Encompass Health®

ANNUAL REPORT 2020

Encompass Health Corporation

Who we are

Inpatient rehabilitation hospitals

137

Home health locations

241

Hospice locations

82

#1 Owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues and number of hospitals

4th Largest provider of Medicare-certified skilled home health services

8th Largest provider of hospice services

Number of states in which we operate

39

and Puerto Rico

~31%

Share of Medicare patients receiving inpatient rehabilitation services from Encompass Health

Placing patients first, both business segments retained a leading position in quality of care in 2020.

INPATIENT REHABILITATION

Discharge to acute
11.1% | 10.4%
Lower is better

Discharge to community
80.8% | 79.8%
Higher is better

Discharge to SNF
7.5% | 9.1%
Lower is better

HOME HEALTH & HOSPICE

Patient satisfaction
4.3 stars | 3.5 stars
Higher is better

Quality of care
3.9 stars | 3.0 stars
Higher is better

30-day hospitalization readmission
16.1% | 17.6%
Lower is better

Encompass Health
Benchmark

Encompass Health continued to develop innovative solutions to provide high-quality outcomes for both our patients and partners in care.

INPATIENT REHABILITATION

We deployed the readmission prevention program, which uses predictive analytics to determine the risk of a patient readmitting to an acute care hospital after they leave our care.

HOME HEALTH

We fully deployed the Medalogix Care module to further assist us in the effective management of our care plans for home health patients and to promote discharge to community.

Encompass Health is well positioned for the future.

We consistently generate high levels of free cash flow.

$579.9

Million in adjusted free cash flow

2020

$516.5

Million in adjusted free cash flow

2019

Expected 5% to 7% CAGR for adjusted free cash flow from 2020 through 2025

We are well positioned to fund growth opportunities in both of our core business segments.

GROWTH TARGETS

INPATIENT REHABILITATION

6 to **10**
de novos **per year**

HOME HEALTH & HOSPICE

$50 to **$100** million
of acquisitions **per year**

Data disclosed reflects 2020 results for Encompass Health. Disclosures for non-GAAP financial information can be found *here*.

On December 9, 2020, the Company announced it is exploring strategic alternatives for its home health and hospice business. The review is ongoing, and no decision has been made. Accordingly, the Company's longer term growth targets assume the continuation of the current structure of the business. The growth targets may change depending on the ultimate outcome of the review.

Encompass Health®

Notice of the 2021 Annual Meeting of Stockholders
Thursday, May 6, 2021

Proxy Statement
and
Annual Report on Form 10-K
for the year ended
December 31, 2020

Encompass Health®

Dear valued stockholders,

At Encompass Health, we have a history of adapting to change and doing it well. If there was ever a year that proved that, it was 2020. Looking back, we're proud of our Company and how we responded to the changes going on in the world around us. Both of our business segments quickly responded to meet the needs of our patients, employees and business partners.

- We continued to provide vital care to an aging population. In 2020, we cared for more than 181,800 patients in our inpatient rehabilitation hospitals and more than 207,000 patients in our home health and hospice agencies.
- We opened four new hospitals and expanded existing hospitals by 117 beds.
- We continued to develop innovative solutions for both our patients and partners in care. We deployed the readmission prevention program, which uses predictive analytics to determine the risk of a patient being readmitted to a hospital after they leave our care. We also fully deployed the Medalogix Care module to further assist us in the effective management of our care plans for home health patients.
- We continue to place a great deal of importance on inclusion, diversity and equity. In 2020, we continued our commitment to inclusion, diversity and equity initiatives in workforce development, patient experience, community partnership and supplier diversity. We emphasized our commitment through our participation in the CEO Action for Diversity and Inclusion Pledge and production of a series of video conversations with various employees and members of executive management in order to highlight personal experience with prejudice and injustice.
- Our hospitals have treated over 8,000 patients suffering or recovering from COVID-19. Our focus on specialized rehabilitative care also means that in many cases our hospitals are ideal settings for treating the debilitating effects of COVID-19, such as significant muscle weakness, cognitive impairments, shortness of breath with activity and malnutrition. In addition, our home health agencies have also cared for over 9,000 patients suffering or recovering from COVID-19.
- We stayed focused on the patient experience. The impact of our caring and compassionate teams was on full display in 2020. As our hospitals were forced to close their doors to visitors and as our homebound seniors were isolated from family and friends, often the only contacts patients had for weeks at a time were their Encompass Health clinicians. When COVID-19 shut most of the world down, our employees came to work, putting the well-being of our patients first. They truly are heroes.

In December 2020, we announced that we are exploring strategic alternatives for our home health and hospice business. We are one of the top home health providers in the nation, as measured by both our financial results and quality outcomes, and that allows us to consider a wide array of transactions and structures. Our strategic review is ongoing, and no timetable has been established for its completion. Accordingly, we remain focused on the diligent execution of our strategy for both segments.

As we look ahead into 2021, we are confident the fundamentals of our business are intact and strong. In fact, we believe COVID-19 has created an even stronger awareness of the high level of care we provide in our inpatient rehabilitation hospitals and further reinforced home as a preferred care setting. And, as the population ages, the demand for our high-quality services will increase. In 2021, we plan to open eight new hospitals and add 100 to 150 beds to existing hospitals. Development will continue in 2022, as we expect to open an additional 10 hospitals. In our home health and hospice segment, we expect opportunities for accelerating market share capture both organically and through industry consolidation. We also look forward to the continued rollout of the vaccine and return of elective procedures in 2021 and the resulting growth that will return for both of our segments.

Sincerely,

Leo I Higdon Jr.
Chairman – Board of Directors

Mark Tarr
President and Chief Executive Officer

March 26, 2021

Dear Fellow Stockholder:

I am pleased to invite you to attend our 2021 Annual Meeting of Stockholders of Encompass Health Corporation, to be held on Thursday, May 6, 2021, at 11:00 a.m., central time. As we continue our precautions relating to the COVID-19 pandemic, we will conduct this year's annual meeting by live webcast on the internet. You will be able to attend and participate in the meeting by visiting www.virtualshareholdermeeting.com/EHC2021 and entering the 16-digit control number included on your Notice of Internet Availability of Proxy Materials (the "Notice") or on your proxy card if you receive the proxy materials by mail. Due to public health and safety considerations, there will not be an in-person meeting this year.

We will consider the items of business described in the Notice and in the Proxy Statement accompanying this letter and respond to any questions you may have. The Proxy Statement contains important information about the matters to be voted on and the process for voting, along with information about Encompass Health, its management and its directors.

Every stockholder's vote is important to us. Even if you plan to attend the annual meeting by logging into the virtual annual meeting website, *please promptly vote* by submitting your proxy by phone, by internet or by mail. The "Commonly Asked Questions" section of the Proxy Statement and the enclosed proxy card contain detailed instructions for submitting your proxy. If you plan to attend the annual meeting by logging into the virtual annual meeting website, you must provide proof of share ownership by entering the 16-digit control number included on your Notice.

On behalf of the directors, management and employees of Encompass Health, thank you for your continued support of and ownership in our company.

Sincerely,

Leo I. Higdon, Jr.
Chairman of the Board of Directors

ENCOMPASS HEALTH CORPORATION

Notice of Annual Meeting of Stockholders

TIME	11:00 a.m., central time, on Thursday, May 6, 2021
PLACE	As a precaution intended to protect the health and well-being of our employees, stockholders and others during the COVID-19 pandemic, this year's annual meeting will be conducted by live webcast on the internet. You may attend and participate in the meeting by visiting www.virtualshareholdermeeting.com/EHC2021 and entering the 16-digit control number included on your proxy card or Notice of Internet Availability of Proxy Materials. If you hold your shares through an intermediary, such as a bank or broker, and do not have a control number, please contact the bank or broker. Due to public health and safety considerations, there will not be an in-person meeting.
ITEMS OF BUSINESS	• To elect 14 directors to the board of directors to serve until our 2022 annual meeting of stockholders. ➢ **The board of directors recommends a vote FOR each nominee.** • To ratify the appointment by Encompass Health's Audit Committee of PricewaterhouseCoopers LLP as Encompass Health's independent registered public accounting firm. ➢ **The board of directors recommends a vote FOR ratification.** • To approve, on an advisory basis, the compensation of the named executive officers as disclosed in Encompass Health's Definitive Proxy Statement for the 2021 annual meeting. ➢ **The board of directors recommends a vote FOR the approval of the compensation of our named executive officers.** • To transact such other business as may properly come before the annual meeting and any adjournment or postponement.
RECORD DATE	You can vote if you are a holder of record of Encompass Health common stock on March 9, 2021.
PROXY VOTING	Your vote is important. Please vote in one of these ways: • Via internet: Go to http://www.proxyvote.com and follow the instructions. You will need to enter the control number printed on your proxy card or Notice of Internet Availability of Proxy Materials; • By telephone: Call toll-free 1-800-690-6903 and follow the instructions. You will need to enter the control number printed on your proxy card or Notice of Internet Availability of Proxy Materials; • In writing: Complete, sign, date and promptly return your proxy card in the enclosed envelope; or • Submit a vote during the virtual annual meeting at www.virtualshareholdermeeting.com/EHC2021.

Important Notice for the Stockholders Meeting to be Held on May 6, 2021

Encompass Health's Proxy Statement on Schedule 14A, form of proxy card, and 2020 Annual Report (including the 2020 Annual Report on Form 10-K) are available at http://www.proxyvote.com after entering the control number printed on your proxy card or Notice of Internet Availability of Proxy Materials.

Patrick Darby

Birmingham, Alabama
March 26, 2021

Patrick Darby
Secretary

ENCOMPASS HEALTH CORPORATION
PROXY STATEMENT

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NOTE TO READERS

As used in this report, the terms “Encompass Health,” “we,” “us,” “our,” and the “Company” refer to Encompass Health Corporation and its consolidated subsidiaries, unless otherwise stated or indicated by context. We use the term “Encompass Health Corporation” to refer to Encompass Health Corporation alone wherever a distinction between Encompass Health Corporation and its subsidiaries is required or aids in the understanding of this filing. We refer to our consolidated subsidiary, EHHI Holdings, Inc. and its subsidiaries, which collectively operate our home health and hospice business, as “EHHI.”

This proxy statement and the accompanying form of proxy are first being sent to our stockholders on March 26, 2021.

ENCOMPASS HEALTH CORPORATION
PROXY STATEMENT

PROXY SUMMARY

This summary highlights selected information about the items to be voted on at our annual meeting and information contained elsewhere in this proxy statement. This summary does not contain all of the information that you should consider in deciding how to vote, so you should read the entire proxy statement carefully before voting.

