ORS - includes operating results from July 13, 2015 through December 31, 2015
Reliant - includes operating results from October 1, 2015 through December 31, 2015
CareSouth - includes operating results from November 2, 2015 through December 31, 2015

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 2014 reporting period. For the Reliant and CareSouth acquisitions, the unaudited pro forma information above includes adjustments for: (1) acquisition costs; (2) amortization of incremental identifiable intangible assets; (3) management fees paid to their former equity holders; (4) interest on debt incurred to fund the acquisitions (see Note 9 , *Long-term Debt*); (5) income taxes using a rate of 40% ; and (6) noncontrolling interests.

2014 Acquisitions

Encompass Acquisition

On December 31, 2014, we completed the acquisition of EHHI and its Encompass Home Health and Hospice business. On the acquisition date, Encompass provided home health and hospice services out of 135 locations across 12 states. In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. (“Holdings”), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers, who are members of Encompass management, including April Anthony, the Chief Executive Officer of Encompass, contributed a portion of their shares of common stock of EHHI, valued at approximately $64.5 million , in exchange for shares of common stock of Holdings. As a result of that contribution, they hold approximately 16.7% of the outstanding common stock of Holdings, while HealthSouth owns the remainder. In addition, Ms. Anthony and certain other employees of Encompass entered into amended and restated employment agreements, each agreement having an initial term of three years. We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. See Note 9, *Long-term Debt* .

This acquisition was made to enhance our position and expand our ability to provide post-acute healthcare services to patients. Approximately 23% of the goodwill resulting 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.

We accounted for this transaction under the acquisition method of accounting. Because the acquisition took place on December 31, 2014, our consolidated results of operations for the year ended December 31, 2014 do not include any results of operations from Encompass. Assets acquired, liabilities assumed, and redeemable noncontrolling interests were recorded at their estimated fair values as of the acquisition date. 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 amortizable intangible assets; an income approach utilizing the relief-from-royalty method for the indefinite-lived intangible asset; and an estimated realizable value approach using historical trends and other relevant information for accounts receivable and certain accrued liabilities. 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.

The fair value of the assets acquired and liabilities assumed at the acquisition date for Encompass were as follows (in millions):

Cash and cash equivalents	$ 20.9
Accounts receivable	37.6
Prepaid expenses and other current assets	8.6
Property and equipment	9.6
Identifiable intangible assets:	
Noncompete agreements (useful life of 2 to 5 years)	5.6
Trade name (indefinite life)	135.2
Licenses (useful life of 10 years)	58.2
Internal-use software (useful life of 3 years)	3.2
Goodwill	592.5
Other long-term assets	2.1
Total assets acquired	873.5
Current portion of long-term debt	2.0
Accounts payable	0.9
Accrued payroll	25.8
Other current liabilities	18.5
Long-term debt, net of current portion	2.0
Deferred tax liabilities	64.3
Total liabilities assumed	113.5
Redeemable noncontrolling interests	64.5
Net assets acquired	$ 695.5

Information regarding the net cash paid for the acquisition of Encompass is as follows (in millions):

Fair value of assets acquired, net of $20.9 million of cash acquired	$	260.1
Goodwill		592.5
Fair value of liabilities assumed		(113.5)
Redeemable noncontrolling interests		(64.5)
Net cash paid for acquisition	$	674.6

See also Note 11, *Redeemable Noncontrolling Interests* .

Other Acquisitions

In June 2014, using cash on hand, we acquired an additional 30% equity interest from UMass Memorial Health Care, our joint venture partner in Fairlawn Rehabilitation Hospital ("Fairlawn") in Worcester, Massachusetts. This transaction increased our ownership interest from 50% to 80% and resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $34.0 million , and we recorded a $27 million gain as part of *Other income* during 2014. The Fairlawn transaction was made to increase our ownership in a profitable hospital and continue to grow our core business by consolidating its operations. None of the goodwill resulting from this transaction is deductible for federal income tax purposes. See also Note 15, *Income Taxes* .

In November 2014, we acquired 50.1% of the James H. & Cecile C. Quillen Rehabilitation Hospital ("Quillen"), a 26 -bed inpatient rehabilitation hospital in Johnson City, Tennessee, through a joint venture with Mountain States Health Alliance. The joint venture, which was funded using cash on hand, was not material to our financial position, results of operations, or cash flows. The Quillen transaction was made to enhance our position and ability to provide inpatient rehabilitative services to patients in Johnson City and its surrounding areas. As a result of this transaction, *Goodwill* increased by $0.6 million , none of which is deductible for federal income tax purposes. The noncontrolling interest associated with this agreement includes redemption features that are not solely within our control and, therefore, is considered *Redeemable noncontrolling interests.* See Note 11, *Redeemable Noncontrolling Interests* .

We accounted for all of these transactions under the acquisition method of accounting and reported the results of operations of the acquired or newly consolidated hospitals 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 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 gain access to and penetrate the acquired or consolidated hospitals' 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.

The fair value of the assets acquired and liabilities assumed at the acquisition dates for the other acquisitions completed in 2014 were as follows (in millions):

Total current assets	$	12.1
Property and equipment, net		36.9
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		0.4
Trade names (useful lives of 20 years)		2.9
Certificates of need (useful lives of 20 years)		10.8
Licenses (useful lives of 20 years)		2.1
Goodwill		34.6
Total assets acquired		99.8
Total current liabilities assumed		(7.8)
Total long-term liabilities assumed		(13.4)
Net assets acquired	$	78.6

Information regarding the net cash paid for all other acquisitions during 2014 is as follows (in millions):

Fair value of assets acquired, net of $5.1 million of cash acquired in 2014	$	60.1
Goodwill		34.6
Fair value of liabilities assumed		(21.2)
Fair value of noncontrolling interest owned by joint venture partner		(18.3)
Fair value of equity interest prior to acquisition		(35.0)
Net cash paid for acquisitions	$	20.2

See also Note 8, *Investments in and Advances to Nonconsolidated Affiliates* .

2014 Pro Forma Results of Operations

The following table summarizes the results of operations of the above 2014 transactions 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, 2013 (in millions):

	Net Operating Revenues	Net Income Attributable to HealthSouth
Acquired entities only: Actual from acquisition date to December 31, 2014*	$ 27.2	$ 4.0
Combined entity: Supplemental pro forma from 1/01/2014-12/31/2014 (unaudited)	2,799.8	237.5
Combined entity: Supplemental pro forma from 1/01/2013-12/31/2013 (unaudited)	2,627.6	311.3

* Encompass - Actual amounts are zero due to the acquisition of Encompass on December 31, 2014.
Fairlawn - includes operating results from June 1, 2014 through December 31, 2014
Quillen - includes operating results from November 1, 2014 through December 31, 2014

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 2013 reporting period. For the Encompass acquisition, the unaudited pro forma information above includes adjustments for: (1) acquisition costs; (2) amortization of incremental identifiable intangible assets; (3) management fees paid to Encompass’ former equity holders; (4) interest on debt incurred to fund the acquisition (see Note 9, *Long-term Debt*); (5) income taxes using a rate of 40% ; and (6) noncontrolling interests.

3. Variable Interest Entities :

As of December 31, 2016 , we consolidated ten limited partnership-like entities that are VIEs and of which we are the primary beneficiary. All ten of these entities were also consolidated as of December 31, 2015. Our ownership percentages in these entities range from 6.8% to 99.5% . Through partnership and management agreements with or governing each of these entities, we manage all of these entities and handle all day-to-day operating decisions. Accordingly, we have the decision making power over the activities that most significantly impact the economic performance of our VIEs and an obligation to absorb losses or receive benefits from the VIE that could potentially be significant to the VIE. These decisions and significant activities include, but are not limited to, marketing efforts, oversight of patient admissions, medical training, nurse and therapist scheduling, provision of 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, 2016
Assets	
Current assets:	
Cash and cash equivalents	$ 1.6
Restricted cash	3.8
Accounts receivable, net of allowance for doubtful accounts	30.8
Other current assets	2.0
Total current assets	38.2
Property and equipment, net	140.0
Goodwill	73.5
Intangible assets, net	9.6
Deferred income tax assets	0.6
Other long-term assets	0.4
Total assets	$ 262.3
Liabilities	
Current liabilities:	
Current portion of long-term debt	$ 1.5
Accounts payable	6.8
Accrued payroll	6.6
Accrued interest payable	0.2
Other current liabilities	5.4
Total current liabilities	20.5
Long-term debt, net of current portion	29.8
Total liabilities	$ 50.3

4. Cash and Marketable Securities :

The components of our investments as of December 31, 2016 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 40.5	$ 60.9	$ —	$ 101.4
Equity securities	—	—	57.7	57.7
Total	$ 40.5	$ 60.9	$ 57.7	$ 159.1

The components of our investments as of December 31, 2015 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 61.6	$ 45.9	$ —	$ 107.5
Equity securities	—	—	56.2	56.2
Total	$ 61.6	$ 45.9	$ 56.2	$ 163.7

Restricted Cash—

As of December 31, 2016 and 2015 , *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2016	2015
Affiliate cash	$ 22.9	$ 20.3
Self-insured captive funds	38.0	25.6
Total restricted cash	$ 60.9	$ 45.9

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 10, *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. As of December 31, 2016 and 2015 , all restricted cash was current.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures a substantial portion HealthSouth'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, 2016 and 2015 , $33.5 million and $40.1 million , respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets.

A summary of our restricted marketable securities as of December 31, 2016 is as follows (in millions):

	Cost		Gross Unrealized Gains		Gross Unrealized Losses		Fair Value	
Equity securities	$	59.6	$	0.2	$	(2.1)	$	57.7

A summary of our restricted marketable securities as of December 31, 2015 is as follows (in millions):

	Cost		Gross Unrealized Gains		Gross Unrealized Losses		Fair Value	
Equity securities	$	58.3	$	0.3	$	(2.4)	$	56.2

Cost in the above tables includes adjustments made to the cost basis of our equity securities for other-than-temporary impairments. During the years ended December 31, 2016 , 2015 , and 2014 , we did not record any impairment charges related to our restricted marketable securities.

Investing information related to our restricted marketable securities is as follows (in millions):

	For the Year Ended December 31,					
	2016		2015		2014	
Proceeds from sales of restricted available-for-sale securities	$	—	$	—	$	—
Proceeds from sales of nonrestricted available-for-sale securities	$	—	$	12.8	$	2.7
Gross realized gains	$	—	$	1.2	$	0.5
Gross realized losses	$	—	$	—	$	(0.1)

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 includes marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examine the severity and duration of the impairments in relation to the cost of the individual investments. We also consider the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

5. Accounts Receivable :

Accounts receivable consists of the following (in millions):

	As of December 31,			
	2016		2015	
Current:				
Patient accounts receivable, net of allowance for doubtful accounts of $53.9 million in 2016; $39.3 million in 2015	$	432.0	$	403.3
Other accounts receivable		11.8		7.2
		443.8		410.5
Noncurrent patient accounts receivable, net of allowance for doubtful accounts of $49.5 million in 2016; $32.3 million in 2015		125.9		96.6
Accounts receivable, net	$	569.7	$	507.1

Because the resolution of claims that are part of Medicare audit programs can take in excess of three 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.

At December 31, 2016 and 2015 , our allowance for doubtful accounts represented approximately 15.6% and 12.5% , respectively, of the total patient due accounts receivable balance.

The following is the activity related to our allowance for doubtful accounts (in millions):

For the Year Ended December 31,	Balance at Beginning of Period	Additions and Charges to Expense	Deductions and Accounts Written Off	Balance at End of Period
2016	$ 71.6	$ 61.2	$ (29.4)	$ 103.4
2015	$ 43.0	$ 47.2	$ (18.6)	$ 71.6
2014	$ 33.1	$ 31.6	$ (21.7)	$ 43.0

6. Property and Equipment :

Property and equipment consists of the following (in millions):

	As of December 31, 2016	As of December 31, 2015
Land	$ 125.3	$ 113.3
Buildings	1,601.4	1,521.1
Leasehold improvements	115.2	96.2
Vehicles	11.8	10.0
Furniture, fixtures, and equipment	425.3	392.7
	2,279.0	2,133.3
Less: Accumulated depreciation and amortization	(982.4)	(874.3)
	1,296.6	1,259.0
Construction in progress	95.2	51.1
Property and equipment, net	$ 1,391.8	$ 1,310.1

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

In February 2016, we entered into a development/lease agreement with CR HQ, LLC (the "Developer") to construct our new corporate headquarters in Birmingham, Alabama. Under the terms of this agreement, the Developer is responsible for all costs of constructing the new facility 'shell' which will then be leased to us for an initial term of 15 years with four , five -year renewal options. The lease is expected to commence in the first half of 2018. We are responsible for the costs associated with improvements to the interior of the building. Due to the nature and extent of the tenant improvements we will be making to the new corporate headquarters and certain provisions of the development/lease agreement, we are deemed to be the accounting owner of the new corporate headquarters during the construction period. Construction commenced in the second quarter of 2016. Accordingly, we increased *Property and equipment, net* by $20.3 million , based on the construction costs incurred to date by the Developer, and recorded a corresponding noncurrent financing obligation liability of $20.3 million in *Long-term debt, net of current portion* within our condensed consolidated balance sheet as of December 31, 2016. The total financing obligation associated with the Developer's costs to construct the new corporate headquarters is estimated at $56 million . The amounts recorded for construction costs and the corresponding liability are non-cash activities for purposes of our condensed consolidated statement of cash flows. See Note 9, *Long-term Debt* .

Information related to fully depreciated assets and assets under capital lease obligations is as follows (in millions):

	As of December 31,	
	2016	2015
Fully depreciated assets	$ 289.7	$ 252.4
Assets under capital lease obligations:		
Buildings	$ 331.0	$ 333.9
Vehicles	8.6	6.5
Equipment	0.3	0.3
	339.9	340.7
Less: Accumulated amortization	(83.5)	(66.6)
Assets under capital lease obligations, net	$ 256.4	$ 274.1

The amount of depreciation expense, amortization expense relating to assets under capital lease obligations, interest capitalized, and rent expense under operating leases is as follows (in millions):

	For the Year Ended December 31,		
	2016	2015	2014
Depreciation expense	$ 102.3	$ 91.0	$ 79.9
Amortization expense	$ 21.8	$ 12.7	$ 7.5
Interest capitalized	$ 2.0	$ 1.3	$ 1.5
Rent expense:			
Minimum rent payments	$ 62.6	$ 48.8	$ 37.3
Contingent and other rents	29.4	21.6	18.2
Other	4.0	3.8	3.9
Total rent expense	$ 96.0	$ 74.2	$ 59.4

Leases—

We lease certain land, buildings, and equipment under noncancelable operating leases generally expiring at various dates through 2028 . We also lease certain buildings and equipment under capital leases generally expiring at various dates through 2037 . Operating leases generally have 1 - to 15 -year terms, with one or more renewal options, with terms to be negotiated at the time of renewal. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Contingent rents are included in rent expense in the year incurred.

Some facilities are subleased to other parties. Rental income from subleases approximated $4.1 million , $5.0 million , and $5.1 million for the years ended December 31, 2016 , 2015 , and 2014 , respectively. Total expected future minimum rentals under these noncancelable subleases approximated $4.1 million as of December 31, 2016 .

Certain leases contain annual escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The excess of cumulative rent expense (recognized on a straight-line basis) over cumulative rent payments made on leases with fixed escalation terms is recognized as straight-line rental accrual and is included in *Other long-term liabilities* in the accompanying consolidated balance sheets, as follows (in millions):

	As of December 31,	
	2016	2015
Straight-line rental accrual	$ 11.8	$ 12.4

Future minimum lease payments at December 31, 2016 , 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	Total
2017	$ 62.5	$ 34.7	$ 97.2
2018	56.9	34.9	91.8
2019	51.4	31.0	82.4
2020	42.6	27.8	70.4
2021	32.8	28.4	61.2
2022 and thereafter	173.8	356.5	530.3
	$ 420.0	513.3	$ 933.3
Less: Interest portion		(234.0)	
Obligations under capital leases		$ 279.3	

In addition to the above, and as discussed in Note 9, *Long-term Debt* , "Other Notes Payable," we have two sale/leaseback transactions involving real estate accounted for as financings. Future minimum payments, which are accounted for as interest, under these obligations are $2.7 million in each of the next five years and $5.7 million thereafter.

7. Goodwill and Other Intangible Assets :

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2016 , 2015 , and 2014 (in millions):

	Inpatient Rehabilitation	Home Health and Hospice	Consolidated
Goodwill as of December 31, 2013	$ 456.9	$ —	$ 456.9
Acquisitions	0.6	592.5	593.1
Consolidation of joint venture formerly accounted for under the equity method of accounting	34.0	—	34.0
Goodwill as of December 31, 2014	491.5	592.5	1,084.0
Acquisitions	641.6	164.5	806.1
Goodwill as of December 31, 2015	1,133.1	757.0	1,890.1
Acquisitions	8.9	42.5	51.4
Divestiture of pediatric home health services	—	(14.3)	(14.3)
Goodwill as of December 31, 2016	$ 1,142.0	$ 785.2	$ 1,927.2

Goodwill increased in 2014 as a result of our consolidation of Fairlawn and the remeasurement of our previously held equity interest at fair value and our acquisitions of Encompass and Quillen. *Goodwill* increased in 2015 as a result of our acquisitions of Reliant, CareSouth, and other inpatient and home health and hospice operations. *Goodwill* increased in 2016 as a result of our acquisitions of inpatient and home health and hospice operations offset by the divestiture of our pediatric home health assets to Thrive Skilled Pediatric Care in November 2016 for approximately $21 million . We recorded a $3.3 million gain as part of *Other operating expenses* in our consolidated statements of operations during the year ended December 31, 2016. See Note 2, *Business Combinations* and Note 11, *Redeemable Noncontrolling Interests* .

We performed impairment reviews as of October 1, 2016 , 2015 , and 2014 and concluded no *Goodwill* impairment existed. As of December 31, 2016 , 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:			
2016	$ 98.6	$ (12.9)	$ 85.7
2015	93.9	(6.9)	87.0
Licenses:			
2016	$ 142.0	$ (62.1)	$ 79.9
2015	138.9	(53.7)	85.2
Noncompete agreements:			
2016	$ 62.2	$ (47.3)	$ 14.9
2015	58.0	(37.0)	21.0
Trade name - Encompass:			
2016	$ 135.2	$ —	$ 135.2
2015	135.2	—	135.2
Trade names - all other:			
2016	$ 34.6	$ (13.9)	$ 20.7
2015	32.9	(11.5)	21.4
Internal-use software:			
2016	$ 181.4	$ (110.2)	$ 71.2
2015	155.7	(90.5)	65.2
Market access assets:			
2016	$ 13.2	$ (9.5)	$ 3.7
2015	13.2	(8.8)	4.4
Total intangible assets:			
2016	$ 667.2	$ (255.9)	$ 411.3
2015	627.8	(208.4)	419.4

Amortization expense for other intangible assets is as follows (in millions):

	For the Year Ended December 31,		
	2016	2015	2014
Amortization expense	$ 48.5	$ 36.0	$ 20.3

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
2017	$ 45.6
2018	36.2
2019	31.5
2020	26.6
2021	22.9

8. Investments in and Advances to Nonconsolidated Affiliates :

Investments in and advances to nonconsolidated affiliates as of December 31, 2016 represents our investment in seven partially owned subsidiaries, of which six are general or limited partnerships, limited liability companies, or joint ventures in which HealthSouth or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 1% to 60% . We account for these investments using the cost and equity methods of accounting. 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,	
	2016	2015
Equity method investments:		
Capital contributions	$ 0.9	$ 0.9
Cumulative share of income	97.8	88.0
Cumulative share of distributions	(86.0)	(77.5)
	12.7	11.4
Cost method investments:		
Capital contributions, net of distributions and impairments	0.3	0.3
Total investments in and advances to nonconsolidated affiliates	$ 13.0	$ 11.7

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,	
	2016	2015
Assets—		
Current	$ 13.1	$ 7.8
Noncurrent	19.2	20.5
Total assets	$ 32.3	$ 28.3
Liabilities and equity—		
Current liabilities	$ 2.7	$ 1.4
Noncurrent liabilities	0.2	0.1
Partners' capital and shareholders' equity—		
HealthSouth	12.7	11.4
Outside partners	16.7	15.4
Total liabilities and equity	$ 32.3	$ 28.3

Condensed statements of operations (in millions):

	For the Year Ended December 31,		
	2016	2015	2014
Net operating revenues	$ 44.8	$ 36.5	$ 50.2
Operating expenses	(24.3)	(16.9)	(25.9)
Income from continuing operations, net of tax	20.5	18.9	30.9
Net income	20.5	18.9	30.9

See Note 2, *Business Combinations* .

9. Long-term Debt :

Our long-term debt outstanding consists of the following (in millions):

	As of December 31,	
	2016	2015
Credit Agreement—		
Advances under revolving credit facility	$ 152.0	$ 130.0
Term loan facilities	421.2	443.3
Bonds payable—		
7.75% Senior Notes due 2022	—	174.3
5.125% Senior Notes due 2023	295.3	294.6
5.75% Senior Notes due 2024	1,193.2	1,192.6
5.75% Senior Notes due 2025	343.9	343.4
2.00% Convertible Senior Subordinated Notes due 2043	275.7	265.9
Other notes payable	55.8	39.2
Capital lease obligations	279.3	288.2
	3,016.4	3,171.5
Less: Current portion	(37.1)	(36.8)
Long-term debt, net of current portion	$ 2,979.3	$ 3,134.7

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
2017	$ 37.1	$ 37.1
2018	38.1	38.1
2019	39.7	39.6
2020	836.2	790.7
2021	10.7	10.7
Thereafter	2,117.9	2,100.2
Total	$ 3,079.7	$ 3,016.4

As a result of the 2016, 2015, and 2014 redemptions discussed below, we recorded a $7.4 million , $22.4 million , and $13.2 million *Loss on early extinguishment of debt* in 2016, 2015, and 2014, respectively.

Senior Secured Credit Agreement—

Credit Agreement

In June and July 2015, we amended our existing credit agreement, previously amended on December 23, 2014 (the "Credit Agreement"). The Credit Agreement provided for $500 million of term loan commitments and a $600 million revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in July 2020. Outstanding term loan borrowings are payable in equal consecutive quarterly installments, commencing on March 31, 2016, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2015, 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 2.00% .

The Credit Agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio that change over time. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, 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 1.75x. In the event the senior secured leverage ratio exceeds 1.75x, 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 June 2017 and 4.25x from then until maturity.

As of December 31, 2016 and 2015 , $152 million and $130 million were drawn under the revolving credit facility with an interest rate of 2.7% and 2.3% , respectively. Amounts drawn as of December 31, 2016 and 2015 exclude $33.3 million and $34.2 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. In December 2014, we drew $375 million under our term loan facilities and $325 million under our revolving credit facility to fund the acquisition of Encompass. In September 2015, we borrowed $125 million of the term loan facilities, the proceeds of which were used to fund a portion of the Reliant acquisition. In October 2015, we utilized the remaining $125 million of term loan facility capacity to finance a portion of the CareSouth acquisition. Currently, there are no undrawn term loan commitments under the Credit Agreement. See Note 2, *Business Combinations* .

2014 Credit Agreement

In September and December 2014, we amended our existing credit agreement, previously amended on June 11, 2013 (the "2014 Credit Agreement"). The 2014 Credit Agreement provided for $450 million of term loan commitments and a $600 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 2019. Outstanding term loan borrowings were payable in equal consecutive quarterly installments, commencing on March 31, 2015, of 1.25% of the aggregate principal amount of the term loans outstanding as of March 31, 2015 with the remainder due at maturity. The 2014 Credit Agreement contained the same affirmative and negative covenants and default and acceleration provisions as the Credit Agreement, except for the maximum leverage ratio was 4.25x .

Bonds Payable—

Nonconvertible Notes

The Company's 2020 Notes, 2022 Notes, 2023 Notes, 2024 Notes, and 2025 Notes (collectively, the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009 between us and The Bank of Nova

Scotia Trust Company of New York, as trustee (the "Original Trustee"), as supplemented by each Senior Notes respective supplemental indenture (together with the Base Indenture, the "Indenture"), among us, the Subsidiary Guarantors (as defined in the Indenture), and the Original Trustee. The Original Trustee notified us of its intention to discontinue its corporate trust operations and, accordingly, to resign upon the appointment of a successor trustee. Effective July 29, 2013, Wells Fargo Bank, National Association, was appointed as successor trustee under 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 20, *Condensed Consolidating Financial Information*). The Senior Notes are senior, unsecured obligations of HealthSouth 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.

2018 and 2022 Notes

In October 2010, we completed a public offering of $525.0 million aggregate principal amount of senior notes, which included $275.0 million of our 7.25% Senior Notes due 2018 ("the 2018 Notes") at par and $250.0 million of our 7.75% Senior Notes due 2022 ("the 2022 Notes") at par (collectively, the "2018 and 2022 Senior Notes"). We used the net proceeds from the initial offering of the 2018 and 2022 Senior Notes to repay amounts outstanding under the term loan facility of our former credit agreement dated March 2006.

In March 2011, we completed a public offering of $120 million aggregate principal amount of senior notes, which included an additional $60 million of the 2018 Notes at 103.25% of the principal amount and an additional $60 million of the 2022 Notes at 103.50% of the principal amount. Net proceeds from this offering were approximately $122 million . We used approximately $45 million of the net proceeds to repay a portion of the amounts outstanding under our revolving credit facility. In June 2011, the remainder of the net proceeds were used to redeem a portion of our former senior notes due 2016 outstanding at that time.

In October 2012, $64.5 million of the net proceeds from our public offering of the 5.75% Senior Notes due 2024 ("the 2024 Notes") were used to redeem $33.5 million of the outstanding principal amount of our existing 2018 Notes and $31.0 million of the outstanding principal amount of our existing 2022 Notes. This optional redemption was at a price of 103% , which resulted in an additional cash outlay of $1.9 million from the net proceeds.

In November 2013, we redeemed $30.2 million and $27.9 million of the outstanding principal amount of our existing 2018 Notes and our existing 2022 Notes, respectively. Pursuant to the terms of these senior notes, this optional redemption was at a price of 103% , which resulted in a total cash outlay of approximately $60 million to retire the $58.1 million in principal. We used a combination of cash on hand and availability under our revolving credit facility for this redemption.

In October 2014, we redeemed the remaining $271.4 million outstanding principal amount of our 2018 Notes. Pursuant to the terms of the 2018 Notes, this optional redemption was made at a price of 103.625% , which resulted in a total cash outlay of approximately $281 million to retire the $271.4 million in principal. We used the net proceeds from the $175 million September offering of our existing 2024 Notes discussed below, a $75 million draw under our term loan facilities, and cash on hand for this redemption. The 2018 Notes would have matured on October 1, 2018 . Inclusive of premiums and financing costs, the effective interest rate on the 2018 Notes was 7.5% . Interest was payable semiannually in arrears on April 1 and October 1 of each year.

In December 2014, we redeemed $25.1 million of the outstanding principal amount of our existing 2022 Notes. Pursuant to the terms of the 2022 Notes, this optional redemption was at a price of 103% , which resulted in a total cash outlay of approximately $26 million to retire the $25.1 million in principal. We used cash on hand for this redemption.

In November 2015, we redeemed $50.0 million of the outstanding principal amount of our existing 2022 Notes. Pursuant to the terms of the 2022 Notes, this optional redemption was made at a price of 103.875% , which resulted in a total cash outlay of approximately $52 million . We used borrowings under our revolving credit facility to fund the redemption.

In March and May 2016, we redeemed $50.0 million of the outstanding principal amount of our existing 2022 Notes. Pursuant to the terms of the 2022 Notes, these optional redemptions were made at a price of 103.875% , which resulted in a total cash outlay of approximately $104 million . We used cash on hand and capacity under our revolving credit facility to fund these redemptions.

In September 2016, we redeemed the remaining outstanding principal amount of $76 million of the existing 2022 Notes. Pursuant to the terms of these notes, these optional redemptions were made at a price of 102.583% , which resulted in a total cash outlay of approximately $78 million . We used cash on hand and capacity under our revolving credit facility to fund this redemption. The 2022 Notes would have matured on September 15, 2022. Inclusive of premiums and financing costs, the effective interest rate on the 2022 Notes was 7.9% . Interest was payable semiannually in arrears on March 15 and September 15 of each year.

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. We used the net proceeds from this offering along with cash on hand to redeem all of our senior notes due 2020 outstanding at that time. Pursuant to the terms of these senior notes due 2020, this redemption was made at a price of 104.063% , which resulted in a total cash outlay of approximately $302 million to retire the $290 million in principal. 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, beginning on September 15, 2015.

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*
2018	103.844%
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 2024 Notes at par. Net proceeds from this offering were approximately $270 million . We used $195 million of the net proceeds to repay the amounts outstanding under our revolving credit facility. Additionally, in October 2012, $64.5 million of the net proceeds were used to redeem a portion of our 2018 and 2022 Senior Notes.

In September 2014, we issued an additional $175 million of the 2024 Notes at a price of 103.625% of the principal amount, which resulted in approximately $182 million in net proceeds from the public offering. We used the net proceeds to redeem the 2018 Notes, as discussed above.

In January 2015, we issued an additional $400 million of the 2024 Notes at a price of 102% of the principal amount, which resulted in approximately $406 million in net proceeds from the public offering. We used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility.

In August 2015, we issued an additional $350 million of our 2024 Notes at a price of 100.5% of the principal amount, which resulted in approximately $351 million in net proceeds from the private offering. We used the net proceeds to reduce borrowings under our revolving credit facility and fund a portion of the Reliant acquisition, as discussed in Note 2, *Business Combinations*.

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.

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***
2017	102.875%
2018	101.917%
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, which resulted in approximately $344 million in net proceeds from the private offering. We used the net proceeds from this borrowing to fund a portion of the Reliant acquisition. 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, beginning on March 15, 2016.

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

Convertible Notes

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 "Convertible Notes") for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. The Company's Convertible Notes were issued pursuant to an indenture dated November 18, 2013 (the "Convertible Notes Indenture") between us and Wells Fargo Bank, National Association, as trustee and conversion agent. The Convertible Notes are senior subordinated unsecured obligations of the Company. As such, the Convertible Notes are subordinated to all our existing and future senior unsecured debt and are effectively subordinated to our existing and future secured debt to the extent of the value of the collateral securing such debt. Additionally, the Convertible Notes are structurally subordinated to all existing and future debt and other obligations of our subsidiaries.

The Convertible Notes bear regular interest at a rate of 2.0% per year payable semiannually in arrears in cash on June 1 and December 1 of each year . Beginning with the six-month period starting December 1, 2018, contingent interest is payable, in addition to regular interest, if the trading price of the Convertible Notes for each of the five trading days ending two trading days prior to any six-month contingent interest period is equal to or greater than $1,200. The amount of contingent interest payable per $1,000 principal amount of the Convertible Notes in respect of any contingent interest period is equal to 0.25% of the average trading price of the Convertible Notes during the specified measurement period. Due to discounts and financing costs, the effective interest rate on the Convertible Notes is 6.0% .

The Convertible Notes mature on December 1, 2043 , unless earlier redeemed, repurchased, or converted. The Convertible Notes are convertible, at the option of the holder, at any time on or prior to the close of business on the business day immediately preceding December 1, 2043 into shares of our common stock at an initial conversion rate of 25.2194 shares per $1,000 principal amount of the Convertible Notes, subject to customary antidilution adjustments. This conversion rate equates to an initial conversion price of $39.652 per share. We may elect to settle any conversion, in whole or in part, by delivering cash in lieu of shares. Upon the occurrence of certain change of control events and a redemption prior to December 2018, in either case, in connection with elections by holders to convert their Convertible Notes, we will pay a make-whole premium on any Convertible Notes converted by increasing the conversion rate on such Convertible Notes.

The payment of dividends on our common stock has triggered and will continue to trigger, from time to time, the antidilutive adjustment provisions of the Convertible Notes, except in instances when such adjustments are deemed *de minimis* . The current conversion price of the Convertible Notes is $37.16 , and the current conversion rate i s 26.9106 for each $1,000 principal amount of the Convertible Notes.

Prior to December 1, 2018, we may redeem all or any part of the Convertible Notes if the volume weighted-average price per share of our common stock is at least 120% of the conversion price of the Convertible Notes for at least 20 trading days during any 30 consecutive trading day period, at a redemption price equal to 100% of the principal amount of Convertible Notes to be redeemed, plus accrued and unpaid interest, provided that, as described above, the holders may elect to convert their Convertible Notes in lieu of the redemption and receive any make-whole premium due. On or after December 1, 2018, we may, at our option, redeem all or any part of the Convertible Notes at a redemption price equal to 100% of the principal amount of the Convertible Notes to be redeemed, plus accrued and unpaid interest.

Upon the occurrence of a fundamental change (as defined in the Convertible Notes Indenture), each holder of the Convertible Notes may require us to repurchase for cash all or any portion of such holders' Convertible Notes at a price equal to 100% of the principal amount of the repurchased Convertible Notes, plus accrued and unpaid interest thereon to, but excluding, the repurchase date and, if the fundamental change also constitutes a nonstock change of control (as defined in the Convertible Notes Indenture), the amount of any make-whole premium due. Holders may, at their option, also require us to repurchase all or any portion of such holders' Convertible Notes on December 1 of 2020, 2027, 2034, and 2041 at a price equal to 100% of the principal amount of the repurchased Convertible Notes, plus accrued and unpaid interest thereon to, but excluding, the repurchase date.

The Convertible Notes Indenture contains customary events of default, which includes, among other things, a default in the obligation of the Company to convert the Convertible Notes that continues for five business days.

Other Notes Payable—

Our notes payable consist of the following (in millions):

	As of December 31,		
	2016	2015	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 48.2	$ 28.0	7.5% to 11.2%
Acquisition of an inpatient rehabilitation unit	—	1.3	7.8%
Construction of a new hospital	7.4	9.6	LIBOR + 2.5%; 3.1% and 2.7% as of December 31, 2016 and 2015, respectively
Other	0.2	0.3	6.8%
Other notes payable	$ 55.8	$ 39.2	

See also Note 6, *Property and Equipment* .

Capital Lease Obligations—

We engage in a significant number of leasing transactions including real estate and other equipment utilized in operations. Leases meeting certain accounting criteria have been recorded as an asset and liability at the lower of fair value or the net present value of the aggregate future minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally ranged from 2% to 11% based on our incremental borrowing rate at the inception of the lease. Our leasing transactions include arrangements for vehicles with major finance companies and manufacturers who retain ownership in the equipment during the term of the lease and with a variety of both small and large real estate owners.

10. 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 $28 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, 2016 , 2015 , and 2014 (in millions):

	2016	2015	2014
Balance at beginning of period, gross	$ 142.1	$ 134.3	$ 140.3
Less: Reinsurance receivables	(26.6)	(26.0)	(32.6)
Balance at beginning of period, net	115.5	108.3	107.7
Increase for the provision of current year claims	43.5	37.1	34.7
Decrease for the provision of prior year claims	(0.1)	(4.6)	(3.5)
Expenses related to discontinued operations	(0.4)	(0.5)	(0.3)
Payments related to current year claims	(5.0)	(4.7)	(4.4)
Payments related to prior year claims	(23.5)	(22.5)	(25.9)
Acquisitions	—	2.4	—
Balance at end of period, net	130.0	115.5	108.3
Add: Reinsurance receivables	41.4	26.6	26.0
Balance at end of period, gross	$ 171.4	$ 142.1	$ 134.3

As of December 31, 2016 and 2015 , $61.0 million and $40.5 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 and 1,100 individual claims at December 31, 2016 and 2015 , respectively, 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.

11. 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,		
	2016	2015	2014
Balance at beginning of period	$ 121.1	$ 84.7	$ 13.5
Acquisition of Encompass	—	—	64.5
Net income attributable to noncontrolling interests	14.1	13.8	6.6
Distributions	(7.8)	(7.3)	(8.5)
Contribution to joint venture	—	—	4.3
Change in fair value	10.9	29.9	4.3
Balance at end of period	$ 138.3	$ 121.1	$ 84.7

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 on the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2016	2015	2014
Net income attributable to nonredeemable noncontrolling interests	$ 56.4	$ 55.9	$ 53.1
Net income attributable to redeemable noncontrolling interests	14.1	13.8	6.6
Net income attributable to noncontrolling interests	$ 70.5	$ 69.7	$ 59.7

See also Note 2, *Business Combinations* .

12. 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, 2016	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)]
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 24.2	$ —	$ 24.2	$ —	M
Other long-term assets:					
Restricted marketable securities	33.5	—	33.5	—	M
Redeemable noncontrolling interests	138.3	—	—	138.3	I
As of December 31, 2015					
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 16.1	$ —	$ 16.1	$ —	M
Other long-term assets:					
Restricted marketable securities	40.1	—	40.1	—	M
Redeemable noncontrolling interests	121.1	—	—	121.1	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. During the years ended December 31, 2016 and 2015, 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 a result of our consolidation of Fairlawn in 2014 and the remeasurement of our previously held equity interest at fair value, we recorded a $27.2 million gain as part of *Other income* during the year ended December 31, 2014. We determined the fair value of our previously held equity interest using the income approach. The income approach included the use of

Fairlawn's projected operating results and cash flows discounted using a rate that reflects market participant assumptions. The projected operating results used management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. See Note 2, *Business Combinations* .

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, 2016		As of December 31, 2015	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 152.0	$ 152.0	$ 130.0	$ 130.0
Term loan facilities	421.2	422.5	443.3	445.0
7.75% Senior Notes due 2022	—	—	174.3	183.7
5.125% Senior Notes due 2023	295.3	297.8	294.6	288.0
5.75% Senior Notes due 2024	1,193.2	1,216.6	1,192.6	1,146.0
5.75% Senior Notes due 2025	343.9	349.6	343.4	332.5
2.00% Convertible Senior Subordinated Notes due 2043	275.7	382.6	265.9	345.0
Other notes payable	55.8	55.8	39.2	39.2
Financial commitments:				
Letters of credit	—	33.3	—	34.2

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."

13. 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. Excluding SARs issued in 2014, all employee stock-based compensation awarded between January 1, 2014 and May 8, 2016 was issued under the Amended and Restated 2008 Equity Incentive Plan (the "2008 Plan"), a stockholder-approved plan that reserved and provided for the grant of up to nine million shares of common stock. This plan allowed 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. No additional stock-based compensation will be issued from the 2008 Plan.

In May 2016, our stockholders approved the 2016 Omnibus Performance Incentive Plan, which reserves and provides for the grant of up to 14,000,000 shares of common stock. All employee stock-based compensation awarded after May 8, 2016 was issued under this plan. This plan allows for the same types of equity grants as the 2008 Plan.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of HealthSouth 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 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, 2016 , 2015 , and 2014 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,		
	2016	2015	2014
Expected volatility	37.2%	39.5%	40.3%
Risk-free interest rate	1.6%	1.9%	2.2%
Expected life (years)	7.5	7.7	7.2
Dividend yield	2.1%	2.1%	2.1%

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. In 2016, 2015, and 2014, 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, 2016 , 2015 , and 2014 was $11.55 , $15.11 , and $11.41 , 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, 2015	2,056	$ 21.37		
Granted	186	36.15		
Exercised	(563)	23.14		
Forfeitures	(102)	37.22		
Expirations	(2)	24.72		
Outstanding, December 31, 2016	1,575	21.45	4.3	$ 31.3
Exercisable, December 31, 2016	1,442	19.94	3.9	30.8

We recognized approximatel y $1.6 million , $1.6 million , and $1.9 million of compensation expense related to our stock options for the years ended December 31, 2016 , 2015 , and 2014 , respectively. As of December 31, 2016 , there was $1.1 million o f unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 26 months. The total intrinsic value of options exercised during the years ended December 31, 2016 , 2015 , and 2014 was $9.1 million , $4.2 million , and $2.4 million , respectively.

Stock Appreciation Rights—

In conjunction with the Encompass acquisition, we granted SARs based on Holdings' common stock to certain members of Encompass 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 Encompass' attainment of a specified 2017 performance measure. In general terms, half of the SARs of each type will vest on December 31, 2018 with the remainder vesting on December 31, 2019. The SARs that ultimately vest 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 acquisition 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.

The fair value of the SARs granted in conjunction with the Encompass acquisition has been estimated using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,	
	2016	2015
Expected volatility	25.9%	30.7%
Risk-free interest rate	1.9%	2.1%
Expected life (years)	5.3	6.3
Dividend yield	—%	—%

We did not include a dividend payment as part of our pricing model because Holdings currently does not pay dividends on their common stock. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of SARs granted in conjunction with the Encompass acquisition was $84.33 and $64.09 as of December 31, 2016 and 2015 , respectively.

We recognized approximately $5.8 million and $3.5 million of compensation expense related to our SARs for the years ended December 31, 2016 and 2015 , respectively. As of December 31, 2016 , there was $11.4 million of unrecognized compensation cost related to unvested SARs. This cost is expected to be recognized over a weighted-average period of 63 months . The remaining unrecognized compensation expense for our SARs may vary each reporting period based on changes in both the expected achievement of the performance measure and the specified median market multiple. As of December 31, 2016 , 252,100 SARs were outstanding.

Restricted Stock—

The RSAs granted in 2016 , 2015 , and 2014 included service-based awards, performance-based awards (that also included a service requirement), and (in 2015 and 2014) market condition 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. For RSAs with a market condition, the fair value of the RSA is determined using a lattice model. Inputs into the model include the historical price volatility of our common stock, the historical volatility of the common stock of the companies in the defined peer group, and the risk-free interest rate. Utilizing these inputs and potential future changes in stock prices, multiple trials are run to determine the fair value.

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, 2015	842	$ 28.05
Granted	542	33.56
Vested	(712)	25.63
Forfeited	(54)	35.24
Nonvested shares at December 31, 2016	618	35.06

The weighted-average grant date fair value of restricted stock granted during the years ended December 31, 2015 and 2014 was $27.86 and $23.94 per share, respectively. We recognized approximate ly $18.7 million , $19.5 million , and $20.8

million of compensation expense related to our restricted stock awards for the years ended December 31, 2016 , 2015 , and 2014 , respectively. As of December 31, 2016 , there was $18.6 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. T he 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, 2016 , 2015 , and 2014 wa s $24.3 million , $41.0 million , and $25.9 million , respectively. We accrue dividends on outstanding RSAs which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2016 , 2015 , and 2014 , 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, 2016 , 2015 , and 2014 , we issued 32,031 , 30,744 , and 36,350 RSUs, respectively, with a fair value of $40.75 , $42.46 , and $33.02 , respectively, per unit. We recognized approximately $1.3 million , $1.3 million , and $1.2 million , respectively, of compensation expense upon their issuance in 2016 , 2015 , and 2014 . There was no unrecognized compensation related to unvested shares as of December 31, 2016 . During the years ended Decemb er 31, 2016, 2015, and 2014, we issued an a dditional 10,248 , 7,645 , and 8,149 , respectively, of RSUs as dividend equivalents. As of December 31, 2016 , 434,134 RSUs were ou tstanding.

14. Employee Benefit Plans :

Substantially all HealthSouth hospital employees are eligible to enroll in HealthSouth-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 2016 , 2015 , and 2014 , costs associated with these plans, net of amounts paid by employees, approximated $119.0 million , $109.3 million , and $85.2 million , respectively.

The HealthSouth Retirement Investment Plan is a qualified 401(k) savings plan. The plan 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. HealthSouth’s employer matching contribution is 50% of the first 6% of each participant’s elective deferrals . All contributions to the plan are in the form of cash. Employees who are at least 21 years of age are eligible to participate in the plan. Employer contributions vest 100% after three years of service. Participants are always fully vested in their own contributions.

Employer contributions to the HealthSouth Retirement Investment Plan approximated $16.6 million , $15.0 million , and $13.9 million in 2016 , 2015 , and 2014 , respectively. In 2016 , 2015 , and 2014 , approximately $0.6 million , $0.9 million , and $0.5 million , respectively, from the plan’s forfeiture account were used to fund the matching contributions in accordance with the terms of the plan.

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 2017 , we expect to pay approximately $11.2 million under the program for the year ended December 31, 2016 . In February 2016 and 2015 , we paid $9.4 million and $9.0 million , respectively, under the program for the years ended December 31, 2015 and 2014 .

15. 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,		
	2016	2015	2014
Current:			
Federal	$ 16.1	$ 2.6	$ 2.5
State and other	14.9	12.2	10.8
Total current expense	31.0	14.8	13.3
Deferred:			
Federal	130.5	113.9	95.3
State and other	2.4	13.2	2.1
Total deferred expense	132.9	127.1	97.4
Total income tax expense related to continuing operations	$ 163.9	$ 141.9	$ 110.7

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,		
	2016	2015	2014
Tax expense at statutory rate	35.0 %	35.0 %	35.0 %
Increase (decrease) in tax rate resulting from:			
State and other income taxes, net of federal tax benefit	3.8 %	3.6 %	4.3 %
Increase (decrease) in valuation allowance	0.1 %	1.2 %	(1.9)%
Noncontrolling interests	(4.4)%	(5.3)%	(5.1)%
Acquisition of additional equity interest in Fairlawn	— %	— %	(3.6)%
Other, net	(0.5)%	1.4 %	(0.1)%
Income tax expense	34.0 %	35.9 %	28.6 %

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

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

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

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 HealthSouth's deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2016	2015
Deferred income tax assets:		
Net operating loss	$ 64.8	$ 161.1
Property, net	52.1	48.2
Insurance reserve	32.0	26.0
Stock-based compensation	23.7	23.4
Allowance for doubtful accounts	19.3	24.5
Alternative minimum tax	7.5	10.6
Carrying value of partnerships	12.9	22.1
Other accruals	26.1	25.7
Tax credits	2.6	14.0
Noncontrolling interest	14.8	10.6
Other	0.8	0.8
Total deferred income tax assets	256.6	367.0
Less: Valuation allowance	(27.9)	(27.6)
Net deferred income tax assets	228.7	339.4
Deferred income tax liabilities:		
Intangibles	(113.2)	(112.8)
Convertible debt interest	(38.1)	(35.3)
Other	(1.6)	(0.5)
Total deferred income tax liabilities	(152.9)	(148.6)
Net deferred income tax assets	75.8	190.8

In the consolidated statements of shareholders' equity, the fair value adjustments to redeemable noncontrolling interests have been reported net of tax for each period presented. The amount of tax benefit allocated to *Capital in excess of par value* was ($4.2) million , ($11.7) million , and $(1.8) million for the years ended December 31, 2016, 2015, and 2014, respectively.

As of December 31, 2016 , we had reduced our federal NOL to zero . We recognized $17.3 million related to operating loss carryforwards resulting from excess tax benefits related to share-based awards, the benefits of which, is accounted for as a credit to *Capital in excess of par value* that reduce taxes payable. We also used federal tax credit carryforwards of $19.3 million . Additionally, we have state NOLs of $64.8 million that expire in various amounts at varying times through 2031.

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

For the years ended December 31, 2016 , 2015 , and 2014 , the net changes in our valuation allowance were $0.3 million , $4.6 million , and ($7.7) million , respectively. The increase in our valuation allowance in 2016 related primarily to the valuation of our tax credits. The increase in our valuation allowance in 2015 related primarily to changes to our state apportionment percentages resulting from the acquisitions of Encompass, Reliant, and CareSouth and changes to our current forecast of earnings in each jurisdiction. The decrease in our valuation allowance in 2014 related primarily to the expiration of state NOLs in certain jurisdictions, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws.

As of December 31, 2016 , we have a remaining valuation allowance of $27.9 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, or if the timing of future tax deductions or credit utilizations differs from our expectations.

As of January 1, 2014 , total remaining gross unrecognized tax benefits were $1.1 million , $0.4 million of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2014. Total remaining gross unrecognized tax benefits were $0.9 million as of December 31, 2014, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2015. Total remaining gross unrecognized tax benefits were $2.9 million as of December 31, 2015, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2016. Total remaining gross unrecognized tax benefits were $2.8 million as of December 31, 2016, all of which would affect our effective tax rate if recognized.

A reconciliation of the beginning and ending liability for unrecognized tax benefits is as follows (in millions):

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
January 1, 2014	$ 1.1	$ 0.3
Gross amount of increases in unrecognized tax benefits related to prior periods	0.7	0.1
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.9)	(0.4)
December 31, 2014	0.9	—
Gross amount of increases in unrecognized tax benefits related to prior periods	1.7	—
Gross amount of increases in unrecognized tax benefits related to current period	0.3	—
December 31, 2015	2.9	—
Gross amount of increases in unrecognized tax benefits related to prior periods	0.3	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.4)	—
Gross amount of increases in unrecognized tax benefits related to current period	0.1	—
Gross amount of decreases in unrecognized tax benefits related to current periods	(0.1)	—
December 31, 2016	$ 2.8	$ —

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 2016, 2015, and 2014 was not material. Accrued interest income related to income taxes as of December 31, 2016 and 2015 was not material.

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

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 up to $2.6 million of our unrecognized tax benefits may be released within the next 12 months.

See also Note 1, *Summary of Significant Accounting Policies* , “Recent Accounting Pronouncements.”

16. 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,		
	2016	2015	2014
Basic:			
Numerator:			
Income from continuing operations	$ 318.1	$ 253.7	$ 276.2
Less: Net income attributable to noncontrolling interests included in continuing operations	(70.5)	(69.7)	(59.7)
Less: Income allocated to participating securities	(0.8)	(1.0)	(2.3)
Less: Convertible perpetual preferred stock dividends	—	(1.6)	(6.3)
Income from continuing operations attributable to HealthSouth common shareholders	246.8	181.4	207.9
(Loss) income from discontinued operations, net of tax, attributable to HealthSouth common shareholders	—	(0.9)	5.5
Less: Income from discontinued operations allocated to participating securities	—	—	(0.1)
Net income attributable to HealthSouth common shareholders	$ 246.8	$ 180.5	$ 213.3
Denominator:			
Basic weighted average common shares outstanding	89.1	89.4	86.8
Basic earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.77	$ 2.03	$ 2.40
Discontinued operations	—	(0.01)	0.06
Net income	$ 2.77	$ 2.02	$ 2.46
Diluted:			
Numerator:			
Income from continuing operations	$ 318.1	$ 253.7	$ 276.2
Less: Net income attributable to noncontrolling interests included in continuing operations	(70.5)	(69.7)	(59.7)
Add: Interest on convertible debt, net of tax	9.7	9.4	9.0
Income from continuing operations attributable to HealthSouth common shareholders	257.3	193.4	225.5
(Loss) income from discontinued operations, net of tax, attributable to HealthSouth common shareholders	—	(0.9)	5.5
Net income attributable to HealthSouth common shareholders	$ 257.3	$ 192.5	$ 231.0
Denominator:			
Diluted weighted average common shares outstanding	99.5	101.0	100.7
Diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.59	$ 1.92	$ 2.24
Discontinued operations	—	(0.01)	0.05
Net income	$ 2.59	$ 1.91	$ 2.29

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,		
	2016	2015	2014
Basic weighted average common shares outstanding	89.1	89.4	86.8
Convertible perpetual preferred stock	—	1.0	3.2
Convertible senior subordinated notes	8.5	8.3	8.2
Restricted stock awards, dilutive stock options, and restricted stock units	1.9	2.3	2.5
Diluted weighted average common shares outstanding	99.5	101.0	100.7

Options to purchase approximately 0.1 million shares of common stock were outstanding as of December 31, 2016 and 2015 but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

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. During 2016 , 2015 and 2014 , we repurchased 1.7 million , 1.3 million , and 1.3 million shares of our common stock in the open market for $65.6 million , $45.3 million , and $43.1 million , respectively.

In July 2013, our board of directors approved the initiation of a quarterly cash dividend of $0.18 per share on our common stock and it was declared and paid each quarter through July 2014. In July 2014, our board of directors approved an increase in the quarterly cash dividend on our common stock and declared a dividend of $0.21 per share. The cash dividend of $0.21 per common share was declared and paid each quarter through July 2015. In July 2015, our board of directors approved an increase in the quarterly cash dividend and declared a dividend of $0.23 per share. The cash dividend of $0.23 per common share was declared and paid each quarter through July 2016. 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 in July 2016 and October 2016 and paid in October 2016 and January 2017. As of December 31, 2016 and 2015 , accrued common stock dividends of $22.2 million and $21.3 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 April 22, 2015, we delivered notice of the exercise of our rights to force conversion of all outstanding shares of our *Convertible perpetual preferred stock* (par value of $0.10 per share and liquidation preference of $1,000 per share) pursuant to the underlying certificate of designations. The effective date of the conversion was April 23, 2015. On that date, each share of preferred stock automatically converted into 33.9905 shares of our common stock (par value of $0.01 per share). We completed the forced conversion by issuing and delivering in the aggregate 3,271,415 shares of our common stock to the registered holders of the 96,245 shares of the preferred stock outstanding and paying cash in lieu of fractional shares due to those holders.

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

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

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

The above exercises resulted in the issuance of 0.7 million shares of common stock in January 2017. Cash exercises resulted in gross proceeds of $26.7 million in January 2017.

See also Note 9, *Long-term Debt* .

17. Contingencies and Other Commitments :

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

Nichols Litigation—

We have been named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned *Nichols v. HealthSouth Corp* . The plaintiffs allege that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiffs are seeking compensatory and punitive damages. This case was stayed in the Circuit Court on August 8, 2005. The plaintiffs filed an amended complaint on November 9, 2010 to which we responded with a motion to dismiss filed on December 22, 2010. During a hearing on February 24, 2012, plaintiffs' counsel indicated his intent to dismiss certain claims against us. Instead, on March 9, 2012, the plaintiffs amended their complaint to include additional securities fraud claims against HealthSouth and add several former officers to the lawsuit. On September 12, 2012, the plaintiffs further amended their complaint to request certification as a class action. One of those named officers has repeatedly attempted to remove the case to federal district court, most recently on December 11, 2012. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. On November 25, 2014, the plaintiffs filed another amended complaint to assert new allegations relating to the time period of 1997 to 2002. On December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lack standing because their claims are derivative in nature, and the claims are time-barred by the statute of limitations. On May 26, 2016, the court granted our motion to dismiss. The plaintiffs appealed the dismissal of the case to the Supreme Court of Alabama on June 28, 2016. The Supreme Court has not yet scheduled a hearing on the appeal.

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

Other Litigation—

One of our hospital subsidiaries was named as a defendant in a lawsuit filed August 12, 2013 by an individual in the Circuit Court of Etowah County, Alabama, captioned *Honts v. HealthSouth Rehabilitation Hospital of Gadsden, LLC.* The plaintiff alleged that her mother, who died more than three months after being discharged from our hospital, received an unprescribed opiate medication at the hospital. We deny the patient received any such medication, accounted for all the opiates at the hospital and argued the plaintiff established no causal liability between the actions of our staff and her mother's death. The plaintiff sought recovery for punitive damages. On May 18, 2016, the jury in this case returned a verdict in favor of the plaintiff for $20.0 million . On June 17, 2016, we filed a renewed motion for judgment as a matter of law or, in the alternative, a motion for new trial or, in the further alternative, a motion seeking reduction of the damages awarded (collectively, the "post-judgment motions"). The trial court denied the post-judgment motions. We appealed the verdict as well as the rulings on the post-judgment motions to the Supreme Court of Alabama on October 12, 2016. The Supreme Court has not yet scheduled a hearing on the appeal. We posted a bond in the amount of the judgment pending resolution of our appeal. We intend to vigorously defend ourselves in this case. Although we continue to believe in the merit of our defenses and counterarguments, we have recorded a liability of $21.0 million (including $1.0 million in fees and expenses) in *Other current liabilities* in our condensed consolidated balance sheet as of December 31, 2016 with a corresponding receivable of $15.0 million in *Other current assets* for the portion of the liability we would expect to be covered through our excess insurance coverages, resulting in a net charge of an additional $5.7 million to *Other operating expenses* in our condensed consolidated statements of operations for the year ended December 31, 2016. The $6.0 million portion of this liability would be a covered claim through our captive insurance subsidiary, HCS, Ltd.