Proposals That Require Your Vote

Proposals	Board Recommendation	Votes Required for Approval	More Information
1. Election of 14 directors to serve until our 2022 annual meeting	**FOR each nominee**	Votes for the nominee exceed 50% of the votes cast with respect to such nominee	Page 9
2. Ratification of the appointment of our independent registered public accounting firm	**FOR**	Votes for the proposal exceed the votes against the proposal	Page 17
3. Approval, on an advisory basis, of our executive compensation	**FOR**	Votes for the proposal exceed the votes against the proposal	Page 19

Say-on-Pay Highlights

We have received a say-on-pay approval vote of greater than 93% every year. We believe our stockholders have overwhelmingly endorsed our pay-for-performance track record, strong corporate governance, and compensation risk mitigation practices, including the following best practices related to executive compensation:

- ✓ **Annual and long-term incentive plans have maximum award opportunities.**
- ✓ **Annual and long-term incentive plans are designed with multiple measures of performance.**
- ✓ **Annual incentive plan includes both financial and quality of care (ESG) metrics.**
- ✓ **Compensation recoupment, or "claw-back," policy applies to both cash and equity incentives.**
- ✓ **Equity ownership guidelines for executives require retention of 50% of net shares at the time of exercise/vest until the ownership multiple is met. Non-employee directors must hold awards until departure.**
- ✓ **Insider trading policy expressly prohibits hedging or pledging of our stock by executives and directors.**
- ✓ **Supplemental executive benefits or perquisites are substantially limited to a nonqualified 401(k) plan and optional executive physical examinations.**
- ✓ **Independent sessions are scheduled at every regular meeting of our board and its committees (no members of management are present at these independent sessions).**
- ✓ **Change-of-control compensation arrangements include "double triggers" and do not gross-up for taxes.**

Our pay-for-performance and other compensation best practices are discussed further beginning on page 38.

Governance Highlights

✓	Independent, non-executive chairman of the board
✓	13 of 14 independent directors (all except CEO)
✓	All standing board committees are fully independent
✓	Heightened board independence requirement (75% of directors must be independent)
✓	All directors attended at least 75% of the meetings of the board and the respective committees
✓	Robust stock ownership requirements for directors and officers
✓	Majority voting in uncontested director elections, combined with contingent resignations of directors
✓	Declassified board with annual elections
✓	None of the directors serve on more than 3 outside public company boards
✓	Gender diversity (women comprise 36% of the board and 38% of executive officers)
✓	No poison pill in place
✓	Annual board and committee performance evaluations and periodic involvement of outside advisors in such evaluations
✓	Active stockholder engagement program
✓	Focus on diversity in succession planning (see page 28 for latest on board refreshment process)
✓	Regular reviews of succession plans for CEO and other senior executives
✓	Stockholders may amend our bylaws by simple majority vote
✓	Proxy reimbursement bylaw for stockholder proxy solicitation expenses (see page 29)
✓	Stockholder-adopted exclusive forum bylaw
✓	Stockholders may act by written consent
✓	Stockholders representing 20% of outstanding shares may call a special meeting
✓	Term limit for directors of 15 years, subject to exceptions at the board's discretion
✓	Mandatory retirement age for directors of 75, subject to exceptions at the board's discretion
✓	No related party transactions with directors
✓	Limitations on directorships for executive officers
✓	Enterprise risk management, including cybersecurity, oversight by full board and designated committees on regular schedule (see pages 20-22)
✓	ESG oversight by full board and designated committees on regular schedule (see pages 21-22)
✓	Sustainability targets in the executive compensation program (quality of care metrics) (see pages 43-44)
✓	Organizational focus on a strong culture that values inclusion, diversity, and equity and employee development and engagement (see the discussion in our 2020 Annual Report on Form 10-K)

COMMONLY ASKED QUESTIONS

Why did I receive these proxy materials?

We are furnishing this proxy statement in connection with the solicitation by our board of directors of proxies to be voted at our 2021 annual meeting of stockholders and at any adjournment or postponement. As a reminder, our annual meeting will be entirely by means of live internet webcast, frequently referred to as a “virtual annual meeting.” At our annual meeting, stockholders will act upon the following proposals:

(1) to elect 14 directors to the board of directors to serve until our 2022 annual meeting of stockholders;

(2) to ratify the appointment by the Audit Committee of our board of directors of PricewaterhouseCoopers LLP as our independent registered public accounting firm;

(3) to approve, on an advisory basis, the compensation of the named executive officers, as disclosed in this proxy statement for the 2021 annual meeting; and

(4) to transact such other business as may properly come before the 2021 annual meeting of stockholders and any adjournment or postponement.

These proxy solicitation materials are being sent to our stockholders on or about March 26, 2021 and summarize the purposes of the meeting and the information you need to know to vote at the annual meeting.

How can I participate in the virtual annual meeting?

Attendance at the 2021 annual meeting of stockholders is limited to stockholders. You will be able to attend and participate in the virtual annual meeting by visiting www.virtualshareholdermeeting.com/EHC2021 and entering the 16-digit control number included on your proxy card or Notice of Internet Availability of Proxy Materials. If you hold your shares through an intermediary or nominee, such as a bank or stockbroker, and do not have a control number, please contact the bank, broker or nominee for instructions. Please log in to the website by 10:45 a.m., central time, on the day of the meeting.

You may vote and submit questions during the annual meeting by following the instructions available on the meeting website. All questions that comply with the rules for the meeting posted on the meeting website will be answered. If the time allotted for the meeting is not sufficient to allow for answering all the questions submitted, we will post the question and our response on our website at https://investor.encompasshealth.com at our earliest convenience. Out of fairness and respect to all attendees, we will not answer questions that are:

- not pertinent to the business of the Company or to the business of the annual meeting,
- related to material non-public information of the Company,
- related to personal grievances or individual personnel matters or not otherwise a matter of interest to stockholders generally,
- derogatory references to individuals or that are otherwise offensive or in bad taste,
- repetitious questions or statements already submitted or made by another stockholder,
- related to pending or threatened litigation, or
- otherwise not in compliance with the rules for the meeting posted on the meeting website.

Who is entitled to vote at the meeting?

The board of directors has determined that those stockholders who are recorded in our record books as owning shares of our common stock as of the close of business on March 9, 2021, are entitled to receive notice of and to vote at the annual meeting of stockholders. As of February 12, 2021, there were 99,265,706 shares of our common stock issued and outstanding. Your shares may be (1) held directly in your name as the stockholder of record or (2) held for you as the beneficial owner through a stockbroker, bank or other nominee, or both. Our common stock is our only class of outstanding voting securities. Each share of common stock owned as of the close of business on March 9, 2021 is entitled to one vote on each matter properly brought before the annual meeting.

What is the difference between holding shares as a stockholder of record and as a beneficial owner?

Most of our stockholders hold their shares through a stockbroker, bank or other nominee rather than directly in their own name. As summarized below, there are some distinctions between shares held of record and those owned beneficially.

Stockholder of Record. If your shares are registered directly in your name with our transfer agent, Computershare Trust Company, N.A., you are considered, with respect to those shares, the stockholder of record, and these proxy materials are being sent directly to you by us. As the stockholder of record, you have the right to grant your voting proxy directly to us or to vote during the meeting on the virtual annual meeting website. If you requested a paper copy of the proxy materials, we have enclosed a proxy card for you to use.

Beneficial Owner. If your shares are held in a stock brokerage account or by a bank or other nominee, you are considered the beneficial owner of shares held in street name, and these proxy materials are being forwarded to you by your broker, bank, or nominee which is considered, with respect to those shares, the stockholder of record. As the beneficial owner, you have the right to direct your broker on how to vote and are also invited to attend the meeting. However, because you are not the stockholder of record, you may not vote these shares during the meeting on the virtual annual meeting website unless you obtain a signed proxy from the record holder giving you the right to vote the shares. Your broker, bank, or nominee has enclosed or provided a voting instruction card for you to use in directing the broker or nominee how to vote your shares. If you do not provide the stockholder of record with voting instructions, your shares will constitute broker non-votes. The effect of broker non-votes is more specifically described in “What vote is required to approve each item?” below.

How can I vote my shares at the virtual annual meeting?

Shares held directly in your name as the stockholder of record may be voted during the virtual annual meeting, and you will need the control number included on your proxy card or Notice of Internet Availability of Proxy Materials. Submitting your proxy by telephone, by internet or by mail will in no way limit your right to vote during the virtual annual meeting.

Shares held beneficially in street name may be voted by you only if you obtain a signed proxy from the record holder giving you the right to vote the shares. Owners of shares held in street name that expect to attend and vote during the virtual annual meeting should contact their broker, bank or nominee as soon as possible to obtain the necessary proxy.

Even if you currently plan to attend the virtual annual meeting, we recommend that you also submit your proxy as described below so your vote will be counted if you later decide not to attend the meeting.

How can I vote my shares without attending the meeting?

Whether you hold shares directly as the stockholder of record or beneficially in street name, you may direct your vote without attending the meeting. You may vote by granting a proxy or, for shares held in street name, by submitting voting instructions to your broker, bank, or nominee.

Please refer to the summary instructions below and those included on your proxy card or, for shares held in street name, the voting instruction card included by your broker, bank, or nominee. The internet and telephone voting procedures established for our stockholders of record are designed to authenticate your identity, to allow you to give your voting instructions, and to confirm those instructions have been properly recorded. Internet and telephone voting for stockholders of record will be available 24 hours a day, and will close at 11:59 p.m. eastern time on May 5, 2021. The availability of internet and telephone voting for beneficial owners will depend on the voting processes of your broker, bank or other holder of record. Therefore, we recommend that you follow the voting instructions you receive.

- BY INTERNET – If you have internet access, you may submit your proxy from any location in the world by following the “internet” instructions on the proxy card or Notice of Internet Availability of Proxy Materials. Please have one of those documents in hand when accessing the website as you will need the control number found there.
- BY TELEPHONE – If you live in the United States, Puerto Rico, or Canada, you may submit your proxy by following the “telephone” instructions on your proxy card or Notice of Internet Availability of Proxy Materials. Please have one of those documents in hand when you call as you will need the control number found there.

- BY MAIL – If you requested a paper copy of the proxy materials, you may vote by mail by marking, signing, and dating your proxy card or, for shares held in street name, the voting instruction card included by your broker, bank, or nominee and mailing it in the accompanying enclosed, pre-addressed envelope. If you provide specific voting instructions, your shares will be voted as you instruct. If you do not have the pre-addressed envelope available, please mail your completed proxy card to: Vote Processing, c/o Broadridge, 51 Mercedes Way, Edgewood, NY 11717. Mailed proxy cards must be received no later than May 5, 2021 in order to be counted.

If you cast your vote in any of the ways set forth above, your shares will be voted in accordance with your voting instructions unless you validly revoke your proxy. We do not currently anticipate that any other matters will be presented for action at the annual meeting. If any other matters are properly presented for action, the persons named as your proxies will vote your shares on these other matters in their discretion, under the discretionary authority you have granted to them in your proxy.

Shares cannot be voted by marking, writing on and/or returning a Notice of Internet Availability of Proxy Materials. Any Notices of Internet Availability that are returned will not be counted as votes.

Can I access the proxy statement and annual report on the internet?

Yes. You may have received a Notice of Internet Availability of Proxy Materials with instructions on how to access the materials on the internet. Regardless, this proxy statement, the form of proxy card and our Annual Report on Form 10-K for the year ended December 31, 2020 (the "2020 Form 10-K") are available at http://www.proxyvote.com. If you received a paper copy of the proxy materials, you have made a previous election to that effect. If you are a stockholder of record and would like to access future proxy materials electronically instead of receiving paper copies in the mail, there are several ways to do this. You can mark the appropriate box on your proxy card or follow the instructions if you vote by telephone or the internet. If you have internet access, we hope you make this choice. Receiving future annual reports and proxy statements via the internet will be simpler for you, will save the Company money and is friendlier to the environment.