Governmental Inquiries and Investigations—

On June 24, 2011, we received a document subpoena addressed to HealthSouth Hospital of Houston, a long-term acute care hospital ("LTCH") we closed in August 2011, and issued from the Dallas, Texas office of the HHS-OIG. The subpoena stated it was in connection with an investigation of possible false or otherwise improper claims submitted to Medicare and Medicaid and requested documents and materials relating to patient admissions, length of stay, and discharge matters at this closed LTCH. We furnished the documents requested and have heard nothing from the HHS-OIG since December 2012.

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

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

We are cooperating fully with the DOJ in connection with this investigation and are currently unable to predict the timing or outcome of it. We intend to vigorously defend ourselves in this matter. Based on discussions with the DOJ, review of the current facts and circumstances as we understand them, and the nature of the investigation, it is not possible to estimate an amount of loss, if any, or range of possible loss that might result from it.

Other Matters—

The False Claims Act allows private citizens, called "relators," to institute civil proceedings alleging violations of the False Claims Act. These *qui tam* cases are sealed by the court at the time of filing. Prior to the release of the seal by the presiding court, the only parties typically privy to the information contained in the complaint are the relator, the federal government, and the court. It is possible that *qui tam* lawsuits have been filed against us and that those suits remain under seal or that we are unaware of such filings or prevented by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

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, HealthSouth 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 $34.2 million in 2017 , $24.7 million in 2018 , $14.2 million in 2019 , $12.2 million in 2020 , $6.8 million in 2021 , and $0.8 million thereafter. These contracts primarily relate to software licensing and support.

18. Segment Reporting :

As described in Note 2, *Business Combinations* , we completed the acquisition of Encompass on December 31, 2014. As a result of this transaction, in the first quarter of 2015, management changed the way it manages and operates the consolidated reporting entity and modified the reports used by our chief operating decision maker to assess performance and allocate resources. These changes required us to revise our segment reporting from our historic presentation of only one reportable segment.

Our internal financial reporting and management structure is focused on the major types of services provided by HealthSouth. Beginning in the first quarter of 2015, we manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. The 2014 information has been adjusted to conform to the current period presentation. Specifically, HealthSouth's legacy 25 hospital-based home health agencies have been reclassified from our inpatient rehabilitation segment to our home health and hospice segment for all periods presented.

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 30 states and Puerto Rico, with a concentration of hospitals in the eastern half of the United States and Texas. As of December 31, 2016 , we operate 123 inpatient rehabilitation hospitals, including one hospital that operates as a joint venture which we account for using the equity method of accounting. In addition, we manage five 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, 2016 , we provide home health and hospice services in 223 locations across 25 states with concentrations in the Southeast, Oklahoma, and Texas. In addition, two of these agencies operate as joint ventures which we account for using the equity method of accounting. Our home health services include a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational, and speech therapy, medical social work, and home health aide services. Our hospice services 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 payor composition of our revenues. No corporate overhead is allocated to either of our reportable segments. Our chief operating decision maker evaluates the performance of our segments and allocates resources to them based on adjusted earnings before interest, taxes, depreciation, and amortization ("Segment Adjusted EBITDA").

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

	Inpatient Rehabilitation			Home Health and Hospice		
	For the Year Ended December 31,			For the Year Ended December 31,		
	2016	2015	2014	2016	2015	2014
Net operating revenues	$ 3,021.1	$ 2,653.1	$ 2,377.3	$ 686.1	$ 509.8	$ 28.6
Less: Provision for doubtful accounts	(57.0)	(44.7)	(31.2)	(4.2)	(2.5)	(0.4)
Net operating revenues less provision for doubtful accounts	2,964.1	2,608.4	2,346.1	681.9	507.3	28.2
Operating expenses:						
Inpatient rehabilitation:						
Salaries and benefits	1,493.4	1,310.6	1,141.0	—	—	—
Other operating expenses	431.5	387.7	342.5	—	—	—
Supplies	128.8	120.9	111.5	—	—	—
Occupancy costs	61.2	46.2	41.2	—	—	—
Home health and hospice:						
Cost of services sold (excluding depreciation and amortization)	—	—	—	336.5	244.8	17.0
Support and overhead costs	—	—	—	237.2	172.7	6.9
	2,114.9	1,865.4	1,636.2	573.7	417.5	23.9
Other income	(2.9)	(2.3)	(4.0)	—	—	—
Equity in net income of nonconsolidated affiliates	(9.1)	(8.6)	(10.7)	(0.7)	(0.1)	—
Noncontrolling interests	64.0	62.9	59.3	6.5	6.8	0.4
Segment Adjusted EBITDA	$ 797.2	$ 691.0	$ 665.3	$ 102.4	$ 83.1	$ 3.9
Capital expenditures	$ 97.7	$ 151.7	$ 187.9	$ 6.5	$ 5.8	$ —

	Inpatient Rehabilitation	Home Health and Hospice	HealthSouth Consolidated
As of December 31, 2016			
Total assets	$ 3,629.6	$ 1,123.7	$ 4,681.9
Investments in and advances to nonconsolidated affiliates	10.6	2.4	13.0
As of December 31, 2015			
Total assets	$ 3,589.0	$ 1,088.4	$ 4,606.1
Investments in and advances to nonconsolidated affiliates	9.3	2.4	11.7

Segment reconciliations (in millions):

	For the Year Ended December 31,		
	2016	2015	2014
Total segment Adjusted EBITDA	$ 899.6	$ 774.1	$ 669.2
General and administrative expenses	(133.4)	(133.3)	(124.8)
Depreciation and amortization	(172.6)	(139.7)	(107.7)
Loss on disposal or impairment of assets	(0.7)	(2.6)	(6.7)
Government, class action, and related settlements	—	(7.5)	1.7
Professional fees - accounting, tax, and legal	(1.9)	(3.0)	(9.3)
Loss on early extinguishment of debt	(7.4)	(22.4)	(13.2)
Interest expense and amortization of debt discounts and fees	(172.1)	(142.9)	(109.2)
Gain on consolidation of former equity method hospital	—	—	27.2
Net income attributable to noncontrolling interests	70.5	69.7	59.7
Gain related to SCA equity interest	—	3.2	—
Income from continuing operations before income tax expense	$ 482.0	$ 395.6	$ 386.9

	As of December 31, 2016	As of December 31, 2015
Total assets for reportable segments	$ 4,753.3	$ 4,677.4
Reclassification of noncurrent deferred income tax liabilities to net noncurrent deferred income tax assets	(71.4)	(71.3)
Total consolidated assets	$ 4,681.9	$ 4,606.1

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

	For the Year Ended December 31,		
	2016	2015	2014
Inpatient rehabilitation:			
Inpatient	$ 2,905.5	$ 2,547.2	$ 2,272.5
Outpatient and other	115.6	105.9	104.8
Total inpatient rehabilitation	3,021.1	2,653.1	2,377.3
Home health and hospice:			
Home health	635.2	478.1	28.6
Hospice	50.9	31.7	—
Total home health and hospice	686.1	509.8	28.6
Total net operating revenues	$ 3,707.2	$ 3,162.9	$ 2,405.9

19. Quarterly Data (Unaudited) :

	2016				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 909.8	$ 920.7	$ 926.8	$ 949.9	$ 3,707.2
Operating earnings [(a)]	144.2	150.2	148.2	145.5	588.1
Provision for income tax expense	39.7	42.4	42.1	39.7	163.9
Income from continuing operations	76.8	81.3	78.2	81.8	318.1
(Loss) income from discontinued operations, net of tax	(0.1)	(0.1)	(0.1)	0.3	—
Net income	76.7	81.2	78.1	82.1	318.1
Less: Net income attributable to noncontrolling interests	(18.7)	(18.6)	(16.4)	(16.8)	(70.5)
Net income attributable to HealthSouth	$ 58.0	$ 62.6	$ 61.7	$ 65.3	$ 247.6
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders: [(b)]					
Continuing operations	$ 0.65	$ 0.70	$ 0.69	$ 0.73	$ 2.77
Discontinued operations	—	—	—	—	—
Net income	$ 0.65	$ 0.70	$ 0.69	$ 0.73	$ 2.77
Diluted earnings per share attributable to HealthSouth common shareholders: [(b)]					
Continuing operations	$ 0.61	$ 0.65	$ 0.64	$ 0.68	$ 2.59
Discontinued operations	—	—	—	—	—
Net income	$ 0.61	$ 0.65	$ 0.64	$ 0.68	$ 2.59

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

	2015				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 740.6	$ 764.4	$ 778.6	$ 879.3	$ 3,162.9
Operating earnings [(a)]	105.6	123.4	121.2	135.5	485.7
Provision for income tax expense	30.3	32.2	35.9	43.5	141.9
Income from continuing operations	59.3	61.8	67.5	65.1	253.7
(Loss) income from discontinued operations, net of tax	(0.3)	(1.6)	0.3	0.7	(0.9)
Net income	59.0	60.2	67.8	65.8	252.8
Less: Net income attributable to noncontrolling interests	(16.5)	(17.3)	(17.1)	(18.8)	(69.7)
Net income attributable to HealthSouth	$ 42.5	$ 42.9	$ 50.7	$ 47.0	$ 183.1
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders: [(b)]					
Continuing operations	$ 0.47	$ 0.49	$ 0.56	$ 0.51	$ 2.03
Discontinued operations	—	(0.02)	—	0.01	(0.01)
Net income	$ 0.47	$ 0.47	$ 0.56	$ 0.52	$ 2.02
Diluted earnings per share attributable to HealthSouth common shareholders:					
Continuing operations	$ 0.44	$ 0.47	$ 0.52	$ 0.48	$ 1.92
Discontinued operations	—	(0.02)	—	0.01	(0.01)
Net income	$ 0.44	$ 0.45	$ 0.52	$ 0.49	$ 1.91

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

20. 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 HealthSouth, and all guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. HealthSouth’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 1.75 x. 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 2 x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture’s restricted payments covenant to declare and pay dividends. See Note 9, *Long-term Debt* .

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

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2016				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Net operating revenues	$ 20.1	$ 2,190.3	$ 1,614.7	$ (117.9)	$ 3,707.2
Less: Provision for doubtful accounts	—	(42.2)	(19.0)	—	(61.2)
Net operating revenues less provision for doubtful accounts	20.1	2,148.1	1,595.7	(117.9)	3,646.0
Operating expenses:					
Salaries and benefits	45.5	1,013.7	945.0	(18.3)	1,985.9
Other operating expenses	25.5	313.2	199.7	(46.3)	492.1
Occupancy costs	2.9	89.8	31.9	(53.3)	71.3
Supplies	—	90.7	49.3	—	140.0
General and administrative expenses	126.7	—	6.7	—	133.4
Depreciation and amortization	9.4	103.6	59.6	—	172.6
Professional fees—accounting, tax, and legal	1.9	—	—	—	1.9
Total operating expenses	211.9	1,611.0	1,292.2	(117.9)	2,997.2
Loss on early extinguishment of debt	7.4	—	—	—	7.4
Interest expense and amortization of debt discounts and fees	147.3	21.6	23.1	(19.9)	172.1
Other income	(19.6)	(0.4)	(2.8)	19.9	(2.9)
Equity in net income of nonconsolidated affiliates	—	(9.0)	(0.8)	—	(9.8)
Equity in net income of consolidated affiliates	(348.3)	(38.3)	—	386.6	—
Management fees	(136.2)	104.0	32.2	—	—
Income from continuing operations before income tax (benefit) expense	157.6	459.2	251.8	(386.6)	482.0
Provision for income tax (benefit) expense	(90.0)	183.3	70.6	—	163.9
Income from continuing operations	247.6	275.9	181.2	(386.6)	318.1
Income from discontinued operations, net of tax	—	—	—	—	—
Net income	247.6	275.9	181.2	(386.6)	318.1
Less: Net income attributable to noncontrolling interests	—	—	(70.5)	—	(70.5)
Net income attributable to HealthSouth	$ 247.6	$ 275.9	$ 110.7	$ (386.6)	$ 247.6
Comprehensive income	$ 247.6	$ 275.9	$ 181.2	$ (386.6)	$ 318.1
Comprehensive income attributable to HealthSouth	$ 247.6	$ 275.9	$ 110.7	$ (386.6)	$ 247.6

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2015				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 19.4	$ 1,889.2	$ 1,357.8	$ (103.5)	$ 3,162.9
Less: Provision for doubtful accounts	—	(33.9)	(13.3)	—	(47.2)
Net operating revenues less provision for doubtful accounts	19.4	1,855.3	1,344.5	(103.5)	3,115.7
Operating expenses:					
Salaries and benefits	49.4	874.0	764.5	(17.1)	1,670.8
Other operating expenses	31.3	269.2	172.9	(41.3)	432.1
Occupancy costs	4.0	66.9	28.1	(45.1)	53.9
Supplies	—	83.6	45.1	—	128.7
General and administrative expenses	128.3	—	5.0	—	133.3
Depreciation and amortization	9.9	83.6	46.2	—	139.7
Government, class action, and related settlements	7.5	—	—	—	7.5
Professional fees—accounting, tax, and legal	3.0	—	—	—	3.0
Total operating expenses	233.4	1,377.3	1,061.8	(103.5)	2,569.0
Loss on early extinguishment of debt	22.4	—	—	—	22.4
Interest expense and amortization of debt discounts and fees	130.0	11.2	13.1	(11.4)	142.9
Other income	(13.6)	(0.2)	(3.1)	11.4	(5.5)
Equity in net income of nonconsolidated affiliates	—	(8.5)	(0.2)	—	(8.7)
Equity in net income of consolidated affiliates	(321.5)	(37.5)	—	359.0	—
Management fees	(119.7)	89.7	30.0	—	—
Income from continuing operations before income tax (benefit) expense	88.4	423.3	242.9	(359.0)	395.6
Provision for income tax (benefit) expense	(95.8)	168.9	68.8	—	141.9
Income from continuing operations	184.2	254.4	174.1	(359.0)	253.7
(Loss) income from discontinued operations, net of tax	(1.1)	—	0.2	—	(0.9)
Net income	183.1	254.4	174.3	(359.0)	252.8
Less: Net income attributable to noncontrolling interests	—	—	(69.7)	—	(69.7)
Net income attributable to HealthSouth	$ 183.1	$ 254.4	$ 104.6	$ (359.0)	$ 183.1
Comprehensive income	$ 182.4	$ 254.4	$ 174.3	$ (359.0)	$ 252.1
Comprehensive income attributable to HealthSouth	$ 182.4	$ 254.4	$ 104.6	$ (359.0)	$ 182.4

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2014				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Net operating revenues	$ 16.1	$ 1,683.4	$ 796.8	$ (90.4)	$ 2,405.9
Less: Provision for doubtful accounts	—	(21.8)	(9.8)	—	(31.6)
Net operating revenues less provision for doubtful accounts	16.1	1,661.6	787	(90.4)	2,374.3
Operating expenses:					
Salaries and benefits	22.3	776.6	377.9	(15.1)	1,161.7
Other operating expenses	21.6	240.7	126.1	(36.8)	351.6
Occupancy costs	4.2	55.7	20.2	(38.5)	41.6
Supplies	—	77.0	34.9	—	111.9
General and administrative expenses	124.8	—	—	—	124.8
Depreciation and amortization	9.7	71.0	27.0	—	107.7
Government, class action, and related settlements	(1.7)	—	—	—	(1.7)
Professional fees—accounting, tax, and legal	9.3	—	—	—	9.3
Total operating expenses	190.2	1,221.0	586.1	(90.4)	1,906.9
Loss on early extinguishment of debt	13.2	—	—	—	13.2
Interest expense and amortization of debt discounts and fees	99.8	7.8	2.8	(1.2)	109.2
Other income	(0.7)	(28.5)	(3.2)	1.2	(31.2)
Equity in net income of nonconsolidated affiliates	—	(10.7)	—	—	(10.7)
Equity in net income of consolidated affiliates	(313.2)	(32.5)	—	345.7	—
Management fees	(107.9)	80.3	27.6	—	—
Income from continuing operations before income tax (benefit) expense	134.7	424.2	173.7	(345.7)	386.9
Provision for income tax (benefit) expense	(81.6)	147.5	44.8	—	110.7
Income from continuing operations	216.3	276.7	128.9	(345.7)	276.2
Income (loss) from discontinued operations, net of tax	5.7	—	(0.2)	—	5.5
Net income	222.0	276.7	128.7	(345.7)	281.7
Less: Net income attributable to noncontrolling interests	—	—	(59.7)	—	(59.7)
Net income attributable to HealthSouth	$ 222.0	$ 276.7	$ 69.0	$ (345.7)	$ 222.0
Comprehensive income	$ 221.6	$ 276.7	$ 128.7	$ (345.7)	$ 281.3
Comprehensive income attributable to HealthSouth	$ 221.6	$ 276.7	$ 69.0	$ (345.7)	$ 221.6

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2016				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Assets					
Current assets:					
Cash and cash equivalents	$ 20.6	$ 1.6	$ 18.3	$ —	$ 40.5
Restricted cash	—	—	60.9	—	60.9
Accounts receivable, net	—	276.5	167.3	—	443.8
Prepaid expenses and other current assets	49.9	24.2	53.8	(18.6)	109.3
Total current assets	70.5	302.3	300.3	(18.6)	654.5
Property and equipment, net	41.6	987.3	362.9	—	1,391.8
Goodwill	—	860.6	1,066.6	—	1,927.2
Intangible assets, net	12.0	115.6	283.7	—	411.3
Deferred income tax assets	90.9	57.6	—	(72.7)	75.8
Other long-term assets	49.0	95.1	77.2	—	221.3
Intercompany notes receivable	528.8	—	—	(528.8)	—
Intercompany receivable and investments in consolidated affiliates	2,855.5	96.3	—	(2,951.8)	—
Total assets	$ 3,648.3	$ 2,514.8	$ 2,090.7	$ (3,571.9)	$ 4,681.9
Liabilities and Shareholders’ Equity					
Current liabilities:					
Current portion of long-term debt	$ 40.0	$ 6.4	$ 8.2	$ (17.5)	$ 37.1
Accounts payable	7.0	37.4	23.9	—	68.3
Accrued payroll	31.6	57.9	57.8	—	147.3
Accrued interest payable	22.8	2.8	0.2	—	25.8
Other current liabilities	96.3	21.6	80.3	(1.1)	197.1
Total current liabilities	197.7	126.1	170.4	(18.6)	475.6
Long-term debt, net of current portion	2,679.2	248.9	51.2	—	2,979.3
Intercompany notes payable	—	—	528.8	(528.8)	—
Self-insured risks	14.1	—	96.3	—	110.4
Other long-term liabilities	21.4	15.2	85.3	(72.3)	49.6
Intercompany payable	—	—	168.2	(168.2)	—
	2,912.4	390.2	1,100.2	(787.9)	3,614.9
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	138.3	—	138.3
Shareholders’ equity:					
HealthSouth shareholders’ equity	735.9	2,124.6	659.4	(2,784.0)	735.9
Noncontrolling interests	—	—	192.8	—	192.8
Total shareholders’ equity	735.9	2,124.6	852.2	(2,784.0)	928.7
Total liabilities and shareholders’ equity	$ 3,648.3	$ 2,514.8	$ 2,090.7	$ (3,571.9)	$ 4,681.9

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2015				
	HealthSouth Corporation	**Guarantor Subsidiaries**	**Nonguarantor Subsidiaries**	**Eliminating Entries**	**HealthSouth Consolidated**
	(In Millions)				
Assets					
Current assets:					
Cash and cash equivalents	$ 41.2	$ 1.2	$ 19.2	$ —	$ 61.6
Restricted cash	—	—	45.9	—	45.9
Accounts receivable, net	—	261.5	149.0	—	410.5
Prepaid expenses and other current assets	29.3	22.2	48.0	(18.8)	80.7
Total current assets	70.5	284.9	262.1	(18.8)	598.7
Property and equipment, net	14.5	988.4	307.2	—	1,310.1
Goodwill	—	860.7	1,029.4	—	1,890.1
Intangible assets, net	8.8	122.4	288.2	—	419.4
Deferred income tax assets	176.2	64.1	—	(49.5)	190.8
Other long-term assets	48.6	75.3	73.1	—	197.0
Intercompany notes receivable	546.6	—	—	(546.6)	—
Intercompany receivable and investments in consolidated affiliates	2,779.7	—	—	(2,779.7)	—
Total assets	$ 3,644.9	$ 2,395.8	$ 1,960.0	$ (3,394.6)	$ 4,606.1
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 40.0	$ 6.8	$ 7.5	$ (17.5)	$ 36.8
Accounts payable	5.8	35.4	20.4	—	61.6
Accrued payroll	27.7	50.1	48.4	—	126.2
Accrued interest payable	26.5	2.9	0.3	—	29.7
Other current liabilities	68.0	18.8	86.6	(1.3)	172.1
Total current liabilities	168.0	114.0	163.2	(18.8)	426.4
Long-term debt, net of current portion	2,821.9	255.6	57.2	—	3,134.7
Intercompany notes payable	—	—	546.6	(546.6)	—
Self-insured risks	19.8	—	81.8	—	101.6
Other long-term liabilities	23.8	12.3	56.0	(49.1)	43.0
Intercompany payable	—	156.7	157.5	(314.2)	—
	3,033.5	538.6	1,062.3	(928.7)	3,705.7
Commitments and contingencies					
Redeemable noncontrolling interests	—	—	121.1	—	121.1
Shareholders' equity:					
HealthSouth shareholders' equity	611.4	1,857.2	608.7	(2,465.9)	611.4
Noncontrolling interests	—	—	167.9	—	167.9
Total shareholders' equity	611.4	1,857.2	776.6	(2,465.9)	779.3
Total liabilities and shareholders' equity	$ 3,644.9	$ 2,395.8	$ 1,960.0	$ (3,394.6)	$ 4,606.1

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2016				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Net cash provided by operating activities	$ 35.8	$ 331.8	$ 237.9	$ —	$ 605.5
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	—	—	(48.1)	—	(48.1)
Purchases of property and equipment	(21.8)	(77.8)	(78.1)	—	(177.7)
Capitalized software costs	(22.8)	(0.2)	(2.2)	—	(25.2)
Proceeds from disposal of assets	—	0.7	23.2	—	23.9
Purchases of restricted investments	—	—	(1.3)	—	(1.3)
Net change in restricted cash	—	—	(15.1)	—	(15.1)
Funding of intercompany note receivable	(22.5)	—	—	22.5	—
Proceeds from repayment of intercompany note receivable	52.0	—	—	(52.0)	—
Other	(3.7)	(0.2)	2.3	—	(1.6)
Net cash provided by investing activities of discontinued operations	0.1	—	—	—	0.1
Net cash used in investing activities	(18.7)	(77.5)	(119.3)	(29.5)	(245.0)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(198.5)	(1.3)	(2.3)	—	(202.1)
Principal borrowings on intercompany note payable	—	—	22.5	(22.5)	—
Principal payments on intercompany note payable	—	—	(52.0)	52.0	—
Borrowings on revolving credit facility	335.0	—	—	—	335.0
Payments on revolving credit facility	(313.0)	—	—	—	(313.0)
Principal payments under capital lease obligations	(0.1)	(5.9)	(7.3)	—	(13.3)
Repurchases of common stock, including fees and expenses	(65.6)	—	—	—	(65.6)
Dividends paid on common stock	(83.8)	—	—	—	(83.8)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(64.9)	—	(64.9)
Windfall tax benefit from share-based compensation	17.3	—	—	—	17.3
Other	6.9	—	1.9	—	8.8
Change in intercompany advances	264.1	(246.7)	(17.4)	—	—
Net cash provided by (used in) financing activities	(37.7)	(253.9)	(119.5)	29.5	(381.6)
(Decrease) increase in cash and cash equivalents	(20.6)	0.4	(0.9)	—	(21.1)
Cash and cash equivalents at beginning of year	41.2	1.2	19.2	—	61.6
Cash and cash equivalents at end of year	$ 20.6	$ 1.6	$ 18.3	$ —	$ 40.5
Supplemental schedule of noncash investing activity:					
Intercompany note activity	(11.7)	—	11.7	—	—

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2015				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Net cash provided by operating activities	$ 41.4	$ 218.9	$ 224.5	$ —	$ 484.8
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	(954.6)	—	(30.5)	—	(985.1)
Purchases of property and equipment	(15.9)	(62.3)	(50.2)	—	(128.4)
Capitalized software costs	(24.5)	(0.4)	(3.2)	—	(28.1)
Proceeds from disposal of assets	—	3.5	0.5	—	4.0
Proceeds from sale of marketable securities	12.8	—	—	—	12.8
Purchases of restricted investments	—	—	(7.1)	—	(7.1)
Net change in restricted cash	—	—	2.7	—	2.7
Funding of intercompany note receivable	(2.0)	—	—	2.0	—
Proceeds from repayment of intercompany note receivable	24.0	—	—	(24.0)	—
Other	(0.5)	(1.9)	1.3	—	(1.1)
Net cash provided by investing activities of discontinued operations	0.5	—	—	—	0.5
Net cash used in investing activities	(960.2)	(61.1)	(86.5)	(22.0)	(1,129.8)
Cash flows from financing activities:					
Principal borrowings on term loan facilities	250.0	—	—	—	250.0
Proceeds from bond issuance	1,400.0	—	—	—	1,400.0
Principal payments on debt, including pre-payments	(595.0)	(1.6)	(0.8)	—	(597.4)
Principal borrowings on intercompany notes payable	—	—	2.0	(2.0)	—
Principal payments on intercompany notes payable	—	—	(24.0)	24.0	—
Borrowings on revolving credit facility	540.0	—	—	—	540.0
Payments on revolving credit facility	(735.0)	—	—	—	(735.0)
Debt amendment and issuance costs	(31.9)	—	—	—	(31.9)
Principal payments under capital lease obligations	(0.3)	(4.5)	(6.2)	—	(11.0)
Repurchases of common stock, including fees and expenses	(45.3)	—	—	—	(45.3)
Dividends paid on common stock	(77.2)	—	—	—	(77.2)
Dividends paid on convertible perpetual preferred stock	(3.1)	—	—	—	(3.1)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(54.4)	—	(54.4)
Other	2.2	1.5	1.5	—	5.2
Change in intercompany advances	213.7	(153.4)	(60.3)	—	—
Net cash provided by (used in) financing activities	918.1	(158.0)	(142.2)	22.0	639.9
Decrease in cash and cash equivalents	(0.7)	(0.2)	(4.2)	—	(5.1)
Cash and cash equivalents at beginning of year	41.9	1.4	23.4	—	66.7
Cash and cash equivalents at end of year	$ 41.2	$ 1.2	$ 19.2	$ —	$ 61.6
Supplemental schedule of noncash financing activities:					
Conversion of preferred stock to common stock	$ 93.2	$ —	$ —	$ —	$ 93.2
Intercompany note activity	(183.5)	—	183.5	—	—

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2014				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
	(In Millions)				
Net cash provided by operating activities	$ 22.8	$ 261.6	$ 160.5	$ —	$ 444.9
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	(674.6)	—	(20.2)	—	(694.8)
Purchases of property and equipment	(15.6)	(127.9)	(27.4)	—	(170.9)
Capitalized software costs	(8.6)	(1.4)	(7.0)	—	(17.0)
Proceeds from disposal of assets	—	0.1	0.1	—	0.2
Purchases of restricted investments	—	—	(3.5)	—	(3.5)
Net change in restricted cash	1.0	—	5.8	—	6.8
Other	—	(0.8)	3.1	—	2.3
Net cash used in investing activities	(697.8)	(130.0)	(49.1)	—	(876.9)
Cash flows from financing activities:					
Principal borrowings on term loan facilities	450.0	—	—	—	450.0
Proceeds from bond issuance	175.0	—	—	—	175.0
Principal payments on debt, including pre-payments	(298.0)	(1.5)	(3.1)	—	(302.6)
Borrowings on revolving credit facility	440.0	—	—	—	440.0
Payments on revolving credit facility	(160.0)	—	—	—	(160.0)
Principal payments under capital lease obligations	(0.3)	(2.5)	(3.3)	—	(6.1)
Debt amendment and issuance costs	(6.5)	—	—	—	(6.5)
Repurchases of common stock, including fees and expenses	(43.1)	—	—	—	(43.1)
Dividends paid on common stock	(65.8)	—	—	—	(65.8)
Dividends paid on convertible perpetual preferred stock	(6.3)	—	—	—	(6.3)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(54.1)	—	(54.1)
Other	13.7	—	—	—	13.7
Change in intercompany advances	157.7	(128.4)	(29.3)	—	—
Net cash provided by (used in) financing activities	656.4	(132.4)	(89.8)	—	434.2
(Decrease) increase in cash and cash equivalents	(18.6)	(0.8)	21.6	—	2.2
Cash and cash equivalents at beginning of year	60.5	2.2	1.8	—	64.5
Cash and cash equivalents at end of year	$ 41.9	$ 1.4	$ 23.4	$ —	$ 66.7
Supplemental schedule of noncash financing activities:					
Equity rollover from Encompass management	$ —	$ —	$ 64.5	$ —	$ 64.5

EXHIBIT LIST

No.	Description
2.1	Stock Purchase Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., the sellers party thereto, HealthSouth Corporation, HealthSouth Home Health Corporation, and the sellers' representative named therein (incorporated by reference to Exhibit 2.1 to HealthSouth's Annual Report on Form 10-K filed on March 2, 2015).#
2.2	Rollover Stock Agreement, dated as of November 23, 2014, by and among HealthSouth Corporation, HealthSouth Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein (incorporated by reference to Exhibit 2.2 to HealthSouth's Annual Report on Form 10-K filed on March 2, 2015).#
2.3	Acquisition Agreement, dated as of June 10, 2015, by and among HealthSouth Corporation, HealthSouth Acquisition Holdings, LLC, Reliant Holding Company, LLC, Reliant Hospital Partners, LLC, Nautic Partners VI, L.P., Nautic Partners VI-A, L.P., Reliant Blocker Corp., the additional indemnitors listed therein, and the sellers' representative named therein (incorporated by reference to Exhibit 2.1 to HealthSouth's Current Report on Form 8-K filed on June 12, 2015).#
3.1.1	Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on May 21, 1998.*
3.1.2	Certificate of Amendment to the Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on October 25, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on October 31, 2006).
3.1.3	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 HealthSouth's Current Report on Form 8-K filed on March 9, 2006).
3.2	Amended and Restated Bylaws of HealthSouth Corporation, effective as of May 7, 2015 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on May 11, 2015).
4.1	Warrant Agreement, dated as of September 30, 2009, among HealthSouth Corporation and Computershare Inc. and Computershare Trust Company, N.A., jointly and severally as warrant agent (incorporated by reference to Exhibit 4.1 to HealthSouth's Registration Statement on Form 8-A filed on October 1, 2009).
4.2.1	Indenture, dated as of December 1, 2009, between HealthSouth 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 HealthSouth'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 HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.2	First Supplemental Indenture, dated December 1, 2009, among HealthSouth 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 HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.3	Second Supplemental Indenture, dated as of October 7, 2010, among HealthSouth 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 HealthSouth's Current Report on Form 8-K filed on October 12, 2010).
4.2.4	Third Supplemental Indenture, dated October 7, 2010, among HealthSouth 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 HealthSouth's Current Report on Form 8-K filed on October 12, 2010).
4.2.5	Fourth Supplemental Indenture, dated September 11, 2012, among HealthSouth 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 HealthSouth's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on September 11, 2012).

4.2.6	Fifth Supplemental Indenture, dated as of March 12, 2015, among HealthSouth Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to HealthSouth's 5.125% Senior Notes due 2023 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on March 12, 2015).
4.2.7	Sixth Supplemental Indenture, dated as of August 7, 2015, among HealthSouth Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to HealthSouth's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.4 to HealthSouth's Current Report on Form 8-K filed on August 12, 2015).
4.2.8	Seventh Supplemental Indenture, dated as of September 16, 2015, among HealthSouth 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 HealthSouth's 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on September 21, 2015).
4.3	Indenture, dated November 18, 2013, by and between HealthSouth Corporation and Wells Fargo Bank, National Association, as trustee, relating to HealthSouth's 2.00% Convertible Senior Subordinated Notes due 2043 (incorporated by reference to Exhibit 4.1 to HealthSouth's Current Report on Form 8-K filed on November 19, 2013).
10.1.1	HealthSouth Corporation Amended and Restated 2004 Director Incentive Plan.** +
10.1.2	Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan).** +
10.2	Form of Indemnity Agreement entered into between HealthSouth Corporation and the directors of HealthSouth.* +
10.3	HealthSouth Corporation Third Amended and Restated Change in Control Benefits Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on December 8, 2014). +
10.4	Description of the HealthSouth Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, "Other Matters," in HealthSouth's Quarterly Report on Form 10-Q filed on November 4, 2009).+
10.5	Description of the HealthSouth 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 HealthSouth's Definitive Proxy Statement on Schedule 14A filed on April 5, 2016).+
10.6	Description of the annual compensation arrangement for non-employee directors of HealthSouth Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in HealthSouth's Definitive Proxy Statement on Schedule 14A, filed on April 5, 2016).+
10.7	HealthSouth Corporation Fourth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on October 29, 2013).+
10.8	HealthSouth Corporation Nonqualified 401(k) Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on July 29, 2014).+
10.9.1	HealthSouth Corporation 2005 Equity Incentive Plan (incorporated by reference to Exhibit 10 to HealthSouth's Current Report on Form 8-K, filed on November 21, 2005).+
10.9.2	Form of Non-Qualified Stock Option Agreement (2005 Equity Incentive Plan).+
10.10.1	HealthSouth Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to HealthSouth's Registration Statement on Form S-8 filed on August 2, 2011).+
10.10.2	Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan).+
10.10.3	Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan).+
10.10.4	Form of Restricted Stock Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.3 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.10.5	Form of Performance Share Unit Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.4 to

HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011 and the description in Item 5, "Other Items," in HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).+

10.10.6	Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.11	HealthSouth Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to HealthSouth's Annual Report on Form 10-K filed on February 19, 2013).+
10.12.1	HealthSouth 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).+
10.12.2	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).+
10.12.3	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).+
10.12.4	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).+
10.12.5	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).+
10.13.1	Third Amended and Restated Credit Agreement, dated August 10, 2012, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, 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 HealthSouth's Quarterly Report on Form 10-Q filed on October 26, 2012).
10.13.2	First Amendment to the Third Amended and Restated Credit Agreement, dated June 11, 2013, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, 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 HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).
10.13.3	Second Amendment and Additional Tranche Term Loan Amendment to Third Amended and Restated Credit Agreement, dated as of September 22, 2014, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, 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 HealthSouth's Current Report on Form 8-K filed on September 24, 2014).
10.13.4	Additional Tranche Term Loan Amendment to Third Amended and Restated Credit Agreement, dated as of December 23, 2014, among HealthSouth Corporation, its subsidiary guarantors, the lenders party thereto, and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on December 23, 2014).
10.13.5	Third Amendment and Additional Tranche Term Loan Amendment to Third Amended and Restated Credit Agreement, dated as of June 24, 2015, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, 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 HealthSouth's Current Report on Form 8-K filed on June 25, 2015).
10.13.6	Fourth Amendment and Additional Tranches of Term Loans Amendment to Third Amended and Restated Credit Agreement, dated as of July 29, 2015, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.2 to HealthSouth's Quarterly Report on Form 10-Q filed on October 29, 2015).
10.13.7	Amended and Restated Collateral and Guarantee Agreement, dated as of October 26, 2010, among HealthSouth Corporation, its subsidiaries identified herein, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.3 to HealthSouth's Current Report on Form 8-K/A filed on November 23, 2010).
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 HealthSouth's Annual Report on Form 10-K filed on March 2, 2015).ˆ

10.15	Stockholders' Agreement relating to HealthSouth Home Health Holdings, Inc., dated as of December 31, 2014, by and among HealthSouth Corporation, HealthSouth Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein.
10.16	Amended and Restated Senior Management Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., April Anthony, HealthSouth Corporation, and solely for purposes of Sections 6(b) and 6(j) thereof, Thoma Cressey Fund VIII, L.P. (incorporated by reference to Exhibit 10.20 to HealthSouth's Annual Report on Form 10-K filed on March 2, 2015).+
10.17	Non-Competition and Non-Solicitation Agreement, effective as of December 31, 2014, by and among April Anthony, HealthSouth Corporation, and HealthSouth Home Health Corporation.+
12.1	Computation of Ratios.
21.1	Subsidiaries of HealthSouth 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 HealthSouth Corporation Annual Report on Form 10-K for the year ended December 31, 2016, 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

Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule will be furnished supplementally to the Securities and Exchange Commission upon request.

* Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on June 27, 2005.

** Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on March 29, 2006.

\+ Management contract or compensatory plan or arrangement.

ˆ 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 10.15

Stockholders' Agreement

Relating to

HealthSouth Home Health Holdings, Inc.

by and among

HealthSouth Home Health Holdings, Inc.,

HealthSouth Corporation,

and

the Other Stockholders Named herein

Dated as of December 31, 2014

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Article V

Additional Covenants

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Miscellaneous

STOCKHOLDERS' AGREEMENT

This STOCKHOLDERS' AGREEMENT (this *"Agreement"*), dated as of December 31, 2014, which may be amended from time to time in accordance with the terms hereof, is made and entered into by and among HealthSouth Home Health Holdings, Inc., a Delaware corporation (the " *Company* "), HealthSouth Corporation, a Delaware corporation (*"HealthSouth"*), and the other stockholders of the Company listed as "Management Investors" on Schedule I attached hereto, as the same may be amended from time to time in accordance with the terms hereof (the *"Management Investors"* and together with HealthSouth, hereinafter the " *Stockholders* " and each individually, a " *Stockholder* ").

W I T N E S S E T H:

WHEREAS, as of the date hereof, HealthSouth owns all of the issued and outstanding shares of Common Stock, par value $0.01 per share, of the Company (the " *Common Stock* "); and

WHEREAS, pursuant to that certain Stock Purchase Agreement (*"SPA"*) and that certain Rollover Stock Agreement (the " *RSA* "), each dated as of November 23, 2014, the Management Investors agreed to contribute certain of their shares of Class A Common Stock, par value $0.01 per share, of EHHI Holdings, Inc. a Delaware corporation (" *EHHI* "), or Class B Common Stock, par value $.01 per share, of EHHI (collectively, the " *Contributed Stock* ") to the Company in exchange for non-voting shares of Common Stock;

WHEREAS, since the date of the SPA and RSA, the parties hereto have agreed that, notwithstanding anything to the contrary in the SPA or RSA, the Contributed Stock will be exchanged for shares of Common Stock, rather than for non-voting shares of Common Stock;

WHEREAS, as of the closing of the acquisition of EHHI by HealthSouth pursuant to the SPA, each Stockholder will own the number of shares of Common Stock set forth opposite such Stockholder's name on Schedule I hereto; and

WHEREAS, the Company and each Stockholder desires to enter into this Agreement, all in accordance with the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties, intending to be legally bound, agree as follows:

Article I

CERTAIN DEFINITIONS

For purposes of this Agreement, terms defined in the preamble and other Sections of this Agreement shall have the meanings set forth therein, and the following terms shall have the following meanings:

(a) The term “ *Action* ” means any claim, suit, litigation or action brought by or before any Governmental Authority.

(b) The term “ *Adjusted EBITDA* ” with respect to the Company shall be calculated based on the Company’s combined net income for the twelve-month period ending on the last day of the applicable calendar quarter (the “Relevant Period”), *plus* , without duplication and to the extent reflected as a charge in the statement of such net income for such Relevant Period: (1) state and federal income tax expense for the Relevant Period, *plus* (2) depreciation and amortization for the Relevant Period, *plus* (3) accrued interest expense on the HealthSouth Note and interest expense on any other indebtedness of the Company or its Subsidiaries for the Relevant Period, *plus* (4) accrued incentive equity compensation/SARs/Restricted Stock expenses for the Relevant Period, *plus* (5) gain/loss on disposal of any assets, *plus* (6) any severance costs and expenses incurred in connection with, or as a result of, (A) the transactions contemplated by the SPA or (B) the realization of cost synergies, in each case of (A) and (B), pursuant to any severance agreements entered into in connection with any terminations requested by HealthSouth or the transactions contemplated by the SPA, *plus* (7) any extraordinary charges or losses determined in accordance with GAAP. Adjusted EBITDA shall be based on results of the Company under GAAP, without allocation of any HealthSouth corporate overhead or charges for corporate services, other than those approved or permitted pursuant to Section 5.01 .

(c) The term “ *Affiliate* ” means, with respect to a given Person (in this definition, the “Relevant Person”), any other Person who (a) directly or indirectly, Controls, or is Controlled by, or is under a common Control with, the Relevant Person, (b) from time to time, is managed by (i) the same investment manager as the Relevant Person is managed by, or (ii) an investment manager that is Controlled by the same Person that Controls the Relevant Person or (c) with respect to a natural Person, is a member of the same family; provided that in no event shall a limited partner, solely in its capacity as a limited partner, of any entity be considered an “Affiliate” of such Person.

(d) The term “ *Business Day* ” means any day other than a day on which banks in the State of Delaware are authorized or obligated to be closed.

(e) The term " *Cause* " means, with respect to any Person who is an employee of the Company or any Subsidiary of the Company, (i) if such Person is a party to an employment agreement with the Company or any Subsidiary of the Company that includes a definition of "Cause," the definition of "Cause" set forth in such agreement; or (ii) if such Person is not a party to any employment agreement with the Company or any Subsidiary of the Company that includes a definition of "Cause," (1) dishonesty, fraud, or any act involving moral turpitude on such Person's part in connection with the performance of his or her duties which is materially detrimental to the Company or any of its Affiliates, (2) 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), (3) such Person's willful and repeated refusal to follow lawful directives of the board of directors (or other governing body) of the Company or the Company's Subsidiary with which such Person is employed in a manner that is materially detrimental to the Company, (4) such Person's intentional or gross neglect of the performance of his or her duties as an employee of the Company or any of its Subsidiaries, (5) if such Person is an executive officer of the Company or a Subsidiary of the Company, such Person's misappropriation of any corporate opportunity, provided such Person's pursuit or referral of an opportunity shall not be improper or misappropriation if (A) such Person first presents an opportunity to the Company and the Company does not express an interest in pursuing it within thirty (30) days or (B) the Board authorizes such Person to pursue or refer an opportunity to another Person or entity, or (6) such Person's conviction of a felony.

(f) The term " *Certificate of Incorporation* " means the Certificate of Incorporation of the Company, as the same may be amended from time to time.

(g) The terms " *Control* ," " *Controlling* " and " *Controlled* " mean the possession, direct or indirect, of the power to direct, or cause the direction of, the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise.

(h) The term " *Equity Securities* " means Common Stock or any other equity securities of the Company, including any class or series of common or preferred stock or any debt security convertible into or exercisable or exchangeable for any class or series of common or preferred stock.

(i) The term " *Exchange Act* " means the Securities Exchange Act of 1934, as amended.

(j) For purposes of Section 3.06 and Section 3.07 , the " *Fair Market Value* " of the Common Stock per share means, as of a given time, the result of (a)(i) the product of the Adjusted EBITDA of the Company for the twelve-month period ending on the last day of the most recently completed calendar quarter *multiplied by* the Market Multiple (as defined herein), *less* (ii) the outstanding balance of the HealthSouth Note as of the last day of such calendar quarter, *plus* or *minus* (iii) the amount of net debt of the Company (which shall be calculated as available cash less any indebtedness for borrowed money of the Company other than the HealthSouth Note) as of the last day of such calendar quarter, *divided by* (b) the total number of shares of Common Stock outstanding as of such time on a fully diluted basis.

As used herein, "Market Multiple" means the median of the fair value *divided by* LTM EBITDA multiples (adjusted for acquisitions) of the companies then-included on either the Public Home Health Trading Comparable List or the Home Health Transaction Comparable List, in each case as most recently publicly reported by such company (provided that, for the companies then-included on the Public Home Health Trading Comparable List, the "fair value" shall be determined based on the average daily stock price for the last two (2) weeks of the most recently completed calendar quarter); provided , however , that LTM EBITDA of any such company shall be adjusted to account for any variation from the definition of Adjusted EBITDA, to the extent that the information necessary to make any such adjustment is publicly available. As used herein, the "Public Home Health Trading Comparable List" includes those companies in the home health business and whose securities are listed for trading on a national securities exchange, including, without limitation, HealthSouth, Kindred Healthcare, Inc., Amedisys, Inc., LHC Group, Inc. and Almost Family, Inc.; provided that the Public Home Health Trading Comparable List may be revised as reasonably agreed upon by the parties hereto to include additional home health companies that become listed on a national securities exchange or to remove companies that are no longer listed on a national securities exchange. As used herein, the "Home Health Transaction Comparable List" means, at a given time, those transactions closing in the preceding twelve months (determined on a rolling basis) that meet the following criteria: (x) more than 60% of the target company's and its subsidiaries' consolidated revenue is from home health services; (y) the aggregate transaction value equals or exceeds $400 million; and (z) none of HealthSouth or any of its Affiliates is a party to the transaction. As used herein, "LTM EBITDA" means "EBITDA" (as publicly reported by a given company) over the preceding period of twelve months.

(k) The term " *GAAP* " means United States generally accepted accounting principles, as in effect from time to time, consistently applied.

(l) The term " *Good Reason* " means, with respect to any Person who is an employee of the Company or any Subsidiary of the Company, (i) if such Person is a party to an employment agreement with the Company or any Subsidiary of the Company that includes a definition of “Good Reason,” the definition of “Good Reason” set forth in such agreement; or (ii) if such Person is not a party to any employment agreement with the Company or any Subsidiary of the Company that includes a definition of “Good Reason,” (1) any material reduction in such Person’s pay or benefits or failure to provide any compensation or benefit to which such Person is entitled, other than in connection with a Company-wide reduction in pay or benefits, (2) any relocation of such Person’s primary work site by more than twenty (20) miles from both such Person’s prior primary work site and such Person’s primary residence, or (3) a material diminution of such Person’s duties, responsibilities or title; provided, that in the circumstances described in (1), (2) and (3) the Company shall have fifteen (15) days to cure the default after delivery of written notice by such Person, such written notice to state the nature of the issue and subsection of the Good Reason definition that such Person believes to be present.

(m) The term “ *Governmental Authority* ” means any government or governmental or regulatory authority or entity, whether U.S. federal, state, provincial or local or foreign, including any political subdivision thereof, and any department, court, agency or official of any of the foregoing.

(n) The term *“HealthSouth Note* means that certain promissory note, dated on or about the date hereof, issued by the Company in favor of HealthSouth, with an initial aggregate principal amount of $385,137,500, pursuant to which the Company will have borrowed from HealthSouth and HealthSouth will have lent to the Company at the closing date of the transactions contemplated by the SPA, and which amount accrues interest at the same per annum interest rate as HealthSouth’s then-existing revolving credit facility and will be repaid from time to time with excess cash of the Company; provided , that if, after the date the HealthSouth Note is issued, HealthSouth provides funds to the Company or its Subsidiaries for acquisitions, capital expenditures or other corporate purposes (including, without limitation, for losses relating to breaches of representations, warranties or covenants in the SPA relating to the acquisition of the Company contemplated thereby that are not covered by indemnification pursuant to the SPA or by insurance), such amounts will be added to the principal amount of the HealthSouth Note, and interest will accrue on such amounts from the date such funds are provided to the Company or its Subsidiaries.

(o) The term “ *Law* ” means any foreign or U.S. federal, state or local statute, law, ordinance, code, rule, regulation or requirement from a Governmental Authority, including any Governmental Order; provided, that the term “Governmental Order” means any ruling, award, decision, injunction, judgment, order or decree entered, issued or made by any Governmental Authority.

(p) The term “ *Management Note* ” means a personal promissory note issued by a Management Investor in favor of the Company, with an aggregate principal amount equal to the portion of the purchase price for the Shares being purchased by such Management Investor upon such Management Investor's exercise of its Preemptive Right pursuant to Section 4.01 , and which amount will accrue interest at the same per annum interest rate as HealthSouth's then-existing revolving credit facility and may be prepaid at any time without any prepayment premium or penalty, which Management Note (i) shall become due and payable (including all accrued interest thereon) (x) in connection with the consummation of a Transfer of the applicable Management Investor's Shares (other than to a Permitted Transferee), (y) in connection with the consummation of a Transfer following exercise of any put or call option on the applicable Management Investor's Shares pursuant to Section 3.06 or Section 3.07 or (z) at such time as (1) such Management Investor becomes an executive officer of HealthSouth, or (2) the indebtedness represented by the Management Note would violate the rules and regulations promulgated under the Exchange Act or the Listed Company Manual of the New York Stock Exchange; and (ii) at the election of such Management Investor, may be nonrecourse and secured only by the Shares acquired by such Management Investor in the applicable issuance.

(q) The term " *Permitted Transferee* " means, with respect to each Management Investor bound by the terms of this Agreement, (i) the Company; (ii) a transferee by testamentary or intestate disposition; (iii) a transferee by inter vivos transfer to the transferring Person's spouse, children and/or other lineal descendants; (iv) a trust (or limited liability company, partnership or other estate planning vehicle) for the benefit of such Management Investor and/or Members of the Immediate Family of such Management Investor; (v) any other trust (or limited liability company, partnership or other estate planning vehicle) in respect of which such Management Investor serves as trustee (or as managing member, manager, general partner or otherwise, as applicable); and (vi) a Person approved by HealthSouth; provided that, with respect to the trusts described in clauses (iv) and (v), the trust agreement governing such trust (or limited liability company agreement or partnership agreement, as applicable) must provide, for the benefit of the Company, which shall be a third party beneficiary with respect thereto, that such Management Investor, as trustee (or managing member, manager, general partner or otherwise, as applicable), must retain sole and exclusive control over the voting and disposition of such Management Investor's Shares until the termination of this Agreement. As used in this definition, "Members of the Immediate Family" means, with respect to any individual, each spouse or child or other descendants of such individual, each trust created solely for the benefit of one or more of the aforementioned Persons and their spouses and each custodian or guardian of any property of one or more of the aforementioned Persons in his or her capacity as such custodian or guardian.

(r) The term " *Person* " means any natural person or any corporation, partnership, limited liability company, other legal entity or Governmental Authority.

(s) The terms " *Securities Act* " means the Securities Act of 1933, as amended.

(t) The term " *Share Percentage* " means, with respect to any Stockholder as of the date of determination, a percentage equal to the quotient of (i) the total number of Shares held by such Stockholder on a fully-diluted basis, *divided by* (ii) the aggregate number of Shares outstanding on a fully-diluted basis.

(u) The term " *Shares"* means the shares of Common Stock owned by each Stockholder on the date hereof, as set forth opposite each Stockholder's name on Schedule I attached hereto, and all additional shares of Common Stock acquired by any Stockholder after the date of this Agreement not in contravention of the terms of this Agreement.

(v) The term " *Subsidiary* " or " *Subsidiaries* " of any Person means another Person, of which at least a majority of the securities or ownership interests having by their terms ordinary voting power to elect a majority of the board of directors or other Persons performing similar functions is owned or controlled directly or indirectly by such first Person.

(w) The term " *Transfer"* means any voluntary or involuntary sale, assignment, transfer, grant of participation in, pledge or other disposition of any Shares to any other Person, whether directly or indirectly, and "Transferred," "Transferee" and "Transferring" shall each have a correlative meaning.

ARTICLE II

REPRESENTATIONS AND WARRANTIES AND COVENANTS

Section 2.01 Representations and Warranties of the Company . The Company represents and warrants to each Stockholder as of the date of this Agreement as follows:

(a) Corporate Authority . The Company has full power and authority to execute, deliver and perform this Agreement;

(b) Due Authorization . This Agreement has been duly and validly authorized, executed and delivered by the Company and constitutes a valid and binding obligation of the Company, enforceable against the Company in accordance with its terms, except that (i) the enforceability hereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar Laws now or hereafter in effect affecting creditors' rights, and (ii) the remedy of specific performance and injunctive and other forms of equitable relief may be subject to certain equitable defenses and to the discretion of the court before which any proceedings therefor may be brought; and

(c) No Conflict. The execution, delivery and performance of this Agreement by the Company do not violate or conflict with or constitute a default under (i) the Certificate of Incorporation or the by-laws of the Company, (ii) any Law applicable to the Company, or (iii) any material agreement to which the Company is a party or by which it or its property is bound.

Section 2.02 Representations and Warranties of the Stockholders. Each Stockholder individually represents and warrants to each other Stockholder and the Company as follows as of the date of this Agreement:

(a) Authority. In the case of a Stockholder that is not an individual, such Stockholder has full corporate or other power and authority to execute, deliver and perform this Agreement. In the case of a Stockholder who is a natural person, such Stockholder has full power and authority to execute, deliver and perform this Agreement;

(b) Due Authorization. This Agreement has been duly and validly authorized, executed and delivered by such Stockholder and constitutes a valid and binding obligation of such Stockholder, enforceable against such Stockholder in accordance with its terms, except that (i) the enforceability hereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar Laws now or hereafter in effect affecting creditors' rights, and (ii) the remedy of specific performance and injunctive and other forms of equitable relief may be subject to certain equitable defenses and to the discretion of the court before which any proceedings therefor may be brought; and

(c) No Conflict. The execution, delivery and performance of this Agreement by such Stockholder do not violate or conflict with or constitute a default under (i) in the case of Stockholders that are not individuals, such Stockholder's organizational documents, (ii) any Law applicable to such Stockholder, or (iii) any material agreement to which such Stockholder is a party or by which it or its property is bound.

Section 2.03 Investment Representations and Warranties. Each Management Investor individually represents and warrants to each other Stockholder and the Company as follows as of the date of this Agreement:

(a) Such Management Investor is acquiring the Shares for such Management Investor's own account, for investment, and not with a view to the distribution thereof, nor with any present intention of distributing the same.

(b) Such Management Investor understands that the Shares acquired by such Management Investor have not been registered under the Securities Act or the securities laws of any state; and that such Shares are being issued in a transaction exempt from the registration requirements of the Securities Act and the rules and regulations thereunder; and that such Shares must be held indefinitely unless a subsequent disposition thereof is registered under the Securities Act or is exempt from registration thereunder. The Shares have not been approved or disapproved by the United States Securities and Exchange Commission, any state securities commission, or any other regulatory authority.

(c) Such Management Investor has such knowledge and experience in business and financial matters as to enable such Management Investor to understand and evaluate the risks of such investment and form an investment decision with respect thereto. Such Management Investor has relied only on its own tax advisor and legal counsel, and not on HealthSouth, the Company, or any of their respective advisors, with respect to the federal, state, local, foreign and other tax consequences arising from such Management Investor's acquisition, ownership, and disposition of Shares.

(d) Such Management Investor (i) has been advised and understands that no public market now exists for Shares and that a public market may never exist for Shares, (ii) has no need for liquidity in its investment in the Company, (iii) is able to bear the economic risk of such investment for an indefinite period and to afford a complete loss thereof, and (iv) understands all of the risks associated with the acquisition of Shares and may sustain a loss of such Management Investor's entire investment.

(e) Such Management Investor agrees that the Shares will be subject to the terms and conditions of this Agreement. The certificate representing the Shares shall bear a restrictive legend.