A copy of our 2020 Form 10-K and the proxy materials are also available without charge from the "Investors" section of our website at https://investor.encompasshealth.com. **The 2020 Form 10-K and the proxy materials are also available in print to stockholders without charge and upon request, addressed to Encompass Health Corporation, 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Corporate Secretary.**

Rules adopted by the Securities and Exchange Commission permit us to provide stockholders with proxy materials electronically instead of in paper form. We have decided to provide a Notice of Internet Availability of Proxy Materials with instructions on how to access the materials on the internet except in the event a stockholder has previously elected to receive printed material.

Can I change my vote after I submit my proxy?

Yes. Even after you have submitted your proxy, you may change your vote at any time prior to the close of voting at the annual meeting by:

- filing with our corporate secretary at 9001 Liberty Parkway, Birmingham, Alabama 35242, a signed, original written notice of revocation dated later than the proxy you submitted;
- submitting a duly executed proxy bearing a later date;
- voting by telephone or internet on a later date; or
- attending the virtual annual meeting and voting during the meeting on the meeting website.

In order to revoke your proxy, you must send an original notice of revocation of your proxy to the address in the first bullet above sent by U.S. mail or overnight courier prior to the voting deadline. You may not revoke your proxy by any other means. If you grant a proxy, you are not prevented from attending the virtual annual meeting and voting. However, your attendance at the virtual annual meeting will not by itself revoke a proxy you have previously granted; you must vote during the virtual annual meeting to revoke your proxy.

If your shares are held by a broker, bank or other nominee, you may revoke your proxy by following the instructions provided by your broker, bank, or nominee. All valid proxies not revoked will be voted at the annual meeting.

What is "householding" and how does it affect me?

We are delivering the Notice of Internet Availability of Proxy Materials or other proxy materials addressed to all stockholders who share a single address unless they have notified us they wish to "opt out" of the program known as "householding." Under the householding procedure, stockholders of record who have the same address and last name receive only one copy of the Notice of Internet Availability or other proxy materials. Householding is intended to reduce our printing and postage costs and material waste. WE WILL DELIVER A SEPARATE COPY OF THE ANNUAL REPORT, PROXY STATEMENT, OR NOTICE OF INTERNET AVAILABILITY OF PROXY MATERIALS PROMPTLY UPON WRITTEN OR ORAL REQUEST. You may request a separate copy by contacting our corporate secretary at 9001 Liberty Parkway, Birmingham, Alabama 35242, or by calling 1-205-967-7116.

If you are a stockholder of record and you choose not to have these disclosure documents sent to a single household address as described above, you must "opt-out" by writing to: Broadridge Financial Solutions, Inc., Householding Department, 51 Mercedes Way, Edgewood, New York 11717, or by calling 1-866-540-7095, and we will cease householding disclosure documents within 30 days. If we do not receive instructions to remove your account(s) from this service, your account(s) will continue to be householded. Conversely, if you are receiving multiple copies of these disclosure documents and wish to receive only one copy, you should contact your bank or broker for information regarding householding of disclosure documents and to request a change in delivery status.

Is there a list of stockholders entitled to vote at the meeting?

A complete list of stockholders entitled to vote at the meeting will be open for examination by our stockholders for any purpose germane to the meeting, during regular business hours at the meeting place, for ten days prior to the meeting.

What constitutes a quorum to transact business at the meeting?

Before any business may be transacted at the annual meeting, a quorum must be present. The presence at the annual meeting, by participation in the virtual meeting or by proxy, of the holders of a majority of the shares of all of our capital stock outstanding and entitled to vote on the record date will constitute a quorum. At the close of business on February 12, 2021, 99,265,706 shares of our common stock were issued and outstanding. Proxies received but marked as abstentions and broker non-votes will be included in the calculation of the number of shares considered to be present at the annual meeting for purposes of a quorum.

If a quorum is not present or if we decide that more time is necessary for the solicitation of proxies, we may adjourn the annual meeting. We may do this with or without a stockholder vote. If the stockholders vote to adjourn the annual meeting in accordance with our Bylaws, the named proxies will vote all shares of common stock for which they have voting authority in favor of adjournment.

What is the recommendation of the board of directors?

Our board of directors unanimously recommends a vote:

- **"FOR" the election of each of our 14 nominees to the board of directors;**
- **"FOR" the ratification of the appointment of PricewaterhouseCoopers LLP as Encompass Health's independent registered public accounting firm; and**
- **"FOR" the approval of the compensation of our named executive officers, as disclosed in this proxy statement pursuant to the compensation disclosure rules of the Securities and Exchange Commission.**

With respect to any other matter that properly comes before the annual meeting, the proxy holders will vote in accordance with their judgment on such matter.

What vote is required to approve each item?

The vote requirements for Proposals One and Two are as follows:

- Each nominee for director named in Proposal One will be elected if the votes for the nominee exceed 50% of the number of votes cast with respect to such nominee. Votes cast with respect to a nominee will include votes to withhold authority but will exclude abstentions and broker non-votes.
- The ratification of the appointment of PricewaterhouseCoopers LLP as our independent registered public accounting firm will be approved if the votes cast for the proposal exceed those cast against the proposal. Broker non-votes will not be counted as votes cast for or against the proposal.

Please note that "say-on-pay," Proposal Three, is only advisory in nature and has no binding effect on the Company or our board of directors. The board will consider the proposal approved if the votes cast in favor of it exceed the votes cast against it. Broker non-votes will not be counted as votes cast for or against it.

A "broker non-vote" occurs when a bank, broker or other holder of record holding shares for a beneficial owner does not vote on a particular proposal because that holder does not have discretionary voting power for that particular item and has not received instructions from the beneficial owner. If you are a beneficial owner, your bank, broker or other holder of record is permitted to vote your shares on the ratification of the independent registered public accounting firm even if the record holder does not receive voting instructions from you. Absent instructions from you, the record holder may not vote on any "nondiscretionary" matter including a director election, an equity compensation plan, a matter relating to executive compensation, certain corporate governance changes, or any stockholder proposal. In that case, without your voting instructions, a broker non-vote will occur. An "abstention" will occur at the annual meeting if your shares are deemed to be present at the annual meeting, either because you attend the annual meeting or because you have properly completed and returned a proxy, but you do not vote on any proposal or other matter which is required to be voted on by our stockholders at the annual meeting. You should consult your broker if you have questions about this.

The affirmative vote of at least a majority of our issued and outstanding shares present, by logging into the virtual annual meeting website or by proxy, and entitled to vote at the annual meeting will be required to approve any stockholder proposal validly presented at a meeting of stockholders. Under applicable Delaware law, in determining whether any stockholder proposal has received the requisite number of affirmative votes, abstentions will have the same effect as a vote against any stockholder proposal. Broker non-votes will be ignored. There are no dissenters' rights of appraisal in connection with any stockholder vote to be taken at the annual meeting.

What does it mean if I receive more than one proxy or voting instruction card?

It means your shares of common stock are registered differently or are in more than one account. Please return each proxy and voting instruction card you receive. For each Notice of Internet Availability of Proxy Materials you receive, please submit your vote for each control number you have been assigned.

Where can I find the voting results of the meeting?

We will announce preliminary voting results at the meeting. We will publish the voting results in a Current Report on Form 8-K to be filed with the SEC no later than four business days following the end of the annual meeting. If preliminary results are reported initially, we will update the filing when final, certified results are available.

Who will count the votes?

A representative of Broadridge Financial Solutions, Inc., acting as the inspector of election, will tabulate and certify the votes.

Who will pay for the cost of this proxy solicitation?

We are making this solicitation and will pay the entire cost of preparing, assembling, printing, mailing, and distributing these proxy materials. If you choose to access the proxy materials or vote over the internet, however, you are responsible for internet access charges you may incur. In addition to the mailing of these proxy materials, the solicitation of proxies or votes may be made in person, by telephone, or by electronic communication by our directors, officers and employees, who will not receive any additional compensation for such solicitation activities. We will request banks, brokers, nominees, custodians, and other fiduciaries who hold shares of our stock in street name, to forward these proxy solicitation materials to the beneficial owners of those shares and we will reimburse the reasonable out-of-pocket expenses they incur in doing so.

Who should I contact if I have questions?

If you hold our common stock through a brokerage account and you have any questions or need assistance in voting your shares, you should contact the broker or bank where you hold the account. If you are a registered holder of our common stock and you have any questions or need assistance in voting your shares, please call our Investor Relations department at 1-205-968-6400. As an additional resource, the SEC website has a variety of information about the proxy voting process at www.sec.gov/spotlight/proxymatters.shtml.

NO PERSON IS AUTHORIZED TO GIVE ANY INFORMATION OR TO MAKE ANY REPRESENTATION OTHER THAN THOSE CONTAINED IN THIS PROXY STATEMENT, AND, IF GIVEN OR MADE, SUCH INFORMATION MUST NOT BE RELIED UPON AS HAVING BEEN AUTHORIZED. THE DELIVERY OF THIS PROXY STATEMENT WILL, UNDER NO CIRCUMSTANCES, CREATE ANY IMPLICATION THAT THERE HAS BEEN NO CHANGE IN THE AFFAIRS OF THE COMPANY SINCE THE DATE OF THIS PROXY STATEMENT.

ITEMS OF BUSINESS REQUIRING YOUR VOTE

Proposal 1 – Election of Directors

Director Nominees

Our board of directors currently consists of 14 members. Based on the recommendation of the Nominating/ Corporate Governance Committee, our board proposes that each of the 14 nominees listed below be elected as directors at this annual meeting and serve until our 2022 annual meeting of stockholders.

Each director nominee named in Proposal One will be elected if the votes for that nominee exceed 50% of the number of votes cast with respect to that nominee. Votes cast with respect to a nominee will include votes to withhold authority but will exclude abstentions and broker non-votes. If a nominee becomes unable or unwilling to accept the nomination or election, the persons designated as proxies will be entitled to vote for any other person designated as a substitute nominee by our board of directors. We have no reason to believe that any of the following nominees will be unable to serve. Below we have provided information relating to each of the director nominees proposed for election by our board, including a brief description of why he or she was nominated.

Name of Nominee	Age	Current Roles	Director
Greg D. Carmichael*	58	Member of Compensation and Human Capital Committee and Nominating/Corporate Governance Committee	1/1/2020
John W. Chidsey *	58	Member of Audit Committee (Chair) and Finance Committee	10/2/2007
Donald L. Correll *	70	Member of Compensation and Human Capital Committee and Finance Committee (Chair)	6/29/2005
Yvonne M. Curl *	66	Member of Compensation and Human Capital Committee (Chair) and Nominating/Corporate Governance Committee	11/18/2004
Charles M. Elson *	61	Member of Finance Committee and Nominating/Corporate Governance Committee	9/9/2004
Joan E. Herman *	67	Member of Audit Committee and Compliance/Quality of Care Committee (Chair)	1/25/2013
Leo I. Higdon, Jr. *	74	Chairman of the Board of Directors; Member of Compensation and Human Capital Committee and Nominating/Corporate Governance Committee	8/17/2004
Leslye G. Katz *	66	Member of Finance Committee and Nominating/Corporate Governance Committee	1/25/2013
Patricia A. Maryland*	67	Member of Compensation and Human Capital Committee and Compliance/Quality of Care Committee	1/1/2020
John E. Maupin, Jr. *	74	Member of Compensation and Human Capital Committee and Compliance/Quality of Care Committee	8/17/2004
Nancy M. Schlichting*	66	Member of Audit Committee and Compliance/Quality of Care Committee	12/11/2017
L. Edward Shaw, Jr. *	76	Member of Compensation and Human Capital Committee and Nominating/Corporate Governance Committee (Chair)	6/29/2005
Mark J. Tarr	59	President and Chief Executive Officer	12/29/2016
Terrance Williams*	52	Member of Audit Committee and Finance Committee	1/1/2020

* Denotes independent director.