ARTICLE III

RESTRICTIONS ON TRANSFER

Section 3.01 General Restrictions. Except as set forth in this Article III, no Management Investor may Transfer any Shares, without the prior written approval of HealthSouth, in its sole discretion, except for Transfers pursuant to Section 3.04, Section 3.05, Section 3.06, or Section 3.07 or to any of its Permitted Transferees. Prior to any Transfer of Shares to a Permitted Transferee, the Person to whom such Shares are being Transferred shall, as a condition precedent to such Transfer, agree in writing to take such Shares subject to, and to comply with, all of the provisions of this Agreement, a copy of which agreement shall be filed with the Secretary of the Company and shall include the address of the Person to whom such Shares are being Transferred to which notices hereunder shall be sent. Each Management Investor agrees that it shall provide the Company with prior written notice of any proposed Transfer of Shares.

Section 3.02 Compliance with Securities Laws. Each Stockholder agrees that any Transfer of Shares engaged in by such Stockholder shall be required to comply with all federal, state and local securities Laws applicable to such transaction. At the request of the Company, the transferring Stockholder shall deliver to the Company an opinion of counsel, which counsel and opinion shall be reasonably satisfactory to the Company, to the effect that the Transfer satisfies this Section 3.02.

Section 3.03 Transfers Not In Compliance. A purported or attempted Transfer of Shares by a Stockholder that does not comply with the terms of this Agreement shall be void *ab initio*, and the purported transferee or successor by operation of Law shall not be deemed to be a stockholder of the Company for any purpose and shall not be entitled to any of the rights of a stockholder, including, without limitation, the right to vote the Shares or to receive a certificate for the Common Stock or any dividends or other distribution on or with respect to the Common Stock.

Section 3.04 Tag-Along Rights.

(a) If, at any time during the term of this Agreement, HealthSouth proposes to Transfer, directly or indirectly, in one transaction or a series of related transactions, more than an aggregate of ten percent (10%) of the number of Shares owned by HealthSouth on the date of the proposed Transfer (or, in the case of a series of related transactions, on the date of the first proposed Transfer) to one or more Persons, other than to Affiliates of HealthSouth, HealthSouth shall provide each other Stockholder (each, a "*Notice Recipient*") with not less than twenty (20) Business Days' prior written notice (the "*Sale Notice*") of such proposed Transfer(s), which notice shall include the material terms and conditions of such proposed Transfer(s) and which shall identify such purchaser or purchasers (the "*Tag-Along Purchaser(s)*"). Each Notice Recipient shall have the option, exercisable by written notice to HealthSouth within ten (10) Business Days after the receipt of the Sale Notice, to require HealthSouth to arrange for such Tag-Along Purchaser(s) to purchase the same percentage (the "*Percentage*") of the Shares then owned by such Notice Recipient as the ratio of (i) the total number of Shares which are to be Transferred by HealthSouth pursuant to the proposed Transfer(s) to (ii) the total number of Shares owned by HealthSouth immediately prior to such Transfer(s), or any lesser amount of Shares as such Notice Recipient shall desire, together with HealthSouth's Shares at the same time, and upon the same terms and conditions (other than any non-competition, non-solicitation and non-hire covenants), as HealthSouth sells its Shares. If a Notice Recipient shall so elect, HealthSouth agrees that it shall either (A) arrange for the proposed purchaser or purchasers to purchase all or a portion (as such Notice Recipient shall specify) of the same Percentage of the Shares then owned by such Notice Recipient at the same time, and upon the same terms and conditions (other than any non-competition, non-solicitation and non-hire covenants), as HealthSouth sells its Shares, including any indemnification or holdback; provided that, if such

Tag-Along Purchaser(s) shall elect to purchase only such aggregate number of Shares as originally agreed with HealthSouth, then the number of Shares to be sold by HealthSouth and all Notice Recipients electing to participate in the proposed Transfer shall be reduced *pro rata* to such aggregate number, or (B) not effect the proposed Transfer to such Tag-Along Purchaser(s). In the event that a Notice Recipient does not exercise its right to participate in such Transfer or declines to so participate, HealthSouth shall have one hundred eighty (180) days from the date of such Sale Notice to consummate the transaction on the terms set forth therein without being required to provide an additional Sale Notice to the other Stockholders and comply with the terms of this Section 3.04 .

(b) In furtherance and not in limitation of the foregoing, each Stockholder exercising its right to sell Shares pursuant to Section 3.04(a) hereof (each, a " *Tag-Along Stockholder* ") shall (i) make the same representations, warranties, covenants, indemnities and agreements as made by HealthSouth in connection with HealthSouth's Transfer of Shares to the Tag-Along Purchaser(s) (other than any non-competition, non-solicitation and non-hire covenants) and (ii) agree to the same terms and conditions (other than any non-competition, non-solicitation and non-hire covenants) to the Transfer as those to which HealthSouth agrees. Notwithstanding the foregoing, (x) all such representations, warranties, covenants, indemnities and agreements shall be made by HealthSouth and each Tag-Along Stockholder, severally and not jointly, and any liability for breach of any such representations and warranties related to the Company shall be allocated among HealthSouth and each Tag-Along Stockholder *pro rata* based on the relative number of Shares Transferred by each of them, and (y) no Management Investor (or any of its Permitted Transferees) will be required to be liable for more than its *pro rata* share (based on the number of Shares Transferred by such Management Investor relative to the total number of Shares Transferred by all Stockholders) of any indemnification or similar obligations (other than with respect to representations and warranties regarding ownership of its Shares) and, in any event, will not be required to be liable for any amounts in excess of the net proceeds received by such Management Investor in such Transfer(s).

Section 3.05 Drag-Along Rights .

(a) If, at any time during the term of this Agreement, HealthSouth proposes to Transfer to a Person, other than to an Affiliate of HealthSouth, by means of one transaction or a series of related transactions, including pursuant to a merger or consolidation involving the Company, Shares that constitute more than fifty percent (50%) of the number of Shares owned by HealthSouth on the date of the proposed Transfer (or, in the case of a series of related transactions, on the date of the first proposed Transfer), HealthSouth shall have the right (but not the obligation), upon not less than twenty (20) Business Days' prior written notice of such proposed sale (the " *Purchase Notice* "), which notice shall include all of the material terms and conditions of such proposed sale and which shall identify the proposed purchaser(s) of such

Shares (" *Drag-Along Purchaser(s)* "), to require each other Stockholder to sell to the Drag-Along Purchaser(s) that number of Shares (" *Call Shares* ") equal to the product, rounded down to the nearest whole number, of (a) a fraction, the numerator of which is the total number of Shares proposed to be sold by HealthSouth and the denominator of which is the total number of Shares owned by HealthSouth on the date of the proposed Transfer (or, in the case of a series of related transactions, on the date of the first proposed Transfer), multiplied by (b) the number of Shares then owned by such Stockholders. If HealthSouth shall elect to require the Stockholders to sell Shares pursuant to the foregoing in this Section 3.05(a) , HealthSouth shall arrange for such Drag-Along Purchaser(s) to purchase the Call Shares at the same time, and upon the same terms and conditions (other than any non-competition, non-solicitation and non-hire covenants), as HealthSouth sells its Shares, including any indemnification or holdback. Subject to the foregoing, upon receipt of the Purchase Notice, the Stockholders shall cooperate with HealthSouth and otherwise take, or cause to be taken, all actions and do, or cause to be done, all things reasonably necessary or appropriate to enter into, consummate and make effective the sale and purchase of the Call Shares, together with HealthSouth's Shares being so Transferred. Notwithstanding any provision hereof to the contrary, from and after the date on which HealthSouth consummates a Transfer subject to this Section 3.05 , (i) the Stockholder shall have no rights of a Stockholder with respect to the Call Shares sold and purchased in such transaction and (ii) the Stockholder shall not seek, nor shall the Company have any obligation, to enforce any such right with respect to such Call Shares.

(b) In furtherance and not in limitation of the foregoing, each Stockholder required to sell Shares pursuant to Section 3.05(a) hereof (each, a " *Drag-Along Stockholder* ") shall (i) make the same representations, warranties, covenants, indemnities and agreements as made by HealthSouth in connection with HealthSouth's Transfer of Shares to the Drag-Along Purchaser(s) (other than any non-competition, non-solicitation and non-hire covenants) and (ii) agree to the same terms and conditions (other than any non-competition, non-solicitation and non-hire covenants) to the Transfer as those to which HealthSouth agrees. Notwithstanding the foregoing, (x) all such representations, warranties, covenants, indemnities and agreements shall be made by HealthSouth and each Drag-Along Stockholder, severally and not jointly, and any liability for breach of any such representations and warranties related to the Company shall be allocated among HealthSouth and each Drag-Along Stockholder *pro rata* based on the relative number of Shares Transferred by each of them, and (y) no Management Investor (or any of its Permitted Transferees) will be required to be liable for more than its *pro rata* share (based on the number of Shares Transferred by such Management Investor relative to the total number of Shares Transferred by all Stockholders) of any indemnification or similar obligations (other than with respect to representations and warranties regarding ownership of its Shares) and, in any event, will not be required to be liable for any amounts in excess of the net proceeds received by such Management Investor in such Transfer(s).

(c) In the event that any Transfer pursuant to this Section 3.05 is structured as a merger, consolidation or similar business combination, each Drag-Along Stockholder shall (i) take all actions necessary to waive any appraisal or other similar rights with respect thereto and (ii) subject to the foregoing provisions of this Section 3.05 , take such other action as are reasonably required to effect such transaction.

(d) If any Drag-Along Stockholder fails to Transfer to the purchaser or purchasers the Call Shares to be sold pursuant to this Section 3.05 , HealthSouth may, at its option, in addition to all other remedies it may have, deposit the purchase price (including any promissory note or other securities constituting all or any portion thereof) for such Call Shares with any national bank or trust company having combined capital, surplus and undivided profits in excess of $500 million (the " *Escrow Agent* "), and thereupon, other than the right to receive the purchase price in accordance with the immediately following sentence, all of such Drag-Along Stockholder's rights in and to such Call Shares shall terminate. Thereafter, upon delivery to the Company by such Drag-Along Stockholder of appropriate documentation evidencing the Transfer of such Call Shares to the Drag-Along Purchaser(s), HealthSouth shall instruct the Escrow Agent to deliver the purchase price (without any interest from the date of the closing to the date of such delivery, any such interest to accrue to the Company) to such Drag-Along Stockholder.

(e) All costs and expenses of any transaction pursuant to this Section 3.05 that are incurred by any Drag-Along Stockholder shall be borne by such Drag-Along Stockholder; provided, that the reasonable fees and expenses of a single legal counsel representing any or all of the Management Investors in connection with such transaction shall be paid by the Company. Notwithstanding the foregoing, the Drag-Along Stockholders shall not be required to bear any costs and expenses of such transaction (including any break-up or termination fee) incurred by the HealthSouth (it being understood that such costs and expenses incurred for the benefit of the Drag-Along Stockholders and HealthSouth may be paid for by the Company or the proposed purchaser).

Section 3.06 Call Rights .

(a) At any time after December 31, 2019, HealthSouth (or any designee of HealthSouth) shall have the right (but not the obligation), upon not less than twenty (20) Business Days' prior written notice, to purchase all or any portion of the Shares owned by the Management Investors and their Permitted Transferees (or any of them) for a cash purchase price per share equal to the Fair Market Value of the Common Stock per share as of the last day of the most recent calendar quarter completed prior to the date of such notice.

(b) Within one hundred twenty (120) days following the termination of employment with the Company and all of its Subsidiaries of any Management Investor (or, in the case of (i) HCHB Consulting, Inc. (" *HCHB* ") and AGM Children's Homecare, Inc. (" *AGM* "), the termination of employment of April Anthony with the Company and all of its Subsidiaries and (ii) any Permitted Transferee, the termination of the employment with the Company and all of its Subsidiaries of the Management Investor who initially owned the Shares then owned by such Permitted Transferee), in each case other than termination of employment without Cause, for Good Reason, or upon the death or disability of such Management Investor, upon written notice to such Management Investor or his or her Permitted Transferees, HealthSouth (or any designee of HealthSouth) shall have the right (but not the obligation) to purchase all, but not less than all, of the Shares owned by such Management Investor, and his or her Permitted Transferees, for a cash purchase price per share equal to the Fair Market Value of the Common Stock per share as of the last day of the most recent calendar quarter completed prior to the date of such termination of employment. The right set forth in this Section 3.06(b) will expire and no longer be applicable with respect to the Shares held by (1) any Management Investor (other than HCHB or AGM) who remains an employee of the Company or any Subsidiary of the Company through December 31, 2017, and (2) HCHB or AGM, in the event that April Anthony remains an employee of the Company or any Subsidiary of the Company through December 31, 2017, or (3) any Permitted Transferee, in the event that the Management Investor who initially owned the Shares then owned by such Permitted Transferee remains an employee of the Company or any Subsidiary through December 31, 2017.

(c) Any transaction pursuant to this Section 3.06 shall be consummated no later than ninety (90) days following delivery of the applicable notice, and, in exchange for the cash purchase price for the Shares sold by a Management Investor (or his or her Permitted Transferee) pursuant to this Section 3.06 , such Management Investor (or his or her Permitted Transferee) shall deliver, or cause to be delivered, to the Company the stock certificates representing such Shares, together with duly executed stock powers in proper form for Transfer.

Section 3.07 Management Investors' Put Right.

(a) At any time after December 31, 2017, each Management Investor and his or her Permitted Transferees shall have the right (but not the obligation), upon not less than twenty (20) Business Days' prior written notice, to require HealthSouth (or any designee of HealthSouth) to purchase such Management Investor's (or his or her Permitted Transferees') Shares for a cash purchase price per share equal to the Fair Market Value of the Common Stock per share as of the last day of the most recent calendar quarter completed prior to the date of such notice; provided that, prior to January 1, 2019, no Management Investor (together with his or her Permitted Transferees) may require HealthSouth (or its designee) to purchase pursuant to this Section 3.07 more than one third of the Shares owned by such Management Investor (and his or her Permitted Transferees); provided, further, that, prior to January 1, 2020, no Management Investor (together with his or her Permitted Transferees) may require HealthSouth (or its designee) to purchase pursuant to this Section 3.07 more than two thirds of the Shares owned by such Management Investor (and its Permitted Transferees); and provided, further, that, from and after January 1, 2020, each Management Investor (together with his or her Permitted Transferees) may require HealthSouth (or its designee) to purchase any and all of such Management Investor's (and his or her Permitted Transferees') Shares pursuant to this Section 3.07.

(b) Any transaction pursuant to this Section 3.07 shall be consummated no later than ninety (90) days following delivery of the applicable notice, and, in exchange for the cash purchase price of the Shares sold by a Management Investor pursuant to this Section 3.07, such Management Investor shall deliver, or cause to be delivered, to the Company the stock certificates representing such Shares, together with duly executed stock powers in proper form for Transfer.

ARTICLE IV

ADDITIONAL RIGHTS

Section 4.01 Preemptive Rights.

(a) Each Stockholder shall have the right to purchase (the "*Preemptive Right*"), with respect to any issuance by the Company of Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities, a number of such additional Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities as are necessary in order for such Stockholder (together with his or her Permitted Transferees) to maintain its then current Share Percentage as of immediately prior to such issuance on a fully diluted basis; provided, however, that no Stockholder shall have a Preemptive Right with respect to the issuance by the Company of any Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities (i) to officers, employees, or consultants of the Company or any Company Subsidiary in respect of services rendered to the Company or any Company Subsidiary, (ii) pursuant to any equity incentive plan, (iii) as consideration in any merger or consolidation involving the Company or any Subsidiary of the Company or as consideration for the acquisition by the Company or any Subsidiary of the Company of the assets or capital stock of any Person that is not Affiliated with the Company, or (iv) in connection with any Share split or split of other Equity Securities, recapitalization (other than third-party sponsored recapitalizations) or other subdivision or combination of securities. Such Preemptive Right will be offered to each Stockholder (such offer, the " *Preemptive Rights Offer* ") pursuant to a written notice from the Company offering such Stockholder the Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities on the same terms and conditions as offered to the proposed purchaser(s) (such written notice, the " *Preemptive Rights Notice* "). The Preemptive Rights Notice will specify the material terms and conditions of the offering, including (A) the aggregate offering amount and offering price per Share, other Equity Security or security convertible into or exercisable for Equity Securities, (B) the identity of each proposed purchaser in the offering, and (C) the number of Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities proposed to be acquired by each proposed purchaser. Each Stockholder will have twenty (20) Business Days from the date of delivery of the Preemptive Rights Notice to notify the Company in writing of its binding acceptance of such Preemptive Rights Offer with respect to all or any portion of the Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities that are offered to such Stockholder pursuant to the Preemptive Rights Offer.

(b) In the event that any Stockholder elects to purchase Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities pursuant to a Preemptive Rights Offer, the closing of the issuance(s) related to such Preemptive Rights Offer shall be consummated concurrently with the issuance of the Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities to the proposed purchaser(s) in such offering. After consulting with the Chief Executive Officer of EHHI, each Management Investor that is not then an executive officer of HealthSouth may, unless otherwise prohibited by the rules and regulations promulgated under the Exchange Act or the Listed Company Manual of the New York Stock Exchange, exercise all or any portion of its Preemptive Right by issuing a Management Note.

(c) In the event that any Stockholder does not accept a Preemptive Rights Offer within the applicable period of twenty (20) Business Days, the Company shall have the right to issue the Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities on terms and conditions (including, without limitation, price) no less favorable to the Company than those set forth in the Preemptive Rights Notice, pursuant to a definitive agreement to be entered into no later than sixty (60) days after such date. Nothing contained herein shall preclude the Company from permitting any of the Stockholders to purchase all or a portion of the additional Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities prior to the closing referred to above, subject to the rights of the other Stockholders with respect to such additional Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities set forth in this Section 4.01 ; provided that such Stockholder(s) agree in writing to take such additional Shares, other Equity Securities or securities convertible into or exercisable for Equity Securities subject to the provisions of this Section 4.01 .

Section 4.02 Information Rights . During the term of this Agreement, for so long as a Management Investor holds Shares, the Company will provide such Management Investor with annual financial statements for each year during the term of this Agreement and quarterly financial information for each quarter during the term of this Agreement, in each case with respect to the Company and its Subsidiaries and in each case promptly following their availability following such year or quarter, as applicable.

ARTICLE V

ADDITIONAL COVENANTS

Section 5.01 Transactions with Affiliates . Except for Transfers pursuant to Section 3.04 , Section 3.05 , Section 3.06 , Section 3.07 , Section 4.01 or Section 5.02 , the Company will not enter into any transaction with any Affiliate unless such transaction is on arm's length terms that are no less favorable to the Company than would otherwise be available from an unaffiliated third party, as determined in good faith by the Chief Executive Officer of EHHI; provided , however , that such restriction shall not preclude HealthSouth from providing any service reasonably necessary to resolve any regulatory or compliance issue. For the avoidance of doubt, the restrictions in this Section 5.01 shall not apply to the cash management policies and practices of the Company and HealthSouth, to any tax-sharing agreement or other shared services agreement between the Company and HealthSouth, to HealthSouth's provision of funds to the Company or its Subsidiaries for acquisitions, capital expenditures or other corporate purposes pursuant to the terms of the HealthSouth Note, or to the repayment of the HealthSouth Note.

Section 5.02 Purchase or Contribution of HealthSouth's Home Healthcare Business . On or prior to June 30, 2015, HealthSouth may sell or contribute its existing home healthcare business to the Company in exchange for an increase in the HealthSouth Note in an amount equal to (a) such business's 2014 EBITDA (determined on a basis consistent with the calculation of "Adjusted EBITDA" of the Company for such period), without giving effect to any HealthSouth corporate overhead charges, *multiplied by* (b) a multiple to be agreed upon by

HealthSouth and the Management Investors that takes into consideration comparable acquisitions made by Wildcat during 2014 and the first six months of 2015 (and no additional consideration).

Section 5.03 Issuance of Restricted Stock . On or prior to March 31st of each of 2015, 2016, 2017, 2018 and 2019 (each, a " *RS Year* "), unless otherwise recommended by the Chief Executive Officer of EHHI and approved by the Compensation Committee of the Board of Directors of HealthSouth, HealthSouth shall issue to members of the EHHI management team (which may include one or more Management Investors) recommended by the Chief Executive Officer of EHHI and approved by the Compensation Committee of the Board of Directors of HealthSouth, aggregate annual grants of not less than $2,500,000 of restricted stock of HealthSouth (the " *Minimum Annual RS Amount* "), issued pursuant to HealthSouth's Amended and Restated 2008 Equity Incentive Plan or such other plan approved by HealthSouth's stockholders or other cash settled award of similar value, valued as of the date of grant, and on the other terms set forth in Annex B to the RSA and the revised vesting schedule set forth in Schedule II attached hereto (which shall replace the section "Performance Objectives; Continued Employment" in Annex B to the RSA in its entirety). If, in any RS Year, upon the recommendation of the Chief Executive Officer of EHHI and with the approval of the Compensation Committee of the Board of Directors of HealthSouth, any portion of the Minimum Annual RS Amount for such RS Year is waived, such waived portion of the Minimum Annual RS Amount shall be allocated to, and shall increase the Minimum Annual RS Amount for, a subsequent RS Year. For the avoidance of doubt, the parties hereto hereby agree and acknowledge that the Management Investors may enforce this Section 5.03 .

ARTICLE VI

MISCELLANEOUS

Section 6.01 Specific Performance . Each of the parties hereto acknowledges and agrees that the other parties would be damaged immediately, extensively, and irreparably and no adequate remedy at law would exist in the event that any of the provisions of this Agreement were not performed in accordance with their specific terms or were otherwise breached or violated. Accordingly, in addition to, and not in limitation of, any other remedy available to any party, the parties agree that, without posting bond or similar undertaking, each of the other parties shall be entitled to an injunction or injunctions to prevent breaches or violations of the provisions of this Agreement and to the remedy of specific performance of this Agreement and the terms and provisions hereof. Subject to Section 6.09 , such remedies, and any and all other remedies provided for in this Agreement, will, however, be cumulative in nature and not exclusive and will be in addition to any other remedies to which such party may be entitled. Each party further agrees that, in the event of any action for injunctive relief or for specific performance in respect of any breach or violation, or threatened breach or violation, of this

Agreement, it shall not assert the defense that a remedy at law would be adequate or that specific performance or injunctive relief in respect of such breach or violation should not be available on any other grounds.

Section 6.02 Entire Agreement . This Agreement constitutes the entire agreement and understanding of the parties hereto in respect of the subject matter contained herein, and there are no restrictions, promises, representations, warranties, covenants, conditions or undertakings with respect to the subject matter hereof, other than those expressly set forth or referred to herein. This Agreement supersedes all prior agreements and understandings between the parties hereto with respect to the subject matter hereof.

Section 6.03 Further Assurances . The Company and each of the Stockholders agree that, upon the request of any of the others from time to time after the date of this Agreement, and at the expense of the requesting party but without further consideration, such party shall sign such documents and take such actions as may be necessary or otherwise reasonably requested to effect, or make more fully effective, the terms and provisions of this Agreement.

Section 6.04 Notices . All notices, requests, demands, claims and other communications required or permitted hereunder will be in writing and will be sent by personal delivery, nationally recognized overnight courier or facsimile or, provided that one of the foregoing methods of delivery is also used, by e-mail (as a PDF). Any notice, request, demand, claim, or other communication required or permitted hereunder will be deemed duly given, as applicable, (a) upon personal delivery, (b) one (1) Business Day following the date sent when sent by courier delivery or (c) upon confirmation of receipt when sent by facsimile or e-mail (as a PDF), addressed as follows:

If to the Company or HealthSouth Corporation, to:

HealthSouth Home Health Corporation
c/o: HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
Telephone number: (205) 967-7116
Facsimile number: (205) 262-3948
Attention: Douglas E. Coltharp
John P. Whittington

with a copy (which will not constitute notice) to:

Skadden, Arps, Slate, Meagher & Flom LLP
920 North King Street
Wilmington, Delaware 19801
Telephone number: (302) 651-3000
Facsimile number: (302) 434-3090
Attention: Robert B. Pincus

If to a Holder, at the address set forth under such Holder's name on Schedule I or to such other address as the party to whom notice is to be given may have furnished to the other parties in writing in accordance herewith.

Any party may change the address to which notices, requests, demands, claims, and other communications required or permitted hereunder are to be delivered by providing to the other parties notice in the manner herein set forth.

Section 6.05 Applicable Law. This Agreement, and all claims arising in whole or in part out of, related to, based upon, or in connection herewith or the subject matter hereof or the transactions contemplated hereby will be governed by, construed and enforced in accordance with the laws of the State of Delaware, without giving effect to any choice or conflict of law provision or rule that would cause the application of the laws of any other jurisdiction.

Section 6.06 Severability. The invalidity, illegality or unenforceability of one or more of the provisions of this Agreement in any jurisdiction shall not affect the validity, legality or enforceability of the remainder of this Agreement in such jurisdiction or the validity, legality or enforceability of this Agreement, including any such provision, in any other jurisdiction, it being intended that all rights and obligations of the parties hereunder shall be enforceable to the fullest extent permitted by Law.

Section 6.07 Successors; Assigns. The provisions of this Agreement shall be binding upon the parties hereto and their respective heirs, successors and permitted assigns. Neither this Agreement nor the rights or obligations of any Stockholder hereunder may be assigned, except in connection with the Transfer by a Stockholder of shares of Common Stock to a Permitted Transferee. Any such attempted assignment in contravention of this Agreement shall be void and of no effect.

Section 6.08 Termination; Amendments. This Agreement shall remain in full force and effect until the sooner of (a) termination of this Agreement pursuant to the mutual written agreement of each of the parties hereto; (b) with respect to any Stockholder Transferring all or part of its Shares in accordance with the terms of this Agreement, the date upon which such Stockholder ceases to own any Common Stock in the Company, or (c) the dissolution of the Company as approved by the Stockholders or otherwise in accordance with the terms of this Agreement. Except as otherwise provided for, this Agreement may be amended, and the observance of any term of this Agreement may be waived, with (and only with) the written consent of the holders of (i) a majority of the outstanding Common Stock held by all Stockholders and (ii) a majority of the outstanding Shares held by the Management Investors (and their Permitted Transferees, other than those Permitted Transferees who fall within clause (vi) of the definition thereof); provided that any such change shall become effective only when reduced to writing and signed by such holders of Common Stock and such Management Investors (or their Permitted Transferees).

Section 6.09 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Delaware, without regard to the choice of law or conflicts of law provisions thereof. The parties hereto agree that any action, suit, or proceeding at law, in equity or otherwise which in any way arises out of or relates to this Agreement or the transactions contemplated hereby shall be brought solely in the Delaware Court of Chancery, unless the Delaware Court of Chancery lacks jurisdiction, in which case any such claim shall be brought in such state or federal court of competent jurisdiction located in New Castle County, Delaware, and all objections to personal jurisdiction and venue in any action, suit or proceeding so commenced are hereby expressly waived by all parties hereto. The parties waive personal service of any and all process on each of them and consent that all such service of process shall be made in the manner, to the party and at the address set forth in Schedule I of this Agreement, and service so made shall be complete as stated in such section.

Section 6.10 Waiver. Any waiver (express or implied) of any default or breach of this Agreement shall not constitute a waiver of any other or subsequent default or breach.

Section 6.11 Parties in Interest. This Agreement shall be binding upon and inure solely to the benefit of each party hereto and its respective successors and permitted assigns, and no provision of this Agreement, express or implied, is intended to or shall confer upon any other person any right, benefit or remedy of any nature whatsoever under or by reason of this Agreement.

Section 6.12 Headings. The headings in this Agreement are for convenience of reference only and shall not control or affect the meaning or construction of any provisions hereof.

Section 6.13 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same Agreement.

[SIGNATURE PAGES FOLLOW]

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

HEALTHSOUTH HOME HEALTH HOLDINGS, INC.