There are no arrangements or understandings known to us between any of the nominees listed above and any other person pursuant to which that person was or is to be selected as a director or nominee, other than any arrangements or understandings with persons acting solely as directors or officers of Encompass Health.

Greg D. Carmichael

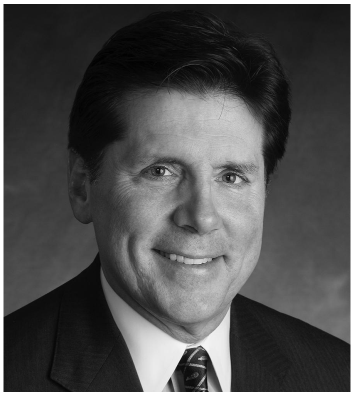
Mr. Carmichael is the chairman and chief executive officer of Fifth Third Bancorp. He joined Fifth Third in June 2003 as executive vice president and chief information officer. After being named chief operating officer in 2006, he became president in 2012. He was appointed to Fifth Third's board of directors and became CEO in 2015 and was elected chairman of the board in 2018. From 2000 to 2003, Mr. Carmichael was vice president and chief information officer for Emerson Electric, a worldwide provider of technology and energy solutions. From 1996 to 2000, he served in the same roles for a subsidiary of Emerson, and from 1986 to 1996, he served in several information technology and leadership roles at General Electric. Mr. Carmichael currently serves on the board of the American Bankers Association.

Mr. Carmichael has extensive experience in matters of information technology, cybersecurity, finance, corporate strategy and senior leadership relevant to large public companies. He qualifies as an "audit committee financial expert" within the meaning of SEC regulations.

John W. Chidsey

Mr. Chidsey is the chief executive officer of Subway Restaurants. Prior to joining Subway in November 2019, he served as an executive board member of TopTech Holdings, LLC, a provider of comprehensive cloud-based technology with expertise in hiring, training, scheduling, back office and standardization, prior to the sale of that company in August 2019. From the time of the October 2010 sale of Burger King Holdings, Inc. to 3G Capital until April 18, 2011, Mr. Chidsey served as co-chairman of the board of directors of Burger King Holdings, Inc. Before the sale, he served as chief executive officer and a member of its board from April 2006, including as chairman of the board from July 2008. From September 2005 until April 2006, he served as president and chief financial officer. He served as president, North America, from June 2004 to September 2005, and as executive vice president, chief administrative and financial officer from March 2004 until June 2004. Prior to joining Burger King, Mr. Chidsey served as chairman and chief executive officer for two corporate divisions of Cendant Corporation: the Vehicle Services Division that included Avis Rent A Car, Budget Rent A Car Systems, PHH and Wright Express and the Financial Services Division that included Jackson Hewitt and various membership and insurance companies. Mr. Chidsey currently serves on the board and the audit and compensation committees of Norwegian Cruise Line Holdings Ltd. He recently served as a director of Brinker International, Inc.

Mr. Chidsey has extensive experience in matters of finance, corporate strategy and senior leadership relevant to large public companies. Mr. Chidsey is a certified public accountant and a member of the Georgia Bar Association. He qualifies as an "audit committee financial expert" within the meaning of SEC regulations.



Donald L. Correll

Mr. Correll is chief executive officer and co-founder of Water Capital Partners, LLC, a firm that identifies, invests in, advises, and manages water and wastewater infrastructure assets and operations. Mr. Correll served as the president and chief executive officer and a director of American Water Works Company, Inc., the largest and most geographically diversified provider of water services in North America, from April 2006 to August 2010. Between August 2003 and April 2006, Mr. Correll served as president and chief executive officer of Pennichuck Corporation, a publicly traded holding company which, through its subsidiaries, provides public water supply services, certain water related services, and certain real estate activities, including property development and management. From 2001 to 2003, Mr. Correll served as an independent advisor to water service and investment firms on issues relating to marketing, acquisitions, and investments in the water services sector. From 1991 to 2001, Mr. Correll served as chairman, president and chief executive officer of United Water Resources, Inc., a water and wastewater utility company. He currently serves as the non-executive chairman as well as a member of the audit, leadership development and compensation, and executive committees of New Jersey Resources Corporation.

Mr. Correll has extensive experience in matters of accounting, finance, corporate strategy and senior leadership relevant to large public companies. He is a certified public accountant and has experience with a major public accounting firm. Mr. Correll qualifies as an "audit committee financial expert" within the meaning of SEC regulations.

Yvonne M. Curl

Ms. Curl is a former vice president and chief marketing officer of Avaya, Inc., a global provider of next-generation business collaboration and communications solutions, which position she held from October 2000 through April 2004. Before joining Avaya, Ms. Curl was employed by Xerox Corporation beginning in 1976, where she held a number of middle and senior management positions in sales, marketing and field operations, culminating with her appointment to corporate vice president. Ms. Curl currently serves as a director/trustee of VALIC Companies I & II, a mutual fund complex sponsored by American International Group, Inc., and as a director on the boards of the Hilton Head Community Foundation and the Hilton Head Humane Association. In the past five years, she has served as a director of Nationwide Mutual Insurance Company.

Ms. Curl has proven senior executive experience with broad operational experience in sales, marketing, and general management through her previous roles with large public companies as described above. Having served on several compensation committees on the board of directors of public companies, she has experience in the development and oversight of compensation programs and policies.

Charles M. Elson

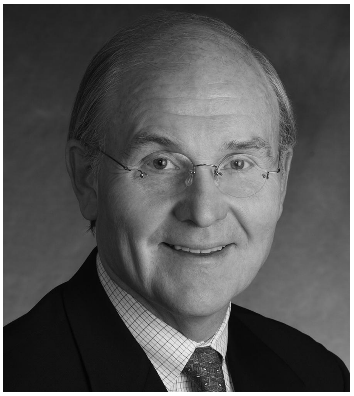
Mr. Elson is a professor of Finance and the Edgar S. Woolard, Jr. Chair in Corporate Governance at the University of Delaware's Alfred Lerner College of Business and Economics. From 2000 to 2020, he served as the director of the John L. Weinberg Center for Corporate Governance at the University of Delaware. Mr. Elson has also served on the National Association of Corporate Directors' Commissions on Director Compensation, Executive Compensation and the Role of the Compensation Committee, Director Professionalism, CEO Succession, Audit Committees, Governance Committee, Strategic Planning, Director Evaluation, Risk Governance, Role of Lead Director, Strategy Development, Board Diversity, Board and Long-term Value Creation, and Building the Strategic Asset Board. Additionally, he has served as a member of the National Association of Corporate Directors' Best Practices Council on Coping with Fraud and Other Illegal Activity and of that organization's Advisory Council. Mr. Elson serves on the board of Blue Bell Creameries U.S.A., Inc., a privately held company. He recently served as a director of Bob Evans Farms, Inc. In addition, Mr. Elson serves as vice chairman of the American Bar Association's Committee on Corporate Governance. Mr. Elson has been Of Counsel/consultant to the law firm of Holland & Knight LLP from 1995 to the present.

Mr. Elson has extensive knowledge of and experience in matters of corporate governance through his leadership roles with professional organizations dedicated to the topic as described above. Through his other professional roles, Mr. Elson is in a unique position to monitor and counsel on developments in corporate governance.

Joan E. Herman

Ms. Herman has served as the president and chief executive officer of Herman & Associates, LLC, a healthcare and management consulting firm, since 2008. Herman & Associates provides services to healthcare providers, pharmacy benefit managers, managed care organizations, and private equity firms. From 1998 to 2008, she served in a number of senior management positions, including president and chief executive officer for two corporate divisions, at Anthem, Inc. (f/k/a WellPoint, Inc.), a leading managed healthcare company that offers network-based managed care plans. Prior to joining Anthem, she served in a number of senior positions at Phoenix Life Insurance Company for 16 years, lastly as senior vice president of strategic development. She currently serves as a director and a member of the audit committee of Ionis Pharmaceuticals, Inc., an RNA-targeted drug discovery and development firm. In the past five years, she has served as a director of Convergys Corporation, a publicly traded company until it was acquired by Synnex Corporation in October 2018.

Ms. Herman has extensive experience leading large complex businesses, including in the healthcare and insurance industries. With Anthem, she gained experience dealing with government reimbursement issues as well as state and federal healthcare and insurance regulators. Additionally, she has completed the National Association of Corporate Directors' Cyber-Risk Oversight Program, which is designed to enhance cybersecurity literacy and strengthen cyber-risk oversight practices, and holds a CERT Certificate in Cybersecurity Oversight. She also qualifies as an "audit committee financial expert" within the meaning of SEC regulations. Her senior involvement and board service with various community and charity organizations, such as the Venice Family Clinic Foundation where she is the board chair, evidences her leadership skills and character.



Leo I. Higdon, Jr.

Mr. Higdon was unanimously elected to serve as chairman of our board of directors on May 1, 2014. He served as president of Connecticut College from July 1, 2006 to December 31, 2013. He served as the president of the College of Charleston from October 2001 to June 2006. Between 1997 and 2001, Mr. Higdon served as president of Babson College in Wellesley, Massachusetts. He also served as dean of the Darden Graduate School of Business Administration at the University of Virginia. His financial experience includes a 20-year tenure at Salomon Brothers, where he became vice chairman and member of the executive committee, managing the Global Investment Banking Division. Mr. Higdon also serves as the lead independent director of Eaton Vance Corp., a provider of investment management and advisory services, and as a director of Citizens Financial Group, Inc.

As a result of his 20 years of experience in the financial services industry combined with his strategic management skills gained through various senior executive positions, including in academia, and service on numerous boards of directors, Mr. Higdon has extensive experience with strategic and financial planning and the operations of large public companies.

Leslye G. Katz

From January 2007 to December 2010, Ms. Katz served as senior vice president and chief financial officer of IMS Health, Inc., a provider of information, services, and technology for clients in the pharmaceutical and healthcare industries. Prior to that, she served as vice president and controller for five years. From July 1998 to July 2001, Ms. Katz served as senior vice president and chief financial officer of American Lawyer Media, Inc., a privately held legal media and publishing company. Prior to joining American Lawyer Media, Ms. Katz held a number of financial management positions with The Dun & Bradstreet Corporation, followed by two years as vice president and treasurer of Cognizant Corporation, a spin-off from D&B. Ms. Katz recently served as a director of ICF International, Inc., a provider of management, technology, and policy consulting and implementation services to government and commercial clients. She currently serves as vice-chair of the board of directors of My Sisters' Place, a not-for-profit provider of shelter, advocacy, and support services to victims of domestic violence.

Ms. Katz has extensive experience in financial management at companies serving the healthcare and pharmaceutical industries, as well as expertise in mergers and acquisitions, treasury, financial planning and analysis, SEC reporting, investor relations, real estate, and procurement. She has further demonstrated her leadership and character in her board service with a community charity. She qualifies as an "audit committee financial expert" within the meaning of SEC regulations.