By: John P. Whittington
Name: John P. Whittington
Title: Vice President and Secretary

HEALTHSOUTH CORPORATION

By: Douglas E. Coltharp
Name: Douglas E. Coltharp
Title: Executive Vice President
and Chief Financial Officer

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Judee Barrett

Judee Barrett

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

AGM CHILDREN'S HOMECARE, INC.

By: April Anthony
Name: April Anthony
Title: President

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

HCHB CONSULTING, INC.

By: April Anthony
Name: April Anthony
Title: President

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Andrew Ingram

Andrew Ingram

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Jesse Luke James
Jesse Luke James

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Tracey Kruse
Tracey Kruse

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Robert D. Peoples
Robert D. Peoples

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: Jennifer L. Polak
Jennifer L. Polak

IN WITNESS WHEREOF, the undersigned hereby agree to be bound by the terms and provisions of this Stockholders' Agreement as of the date first above written.

MANAGEMENT INVESTOR:

By: G. Robert Thompson
G. Robert Thompson

SCHEDULE I

STOCKHOLDERS

Name, Address, Fax No. and Email	Number of Shares
HealthSouth Corporation	
HealthSouth Corporation 3660 Grandview Parkway, Suite 200 Birmingham, Alabama 35243 Facsimile: (205) 262-3948 Attn: Douglas E. Coltharp John P. Whittington	3,208,684
Management Investors:	
HCHB Consulting, Inc. 3606 Princeton Ave. Dallas, Texas 75205	495,979
AGM Children's Homecare, Inc. 3606 Princeton Ave. Dallas, Texas 75205	31,362
G. Robert Thompson 5737 Meadowhaven Dr. Plano, Texas 75093	23,054
Tracey Kruse 9633 Fieldcrest Dallas, Texas 75238	30,863
Jennifer L. Polak 6655 Lakewood Blvd. Dallas, Texas 75214	5,952
Robert D. Peoples 1517 Cottonwood Valley Circle South Irving, Texas 75038	20,289
Jesse Luke James 3405 Centenary Ave. Dallas, Texas 75225	18,246
Andrew Ingram 1127 Longford Circle Southlake, Texas 76092	12,118
Judee Barrett 3825 Colgate Dallas, Texas 75225	6,701
TOTAL	3,853,248

SCHEDULE II

Restricted Stock: Vesting Schedule

Performance Objectives; Continued Employment:	The shares of Restricted Stock will be subject to achievement of the target EBITDA for the year of grant, in each case as such target EBITDA is determined by the Compensation Committee of HealthSouth's Board of Directors after consultation with the Chief Executive Officer of EHHI, as set forth below: Fifty (50%) percent of the Restricted Stock that meet the performance achievement will vest at the end of the second year following grant or, if earlier, upon the consummation of a Change of Control, and the balance of such Restricted Stock that meet the performance achievement will vest at the end of the third year following grant or, if earlier, upon the consummation of a Change of Control. Vested shares of HealthSouth common stock will be freely transferable by the recipients.

Exhibit 10.16

AMENDED AND RESTATED

SENIOR MANAGEMENT AGREEMENT

THIS AMENDED AND RESTATED SENIOR MANAGEMENT AGREEMENT (“ Agreement ”) made and entered into as of November 23, 2014, by and among EHHI Holdings, Inc., a Delaware corporation (the “ Company ”), April Anthony (“ Executive ”), HealthSouth Corporation, a Delaware corporation (“ HLS ”), and, solely for purposes of Sections 6(b) and 6(j) hereof, Thoma Cressey Fund VIII, L.P. (“ TCF ” and, together with Executive, the Company and HLS, the “ Parties ”), amends and restates the Amended and Restated Senior Management Agreement, dated as of August 3, 2007, by and among the Company, Executive, HCHB Consulting, Inc., AGM Children’s Homecare, Inc. and certain individuals identified as Holders therein (the “ Existing Employment Agreement ”).

RECITALS:

WHEREAS, Executive is presently employed by the Company pursuant to the Existing Employment Agreement;

WHEREAS, as of the date hereof, the Company is entering into a Stock Purchase Agreement (the “ Stock Purchase Agreement ”) by and among HLS, the additional Sellers party thereto and the Sellers’ Representative named therein pursuant to which, as of the Closing Date as defined therein (such date for purposes of this Agreement, the “ Effective Date ”), a subsidiary of HLS will acquire certain common stock of the Company;

WHEREAS, in connection with the transactions contemplated by the Stock Purchase Agreement, HLS will form HealthSouth Home Health Holdings, Inc., a Delaware corporation (“ HHHH ”);

WHEREAS, pursuant to Section 12(i) of the Existing Employment Agreement, TCF is to be a party to any amendment or waiver under the Existing Employment Agreement (subject to limitations not relevant here), is joining this Agreement solely for purposes of giving its consent to the contemplated supersession of the Existing Employment Agreement in accordance with Section 6(j) hereof, and following such supersession on the Effective Date, will have no further obligations hereunder;

WHEREAS, Executive desires to continue her employment with the Company, and the Company desires to continue to employ the Executive, pursuant to the terms of this Agreement; and

WHEREAS, the Parties intend that this Agreement shall become effective as of the Effective Date, that as of the Effective Date the Existing Employment Agreement shall cease to be of any force or effect, and that if the Stock Purchase Agreement is terminated before the Effective Date, this Agreement shall be without any force or effect and void ab initio.

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 of 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 such other powers and perform such other duties as may from time to time reasonably be prescribed by the Chief Executive Officer of HLS (the " HLSCEO ") 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. Executive's authority shall be subject to the power of the HLSCEO to expand such duties, responsibilities and authority and to override actions of Executive.

(b) Reporting and Devotion to Duties . Executive shall report to the HLSCEO, 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, that such service does not materially interfere with the provision of Executive's duties and responsibilities to Homecare Homebase, LLC (" Homecare Homebase "). The Company explicitly acknowledges that Executive (i) may continue to serve as the Chief Executive Officer of Homecare Homebase in a manner consistent with Executive's past practices, or (ii) may serve as Executive Chairperson of Homecare Homebase in a capacity that does not, in the aggregate, exceed the time commitment in effect for Executive in her role as the Chief Executive Officer of Homecare Homebase immediately prior to the Effective Date; provided, however, in the case of clauses (i) and (ii), that such service does not materially interfere with the provision of Executive's duties and responsibilities to the Company and its Subsidiaries. Notwithstanding the foregoing, the Company further acknowledges that Executive may serve as a director of Great Lakes Caring LLC, on the board of directors of the Encompass Cares Foundation, and on the board of trustees of Abilene Christian University. For the avoidance of doubt, the Parties agree that (y) the provision of Executive's duties and responsibilities to the Company and its Subsidiaries immediately prior to the Effective Date is deemed not to materially interfere with the provision of Executive's duties and responsibilities to Homecare Homebase and (z) the provision of Executive's duties and responsibilities to Homecare Homebase immediately prior to the Effective Date is deemed not to materially interfere with the provision of Executive's duties and responsibilities to the Company and its Subsidiaries.

(c) Compensation .

(i) Commencing upon the Effective Date and, thereafter, during the Employment Period, Executive's base salary shall be $347,000 per annum or such higher rate as the Board of Directors of HLS or applicable committee thereof (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 ") of up to 50% of her Base Salary based upon the Company's achievement of its annual budget targets to be set by the Board within sixty (60) days of the start of the fiscal year for which such targets will apply. 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) As of the Effective Date, HLS shall cause HHHH to grant to Executive stock appreciation rights in respect of HHHH common stock on the terms and subject to the conditions set forth in Annex B to the Rollover Stock Agreement, dated as of the date hereof, and, each year during the Employment Period through the year ending December 31, 2019, Executive shall be entitled to participate in the HLS Amended and Restated 2008 Equity Incentive Plan (or any successor thereto (the " HLS EIP ")) and receive restricted stock in respect of the common stock of HLS on the terms and subject to the conditions set forth in Annex B to the Rollover Stock Agreement (collectively, the " Equity Grants "). For the avoidance of doubt, nothing in this Section 1(c)(iii) shall prevent HLS from granting (or causing HHHH to grant) Executive such additional equity awards as it may determine from time to time during the Employment Period.

(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 Company policy;

(ii) reimbursement for reasonable business expenses incurred by Executive on the Company's behalf and within the Company'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). Such reimbursements will be made within 90 days from the date the expenses are incurred;

(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 Company policies;

(iv) participation in all retirement plans available to the Company's senior executives; and

(v) any other benefits and perquisites made available to any member of the Company's senior management team.

(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 thirty (30) days prior to termination by the Company without Cause and written notice to the Board shall be required thirty (30) days prior to termination by Executive without Good Reason. The Parties' rights and duties in the event of a termination of employment 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, in lieu of any other payments or benefits hereunder:

(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 the 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 the Executive materially breaches her obligations under Sections 2 or 3 of this Agreement during the period in which the Executive is entitled to such benefits, the Executive no longer shall be entitled to receive such benefits and the Company will have no further obligation to provide such benefits to the Executive. In any event, the Company will reimburse the 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) the Executive terminates her employment without Good Reason, the Company will, in lieu of any other payments or benefits hereunder, pay the 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 the Executive terminates or the Company terminates Executive's employment because of the 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, in lieu of any other payments or benefits hereunder, continue to pay the 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 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 the Employment Period) 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 Period), 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, 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, all of 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. Any copyrightable work 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 work 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 work. Executive shall promptly disclose such Work Product and copyrightable work 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, the Company's and its Affiliates' trade secrets and with other Confidential Information. Executive acknowledges that her services shall be of special, unique and extraordinary value to the Company and its Affiliates and that the Company's ability to accomplish its purposes and to successfully pursue its business plan and compete in the marketplace depends substantially on the skills and expertise of the Executive. Therefore, and in further consideration of the compensation being paid to the Executive hereunder, she agrees that, during the Noncompete Period (as defined below), she shall not directly or indirectly engage or become interested in, whether as an owner, general partner, member, officer, employee, consultant, director, stockholder or otherwise (other than passive ownership of less than five percent (5%) of any class of securities of an entity, but without otherwise participating in the activities of such entity, whose securities are listed on a national or regional securities exchange or stock market and have been registered under Section 12(g) of the Securities Exchange Act of 1934, as amended), 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, are offered or being developed by the Company or any of its Subsidiaries, joint ventures or partnerships, including, without limitation, if applicable, any business directly or indirectly engaged in the business of operating or managing a home health practice or the acquisition of companies so engaged. The " Noncompete Period " shall mean the Employment Period and the period beginning on the Date of Termination and ending upon the second anniversary of the Date of Termination. " Restricted Territory " shall mean any state or territory of the United States in which the Company or its Subsidiaries are located or operate, or is in the process of actively planning to conduct or conducting operations, as of the Date of Termination of the Employment Period; provided the foregoing shall not preclude or limit the Executive's activities relating to Homecare Homebase so long as such activities do not entail the operation of home health agencies in the Restricted Area, or any activities approved by written consent of the Board. 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 Employment Period 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 Affiliates) 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 the Executive's activities relating to Homecare Homebase so long as such activities do not entail the operation of home health agencies in the Restricted Area, or any activities approved by written consent of the Board.

(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, the Company or its 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); provided , however , that for the purposes of this Agreement Homecare Homebase shall not be deemed an Affiliate of Executive, the Company, or any of its Affiliates.

" Cause " shall mean (i) dishonesty, fraud, or any act involving moral turpitude on the 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) the Executive's willful and repeated refusal to follow lawful directives of the Board in a manner that is materially detrimental to the Company, (iv) the Executive's intentional or gross neglect of the performance of her duties as Chief Executive Officer of the Company, (v) the Executive's misappropriation of any corporate opportunity, provided the Executive's pursuit or referral of an opportunity shall not be improper or misappropriation if (A) the Executive first presents an opportunity to the Company and the Company does not express an interest in pursuing it within thirty (30) days or (B) the Board authorizes the Executive to pursue or refer an opportunity to another Person or entity, (vi) the Executive's conviction of a felony, (vii) a material breach by the Executive of this Agreement, including but not limited to Sections 2 and 3; provided , Cause shall not exist unless and until (1) the 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), the Executive shall have fifteen (15) days to cure the alleged default after written notice by the Board, (3) the 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 the Company or its 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, the Company’s and its 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 the 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 the Executive participates.

“ Executive ” means April Anthony.

“ Good Reason ” shall mean (i) any material reduction in the Executive’s pay or benefits or failure to provide any compensation or benefit to which the Executive is entitled other than in connection with a Company-wide reduction in pay or benefits, or any reduction in Base Salary below $247,000, 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 the 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 the Executive, such written notice to state the nature of the issue and subsection of the Good Reason definition that the 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 the 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 :

EHHI Holdings, Inc.
6688 North Central Expressway
Suite 1300
Dallas, TX 75206
Attention: Secretary

With copies (which shall not constitute notice) to :

HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
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.

(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 HLS 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 and the exhibits hereto 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 the Executive 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. The Executive 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) Amendment and Waiver . The provisions of this Agreement may be amended only with the prior written consent of the Company, HLS and Executive, and any provision of this Agreement may be waived only by the Party waiving compliance.

(h) 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.

(i) Indemnification and Reimbursement of Payments on Behalf of Executive . 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 the Executive any federal, state, local or foreign withholding taxes, excise taxes, or employment taxes (" Taxes ") imposed on Executive with respect to the Executive's compensation or other payments from the Company or any of its Affiliates or the Executive's ownership interest in HHHH or HLS, 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. Executive shall be solely responsible for all other taxes, if any, associated with the amounts payable under this Agreement.

(j) Effectiveness of Agreement and Replacement of Prior Agreements . Upon the Closing as such term is defined in the Stock Purchase Agreement, (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. In the event that the Stock Purchase Agreement is terminated before the Effective Date, this Agreement shall be simultaneously and automatically terminated, void ab initio and of no further force or effect, and the Existing Employment Agreement thereupon shall continue in effect in accordance with its terms.

(k) 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.

(l) Generally Accepted Accounting Principles; Adjustments of Numbers . Where any accounting determination or calculation is required to be made under this Agreement or the exhibits hereto, 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.

(m) Reformation; Specified Employee . The Executive 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 the Executive's termination of employment, the 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 the Executive may become entitled under this Agreement as a result of the 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 the Executive shall be paid an aggregate amount equal to six months of payments otherwise due to the 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 the Executive or the Company reasonably believes that Section 409A of the Code will result in adverse tax consequences to the Executive as a result of this Agreement, then the 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 the Executive to the extent reasonably possible.

(n) 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.

(o) 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.

(p) 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 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 the Company and its 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 the Company and its Affiliates, and that money damages would be an inadequate remedy for any such nonperformance or breach. Accordingly, the Executive 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, the Company and its Affiliates agree to submit to the personal jurisdiction of the courts of the State of Texas in any action by 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.

THE COMPANY: EHHI HOLDINGS, INC.

By: /s/ April Anthony
Name: April Anthony
Title:

THE EXECUTIVE: By: /s/ April Anthony
Name: April Anthony

AGREED AND ACCEPTED:

HEALTHSOUTH CORPORATION

By: /s/ Douglas E. Coltharp
Name: Douglas E. Coltharp
Title: Executive Vice President and
Chief Financial Officer

THOMA CRESSEY FUND VIII, L.P. (for purposes of Sections 6(b) and 6(j) hereof only)

By: TC Partners VIII, L.P.
Its: General Partner

By: Thoma Cressey Bravo, Inc.
Its: General Partner

By: /s/ Bryan Cressey
Name: Bryan Cressey
Title:

NON-COMPETITION AND NON-SOLICITATION AGREEMENT

THIS NON-COMPETITION AND NON-SOLICITATION AGREEMENT (the " Agreement ") is made and entered into by and between April Anthony (the " Seller "), on the one hand, and HealthSouth Corporation, a Delaware corporation (the " Parent ") and HealthSouth Home Health Corporation, a Delaware corporation, (the " Buyer "), on the other, effective as of the Closing Date, as defined in the Stock Purchase Agreement dated as of November 23, 2014 by and among the Sellers' Representative (on behalf of the Seller), the Parent, the Buyer, EHHI Holdings, Inc., a Delaware corporation (the " Company ") and the other parties thereto (the " Purchase Agreement "). Capitalized terms not defined herein shall have the respective meanings ascribed to them in the Purchase Agreement.

WHEREAS, pursuant to the Purchase Agreement, certain Shareholders, including the Seller, wish to contribute certain of their Shares to HealthSouth Home Health Holdings, Inc., a Delaware corporation and a newly formed wholly owned subsidiary of the Parent (" HHHH "), in exchange for shares of common stock or other equity securities of HHHH of equal value pursuant to a Rollover Stock Agreement (the " Rollover ");

WHEREAS, immediately following the Rollover, the Shareholders, including the Seller, desire to sell and transfer to the Buyer (a subsidiary of HHHH) all of the Shares not contributed in the Rollover pursuant to the terms and conditions of the Purchase Agreement;

WHEREAS, in order to assure that the Buyer receives and retains the full value of the business rights in the Acquired Companies acquired pursuant to the Purchase Agreement, the parties desire to set forth in this Agreement certain agreed-upon restrictions on the Seller's activities; and

WHEREAS, the Seller's agreement to the restrictions on the Seller's post-Closing activities contained herein is a material condition of the Buyer's willingness to enter into the Purchase Agreement and the Rollover Stock Agreement and to consummate the Contemplated Transactions.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual promises, terms, provisions and conditions set forth in this Agreement, the parties hereby agree as follows:

1. Non-Competition . The Seller agrees that, for a period of five (5) years after the Closing (the " Restriction Period "), the Seller shall not, directly or indirectly, and shall not permit any of the Seller's controlled Affiliates to, directly or indirectly, either for the Seller or any other Person, engage in, own, operate, manage, control, invest in or participate in any manner, act as a consultant or advisor to, render services for (alone or in association with any Person), or otherwise assist in any manner any Person that engages in or owns, operates, manages, controls, invests in or participates in, the business of (i) providing home healthcare or hospice services

(the " Restricted Services ") or (ii) acquiring companies which provide the Restricted Services (the business of (i) or (ii), a " Competing Business ") anywhere in the United States (the " Restricted Area "); provided that ownership of five percent (5%) or less of any class of securities of a company whose securities are registered under the Securities Exchange Act of 1934, as amended, and listed on any national security exchange shall not be deemed, by itself, to constitute engagement in, ownership, operation, management, control, investment in or participation in a Competing Business. Notwithstanding the foregoing, in the event that the Seller's employment with the Company is terminated without Cause or for Good Reason (as such terms are defined in the Amended and Restated Senior Management Agreement by and among the Seller, the Company and the other parties thereto, dated as of the date hereof), then (x) the Restricted Services shall include only those home healthcare or hospice services that are provided by the Acquired Companies as of the date of such Seller's termination of employment and (y) the Restricted Area shall be reduced to include only those geographic areas where the Acquired Companies conduct the Competing Business as of the date of such Seller's termination of employment. For the avoidance of doubt, nothing in this Agreement shall prevent the Seller from (a) fulfilling the Seller's obligations under the Memorandum of Agreement by and between Homecare Homebase, LLC (" HCHB ") and the Seller dated November 25, 2013 or (b) otherwise performing her duties and responsibilities for HCHB, consistent with the nature and scope of such duties and responsibilities immediately prior to the Closing Date.

2. Non-Solicitation . The Seller agrees that, during the Restriction Period, the Seller shall not, and shall not permit any of the Seller's controlled Affiliates to, directly or indirectly, engage, recruit or solicit for employment or engagement, offer employment to, hire, or enter into any independent contractor relationship with, or otherwise seek to influence any relationship with, without the prior written consent of the Buyer, any employee of any Acquired Company as of the Closing Date; provided , however , that the foregoing restriction shall not prohibit (i) any public advertisement or posting or other form of general solicitation that is not directed at any or all of such employees and/or hiring any such individuals who respond to such general solicitations, (ii) any solicitation, engagement, employment or hiring of, or offer to, any Person who, at the time of such solicitation, engagement, employment, hiring or offer has involuntarily had his or her employment terminated by the Company or any of its Subsidiaries, or (iii) any solicitation, engagement, employment or hiring of, or offer to, any Person whose employment with the Company or any of its Subsidiaries terminated for any reason at least six (6) months prior to engaging in any such discussions. The Seller agrees that, during the Restriction Period, the Seller shall not, and shall not permit any of the Seller's controlled Affiliates to, directly or indirectly, without the prior written consent of the Buyer (A) induce any Person which is a customer of any of the Company or its Subsidiaries as of the Closing Date to patronize any Competing Business or (B) request or advise any Person who is a customer or vendor of the Company or any of its Subsidiaries as of the Closing Date to reduce, curtail or cancel any such customer's or vendor's business with the Company or any of its Subsidiaries which is a Subsidiary as of the Closing Date.

3. Confidentiality . During the Restriction Period, the Seller shall, and shall cause each of the Seller's controlled Affiliates and Representatives, to, keep secret and retain in strictest confidence, and shall not, and shall not allow any controlled Affiliate or Representative

to, without the prior written consent of the Buyer, furnish, make available or disclose to any third party, any information relating to the business or affairs of the Company or any of its Subsidiaries, including information relating to financial statements, client or customer identities, potential clients or customers, employees, suppliers, servicing methods, equipment, programs, strategies and information, analyses, profit margins or other proprietary information (collectively, " Confidential Information "), other than any such Confidential Information which is in the public domain or becomes generally known in the public domain through no wrongful act on the part of the Seller, or any of the Seller's respective controlled Affiliates or Representatives. Notwithstanding the foregoing restrictions of this Section 3 , in the event that the Seller, or any of the Seller's controlled Affiliates or Representatives, is requested or required by applicable Legal Requirements, regulation, stock exchange rule or legal process (including pursuant to written or oral question or request for information or documents in any legal proceeding, interrogatory, subpoena or civil investigative demand) to disclose any Confidential Information, the Seller (if and to the extent permitted by applicable Legal Requirements) shall notify the Buyer promptly of the request or requirement so that the Buyer may seek (at its sole cost) an appropriate protective order or waive compliance with the provisions of this Section 3 . In the absence of a protective order or the receipt of a waiver hereunder, such Person may disclose the Confidential Information as so requested or required; provided , however , that such Person shall reasonably cooperate with the Buyer if the Buyer seeks to obtain (at the Buyer's sole cost) an order or other assurance that confidential treatment will be accorded to such portion of the Confidential Information required to be disclosed as the Buyer shall designate.

4. Enforcement of Covenants . The Seller acknowledges that the periods of restriction, the geographical areas of restriction and the restraints imposed by the provisions of Section 1 , Section 2 and Section 3 are fair and reasonably required for the protection of the Buyer. If in the final judgment of a court of competent jurisdiction, any term or provision of Section 1 , Section 2 or Section 3 is invalid or unenforceable, the parties agree that the court making the determination of invalidity or unenforceability shall have the power to reduce the scope, duration or area of the term or provision, to delete specific words or phrases or to replace any invalid or unenforceable term or provision with a term or provision that is valid and enforceable and that comes closest to expressing the intention of the invalid or unenforceable term or provision, and this Agreement shall be enforceable against the parties as so modified. The Seller agrees and acknowledges that money damages would not be an adequate remedy for breach of the provisions of Section 1 , Section 2 and Section 3 .

5. Assignment . Neither the Buyer nor the Seller may make any assignment of this Agreement or any interest herein, by operation of law or otherwise, without the prior written consent of the other. This Agreement shall inure to the benefit of and be binding upon the Buyer and the Seller, their respective successors, executors, administrators, heirs and permitted assigns.

6. Severability . If any portion or provision of this Agreement shall to any extent be declared illegal or unenforceable by a court of competent jurisdiction, then the remainder of this Agreement, or the application of such portion or provision in circumstances other than those as to which it is so declared illegal or unenforceable, shall not be affected thereby, and each portion and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

7. Waiver . No waiver of any provision hereof shall be effective unless made in writing and signed by the waiving party. The failure of either party to require the performance of any term or obligation of this Agreement, or the waiver by either party of any breach of this Agreement, shall not prevent any subsequent enforcement of such term or obligation or be deemed a waiver of any subsequent breach.

8. Notices . All notices, requests, demands, claims and other communications required or permitted to be delivered, given or otherwise provided under this Agreement must be delivered in accordance with Section 11.1 of the Purchase Agreement.

Notices to the Seller shall be sent to:

April Anthony
3606 Princeton Avenue
Dallas, Texas 75205

Notices to the Buyer shall be sent to: HealthSouth Home Health Corporation

c/o HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
Facsimile number: (205) 262-3948
Attention: Douglas E. Coltharp and John P. Whittington

9. Amendment . This Agreement may be amended or modified only by a written instrument signed by the Seller and by an expressly authorized representative of the Buyer.

10. Headings . The headings and captions in this Agreement are for convenience only, and in no way define or describe the scope or content of any provision of this Agreement.

11. Counterparts . This Agreement may be executed in two or more counterparts, each of which shall be an original and all of which together shall constitute one and the same instrument.

12. Governing Law . This Agreement, and all claims arising in whole or in part out of, related to, based upon, or in connection herewith or the subject matter hereof will be governed by, construed and enforced in accordance with the laws of the State of Delaware, without giving effect to any choice or conflict of law provision or rule that would cause the application of the laws of any other jurisdiction.

13. Jurisdiction . Each party to this Agreement, by its execution hereof, hereby irrevocably (a) submits to the exclusive jurisdiction of the Delaware Court of Chancery (or if, but only if, the Delaware Court of Chancery declines to accept jurisdiction, the Superior Court of the State of Delaware or the United States District Court for the District of Delaware) for the purpose of any and all Actions arising in whole or in part out of, related to, based upon or in connection with this Agreement or the subject matter hereof, (b) waives to the extent not

prohibited by applicable law, and agrees not to assert, by way of motion, as a defense or otherwise, in any such Action, any claim that it is not subject personally to the jurisdiction of the above-named courts, that its property is exempt or immune from attachment or execution, that any such action brought in one of the above-named courts should be dismissed on grounds of improper venue or *forum non conveniens* , should be transferred to any court other than one of the above-named courts, or should be stayed by reason of the pendency of some other proceeding in any other court other than one of the above-named courts, or that this Agreement or any claims arising in whole or in part out of, related to, based upon, or in connection herewith or the subject matter hereof may not be enforced in or by such court, (c) agrees not to commence any such Action other than before one of the above-named courts nor to make any motion or take any other action seeking or intending to cause the transfer or removal of any such action to any court other than one of the above-named courts (subject in each case to clause (a) of this sentence) whether on the grounds of inconvenient forum or otherwise, (d) consents to service of process in any such Action in any manner permitted by the laws of the State of Delaware, (e) agrees that service of process made in accordance with clause (d) or made pursuant to Section 8 of this Agreement will constitute good and valid service of process in any such Action, and (f) waives and agrees not to assert (by way of motion, as a defense, or otherwise) in any such Action any claim that service of process made in accordance with clause (d) or clause (e) does not constitute good and valid service of process. Notwithstanding the immediately preceding sentence, a party may commence an Action in any other court to enforce an order or judgment issued by one of the courts described in the immediately preceding sentence.

[Signature page follows immediately.]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date indicated above.

Seller:

/s/ April Anthony
Name: April Anthony

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date indicated above.

Parent:

HEALTHSOUTH CORPORATION

By: /s/ Douglas E. Coltharp
Name: Douglas E. Coltharp
Title: Executive Vice President and Chief Financial Officer

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date indicated above.

Buyer:

HEALTHSOUTH HOME HEALTH CORPORATION

By: /s/ Douglas E. Coltharp
Name: Douglas E. Coltharp
Title: Vice President

[Signature Page to Non-Competition and Non-Solicitation Agreement]

Exhibit 10.9.2

HEALTHSOUTH CORPORATION
NON-QUALIFIED STOCK OPTION AGREEMENT
(Pursuant to the 2005 Equity Incentive Plan)

OPTION granted in Birmingham, Alabama on February 23, 2006 (the "Date of Grant"), by HEALTHSOUTH Corporation, a Delaware corporation (the "Corporation"), to **[__________]** (the "Grantee").

1. **GRANT OF OPTION** . The Corporation hereby grants to the Grantee the irrevocable Option to purchase, on the terms and subject to the conditions set forth herein and in the Plan (as defined below), up to **[_______]** fully paid and nonassessable shares of the Corporation's Common Stock, par value $.01 per share, at the option price of $5.31 per share, being not less than 100% of the fair market value of such Common Stock on the Date of Grant.

The Option is granted pursuant to the Corporation's 2005 Equity Incentive Plan (the "Plan"), a copy of which is attached hereto. The Option is subject in its entirety to all the applicable provisions of the Plan as in effect on the Date of Grant, which are hereby incorporated herein by reference.

2. **PERIOD OF OPTION.** Except as otherwise provided in the Plan, the Option is cumulatively exercisable in installments in accordance with the following schedule:

Year Beginning February 23,	Percent of Shares Subject to Option Purchasable
2006	None
2007	33.3 %
2008	33.3 %
2009	33.3 %
2010	100 %

The Option may be exercised from time to time during the option period as to the total number of shares allowable under this Section 2, or any lesser amount thereof. The Option is not exercisable before February 23, 2007 or after February 23, 2017.

3. **SECURITIES ACT REQUIREMENTS** .

(a) The Company has not filed financial statements for any periods ended after December 31, 2004. The Company does not expect to become current with respect to all of its previously unfiled financial statements until at least the first quarter of 2006 and will not file any registration statement until after such time. **NO OPTION MAY BE EXERCISED UNTIL THE COMPANY COMPLIES WITH ITS REPORTING OBLIGATIONS UNDER THE FEDERAL SECURITIES LAWS AND A REGISTRATION STATEMENT IS DECLARED EFFECTIVE BY THE SECURITIES AND EXCHANGE COMMISSION WITH RESPECT TO SHARES OF STOCK ISSUABLE UNDER THIS AGREEMENT.**

(b) In addition to the requirements set forth herein and in the Plan, (i) the Option shall not be exercisable in whole or in part, and the Company shall not be obligated to issue any shares of Stock subject to any such Option, if such exercise and sale or issuance would, in the opinion of counsel for the Company, violate the Securities Act of 1933 (the "1933 Act") or other Federal or state statutes having similar requirements, as they may be in effect at that time; and (ii) each Option shall be subject to the further requirement that, at any time that the Board of Directors or the Committee, as the case may be, shall determine, in their respective discretion, that the listing, registration or qualification of the shares of Stock subject to such Option under any securities exchange requirements or under any applicable law, or the consent or approval of any governmental regulatory body, is necessary or desirable as a condition of, or in connection with, the issuance of shares of Stock, such Option may not be exercised in whole or in part unless such listing, registration, qualification, consent or approval shall have been effected or obtained free of any conditions not acceptable to the Board of Directors or the Committee, as the case may be.

4. **METHOD OF EXERCISE OF OPTION** . Subject to the provisions of the Plan and Paragraph 3 hereof, the Option may be exercised in whole or in part by the Grantee's giving written notice, specifying the number of shares which the Grantee elects to purchase and the date on which such purchase is to be made to the Corporation or its designated broker.

5. **TRANSFERABILITY** . The Option is not transferable otherwise than by will or pursuant to the laws of descent and distribution and is exercisable during Grantee's lifetime only by Grantee, provided, however, that transfers for estate planning purposes are permitted so long as (w) the Grantee has satisfied his or her stock ownership requirements, (x) the Grantee gives the Committee advance written notice describing the terms and conditions of the proposed transfer, (y) the transferee qualifies as either an "employee" or a "family member" under those definitions set forth in Form S-8 under the 1933 Act and agrees to comply with all of the terms and conditions of the Award that are or would have been applicable to the Grantee and to be bound by the acknowledgements made by the Grantee in connection with the grant of the Option, and (z) the transfer is not a "modification" or "extension" of the Option that would give rise to a "deferral of compensation" within the meaning of Section 409A of the Code.

6. **BINDING AGREEMENT.** This Stock Option Agreement shall be binding upon and shall inure to the benefit of any successor or assign of the Corporation, and, to the extent herein provided, shall be binding upon and inure to the benefit of the Grantee's beneficiary or legal representatives, as the case may be.

7. **ENTIRE AGREEMENT.** This Stock Option Agreement and the Plan set forth the entire agreement of the parties with respect to the Option granted hereby and may not be changed orally but only by an instrument in writing signed by the party against whom enforcement of any change, modification or extension is sought.

If the foregoing is in accordance with your understanding and approved by you, please so confirm by signing and returning the duplicate of this Stock Option Agreement enclosed for that purpose.

HEALTHSOUTH Corporation

By ______________________________

Gregory L. Doody,

Secretary

The foregoing is in accordance with my understanding and is hereby confirmed and agreed to as of the Date of Grant.

____

[________], Grantee

This document is part of a prospectus covering securities that have been registered under the Securities Act of 1933, as amended. This document may be used only in connection with our offer and sale of the securities hereunder. You cannot use this document to offer or sell the securities that you acquire hereunder to anyone else. A paper version of this document and the other documents constituting the complete prospectus are available upon request by contacting ________ in the Human Resources department.

HealthSouth Corporation

NON-QUALIFIED STOCK OPTION AWARD AGREEMENT
(Pursuant to the 2008 Equity Incentive Plan)

Option granted in Birmingham, Alabama by **HealthSouth Corporation** , a Delaware corporation (the "Corporation"), pursuant to a Summary of Grant (the "Summary") previously delivered to you as the person to whom the Option is granted ("Grantee") and/or displayed at the website of Smith Barney Benefit Access ® (www.benefitaccess.com). The Summary, which specifies the name of Grantee, the date as of which the grant is made (the "Date of Grant") and other specific details of the grant, and the electronic acceptance of the Summary are incorporated herein by reference.

1. GRANT OF OPTION . The Corporation hereby grants to Grantee the Option to purchase, on the terms and subject to the conditions set forth herein and in the Plan (as defined below), up to the number of shares specified in the Summary of the Corporation's Common Stock, par value $.01 per share, at the exercise price per share set forth in the Summary, being not less than 100% of the Fair Market Value of such Common Stock on the Date of Grant. The Option is intended to constitute a non-qualified stock option and shall be administered consistently with such intent.

The Option is granted pursuant to the Corporation's 2008 Equity Incentive Plan (the "Plan"), a copy of which has been made available to Grantee electronically. The Option is subject in its entirety to all the applicable provisions of the Plan, which are hereby incorporated herein by reference. Capitalized terms used herein and not otherwise defined herein shall have the meanings set forth in the Plan.

2. PERIOD OF OPTION . Except as provided herein or as otherwise provided in the Plan, the Option is cumulatively exercisable in installments in accordance with the schedule set forth in the Summary. The Options may be exercised from time to time during the term of the Option set forth in the Summary as to the total number of shares allowable under this Paragraph 2, or any lesser amount thereof. The Option is not exercisable before or after the dates specified in the Summary.

3. METHOD OF EXERCISE OF OPTION . Subject to the provisions of Paragraph 2 hereof, the Option may be exercised in whole or in part by Grantee's giving written notice, which notice may be given electronically, specifying the number of shares which Grantee elects to purchase and the date on which such purchase is to be made to the Corporation or its designated broker.

Payment of the exercise price may be made in cash or shares of Common Stock, including, without limitation, a cashless exercise of the Option.

4. TERMINATION OF EMPLOYMENT. The Option shall be subject to the lapse and forfeiture provisions of Section 15.8 of the Plan.

5. TAX ISSUES.

(a) Grantee agrees to notify the Corporation immediately if Grantee recognizes taxable income generated by the grant of the Award by the Corporation to Grantee pursuant to an election under Section 83(b) of the Code.

(b) Grantee acknowledges that the Corporation has not advised Grantee regarding Grantee's income tax liability in connection with the grant or vesting of the Performance Share Units and the delivery of shares of Restricted Common Stock in connection therewith. Grantee has reviewed with Grantee's own tax advisors the federal, state, and local and tax consequences of the grant and vesting of the Performance Share Units and the delivery of shares of Restricted Common Stock in connection therewith as contemplated by this Agreement. Grantee is relying solely on such advisors and not on any statements or representations of the Corporation or any of its agents. Grantee understands that Grantee (and not the Corporation) shall be responsible for Grantee's own tax liability that may arise as a result of the transactions contemplated by this Agreement.

(c) Grantee shall pay to the Corporation promptly upon request, and in any event, no later than at the time the Corporation determines that Grantee will recognize taxable income in respect of the Performance Share Units, an amount equal to the taxes the Corporation determines it is required to withhold under applicable tax laws with respect to the Performance Share Units. Such payment shall be made in the form of (i) cash, (ii) shares of Common Stock already owned for at least six months, (iii) delivering to the Corporation, or having the Corporation withhold, a portion of the shares of Common Stock otherwise to be delivered to Grantee hereunder, or (iv) in a combination of such methods, as irrevocably elected by Grantee prior to the applicable tax due date with respect to the Option.

6. TRANSFERABILITY . Except as provided in Section 15.2 of the Plan, the Option is not transferable otherwise than by will or pursuant to the laws of descent and distribution and is exercisable during Grantee's lifetime only by Grantee, provided, however, that transfers for estate planning purposes are permitted so long as (w) the Grantee has satisfied his or her stock ownership requirements, (x) the Grantee gives the Committee advance written notice describing the terms and conditions of the proposed transfer, (y) the transferee qualifies as either an "employee" or a "family member" under those definitions set forth in Form S-8 under the 1933 Act and agrees to comply with all of the terms and conditions of the Award that are or would have been applicable to the Grantee and to be bound by the acknowledgements made by the Grantee in connection with the grant of the Option, and (z) the transfer is not a "modification" or "extension" of the Option that would give rise to a "deferral of compensation" within the meaning of Section 409A of the Code.

7. **BINDING AGREEMENT** . This Award Agreement shall be binding upon and shall inure to the benefit of any successor or assign of the Corporation, and, to the extent herein provided, shall be binding upon and inure to the benefit of Grantee's beneficiary or legal representatives, as the case may be.

8. **ENTIRE AGREEMENT; AMENDMENT** . This Award Agreement contains the entire agreement of the parties with respect to the Option granted hereby. This Award Agreement may be amended in accordance with the provisions of Section 17.2 of the Plan.

9. **ACCEPTANCE OF AGREEMENT** . By accepting the Summary electronically, Grantee confirms that the grant is in accordance with Grantee's understanding and agrees to the terms of this Award Agreement and the terms of the Plan, all as of the Date of Grant.

10. **APPLICABLE RECOUPMENT POLICY** . This Award is subject to the terms of the Compensation Recoupment Policy (the "Clawback Policy") adopted by the Board of Directors of the Corporation (the "Board"), published with other Plan materials on the website of Smith Barney Benefit Access® (www.benefitaccess.com), and modified from time to time to comply with applicable requirements of law or the listing standards of The New York Stock Exchange. This Award may be cancelled in accordance with the Clawback Policy in the event the Board or a committee thereof determines that one of the events enumerated in the Clawback Policy has occurred and that it is in the best interests of the Corporation to do so.

11. **ADMINISTRATION OF THE PLAN; INTERPRETATION OF THE PLAN AND THE AWARD.** The Plan shall be administered by the Committee, pursuant to Section 4 of the Plan. Furthermore, the interpretation and construction of any provision of the Plan or of the Option by the Committee shall be final, conclusive and binding. In the event there is any inconsistency or discrepancy between the provisions of this Option and the provisions of the Plan, the provisions of the Plan shall prevail.

HealthSouth Corporation

NON-QUALIFIED STOCK OPTION AWARD AGREEMENT
(Pursuant to the Amended and Restated 2008 Equity Incentive Plan)

This Non-Qualified Stock Option Award Agreement (this " *Award* ") is granted in Birmingham, Alabama by **HealthSouth Corporation** , a Delaware corporation (the " *Corporation* "), pursuant to a Summary of Grant (the " *Summary* ") previously delivered to you as the person to whom the Option is granted (" *Grantee* ") and/or displayed at the website of Smith Barney Benefit Access ® (www.benefitaccess.com). The Summary, which specifies the name of Grantee, the date as of which the grant is made (the " *Date of Grant* ") and other specific details of the grant, and the electronic acceptance of the Summary are incorporated herein by reference.

1. **GRANT OF OPTION** . The Corporation hereby grants to Grantee the option to purchase (the " *Option* "), on the terms and subject to the conditions set forth herein and in the Plan (as defined below), up to the number of shares specified in the Summary of the Corporation's common stock, par value $.01 per share (the " *Common Stock* "), at the exercise price per share set forth in the Summary (the " *Exercise Price* "), being not less than 100% of the Fair Market Value of such Common Stock on the Date of Grant. The Option is intended to constitute a non-qualified stock option and shall be administered consistently with such intent.

The Option is granted pursuant to the Corporation's Amended and Restated 2008 Equity Incentive Plan (the " *Plan* "), a copy of which has been made available to Grantee electronically. This Award is subject in its entirety to all the applicable provisions of the Plan, which are hereby incorporated herein by reference. Capitalized terms used herein and not otherwise defined herein shall have the meanings set forth in the Plan.

2. **PERIOD OF OPTION** . Except as provided herein or as otherwise provided in the Plan, the Option is cumulatively vested and exercisable in installments in accordance with the schedule set forth in the Summary. The vested portions of the Option may be exercised from time to time during the term of the Option set forth in the Summary (the " *Term* ") as to the total number of shares allowable under this Section 2, or any lesser amount thereof. The Option is not exercisable before or after the dates specified in the Summary.

3. **METHOD OF EXERCISE OF OPTION** .

(a) Subject to the provisions of Section 2 hereof, the Corporation's Insider Trading Policy and securities laws, the Option may be exercised in whole or in part by Grantee's giving written notice, which notice may be given electronically, specifying the number of shares which Grantee elects to purchase and the date on which such purchase is to be made to the Corporation or its designated broker. Payment of the exercise price may be made in cash or shares of Common Stock, including, without limitation, a cashless exercise of the Option.

(b) In the event (i) there is an unexercised vested portion of the Option outstanding at the expiration of the Term and (ii) on such date, the last reported transaction price of the Common Stock on its primary securities exchange or automated quotation system exceeds the Exercise Price, Grantee hereby elects to exercise all such portions of the Option on such date, provided that such election is not revoked by written notice, which notice may be given electronically, to the Corporation on or before such date. In the event of any Option exercises pursuant to this subsection (b), payment of the Exercise Price shall be made in shares of Common Stock by cashless exercise, unless Grantee instructs the Corporation otherwise.

4. <u>TERMINATION OF EMPLOYMENT</u> .

(a) Except as provided in the subsection (b) below, the Option and this Award shall, upon termination of employment with the Corporation (including its subsidiaries), be subject to lapse and forfeiture or accelerated vesting, as the case may be, pursuant to Sections 15.5, 15.6, 15.7, and 15.8 of the Plan.

(b) In the event that Grantee dies, suffers a Disability or effects a Retirement, any unvested Option shall partially vest and become exercisable according to the following formula: the portion that becomes vested and exercisable shall equal the number of shares represented by the then unvested Option multiplied by the ratio of (i) the number of full months that have elapsed from the most recent vesting date set forth in the Summary to the date of death, Disability or Retirement, to (ii), the number of full months from the most recent vesting date set forth in the Summary to the final vesting date set forth in the Summary. All vested portions of the Option, including those subject to accelerated vesting pursuant to this subsection (b), shall be exercisable for the applicable period following termination set forth in Section 15.8(b) of the Plan.

(c) For purposes of this Award, " *Retirement* " shall mean the voluntary termination of employment by Grantee after attaining (a) age 65 or (b) in the event that Grantee has been employed by the Corporation for ten (10) or more years on the date of such termination, age 60.

5. <u>TAX ISSUES</u> .

(a) Grantee agrees to notify the Corporation immediately if Grantee recognizes taxable income generated by the grant of the Award by the Corporation to Grantee pursuant to an election under Section 83(b) of the Code.

(b) Grantee acknowledges that the Corporation has not advised Grantee regarding Grantee's income tax liability in connection with the grant or vesting of the Option and the delivery of shares of Common Stock in connection with the exercise thereof. Grantee has reviewed with Grantee's own tax advisors the federal, state, and local and tax consequences of the grant and vesting of the Option and the delivery of shares of Common Stock in connection with the exercise thereof as contemplated by this Award and the Plan. Grantee is relying solely on such advisors and not on any statements or representations of the Corporation or any of its agents. Grantee understands that Grantee (and not the Corporation) shall be responsible for Grantee's own tax liability that may arise as a result of the transactions contemplated by this Award.

(c) Grantee shall pay to the Corporation promptly upon request, and in any event, no later than at the time the Corporation determines that Grantee will recognize taxable income in respect of the Option or the related shares of Common Stock, an amount equal to the taxes the Corporation determines it is required to withhold under applicable tax laws with respect to such securities. Such payment shall be made in the form of (i) cash, (ii) securities of the Corporation already owned for at least six months, (iii) delivering to the Corporation, or having the Corporation withhold, a portion of the shares of Common Stock otherwise to be delivered to Grantee hereunder, or (iv) in a combination of such methods, as irrevocably elected by Grantee prior to the applicable tax due date with respect to the Option.

6. **TRANSFERABILITY**. Except as provided in Section 15.2 of the Plan, the Option is not transferable otherwise than by will or pursuant to the laws of descent and distribution and is exercisable during Grantee's lifetime only by Grantee, provided, however, that transfers for estate planning purposes are permitted so long as (w) the Grantee has satisfied his or her stock ownership requirements, (x) the Grantee gives the Committee advance written notice describing the terms and conditions of the proposed transfer, (y) the transferee qualifies as either an "employee" or a "family member" under those definitions set forth in Form S-8 under the 1933 Act and agrees to comply with all of the terms and conditions of the Award that are or would have been applicable to the Grantee and to be bound by the acknowledgements made by the Grantee in connection with the grant of the Option, and (z) the transfer is not a "modification" or "extension" of the Option that would give rise to a "deferral of compensation" within the meaning of Section 409A of the Code.

7. **BINDING AGREEMENT**. This Award shall be binding upon and shall inure to the benefit of any successor or assign of the Corporation, and, to the extent herein provided, shall be binding upon and inure to the benefit of Grantee's beneficiary or legal representatives, as the case may be.

8. **ENTIRE AGREEMENT; AMENDMENT**. This Award contains the entire agreement of the parties with respect to the Option granted hereby. This Award may be amended in accordance with the provisions of Section 17.2 of the Plan.

9. **ACCEPTANCE OF AGREEMENT**. By accepting the Award and/or the Summary electronically, Grantee confirms that the grant is in accordance with Grantee's understanding and agrees to the terms of this Award and the terms of the Plan, all as of the Date of Grant.

10. **APPLICABLE RECOUPMENT POLICY**. Notwithstanding anything to the contrary contained in this Award, this Award is subject to the terms of the Compensation Recoupment

Policy (the " *Clawback Policy* ") adopted by the Board of Directors of the Corporation (the " *Board* "), published with other Plan materials on the website of Smith Barney Benefit Access® (www.benefitaccess.com), and modified from time to time to comply with applicable requirements of law or the listing standards of The New York Stock Exchange. This Award may be cancelled in accordance with the Clawback Policy in the event the Board or a committee thereof determines that one of the events enumerated in the Clawback Policy has occurred and that it is in the best interests of the Corporation to do so.

11. NONCOMPETITION, NONDISCLOSURE AND NONSOLICITATION .

(a) From the date of termination of employment with the Corporation (including its subsidiaries) until the exercise, lapse or forfeiture of all outstanding, vested portions of the Option under this Award (the " *Noncompetition Period* "), Grantee shall not, directly or indirectly, participate in the management, operation or control of, or have any financial or ownership interest in, or aid or knowingly assist anyone else in the conduct of, any business or entity that (i) engages in the business of owning, operating or managing inpatient rehabilitation facilities offering a range of rehabilitative healthcare services, and services directly ancillary thereto (collectively, the " *Company Business* ") in any area within seventy-five (75) miles of where an inpatient rehabilitation facility owned or operated by the Corporation (the " *Restricted Territory* ") is located, or (ii) is, to Grantee's knowledge, making preparations for engaging in the Company Business in any Restricted Territory (collectively, " *Competitive Activity* "); provided, however, that (x) the "beneficial ownership" by Grantee, either individually or as a member of a "group" (as such terms are used in Rule 13d of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended), of not more than one percent (1%) of the voting stock of any publicly held corporation shall not alone constitute a breach of this Section 10(b) and (y) Grantee may enter into, at arm's length, any bona fide joint venture (or partnership or other business arrangement) with any person who is not directly engaged in the Company Business but which is an affiliate of another person engaged in the Company Business.

(b) Grantee shall not, directly or indirectly, within the Noncompetition Period, without the prior written consent of the Corporation, solicit or direct any other person to solicit any officer or other employee of the Corporation to: (i) terminate such officer's or employee's employment with the Corporation; or (ii) seek or accept employment or other affiliation with Grantee or any person engaged in any Competitive Activity in which Grantee is directly or indirectly involved (other than, in each case, any solicitation directed at the public in general in publications available to the public in general or any contact which Grantee can demonstrate was initiated by such officer, director or employee or any contact after such officer's or employee's employment with the Corporation is terminated). Grantee's obligations under this subsection (b) with respect to new Corporation employees hired after the date of termination shall be subject to the condition that Grantee shall have been notified of such new employees.

(c) Grantee shall not, directly or indirectly, within the Noncompetition Period, without the prior written consent of the Corporation, solicit or direct any other Person to solicit any person or entity in a business relationship with the Corporation (whether an independent contractor, joint venture partner or otherwise) to terminated such person or entity's business relationship with the Corporation.

(d) Grantee shall not, directly or indirectly, within the Noncompetition Period, make any statements or comments of a defamatory or disparaging nature to third parties regarding the Corporation or any of their members, principals, officers, managers, directors, personnel, employees, agents, services or products; provided, however, that nothing contained herein shall preclude Grantee from providing truthful testimony in response to a valid subpoena, court order, regulatory request or as may be required by law.

(e) In the event Grantee violates the terms of this Section 11, the Option and the Award shall be immediately cancelled, lapsed and forfeited.

12. ADMINISTRATION OF THE PLAN; INTERPRETATION OF THE PLAN AND THE AWARD. The Plan shall be administered by the Committee pursuant to Section 4 of the Plan. Furthermore, the interpretation and construction of any provision of the Plan or of this Award by the Committee shall be final, conclusive and binding. In the event there is any inconsistency or discrepancy between the provisions of this Award and the provisions of the Plan, the provisions of the Plan shall prevail.

HealthSouth Corporation and Subsidiaries

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES
AND RATIO OF EARNINGS TO COMBINED FIXED CHARGES AND PREFERRED STOCK DIVIDENDS

In computing the ratio of earnings to fixed charges: (1) earnings have been based on income from continuing operations before income taxes, fixed charges (exclusive of interest capitalized), and distributed income of equity investees and (2) fixed charges consist of interest and amortization of debt discounts and fees expense (including amounts capitalized), the estimated interest portion of rents, and dividends on our convertible perpetual preferred stock.

	For the Year Ended December 31,				
	2016	**2015**	**2014**	**2013**	**2012**
COMPUTATION OF FIXED CHARGES:					
Interest expensed and capitalized in continuing operations, including amortization of debt discounts and fees	$ 174.1	$ 144.2	$ 110.7	$ 102.3	$ 95.1
Interest expensed and capitalized in discontinued operations, including amortization of debt discounts and fees	—	—	—	—	0.1
Interest element of rentals [(1)]	28.3	20.6	19.8	21.6	22.1
Total fixed charges	202.4	164.8	130.5	123.9	117.3
COMPUTATION OF EARNINGS:					
Pre-tax income from continuing operations before equity in net income of nonconsolidated affiliates	$ 479.1	$ 386.9	$ 376.2	$ 384.0	$ 327.3
Fixed charges	202.4	164.8	130.5	123.9	117.3
Amortization of capitalized interest	0.2	0.2	0.2	0.1	—
Distributed income of equity investees	8.5	7.7	12.6	11.4	11.0
Interest capitalized	(2.0)	(1.3)	(1.5)	(1.9)	(1.0)
Total earnings	$ 688.2	$ 558.3	$ 518.0	$ 517.5	$ 454.6
RATIO OF EARNINGS TO FIXED CHARGES	3.4	3.4	4.0	4.2	3.9

[(1)] Management has determined the interest component of rent expense to be 33%.