Patricia A. Maryland

Ms. Maryland has 40 years of healthcare administration experience. In 2019, she retired as an Executive Vice President for Ascension and president and chief executive officer at Ascension Healthcare, a leading non-profit health system operating more than 2,600 sites of care including 150 hospitals and more than 50 senior living facilities in 20 states and the District of Columbia. Prior to that, Ms. Maryland held other executive and management positions in the Ascension organization for 13 years, including president and chief executive of the St. John Providence Health System and President of the Indianapolis Hospital, St. Vincent's Health System. Prior to joining Ascension, Ms. Maryland worked in administrative roles with Detroit Medical Center, North Oakland Medical Centers, Cleveland Clinic Foundation and Mercy Hospital. Ms. Maryland also serves as a director on the board of Surgery Partners, Inc., an operator of surgical facilities and provider of ancillary services.

Ms. Maryland has extensive senior management and strategy planning experience with large healthcare provider organizations as described above and as a result brings a wealth of knowledge and understanding of the healthcare industry. She has demonstrated leadership and character through involvement, including board roles, over many years in numerous community and healthcare related non-profit organizations.

John E. Maupin, Jr.

Dr. Maupin is a retired healthcare executive with over 40 years of diverse executive leadership experience in academic medicine, public health, ambulatory care and government relations. He served as president and chief executive officer of Morehouse School of Medicine for eight years until his retirement in July 2014. Prior to that, he was the president and chief executive officer of Meharry Medical College for 12 years. His other executive leadership positions have included chief administrative officer of the Morehouse School of Medicine, chief executive officer of Southside Healthcare, Inc., and Deputy Commissioner Medical Services, Baltimore City Health Department. Dr. Maupin currently serves as a director/trustee of VALIC Companies I & II, a mutual fund complex sponsored by American International Group, Inc. In the past five years, he has served as a director on the boards of LifePoint Health, Inc. and Regions Financial Corp.

Dr. Maupin has a distinguished record as a health policy expert, having served on numerous national public health and scientific advisory boards and panels. He also has extensive experience working with the legislative and executive branches of federal and state government and agencies within the U.S. Department of Health and Human Services. Additionally, he has demonstrated his leadership and character through involvement in board roles in community and civic organizations as well as through his over 20 years of service as a career dental officer in the U.S. Army Reserves, retiring in 1996.

Nancy M. Schlichting

In December 2016, Ms. Schlichting retired as the president and chief executive officer at Henry Ford Health System, Inc., a position she held from June 2003. Prior to that, Ms. Schlichting served as HFHS's executive vice president and chief operating officer from 1998 to 2003. She also served as president and chief executive officer of HFHS's Henry Ford Hospital from 2001 to 2003. During her time at HFHS, the company garnered significant national recognition, including the Malcolm Baldrige National Quality Award and the John M. Eisenberg Patient Safety and Quality Award. Prior to joining HFHS in 1998, Ms. Schlichting served as the president of the Eastern Region of Catholic Health Initiatives, president and chief executive officer of Riverside Methodist Hospitals and executive vice president and chief operating officer of Akron City Hospital and Summa Health System. Ms. Schlichting currently serves as a director of Walgreens Boots Alliance, Inc., where she serves on the audit, compensation and leadership performance committees, and Hill-Rom Holdings, Inc., where she serves on the nominating/corporate governance and compensation and management development committees.

Ms. Schlichting has extensive senior management and administrative experience with large healthcare provider organizations as described above and as a result brings a wealth of knowledge and understanding of the healthcare industry. She has demonstrated leadership and character through involvement, including board roles, over many years in numerous community and healthcare related non-profit organizations. Additionally, she has broad accounting and financial knowledge gained from her education and experience and qualifies as an "audit committee financial expert" within the meaning of SEC regulations.

L. Edward Shaw, Jr.

Following his practice as a partner at Milbank LLP, Mr. Shaw served as general counsel of The Chase Manhattan Bank from 1983 to 1996 and Aetna, Inc. from 1999 to 2003. In addition to his legal role, his responsibilities at both institutions included a wide range of strategic planning, risk management, compliance and public policy issues. From 1996 to 1999, he served as chief corporate officer of the Americas for National Westminster Bank PLC. In 2004, Mr. Shaw was appointed independent counsel to the board of directors of the New York Stock Exchange dealing with regulatory matters. From March 2006 to July 2010, he served on a part-time basis as a senior managing director of Richard C. Breeden & Co., and affiliated companies engaged in investment management, strategic consulting, and governance matters. In the past five years, Mr. Shaw has served as a director of MSA Safety Inc. He currently serves as a director and former chairman of Covenant House, the nation's largest privately funded provider of crisis care to children.

Mr. Shaw has a wide ranging legal and business background, including senior leadership roles, in the context of large public companies as described above with particular experience in corporate governance, risk management and compliance matters. He also has significant experience in the healthcare industry as a result of his position with Aetna.

Mark J. Tarr

Mr. Tarr became our president and chief executive officer on December 29, 2016. Previously, he served as executive vice president of our operations since October 1, 2007, to which the chief operating officer designation was added on February 24, 2011. Mr. Tarr joined us in 1993 and has held various management positions with us, including serving as president of our inpatient division from 2004 to 2007, as senior vice president with responsibility for all inpatient operations in Texas, Louisiana, Arkansas, Oklahoma, and Kansas from 1997 to 2004, as director of operations of our 80-bed rehabilitation hospital in Nashville, Tennessee from 1994 to 1997, and as chief executive officer/administrator of our 70-bed rehabilitation hospital in Vero Beach, Florida from 1992 to 1994.

Mr. Tarr, as our president and chief executive officer, directs the strategic, financial and operational management of the Company and, in this capacity, provides unique insights into its detailed operations. He also has the benefit of more than 25 years of experience in the operation and management of inpatient rehabilitation hospitals.

Terrance Williams

Mr. Williams is the Executive Vice President and General Manager of Allstate Agency Distribution group, where he oversees the Market Operating Committees, Distribution Strategy and Program Development, and Allstate Canada. Before joining Allstate in January 2020, he served as executive vice president and chief marketing officer for Nationwide Mutual Insurance Company as well as the president of the Nationwide's emerging businesses group, which included legacy niche and emerging businesses, innovation teams, and a venture capital fund. During 24 years with Nationwide, he advanced through leadership roles touching almost every aspect of the business, including underwriting, claims, operations, sales and various profit and loss management roles. He currently serves on the board of the Columbus (OH) Regional Airport Authority and the advisory board for Darla Moore School of Business at the University of South Carolina.

Mr. Williams has a deep and broad base of marketing, insurance (payor), and regulated-industry experience. He also brings extensive experience in managing every aspect of business from sales, marketing, and operations to enterprise strategy across a large geographic platform. He qualifies as an "audit committee financial expert" within the meaning of SEC regulations.

Board Recommendation

The board of directors unanimously recommends that you vote "FOR" the election of all 14 director nominees.

Proposal 2 – Ratification of Appointment of Independent Registered Public Accounting Firm

Appointment of PricewaterhouseCoopers LLP

In accordance with its charter, the Audit Committee of our board of directors selected the firm of PricewaterhouseCoopers LLP to be our independent registered public accounting firm for the 2021 audit period, and with the endorsement of the board of directors, recommends to our stockholders that they ratify that appointment. The Audit Committee will reconsider the appointment of PricewaterhouseCoopers LLP for the next audit period if such appointment is not ratified. Representatives of PricewaterhouseCoopers LLP are expected to attend the annual meeting and will have the opportunity to make a statement if they desire, and are expected to be available to respond to appropriate questions.

The Audit Committee recognizes the importance of maintaining the independence of our independent registered public accounting firm, both in fact and appearance. Consistent with its charter, the Audit Committee has evaluated PricewaterhouseCoopers LLP's qualifications, performance, and independence, including that of the lead audit partner. The Audit Committee reviews and approves, in advance, the audit scope, the types of non-audit services, if any, and the estimated fees for each category for the coming year. For each category of proposed service, PricewaterhouseCoopers LLP is required to confirm that the provision of such services does not impair their independence. Before selecting PricewaterhouseCoopers LLP, the Audit Committee carefully considered that firm's qualifications as an independent registered public accounting firm for the Company. This included a review of its performance in prior years, as well as its reputation for integrity and competence in the fields of accounting and auditing. The Audit Committee has expressed its satisfaction with PricewaterhouseCoopers LLP in all of these respects. The Audit Committee's review included inquiry concerning any litigation involving PricewaterhouseCoopers LLP and any proceedings by the SEC against the firm. In this respect, the Audit Committee has concluded that the ability of PricewaterhouseCoopers LLP to perform services for us is in no way adversely affected by any such investigation or litigation.

Pre-Approval of Principal Accountant Services

The Audit Committee is responsible for the appointment, oversight, and evaluation of our independent registered public accounting firm. In accordance with our Audit Committee's charter, our Audit Committee must approve, in advance of the service, all audit and permissible non-audit services provided by our independent registered public accounting firm. Our independent registered public accounting firm may not be retained to perform the non-audit services specified in Section 10A(g) of the Securities Exchange Act of 1934, as amended. The Audit Committee has concluded that provision of the non-audit services described in that section is not compatible with maintaining the independence of PricewaterhouseCoopers LLP.

The Audit Committee has established a policy regarding pre-approval of audit and permissible non-audit services provided by our independent registered public accounting firm, as well as all engagement fees and terms for our independent registered public accounting firm. Under the policy, the Audit Committee must approve the services to be rendered and fees to be charged by our independent registered public accounting firm. Typically, the Audit Committee approves services up to a specific amount of fees. The Audit Committee must then approve, in advance, any services or fees exceeding those pre-approved levels. The Audit Committee may delegate general pre-approval authority to a subcommittee of which the chairman of the Audit Committee is a member, provided that any delegated approval is limited to services with fees of no more than 5% of previously approved amounts.

Principal Accountant Fees and Services

With respect to the audits for the years ended December 31, 2020 and 2019, the Audit Committee approved the audit services to be performed by PricewaterhouseCoopers LLP, as well as certain categories and types of audit-related and permitted non-audit services. In 2020 and 2019, the Audit Committee approved all audit, audit-related, and other fees in accordance with SEC pre-approval rules. The following table shows the aggregate fees paid or accrued for professional services rendered by PricewaterhouseCoopers LLP for the years ended December 31, 2020 and 2019, with respect to various services provided to us and our subsidiaries.

	For the Year Ended December 31,	
	2020	2019
	(In Millions)	
Audit fees[1]	$ 3.16	$ 3.15
Audit-related fees[2]	0.20	0.28
Total audit and audit-related fees	3.36	3.43
Tax fees[3]	0.02	0.03
All other fees[4]	0.09	0.08
Total fees	$ 3.47	$ 3.54

(1) *Audit fees* – Represents aggregate fees paid or accrued for professional services rendered for the audit of our consolidated financial statements and internal control over financial reporting for each year presented; fees for professional services rendered for the review of financial statements included in our Form 10-Qs, and fees for professional services normally provided by our independent registered public accounting firm in connection with statutory and regulatory engagements required by various partnership agreements or state and local laws in the jurisdictions in which we operate or manage hospitals.

(2) *Audit-related fees* – Represents aggregate fees paid or accrued for assurance and related services that are reasonably related to the performance of audit services and traditionally are performed by our independent auditor, including fees related to the delivery of comfort letters for our senior notes offerings.

(3) *Tax fees* – Represents fees for all professional tax services provided by our independent auditor's tax professionals, such as preparation of Puerto Rico tax returns and other tax compliance matters, but not including any services related to the audit of our financial statements.

(4) *All other fees* – Represents fees paid or due to our independent auditor for due diligence work associated with proposed transactions and acquisitions.

Board Recommendation

The board of directors and the Audit Committee unanimously recommend that you vote "FOR" ratifying the appointment of PricewaterhouseCoopers LLP as Encompass Health's independent registered public accounting firm for the 2021 audit period.

Proposal 3 – Advisory Vote on Executive Compensation

We seek your advisory vote on our executive compensation programs and ask that you support the compensation of our named executive officers as disclosed under the heading "Executive Compensation," including the "Executive Summary" section, beginning on page 34 and the accompanying tables and related narrative disclosure. This proposal, commonly referred to as a "say-on-pay" proposal, gives stockholders the opportunity to express their views on the named executive officers' compensation. This vote is not intended to address any specific item of compensation, but rather the overall compensation of the named executive officers and the philosophy, policies, and practices described in this proxy statement.

As described under the heading "Compensation Discussion and Analysis" on page 34, the Company provides annual and long-term compensation programs as well as the other benefit plans, to attract, motivate, and retain the named executive officers, each of whom is critical to the Company's success, and to create a remuneration and incentive program that aligns the interests of the named executive officers with those of stockholders. The board of directors believes the program strikes the appropriate balance between utilizing responsible, measured pay practices and effectively incentivizing the named executive officers to dedicate themselves fully to value creation for our stockholders. At the 2020 annual meeting, 97.4% of stockholders voting on the say-on-pay proposal approved of our executive compensation.

You are encouraged to read the information detailed under the heading "Executive Compensation" beginning on page 34 for additional details about the Company's executive compensation programs.

The board of directors strongly endorses the Company's executive compensation program and recommends that the stockholders vote in favor of the following resolution:

"RESOLVED, that the Company's stockholders approve, on an advisory basis, the compensation of the named executive officers, as disclosed in the Encompass Health Corporation Definitive Proxy Statement for the 2021 annual meeting of stockholders pursuant to the compensation disclosure rules of the Securities and Exchange Commission, including the Compensation Discussion and Analysis, the 2020 Summary Compensation Table and the other related tables and disclosure."

This say-on-pay vote is advisory, and therefore not binding on the Company, the Compensation and Human Capital Committee or the board of directors. Our board of directors and its Compensation and Human Capital Committee value the opinions of our stockholders and to the extent there is any significant vote against the named executive officer compensation as disclosed in this proxy statement, we will consider stockholders' concerns and the Compensation and Human Capital Committee will evaluate whether any actions are necessary to address those concerns. The board has elected to hold the say-on-pay advisory vote annually until further notice, so the next advisory vote is expected to be in connection with the 2022 annual meeting of stockholders.

Board Recommendation

The board of directors unanimously recommends a vote "FOR" the approval of the compensation of our named executive officers, as disclosed in this proxy statement pursuant to the compensation disclosure rules of the Securities and Exchange Commission.

CORPORATE GOVERNANCE AND BOARD STRUCTURE

Corporate Governance

Corporate Governance Guidelines

Our board of directors has developed corporate governance policies and practices in order to help fulfill its responsibilities to stockholders and provide a flexible framework for it to review, evaluate, and oversee the Company's business operations and management. The board adopted Corporate Governance Guidelines provide, among other things, that each member of the board will:

- dedicate sufficient time, energy, and attention to ensure the diligent performance of his or her duties;
- comply with the duties and responsibilities set forth in the guidelines and in our Bylaws;
- comply with all duties of care, loyalty, and confidentiality applicable to directors of publicly traded Delaware corporations; and
- adhere to our Standards of Business Ethics and Conduct, including the policies on conflicts of interest.

Our Nominating/Corporate Governance Committee oversees and periodically reviews the Guidelines, and recommends any proposed changes to the board for approval.

Code of Ethics

We have adopted the Standards of Business Ethics and Conduct, our "code of ethics," that applies to all employees, directors and officers, including our principal executive officer, principal financial officer, and principal accounting officer or controller, or persons performing similar functions. The purpose of the code of ethics is to promote:

- honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
- full, fair, accurate, timely, and understandable disclosure in periodic reports required to be filed by us;
- compliance with all applicable rules and regulations that apply to us and our employees, officers, and directors;
- prompt internal reporting of violations of the code to an appropriate person or persons identified in the code; and
- accountability for adherence to the code.

We disclose any amendments to, or waivers from, certain provisions of these ethical policies and standards for executive officers and directors on our website promptly following the date of the amendment or waiver. Upon written request to our corporate secretary, we will also provide a copy of the code of ethics free of charge.

Corporate Website

We maintain a "Corporate Governance" section on our website at https://investor.encompasshealth.com where you can find copies of our principal governance documents, including:

- Charters of the Company and of each of the standing committees of its board of directors;
- Bylaws;
- Standards of Business Ethics and Conduct; and
- Corporate Governance Guidelines.

Board Oversight of the Company's Risks

We maintain a comprehensive enterprise risk management program designed to identify potential events and conditions that may affect the Company and to manage risks to avoid materially adverse effects on the Company. Our management, including an executive risk committee, is responsible for the design and implementation of the enterprise risk management, or ERM, program. The Audit Committee of the board of directors, pursuant to its charter, is responsible for reviewing and evaluating our policies and procedures relating to risk assessment and management. The full board of directors monitors the ERM program by way of regular reports from our senior executives on management's risk assessments and risk status as well as our risk response and mitigation activities. Individual committees monitor, by way of regular reports, the material risks that relate to the responsibilities of that committee and report to the full board appropriate information. For example, the Compliance/Quality of Care Committee oversees assessment and management of several risk-related topics, such as cybersecurity, privacy, Medicare claims audits, patient satisfaction data, quality of care data, and compliance program administration. In 2020, the Compliance/Quality of Care Committee and the Audit Committee held a joint meeting to review the Company's monitoring and management of the accelerating expansion of local, state and federal regulatory requirements.

The Compensation and Human Capital Committee reviews and considers our compensation policies and programs in light of the board of directors' risk assessment and management responsibilities on an annual basis. In 2020, Mercer (US) Inc. in consultation with our human resources department prepared and presented to the Compensation and Human Capital Committee a risk assessment report that addressed the incentive compensation structure, programs, and processes at the corporate and field operation levels. The assessment included, among other things, a review of pay mix (fixed v. variable, cash v. equity and short v. long-term), performance metrics, target setting, performance measurement practices, pay determination, mitigation practices such as the Compensation Recoupment Policy, and overall governance and administration of pay programs. After reviewing this report and making inquiries of management, the Compensation and Human Capital Committee determined we have no compensation policies and programs that give rise to risks reasonably likely to have a material adverse effect on us. Additionally, the Compensation and Human Capital Committee oversees assessment and management of human capital-related risks, such as those involving recruitment, retention, inclusion and diversity, employee engagement, and employment litigation. For further discussion of our human capital management, see Item 1, *Business,* of our Annual Report on Form 10-K for the year ended December 31, 2020.

Board Oversight of the Company's Cybersecurity Program

The proper function, availability, and security of our information systems are critical to our business. We have structured our cybersecurity program around the National Institute of Standards and Technology ("NIST") Cybersecurity Framework, which provides best practices to identify, protect from, respond to, and recover from cyberattacks. The cybersecurity program, led by our chief security officer ("CSO"), consists of dedicated internal IT employees, including the staff of a security operations center, and long-term third-party security vendors. Members of our internal and external security team also participate in industry and governmental cybersecurity cooperative groups, including the Health Information Sharing and Analysis Center, the Institute for Applied Network Security, and the FBI's InfraGard. The CSO reports directly to our Chief Information Officer ("CIO"). Our CIO provides quarterly reports on our cybersecurity program to the Compliance/Quality of Care Committee and at least annually to our full board of directors. The reports to the committee and the full board include details and metrics on, among other things, our routine vulnerability assessments, internal and external threat intelligence, quarterly NIST framework assessments, quarterly company-wide phishing exercises and training, device encryption, routine resilience efforts including quarterly disaster recovery exercises, annual tabletop incident response exercise, annual business continuity exercise, cyber penetration tests, and 22 other NIST cyber hygiene controls.

Similarly, our chief compliance officer provides quarterly reports to the Compliance/Quality of Care Committee on patient privacy compliance efforts and related matters. We also maintain an inter-departmental privacy and security committee that generally meets at least quarterly and oversees our programs and initiatives that seek to protect and secure patient information as well as our data and systems. For example, this committee is responsible for our IT-security incident response plan and various training and awareness programs that promote good patient privacy and system security practices by employees.

Board Oversight of Sustainability Matters

As a healthcare provider, our business model by definition promotes sustainable ends. As our corporate purpose states, "We believe integrated care delivery across the healthcare continuum is critical to achieving the best outcomes for patients. We exist to provide a better way to care that elevates expectations and outcomes." In other words, our goal is to improve the health and well-being of our patients and, in the case of our hospice services, to support our patients and their caregivers with compassionate end-of-life care. That commitment we have to caring for our patients extends to our employees, as well as the communities in which we serve. For further detail on our sustainability story, please visit https://investor.encompasshealth.com/investor-resources/sustainability. Our website is not and shall not be deemed to be a part of this proxy statement by reference or otherwise incorporated into any other filings we make with the SEC.

In the context of our ERM program, our board has historically overseen those matters now frequently referred to as environmental, social and governance, or ESG, matters that have the potential to be material to the Company. Much of that oversight has been delegated to its committees. For example, the Compliance/Quality of Care Committee is tasked with oversight of patient care and privacy matters, and the Compensation and Human Capital Committee has reviewed employee recruitment and retention matters. The board formalized and approved an ESG reporting structure, set out in the table below, and schedule based in large part on the Sustainability Accounting Standards Board, or SASB, standards for healthcare delivery. Given our business model, not all topics below are material to us. Therefore, those topics are not reviewed by the board on a regular basis. However, we monitor changes in our operations, business model, regulatory requirements, and the broader business environment to assess the materiality of the ESG topics over time. The board is committed to monitoring our business as well as the broader concerns of our stockholders to identify changes in the importance of issues we face.

Board Committee	ESG Topic
Compliance/Quality of Care	Quality of Care and Patient Satisfaction* Patient Privacy and Electronic Health Records* Employee Health and Safety* Pricing and Billing Transparency* Climate Change Impacts on Human Health and Infrastructure*
Audit	Fraud and Unnecessary Procedures* Access for Low-Income Patients* Energy and Waste Efficiency* Management of Controlled Substances* Water Usage Supply Chain Risks
Compensation and Human Capital	Employee Recruitment, Development, and Retention* Inclusion and Diversity Gender Pay Equality Employee Relations Matters (including discrimination and harassment allegations)
Nominating/Corporate Governance	Political Spending Anti-competitive Practices Stockholder Engagement

* Topics from SASB’s Proposed Health Care Delivery SAS, October 2017.

Annual Evaluation of the Performance of the Board and Its Committees

On an annual basis, members of our board complete an evaluation of the performance of the board as well as each committee on which they serve, as required by the Corporate Governance Guidelines. The evaluations are intended to determine whether the board and its committees are functioning effectively and fulfilling the requirements set forth in the Corporate Governance Guidelines or the committee charters, as applicable. The evaluations also provide the board and its committees with an opportunity to reflect upon and improve processes and effectiveness. The board may, and does on occasion, obtain the advice and assistance of outside advisors in performing the evaluation, including conducting private interviews to provide for unattributed feedback. Results are reviewed by the Nominating/Corporate Governance Committee which then shares those results and any follow up recommendations with all members of the board.