HEALTHSOUTH CORPORATION
SUBSIDIARY LIST

Subsidiary Name	Jurisdiction of Incorporation	DBA
Advantage Health, LLC	DE	
AnMed Enterprises, Inc./HealthSouth, L.L.C.	SC	AnMed Health Rehabilitation Hospital, an affiliate entity of AnMed Health and HealthSouth Corporation
BJC/HealthSouth Rehabilitation Center, L.L.C.	MO	The Rehabilitation Institute of St. Louis
		St. Louis Milliken Hand Therapy, a Partnership of BJC HealthCare and HealthSouth
Central Arkansas Rehabilitation Associates, L.P.	DE	St. Vincent Rehabilitation Hospital
		CHI St. Vincent Hot Springs Rehabilitation Hospital an affiliate of HealthSouth
Central Louisiana Rehab Associates, L.P.	DE	HealthSouth Rehabilitation Hospital of Alexandria
CMS Alexandria Rehabilitation, LLC	DE	
CMS Development and Management Company, Inc.	DE	
CMS Fayetteville Rehabilitation, Inc.	DE	
CMS Jonesboro Rehabilitation, Inc.	DE	
CMS Kansas City Rehabilitation, Inc.	DE	
CMS Rehab of WF, L.P.	DE	HealthSouth Rehabilitation Hospital of Wichita Falls
CMS Sherwood Rehabilitation, Inc.	DE	
CMSI Systems of Texas, Inc.	TX	
Continental Medical of Arizona, Inc.	DE	
Continental Medical of Colorado, Inc.	DE	
Continental Medical of Kentucky, Inc.	DE	
Continental Medical Systems, Inc.	DE	
Continental Rehab of W.F., Inc.	TX	
Continental Rehabilitation Hospital of Arizona, Inc.	DE	
HCA Wesley Rehabilitation Hospital, Inc.	DE	Wesley Rehabilitation Hospital, An Affiliate of HealthSouth Wesley Home Health
HCS Limited	Cayman Islands, B.W.I.	
HealthSouth Acquisition Holdings Subsidiary, LLC	DE	
HealthSouth Acquisition Holdings, LLC	DE	
HealthSouth Alabama Real Estate, LLC	DE	
HealthSouth Arizona Real Estate, LLC	DE	
HealthSouth Arkansas Real Estate, LLC	DE	
HealthSouth Aviation, LLC	DE	
HealthSouth Bakersfield Rehabilitation Hospital, LLC	DE	HealthSouth Bakersfield Rehabilitation Hospital
HealthSouth Bryan Holdings, LLC	DE	
HealthSouth Bundling Initiatives, LLC	DE	
HealthSouth C Corp Sub Holdings, Inc.	DE	
HealthSouth California Real Estate, LLC	DE	
HealthSouth Cardinal Hill Rehabilitation Hospital, LLC	DE	Cardinal Hill Rehabilitation Hospital
		Cardinal Hill Home Care
		Cardinal Hill Outpatient Services
		Cardinal Hill Pediatric Services
		Cardinal Hill Skilled Rehabilitation Unit
HealthSouth Clinical Technologies, LLC	DE	

HealthSouth Colorado Real Estate, LLC	DE	
HealthSouth Deaconess Holdings, LLC	DE	
HealthSouth East Valley Rehabilitation Hospital, LLC	DE	HealthSouth East Valley Rehabilitation Hospital
HealthSouth Gulfport Holdings, LLC	DE	
HealthSouth Harmarville Rehabilitation Hospital, LLC	DE	HealthSouth Harmarville Rehabilitation Hospital
HealthSouth Johnson City Holdings, LLC	DE	
HealthSouth Joint Ventures Holdings, LLC	DE	
HealthSouth Kansas Real Estate, LLC	DE	
HealthSouth Kentucky Real Estate, LLC	DE	
HealthSouth Littleton Rehabilitation, LLC	DE	HealthSouth Rehabilitation Hospital of Littleton
HealthSouth Martin County Holdings, LLC	DE	
HealthSouth Maryland Real Estate, LLC	DE	
HealthSouth Massachusetts Real Estate, LLC	DE	
HealthSouth Middletown Rehabilitation Hospital, LLC	DE	HealthSouth Rehabilitation Hospital of Middletown
HealthSouth Midland Odessa Holdings, LLC	DE	
HealthSouth Myrtle Beach Holdings, LLC	DE	
HealthSouth Nevada Real Estate, LLC	DE	
HealthSouth New Mexico Real Estate, LLC	DE	
HealthSouth North Houston GP, LLC	DE	
HealthSouth Northern Kentucky Rehabilitation Hospital, LLC	DE	HealthSouth Northern Kentucky Rehabilitation Hospital
HealthSouth of Altoona, LLC	DE	
HealthSouth of Dothan, Inc.	AL	HealthSouth Rehabilitation Hospital
HealthSouth of East Tennessee, LLC	DE	HealthSouth Rehabilitation Hospital
HealthSouth of Erie, LLC	DE	HealthSouth Rehabilitation Hospital of Erie
HealthSouth of Fort Smith, LLC	DE	HealthSouth Rehabilitation Hospital of Fort Smith
		HealthSouth Outpatient Rehabilitation
HealthSouth of Nittany Valley, Inc.	DE	HealthSouth Nittany Valley Rehabilitation Hospital
		HealthSouth Rehabilitation Center of Lewistown
		HealthSouth Rehabilitation Center of Mifflintown
HealthSouth of Phenix City, Inc.	DE	
HealthSouth of Sea Pines Limited Partnership	AL	HealthSouth Sea Pines Rehabilitation Hospital
HealthSouth of South Carolina, Inc.	DE	HealthSouth Rehabilitation Hospital of Columbia
HealthSouth of Spring Hill, Inc.	DE	HealthSouth Rehabilitation Hospital of Spring Hill
HealthSouth of Toms River, LLC	DE	HealthSouth Rehabilitation Hospital of Toms River
HealthSouth of Treasure Coast, Inc.	DE	HealthSouth Treasure Coast Rehabilitation Hospital
HealthSouth of York, LLC	DE	HealthSouth Rehabilitation Hospital of York
		HealthSouth Rehabilitation Center of Industrial Highway
		HealthSouth-Normandie Drive
HealthSouth of Yuma, Inc.	DE	
HealthSouth Ohio Real Estate, LLC	DE	
HealthSouth Owned Hospitals Holdings, LLC	DE	
HealthSouth Patient Safety Organization, LLC	DE	
HealthSouth Pennsylvania Real Estate, LLC	DE	
HealthSouth Plano Rehabilitation Hospital, LLC	DE	HealthSouth Plano Rehabilitation Hospital
HealthSouth Press, LLC	DE	
HealthSouth Reading Rehabilitation Hospital, LLC	DE	HealthSouth Reading Rehabilitation Hospital
HealthSouth Real Estate, LLC	DE	
HealthSouth Real Property Holding, LLC	DE	
HealthSouth Rehabilitation Center of New Hampshire, Inc.	DE	HealthSouth Rehabilitation Hospital
HealthSouth Rehabilitation Center, Inc.	SC	HealthSouth Rehabilitation Hospital of Florence
HealthSouth Rehabilitation Hospital at Drake, LLC	DE	HealthSouth Rehabilitation Hospital of Cincinnati HealthSouth Rehabilitation Hospital of Cincinnati at Norwood
HealthSouth Rehabilitation Hospital of Abilene, LLC	DE	HealthSouth Rehabilitation Hospital of Abilene

HealthSouth Rehabilitation Hospital of Altoona, LLC	DE	HealthSouth Rehabilitation Hospital of Altoona
		HealthSouth Rehabilitation Center - Bedford
		HealthSouth Rehabilitation Center - Meadowbrook Plaza
		HealthSouth Rehabilitation Center - Regency Square
		HealthSouth Rehabilitation Center - Tyrone
HealthSouth Rehabilitation Hospital of Arlington, LLC	DE	HealthSouth Rehabilitation Hospital of Arlington
HealthSouth Rehabilitation Hospital of Austin, Inc.	DE	HealthSouth Rehabilitation Hospital of Austin
HealthSouth Rehabilitation Hospital of Beaumont, LLC	DE	HealthSouth Rehabilitation Hospital of Beaumont
		HealthSouth Rehabilitation Center - Beaumont
HealthSouth Rehabilitation Hospital of Braintree, LLC	DE	HealthSouth Braintree Rehabilitation Hospital
		HealthSouth Braintree Center for Occupational Health & Rehabilitation
		HealthSouth Braintree Rehabilitation Center at Abington
		HealthSouth Braintree Rehabilitation Center at Brockton
		HealthSouth Braintree Rehabilitation Center at Milford
		HealthSouth Braintree Rehabilitation Center at Plymouth
		HealthSouth Braintree Rehabilitation Center at Taunton
		HealthSouth Braintree Rehabilitation Hospital Outpatient Clinic at Lynnfield
		HealthSouth Braintree Rehabilitation Hospital Pediatric Center
		HealthSouth Braintree Rehabilitation Unit at Framingham
HealthSouth Rehabilitation Hospital of Charleston, LLC	SC	HealthSouth Rehabilitation Hospital of Charleston
HealthSouth Rehabilitation Hospital of Cypress, LLC	DE	HealthSouth Rehabilitation Hospital of Cypress
HealthSouth Rehabilitation Hospital of Dallas, LLC	DE	HealthSouth Rehabilitation Hospital of Dallas
HealthSouth Rehabilitation Hospital of Dayton, LLC	DE	HealthSouth Rehabilitation Hospital of Dayton
HealthSouth Rehabilitation Hospital of Desert Canyon, LLC	DE	HealthSouth Desert Canyon Rehabilitation Hospital
HealthSouth Rehabilitation Hospital of Fort Worth, LLC	DE	HealthSouth Rehabilitation Hospital of Fort Worth
HealthSouth Rehabilitation Hospital of Fredericksburg, LLC	DE	HealthSouth Rehabilitation Hospital of Fredericksburg
HealthSouth Rehabilitation Hospital of Gadsden, LLC	DE	HealthSouth Rehabilitation Hospital of Gadsden
HealthSouth Rehabilitation Hospital of Gulfport, LLC	DE	
HealthSouth Rehabilitation Hospital of Henderson, LLC	DE	HealthSouth Rehabilitation Hospital of Henderson
HealthSouth Rehabilitation Hospital of Humble, LLC	DE	HealthSouth Rehabilitation Hospital of Humble
HealthSouth Rehabilitation Hospital of Jonesboro, LLC	AR	HealthSouth Rehabilitation Hospital of Jonesboro
HealthSouth Rehabilitation Hospital of Largo, LLC	DE	HealthSouth Rehabilitation Hospital of Largo
HealthSouth Rehabilitation Hospital of Las Vegas, LLC	DE	HealthSouth Rehabilitation Hospital of Las Vegas
HealthSouth Rehabilitation Hospital of Manati, Inc.	DE	HealthSouth Rehabilitation Hospital of Manati
HealthSouth Rehabilitation Hospital of Marion County, LLC	DE	HealthSouth Rehabilitation Hospital of Ocala
HealthSouth Rehabilitation Hospital of Martin County, LLC	DE	HealthSouth Rehabilitation Hospital at Martin Health
HealthSouth Rehabilitation Hospital of Mechanicsburg, LLC	DE	HealthSouth Rehabilitation Hospital of Mechanicsburg
		HealthSouth L.I.F.E. (Living Independently in Functional Environments)
HealthSouth Rehabilitation Hospital of Miami, LLC	DE	HealthSouth Rehabilitation Hospital of Miami
HealthSouth Rehabilitation Hospital of Midland/Odessa, LLC	DE	HealthSouth Rehabilitation Hospital of Midland/Odessa
HealthSouth Rehabilitation Hospital of Modesto, LLC	DE	HealthSouth Rehabilitation Hospital of Modesto
HealthSouth Rehabilitation Hospital of Montgomery, Inc.	AL	HealthSouth Rehabilitation Hospital of Montgomery
HealthSouth Rehabilitation Hospital of New England, LLC	DE	HealthSouth New England Rehabilitation Hospital
		HealthSouth New England Rehabilitation Hospital Outpatient Clinic at Billerica
		HealthSouth New England Rehabilitation Hospital Outpatient Clinic at Framingham
		HealthSouth New England Rehabilitation Unit at Beverly
		HealthSouth New England Rehabilitation Hospital at Lowell
HealthSouth Rehabilitation Hospital of New Mexico, LLC	DE	HealthSouth Rehabilitation Hospital

HealthSouth Rehabilitation Hospital of Newnan, LLC	DE	HealthSouth Rehabilitation Hospital of Newnan
HealthSouth Rehabilitation Hospital of North Houston, LP	TX	HealthSouth Rehabilitation Hospital Vision Park
HealthSouth Rehabilitation Hospital of Northern Virginia, LLC	DE	HealthSouth Rehabilitation Hospital of Northern Virginia
HealthSouth Rehabilitation Hospital of Pearland, LLC	DE	HealthSouth Rehabilitation Hospital of Pearland
HealthSouth Rehabilitation Hospital of Petersburg, LLC	DE	HealthSouth Rehabilitation Hospital of Petersburg
HealthSouth Rehabilitation Hospital of Richardson, LLC	DE	HealthSouth Rehabilitation Hospital of Richardson
HealthSouth Rehabilitation Hospital of Round Rock, LLC	DE	HealthSouth Rehabilitation Hospital of Round Rock
HealthSouth Rehabilitation Hospital of San Juan, Inc.	DE	HealthSouth Rehabilitation Hospital of San Juan
		HealthSouth Outpatient Therapy of San Juan
HealthSouth Rehabilitation Hospital of Sarasota, LLC	DE	HealthSouth Rehabilitation Hospital of Sarasota
HealthSouth Rehabilitation Hospital of Seminole County, LLC	DE	HealthSouth Rehabilitation Hospital of Altamonte Springs
HealthSouth Rehabilitation Hospital of Sewickley, LLC	DE	HealthSouth Rehabilitation Hospital of Sewickley
HealthSouth Rehabilitation Hospital of South Austin, LLC	DE	HealthSouth Rehabilitation Hospital of Austin
HealthSouth Rehabilitation Hospital of South Jersey, LLC	DE	HealthSouth Rehabilitation Hospital of Vineland
HealthSouth Rehabilitation Hospital of Sugar Land, LLC	DE	HealthSouth Sugar Land Rehabilitation Hospital
HealthSouth Rehabilitation Hospital of Tallahassee, LLC	DE	HealthSouth Rehabilitation Hospital of Tallahassee
HealthSouth Rehabilitation Hospital of Texarkana, Inc.	DE	HealthSouth Rehabilitation Hospital of Texarkana
HealthSouth Rehabilitation Hospital of the Mid-Cities, LLC	DE	HealthSouth Rehabilitation Hospital of the Mid-Cities
HealthSouth Rehabilitation Hospital of Utah, LLC	DE	HealthSouth Rehabilitation Hospital of Utah
HealthSouth Rehabilitation Hospital of Vintage Park, LLC	DE	HealthSouth Rehabilitation Hospital The Vintage
HealthSouth Rehabilitation Hospital of Westerville, LLC	DE	Mount Carmel Rehabilitation Hospital, in partnership with HealthSouth
HealthSouth Rehabilitation Hospital of Williamson County, LLC	TN	HealthSouth Rehabilitation Hospital of Franklin
HealthSouth Rehabilitation Hospital The Woodlands, Inc.	DE	HealthSouth Rehabilitation Hospital The Woodlands
HealthSouth Rehabilitation Institute of San Antonio (RIOSA), Inc.	DE	HealthSouth Rehabilitation Institute of San Antonio (RIOSA)
HealthSouth Rehabilitation Institute of Tucson, LLC	AL	HealthSouth Rehabilitation Institute of Tucson
HealthSouth Savannah Holdings, LLC	DE	
HealthSouth Scottsdale Rehabilitation Hospital, LLC	DE	HealthSouth Scottsdale Rehabilitation Hospital
HealthSouth Sea Pines Holdings, LLC	DE	
HealthSouth South Carolina Real Estate, LLC	DE	
HealthSouth Sunrise Rehabilitation Hospital, LLC	DE	HealthSouth Sunrise Rehabilitation Hospital Outpatient Therapy and Day Rehab
HealthSouth Support Companies, LLC	DE	
HealthSouth Texas Real Estate, LLC	DE	
HealthSouth Tucson Holdings, LLC	DE	
HealthSouth Tulsa Holdings, LLC	DE	
HealthSouth Utah Real Estate, LLC	DE	
HealthSouth Valley of the Sun Rehabilitation Hospital, LLC	DE	HealthSouth Valley of The Sun Rehabilitation Hospital
HealthSouth Virginia Real Estate, LLC	DE	
HealthSouth Walton Rehabilitation Hospital, LLC	DE	HealthSouth Walton Rehabilitation Hospital
HealthSouth West Virginia Real Estate, LLC	DE	
HealthSouth Westerville Holdings, LLC	DE	
HealthSouth Winston-Salem Holdings, LLC	DE	
HealthSouth/Deaconess L.L.C.	IN	HealthSouth Deaconess Rehabilitation Hospital
HealthSouth/GHS Limited Liability Company	PA	Geisinger HealthSouth Rehabilitation Hospital
		Geisinger HealthSouth Rehabilitation Center of Berwick
		Geisinger HealthSouth Rehabilitation Center of Bloomsburg
		Geisinger HealthSouth Rehabilitation Center of Bucknell
		Geisinger HealthSouth Rehabilitation Center of Danville
		Geisinger HealthSouth Rehabilitation Center of Milton
		Geisinger HealthSouth Rehabilitation Center of Selinsgrove

		Geisinger HealthSouth Rehabilitation - Hospital Outpatient Center
HealthSouth/Maine Medical Center Limited Liability Company	ME	New England Rehabilitation Hospital of Portland, a Joint Venture of Maine Medical Center and HEALTHSOUTH
HealthSouth/Methodist Rehabilitation Hospital Limited Partnership	TN	HealthSouth Rehabilitation Hospital of Memphis
		HealthSouth Rehabilitation Hospital-North
K.C. Rehabilitation Hospital, Inc.	DE	MidAmerica Rehabilitation Hospital
Kansas Rehabilitation Hospital, Inc.	DE	Kansas Rehabilitation Hospital
Lakeshore System Services of Florida, Inc.	FL	HealthSouth Emerald Coast Rehabilitation Hospital
Lakeview Rehabilitation Group Partners	KY	HealthSouth Lakeview Rehabilitation Hospital of Central Kentucky
		HealthSouth Lakeview Outpatient
Myrtle Beach Rehabilitation Hospital, LLC	DE	
New England Rehabilitation Management Co., LLC	NH	
New England Rehabilitation Services of Central Massachusetts, Inc.	MA	Fairlawn Rehabilitation Hospital
Northwest Arkansas Rehabilitation Associates	AR	HealthSouth Rehabilitation Hospital, a Partner with Washington Regional
Novant Health Rehabilitation Hospital of Winston-Salem, LLC	DE	
Piedmont HealthSouth Rehabilitation, LLC	SC	HealthSouth Rehabilitation Hospital of Rock Hill
Plano Health Associates Limited Partnership	DE	
Print Promotions Group, LLC	DE	
Quillen Rehabilitation Hospital of Johnson City, LLC	DE	Quillen Rehabilitation Hospital, a joint venture of Mountain States Health Alliance and HealthSouth
Rebound, LLC	DE	HealthSouth Cane Creek Rehabilitation Hospital
		HealthSouth Chattanooga Rehabilitation Hospital
		HealthSouth Lakeshore Rehabilitation Hospital
		HealthSouth Lakeshore Outpatient
		HealthSouth Rehabilitation Hospital of Huntington
		HealthSouth Rehabilitation Hospital of North Alabama
Rehab Concepts Corp.	DE	
Rehabilitation Hospital Corporation of America, LLC	DE	HealthSouth Chesapeake Rehabilitation Hospital
		HealthSouth Outpatient Therapy Services
		HealthSouth Rehabilitation Hospital of Virginia
		HealthSouth Southern Hills Rehabilitation Hospital
		HealthSouth Western Hills Regional Rehabilitation Hospital
		HealthSouth Western Hills Outpatient
Rehabilitation Hospital of Colorado Springs, Inc.	DE	HEALTHSOUTH Rehabilitation Hospital of Colorado Springs
Rehabilitation Hospital of Phenix City, L.L.C.	AL	Regional Rehabilitation Hospital
Rehabilitation Hospital of Plano, LLC	DE	
Rehabilitation Institute Of Western Massachusetts, LLC	MA	HealthSouth Rehabilitation Hospital of Western Massachusetts
Reliant Blocker Corp.	DE	
Rusk Rehabilitation Center, L.L.C.	MO	Rusk Rehabilitation Center, a Joint Venture of HealthSouth and The University of Missouri - Columbia
Saint Barnabas/HealthSouth Rehabilitation Center, L.L.C.	NJ	HealthSouth Rehabilitation Hospital of Tinton Falls
Savannah Rehabilitation Hospital, LLC	DE	Rehabilitation Hospital of Savannah An Affiliate of HealthSouth
Sherwood Rehabilitation Hospital, Inc.	DE	
Southern Arizona Regional Rehabilitation Hospital, L.P.	DE	HealthSouth Rehabilitation Hospital of Southern Arizona
St. John HealthSouth Rehabilitation Hospital, LLC	DE	St. John Rehabilitation Hospital, affiliated with HealthSouth
St. Joseph HealthSouth Rehabilitation Hospital, LLC	DE	
Tarrant County Rehabilitation Hospital, Inc.	TX	HealthSouth City View Rehabilitation Hospital
Tyler Rehab Associates, L.P.	DE	Christus Trinity Mother Frances Rehabilitation Hospital,

		Affiliated with HealthSouth
Tyler Rehabilitation Hospital, Inc.	TX	
University of Virginia/HealthSouth L.L.C.	VA	UVA-HealthSouth Rehabilitation Hospital
		UVa-HEALTHSOUTH Sports Medicine & Rehabilitation Center
Van Matre Rehabilitation Center LLC	IL	Van Matre HealthSouth Rehabilitation Hospital
Vanderbilt Stallworth Rehabilitation Hospital, L.P.	TN	Vanderbilt Stallworth Rehabilitation Hospital
Wellmont/HealthSouth IRF, LLC	DE	The Rehabilitation Hospital of Southwest Virginia
West Virginia Rehabilitation Hospital, Inc.	WV	HealthSouth Mountain View Regional Rehabilitation Hospital
		HealthSouth Mountainview at Bridgeport
Western Medical Rehab Associates, L.P.	DE	HealthSouth Tustin Rehabilitation Hospital
Western Neuro Care, Inc.	DE	
Yuma Rehabilitation Hospital, L.L.C.	AZ	Yuma Rehabilitation Hospital, a Partnership of HealthSouth & YRMC
HealthSouth Home Health Holdings, Inc.	DE	
HealthSouth Home Health Corporation	DE	
A & B Home Health Solutions, LLC	CT	Encompass Home Health of New England
AHM Action Home Health, LP	TX	Encompass Home Health of East Texas
		Encompass Home Health of Arkansas
		Encompass Home Health of Texarkana
AHM Texas GP, LLC	DE	
AHM Texas LP, Inc.	DE	
Abba Home Health, L.P.	TX	Encompass Home Health of Lubbock
		Encompass Home Health of the Panhandle
		Encompass Hospice of the Panhandle
Advanced Homecare Holdings, Inc.	DE	
Advanced Homecare Management, Inc.	DE	Encompass Home Health
		Encompass Home Health and Hospice
Advantage Hospice, Inc.	TX	
Apex Hospice LLC	TX	Encompass Hospice of DFW
Best Home Care LP	TX	Encompass Home Health of the Permian Basin
CareServices of Bethesda, LLC	FL	Encompass Home Health of Bethesda Health
CareServices of the Treasure Coast, LLC	FL	
CareSouth Health System, Inc.	DE	
CareSouth HHA Holdings of Columbus, LLC	GA	Encompass Home Health of Georgia
CareSouth HHA Holdings of Dothan, LLC	GA	Encompass Home Health of Alabama
CareSouth HHA Holdings of Gainesville, LLC	GA	Encompass Home Health and Hospice
		Encompass Home Health of Georgia
CareSouth HHA Holdings of Greensboro, LLC	GA	Encompass Home Health of North Carolina
CareSouth HHA Holdings of Lexington, LLC	GA	Encompass Home Health of North Carolina
CareSouth HHA Holdings of Middle Georgia, LLC	GA	Encompass Home Health of Georgia
CareSouth HHA Holdings of North Florida, LLC	GA	Encompass Home Health of Florida
CareSouth HHA Holdings of Panama City, LLC	FL	Encompass Home Health of Florida
CareSouth HHA Holdings of Richmond, LLC	VA	Encompass Home Health of Virginia
CareSouth HHA Holdings of South Carolina, LLC	GA	Encompass Home Health of South Carolina
CareSouth HHA Holdings of Tallahassee, LLC	FL	Encompass Home Health of Florida
CareSouth HHA Holdings of the Bay Area, LLC	GA	Encompass Home Health of Florida
CareSouth HHA Holdings of the Treasure Coast, LLC	GA	CareServices of Jupiter Medical Center Encompass Home Health of Jupiter Medical Center
CareSouth HHA Holdings of Valley, LLC	GA	Encompass Home Health of Alabama
CareSouth HHA Holdings of Virginia, LLC	GA	Encompass Home Health of Virginia

		Encompass Home Health of Delaware Lighthouse Home Health
CareSouth HHA Holdings of Washington, LLC	GA	Encompass Home Health of Georgia
CareSouth HHA Holdings of Western Carolina, LLC	GA	Encompass Home Health of North Carolina
CareSouth HHA Holdings of Winchester, LLC	GA	Encompass Home Health of Tennessee Encompass Hospice of Tennessee
CareSouth HHA Holdings, LLC	GA	
CareSouth Hospice, LLC	GA	Encompass Hospice of South Carolina
		Encompass Hospice of Georgia
CareSouth Private Duty Holdings, LLC	GA	
CareSouth Private Duty of Georgia, LLC	GA	
CareSouth Private Duty of South Carolina, LLC	GA	
Continental Home Care, Inc.	OK	Encompass Home Health of Eastern Oklahoma
CS Health & Wellness, LLC	GA	
DRC Health Systems, L.P.	TX	Encompass Home Health of Corpus Christi
		Encompass Home Health of Houston
		Encompass Hospice of Houston
Day-By-Day Staff Relief, Inc.	OK	Encompass Home Health of Kansas
		Encompass Home Health of Northeast Oklahoma
		Encompass Hospice of Kansas
		Encompass Private Duty of Kansas
		Encompass Home Health of Kansas City
		Encompass Hospice of Kansas City
Dosik, Inc.	TX	Encompass Home Health of Livingston
EHHI Holdings, Inc.	DE	
Encompass Home Health of Austin, LLC	TX	Austin Home Health
		Encompass Home Health of Austin
		Encompass Hospice of Austin
		Encompass Home Health of Fredericksburg
		Encompass Home Health of Georgetown
Encompass Home Health of Colorado, LLC	CO	Encompass Home Health of Colorado
		Encompass Hospice of Colorado
Encompass Home Health of DFW, LLC	TX	Encompass Home Health of DFW
Encompass Home Health of East Texas, LLC	TX	Encompass Hospice of Texarkana
Encompass Home Health of New England, LLC	DE	
Encompass Home Health of Roanoke, LLC	DE	Encompass Home Health of Virginia
Encompass Home Health of the Midwest, LLC	DE	Encompass Home Health of Illinois
		Encompass Home Health of Indiana
		Encompass Home Health of Ohio
Encompass Home Health of the Mid Atlantic, LLC	VA	Encompass Home Health of Virginia
		Encompass Home Health of Western Virginia
		Encompass Hospice of Virginia
		Encompass Home Health of Maryland
		Encompass Home Health of Pennsylvania
Encompass Home Health of the Southeast, LLC	FL	Encompass Home Health of Florida
Encompass Home Health of the West, LLC	ID	Encompass Home Health and Hospice of Utah
		Encompass Home Health of Idaho
		Encompass Home Health of Arizona
		Encompass Home Health of Nevada
		Ecompass Home Health of Southern Utah
		Encompass Hospice of Southern Utah
Encompass Hospice of the West, LLC	ID	Encompass Hospice of Idaho
		Encompass Hospice of Utah
Encompass of Fort Worth, LP	TX	Encompass Home Health of North Central Texas

		Encompass Home Health of Wichita Falls
Encompass of West Texas, LP	TX	Encompass Home Health of West Texas
Excella Associates, L.L.C.	MA	
Excella Healthcare, Inc.	MA	
Excella Home Health Agency, LLC	MA	Encompass Home Health of New England
Excella Homecare, Inc.	MA	Encompass Home Health of New England
Guardian Home Care, Inc.	ID	Encompass Home Health & Hospice of Idaho
		Encompass Home Health of Oregon
		Encompass Hospice of Oregon
Hallmark Homecare, L.P.	TX	Encompass Home Health of Bryan/College Station
		Encompass Home Health of Central Texas
		Encompass Hospice of Bryan/College Station
		Family Home Health
HealthCare Innovations Holdings, L.L.C.	TX	
HealthCare Innovations of Oklahoma, L.L.C.	TX	Encompass Home Health of Southeast Oklahoma
		Encompass Hospice of Southeast Oklahoma
HealthCare Innovations of Western Oklahoma, L.L.C.	TX	Encompass Home Health of Western Oklahoma
HealthCare Innovations-Travertine Health Services, L.L.C.	TX	Encompass Home Health of Central Oklahoma
Idaho Homecare Holdings, Inc.	ID	
Orion Homecare, LLC	ID	Encompass Home Health of Western Idaho
		Encompass Home Health of Wyoming
Preferred Home Health, L.P.	TX	Encompass Home Health of Southeast Texas
TH of San Antonio, LLC	TX	Encompass Hospice of Central Texas
Texas Senior Care, L.P.	TX	Encompass Home Health of Greater Dallas
		Encompass Home Health of Northeast Texas
WellCare, Inc.	NM	Encompass Home Health of New Mexico
		Encompass Hospice of New Mexico
Wellmark Healthcare Services of El Paso, Inc.	TX	Encompass Home Health of El Paso

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-141702, 333-157445, 333-175981, and 333-212840) of HealthSouth Corporation of our report dated February 22, 2017 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 22, 2017

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 HealthSouth 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 22, 2017

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 HealthSouth 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 22, 2017

By: /s/ DOUGLAS E. COLTHARP

Name: Douglas E. Coltharp

Title: Executive Vice President and Chief Financial Officer

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 HealthSouth Corporation on Form 10-K for the period ended December 31, 2016 , as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Mark J. Tarr, President and Chief Executive Officer of HealthSouth 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 HealthSouth Corporation.

Date: February 22, 2017

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 HealthSouth Corporation and will be retained by HealthSouth 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 HealthSouth 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 HealthSouth 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 HealthSouth Corporation on Form 10-K for the period ended December 31, 2016 , 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 HealthSouth 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 HealthSouth Corporation.

Date: February 22, 2017

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 HealthSouth Corporation and will be retained by HealthSouth 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 HealthSouth 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 HealthSouth Corporation specifically incorporates it by reference.