Stockholder Engagement and Communications to Directors

We believe that thoughtful stockholder engagement is important, and we have an active engagement program in which we meet regularly with stockholders to discuss our business, strategy, operational initiatives, and corporate governance, as well as other topics of interest to them. Our stockholder engagement efforts allow us to better understand our stockholders' priorities, perspectives, and concerns, and enable the Company to effectively address issues that matter most to our stockholders. Members of management also attend several investor conferences throughout the year. We attend and participate in meetings of the Council of Institutional Investors and other investor groups in order to engage with members of the institutional shareholder community more generally. In March 2020, we hosted an investor day in New York City to give a broad base of our stockholders the opportunity to engage in person with members of our senior management. Our board of directors receives regular reports on feedback given by investors to management.

Stockholders and other parties interested in communicating directly to the board of directors, any committee, or any non-employee director or group of directors may do so by writing to:

ENCOMPASS HEALTH CORPORATION
BOARD OF DIRECTORS
9001 LIBERTY PARKWAY
BIRMINGHAM, ALABAMA 35242
ATTENTION: [Addressee*]

*** Including the name of the specific addressee(s) will allow us to direct the communication to the intended recipient.**

Stockholders and other interested parties may also submit a message electronically via a web-based form at https://investor.encompasshealth.com/corporate-governance/board-of-directors/contact-the-board/default.aspx, which generates an email that is sent to the office of our general counsel. All written and electronic communications will be opened by the office of our general counsel for the sole purpose of determining whether the contents represent a message to our directors. Correspondence appropriately directed to the board that is not in the nature of advertising, promotions of a product or service, or offensive material will be forwarded promptly to the addressee(s). In the case of communications to the board of directors or any group or committee of directors, sufficient copies of the contents will be made for all of the addressees.

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Board Structure and Committees

Board Structure and Meetings

Our business, property, and affairs are managed under the direction of our board of directors. Our Corporate Governance Guidelines provide for an independent director to serve as the non-executive chairman of the board who sets the agenda for, and presides over, board meetings, coordinates the work of the committees of our board of directors, and performs other duties delegated to the chairman by the board. The non-executive chairman also presides over independent sessions generally held at each board meeting. The board adopted this structure to promote decision-making and governance independent of that of our management and to better perform the board's monitoring and evaluation functions. Members of the board are kept informed of our business through discussions with our chief executive officer and other officers, by reviewing materials provided to them, by visiting our offices and facilities, and by participating in meetings of the board and its committees.

Our board met eight times during 2020. Each member of the board attended 75% or more of the meetings of the board and the committees on which he or she served during the year. In addition, it is our expectation that each director attend the annual meeting of stockholders. The members of the board generally hold a meeting the same day and location as the annual meeting of stockholders. All members of our board attended the annual meeting in 2020.

The board has the five standing committees set out in the table below, each of which is governed by a charter and reports its actions and recommendations to the full board. Each committee has the authority to retain, at the expense of the Company, outside advisors, including consultants and legal and accounting advisors. The following table shows the number of meetings and the membership of each board committee as of December 31, 2020.

	Audit	Compensation and Human Capital	Compliance/ Quality of Care	Finance	Nominating/ Corporate Governance
Number of Meetings in 2020:	9	7	6	7	7
Greg D. Carmichael		X			X
John W. Chidsey	Chair			X	
Donald L. Correll		X		Chair	
Yvonne M. Curl		Chair			X
Charles M. Elson				X	X
Joan E. Herman	X		Chair		
Leo I. Higdon, Jr.		X			X
Leslye G. Katz				X	X
Patricia A. Maryland		X	X		
John E. Maupin, Jr.		X	X		
Nancy M. Schlichting	X		X		
L. Edward Shaw, Jr.		X			Chair
Terrance Williams	X			X	

Audit Committee

The Audit Committee's purpose, per the terms of its charter, is to assist the board of directors in fulfilling its responsibilities to the Company and its stockholders, particularly with respect to the oversight of the accounting, auditing, financial reporting, and internal control and compliance practices of the Company. The specific responsibilities of the Audit Committee are, among others, to:

- assist the board in the oversight of the integrity of our financial statements and compliance with legal and regulatory requirements, the qualifications and independence of our independent auditor, and the performance of our internal audit function and our independent auditor;
- appoint, compensate, replace, retain, and oversee the work of our independent auditor;
- at least annually, review a report by our independent auditor regarding its internal quality control procedures, material issues raised by certain reviews, inquiries or investigations relating to independent audits within the last five years, and relationships between the independent auditor and the Company;
- review and evaluate our quarterly and annual financial statements with management and our independent auditor, including management's assessment of and the independent auditor's opinion regarding the effectiveness of our internal control over financial reporting;

- discuss earnings press releases as well as financial information and earnings guidance provided to analysts and rating agencies with management;
- discuss policies with respect to risk assessment and risk management; and
- appoint and oversee the activities of our Inspector General who has the responsibility to identify violations of Company policy and law relating to accounting or public financial reporting.

The Audit Committee Report appears on page 32 of this proxy statement.

Compensation and Human Capital Committee

The Compensation and Human Capital Committee's purpose and objectives are to attract and retain high-quality personnel to better ensure the long-term success of the Company and the creation of long-term shareholder value. Accordingly, this committee oversees our compensation and employee benefit objectives, plans and policies and approves, or recommends to the independent members of the board of directors for approval, the individual compensation of our executive officers. This committee also reviews our human capital strategy and management activities. The specific responsibilities of this committee are, among others, to:

- review and approve our compensation programs and policies, including our benefit plans, incentive compensation plans and equity-based plans and administer those plans as may be required;
- review and approve (or recommend to the board in the case of the chief executive officer) goals and objectives relevant to the compensation of the executive officers and evaluate their performances in light of those goals and objectives;
- determine and approve (together with the other independent directors in the case of the chief executive officer) the compensation levels for the executive officers;
- review and discuss with management the Compensation Discussion and Analysis and recommend inclusion thereof in our annual report or proxy statement;
- review and approve (or recommend to the board in the case of the chief executive officer) employment arrangements, severance arrangements and termination arrangements and change in control arrangements to be made with any executive officer;
- review at least annually our management succession plan and material compensation and human capital related risk exposures as well as management's efforts to monitor and mitigate those exposures; and
- review and recommend to the board the compensation for the non-employee members of the board.

The Compensation and Human Capital Committee Report appears on page 33 of this proxy statement.

As discussed in further detail in the table on page 40, the Compensation and Human Capital Committee engaged the independent compensation consultant, FW Cook, to assist it in its review and evaluation of executive compensation practices. The Compensation and Human Capital Committee has reviewed the independence of FW Cook and of each individual employee of the firm with whom it works. FW Cook does not perform other services for the Company, and the total fees paid to FW Cook during fiscal 2020 did not exceed $120,000. The committee has determined FW Cook has no conflict of interest in providing advisory services.

Compliance/Quality of Care Committee

The Compliance/Quality of Care Committee's function is to assist our board of directors in fulfilling its fiduciary responsibilities relating to our regulatory compliance and cyber risk management activities and to ensure we deliver quality care to our patients. The committee is primarily responsible for overseeing, monitoring, and evaluating our compliance with all of its regulatory obligations other than tax and securities law-related obligations and reviewing the quality of services provided to patients at our facilities. The specific responsibilities of the Compliance/Quality of Care Committee are, among others, to:

- ensure the establishment and maintenance of a regulatory compliance program and the development of a comprehensive quality of care program designed to measure and improve the quality of care and safety furnished to patients;
- appoint and oversee the activities of a chief compliance officer and compliance office with responsibility for developing and implementing our regulatory compliance program;

- oversee the cyber risk management program designed to monitor, mitigate and respond to cyber risks, threats, and incidents, and review periodic reports from the chief information officer, including developments in cyber threat environment and cyber risk mitigation efforts;
- review periodic reports from the chief compliance officer, including an annual regulatory compliance report summarizing compliance-related activities undertaken by us during the year, and the results of all regulatory compliance audits conducted during the year; and
- review and approve annually the quality of care program and review periodic reports from the chief medical officer regarding our efforts to advance patient safety and quality of care.

Finance Committee

The purpose and objectives of the Finance Committee are to assist our board of directors in the oversight of the use and development of our financial resources, including our financial structure, investment policies and objectives, and other matters of a financial and investment nature. The specific responsibilities of the Finance Committee are, among others, to:

- review and approve certain expenditures, contractual obligations and financial commitments per delegated authority from our board; and
- review, evaluate, and make recommendations to the board regarding (i) capital structure and proposed changes thereto, including significant new issuances, purchases, or redemptions of our securities, (ii) plans for allocation and disbursement of capital expenditures, (iii) credit rating, activities with credit rating agencies, and key financial ratios, (iv) long-term financial strategy and financial needs, (v) major activities with respect to mergers, acquisition and divestitures, and (vi) plans to manage insurance and asset risk.

Nominating/Corporate Governance Committee

The purposes and objectives of the Nominating/Corporate Governance Committee are to assist our board of directors in fulfilling its duties and responsibilities to us and our stockholders, and its specific responsibilities include, among others, to:

- recommend nominees for board membership to be submitted for stockholder vote at each annual meeting, and to recommend to the board candidates to fill vacancies on the board and newly-created positions on the board;
- assist the board in determining the appropriate characteristics, skills and experience for the individual directors and the board as a whole and create a process to allow the committee to identify and evaluate individuals qualified to become board members;
- evaluate annually and make recommendations to the board regarding the composition of each standing committee of the board, the policy with respect to rotation of committee memberships and/or chairpersonships, and the functioning of the committees;
- review the suitability for each board member’s continued service as a director when his or her term expires, and recommend whether or not the director should be re-nominated;
- assist the board in considering whether a transaction between a board member and the Company presents an inappropriate conflict of interest and/or impairs the independence of any board member; and
- develop Corporate Governance Guidelines that are consistent with applicable laws and listing standards, periodically review those guidelines, and recommend to the board any changes the committee deems necessary or advisable.

Board Composition and Director Nomination Process

Board Composition

Our board of directors is comprised of skilled directors who represent a diverse set of experiences, expertise and attributes. The board is almost entirely independent, with Mr. Tarr being the only non-independent member. Additionally, we maintain a beneficial mix of short- and long-tenured directors, with an average tenure of slightly less than ten years, in order to ensure that fresh perspectives are provided and that experience, continuity and stability exist on the board. Although there is no formal policy on diversity of nominees, both the board of directors and the Nominating/Corporate Governance Committee believe diversity of skills, perspectives and experiences as represented on the board as a whole, in addition to the primary factors, attributes or qualities discussed below, promote improved monitoring and evaluation of management on behalf of the stockholders and produces more creative thinking and solutions. The Nominating/Corporate Governance Committee considers the distinctive skills, perspectives and experiences that candidates diverse in race, gender, ethnic background, geographic origin and professional experience offer in the broader context of the primary evaluation described below. For a discussion of the individual experiences and qualifications of our board members, please refer to the section entitled “Items of Business Requiring Your Vote - Proposal 1: Election of Directors” in this proxy statement.

Criteria for Board Members

In evaluating the suitability of individual candidates and nominees, the Nominating/Corporate Governance Committee and our board of directors consider relevant factors, including, but not limited to: a general understanding of marketing, finance, information technology and cybersecurity, corporate strategy and other elements relevant to the operation of a large publicly-traded company in today’s business environment, senior leadership experience, an understanding of our business, educational and professional background, diversity of skills, perspectives and experiences, character, and whether the candidate would satisfy the independence standards of the New York Stock Exchange (the “NYSE”). The Nominating/Corporate Governance Committee also considers the following attributes or qualities in evaluating the suitability of candidates and nominees to the board:

- *Integrity*: Candidates should demonstrate high ethical standards and integrity in their personal and professional dealings.
- *Accountability*: Candidates should be willing to be accountable for their decisions as directors.
- *Judgment*: Candidates should possess the ability to provide wise and thoughtful counsel on a broad range of issues.
- *Responsibility*: Candidates should interact with each other in a manner which encourages responsible, open, challenging and inspired discussion. Directors must be able to comply with all duties of care, loyalty, and confidentiality.
- *High Performance Standards*: Candidates should have a history of achievements which reflects high standards for themselves and others.
- *Commitment and Enthusiasm*: Candidates should be committed to, and enthusiastic about, their performance for the Company as directors, both in absolute terms and relative to their peers. Directors should be free from conflicts of interest and be able to devote sufficient time to satisfy their board responsibilities.
- *Financial Literacy*: Candidates should be able to read and understand fundamental financial statements and understand the use of financial ratios and information in evaluating financial performance.
- *Courage*: Candidates should possess the courage to express views openly, even in the face of opposition.

Process for Identifying and Evaluating Candidates

The Nominating/Corporate Governance Committee has two primary methods for identifying director nominees. First, on a periodic basis, the committee solicits ideas for possible candidates from members of the board of directors, senior level executives, and individuals personally known to the members of the board of directors. Second, the committee may from time to time use its authority under its charter to retain, at the Company’s expense, one or more search firms to identify candidates (and to approve such firms’ fees and other retention terms).

The Nominating/Corporate Governance Committee will consider all candidates duly identified and will evaluate each of them based on the same criteria. The process that will be followed by the committee will include meetings from time to time to evaluate biographical information and background material relating to potential candidates and interviews of selected candidates by members of the Nominating/Corporate Governance Committee, other members of the board and senior management. The committee emphasizes creating a pool of candidates diverse in race, gender and ethnicity. The candidates recommended for the board's consideration will be those individuals from that pool who the committee believes will create a board of directors that is, as a whole, strong in its collective knowledge of, and diverse in skills, perspectives, and experience with respect to, accounting and finance, management and leadership, vision and strategy, business operations, business judgment, crisis management, risk assessment, information technology and cybersecurity, industry knowledge, and corporate governance.

Board Succession Planning

In addition to executive and management succession, the Nominating/Corporate Governance Committee regularly oversees and plans for director succession and refreshment of our board of directors to ensure a mix of skills, perspectives, experience, tenure, and diversity that promote and support our long-term strategy. For some time, the Nominating/Corporate Governance Committee has been focused on succession planning issues arising from the fact that approximately half of our non-employee directors were appointed to our board at essentially the same time. That group has now reached the tenure limits set forth in our Corporate Governance Guidelines. Specifically, the committee has attempted to craft an orderly and gradual transition for a majority of the board seats. In connection with this ongoing long-term succession planning, the Nominating/Corporate Governance Committee has engaged a search firm from time to time to identify director candidates for our board in anticipation of replacing the directors who are approaching the tenure limits over the next few years. In December 2017, our board unanimously approved an increase in the number of directors to 11 and appointed Ms. Schlichting to the board. In December 2019, our board unanimously approved an increase in the number of directors to 14 and appointed Mr. Carmichael, Ms. Maryland, and Mr. Williams to the board effective January 1, 2020. These new directors greatly enhance diversity of skills and experiences on our board. For the 2021 stockholder elections, our board waived the tenure limits for Mr. Correll, Ms. Curl, Mr. Elson, Mr. Higdon, Dr. Maupin, and Mr. Shaw in order to facilitate an orderly transition from the legacy board composition to the newly constituted board and allow each longer tenured director to contribute his or her extensive knowledge of, and experience with, the Company during the ongoing board refreshment process. The Nominating/Corporate Governance Committee intends to continue its search for additional director candidates in the near term. Once the new directors have been seated, the board then intends to reduce the number of directors in future years as the longer tenured directors roll off the board.

Director Nominees Proposed by Stockholders

The Nominating/Corporate Governance Committee will consider written proposals from stockholders for director nominees. In considering candidates submitted by stockholders, the Nominating/Corporate Governance Committee will take into consideration the needs of the board of directors and the qualifications of the candidate. In accordance with our Bylaws, any such nominations must be received by the Nominating/Corporate Governance Committee, c/o the corporate secretary, not less than 90 days nor more than 120 days prior to the anniversary date of the immediately preceding annual meeting of stockholders; provided, however, that in the event the annual meeting is called for a date that is not within 30 days before or after such anniversary date, a nomination, in order to be timely, must be received not later than the close of business on the tenth day following the day on which such notice of the date of the annual meeting was mailed or such public disclosure of the date of the annual meeting was made, whichever first occurs. The Nominating/Corporate Governance Committee received no nominee recommendations from stockholders for the 2021 annual meeting. Pursuant to our Bylaws, stockholder nominations for our 2022 annual meeting of stockholders must be received at our principal executive offices on or after January 6, 2022 and not later than February 7, 2022. All stockholder nominations must be sent by mail or courier service and addressed to Encompass Health Corporation, 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Corporate Secretary. Other electronic mail and facsimile delivery are not monitored routinely for stockholder submissions or may change from time to time, so timely delivery cannot be ensured.

Stockholder nominations must include the information set forth in Section 3.4 of our Bylaws and be accompanied by a written consent of each proposed nominee to being named as a nominee and to serving as a director if elected. A stockholder providing notice of a nomination must update and supplement the notice so that the information in the notice is true and correct as of the record date(s) for determining the stockholders entitled to receive notice of and to vote at the annual meeting. Any stockholder that intends to submit a nomination for the board of directors should read the entirety of the requirements in Section 3.4 of our Bylaws which can be found in the "Corporate Governance" section of our website at https://investor.encompasshealth.com. The chairperson of the meeting shall have the power to determine and declare to the meeting whether or not a nomination was made in accordance with the procedures set forth in our Bylaws and, if the chairman determines that a nomination is not in accordance with the procedures set forth in the Bylaws, to declare to the meeting that the defective nomination will be disregarded.

Our Bylaws provide for reimbursement of certain reasonable expenses incurred by a stockholder or a group of stockholders in connection with a proxy solicitation campaign for the election of one nominee to the board of directors. This reimbursement right is subject to conditions including the board's determination that reimbursement is consistent with its fiduciary duties. We will reimburse certain expenses that a nominating stockholder, or group of nominating stockholders, has incurred in connection with nominating a candidate for election to our board if the conditions set out in Section 3.4(c) of our Bylaws are met. If those conditions are met and the proponent's nominee is elected, we will reimburse the actual costs of printing and mailing the proxy materials and the fees and expenses of one law firm for reviewing the proxy materials and one proxy solicitor for conducting the related proxy solicitation. If those conditions are met and the proponent's nominee is not elected but receives 40% or more of all votes cast, we will reimburse the proportion of those qualified expenses equal to the proportion of votes that the nominee received in favor of his or her election to the total votes cast. For additional detail including the conditions to which any potential reimbursement is subject, please read Section 3.4(c) of our Bylaws which can be found in the "Corporate Governance" section of our website at https://investor.encompasshealth.com.

Director Independence

The NYSE listing standards require that the Company have a majority of independent directors and provide that no director will qualify as "independent" for these purposes unless the board of directors affirmatively determines that the director has no material relationship with the Company. Additionally, the listing standards set forth a list of relationships and transactions that would prevent a finding of independence if a director or an immediate family member of that director were a party.

On an annual basis, our board of directors undertakes a review of the independence of the nominees. In accordance with the NYSE listing standards, we do not consider a director to be independent unless the board determines (i) the director meets all NYSE independence requirements and (ii) the director has no material relationship with the Company (either directly or as a partner, stockholder or officer of an organization that has a relationship with the Company). Members of the Audit, Compensation and Human Capital, and Nominating/Corporate Governance Committees must also meet applicable independence tests of the NYSE and the SEC. In connection with this determination, each director and executive officer completes a questionnaire which requires disclosure of, among other topics: any transactions or relationships between any director or any member of his or her immediate family and the Company and its subsidiaries, affiliates, our independent registered public accounting firm or any advisors to the Compensation and Human Capital Committee; any transactions or relationships between any director or any member of his or her immediate family and members of the senior management of the Company or their affiliates; and any charitable contributions to not-for-profit organizations for which our directors or immediate family members serve as executive officers. There were no such director-related transactions or contributions in 2020.

Our board has determined that all 13 of our non-employee directors are independent in accordance with our Corporate Governance Guidelines and the NYSE listing standards. All of the members of the Audit, Compensation and Human Capital, Nominating/Corporate Governance, Compliance/Quality of Care, and Finance Committees satisfy those independence tests. Additionally, our board has determined that each of the members of the Audit Committee qualifies as an "audit committee financial expert" under SEC regulations.

Indemnification and Exculpation

We indemnify our directors and officers to the fullest extent permitted by Delaware law. Our certificate of incorporation also includes provisions that eliminate the personal liability of our directors for monetary damages for breach of fiduciary duty as a director, except for liability:

- for any breach of the director's duty of loyalty to us or our stockholders;
- for acts or omissions not in good faith or that involved intentional misconduct or knowing violation of law;
- under Section 174 of the Delaware law (regarding unlawful payment of dividends); or
- for any transaction from which the director derives an improper personal benefit.

We believe these provisions are necessary to attract and retain qualified people who will be free from undue concern about personal liability in connection with their service to us.

Compensation of Directors

Every year, pursuant to its charter, the Compensation and Human Capital Committee evaluates the compensation of our non-employee directors, including the respective chairperson fees, and recommends any changes it deems advisable to the full board of directors, which is responsible for adopting the final form and amount of non-employee director compensation. As part of its annual review, the Compensation and Human Capital Committee receives comparative peer and industry data and recommendations from its independent compensation consultant, FW Cook. This peer group is the same one used for executive compensation and discussed on page 41. Recognizing there are timing differences in the data and variability year to year, the Compensation and Human Capital Committee and the board attempt to ensure non-employee director compensation, including chairperson fees, is competitive with the corresponding market median compensation levels. In 2020, based on the peer review, the board determined that no change to director compensation was needed. Additionally, the terms of our 2016 Omnibus Performance Incentive Plan, approved by our stockholders in 2016, establish a maximum value ($300,000) for both the equity awards granted and the cash fees paid to a non-employee director in a given year. The total of both cannot exceed $600,000.

In 2020, we provided the following annual compensation to directors who are not employees:

Name	Fees Earned or Paid in Cash ($)(1)	Stock Awards ($)(2)	All Other Compensation ($)(3)	Total ($)
Greg D. Carmichael	100,000	201,745	2,137	303,882
John W. Chidsey	121,538	150,013	75,484	347,035
Donald L. Correll	109,808	150,013	79,051	338,872
Yvonne M. Curl	120,000	150,013	79,051	349,064
Charles M. Elson	100,000	150,013	79,051	329,064
Joan E. Herman	115,000	150,013	29,977	294,990
Leo I. Higdon, Jr.	225,000	150,013	79,051	454,064
Leslye G. Katz	108,654	150,013	29,977	288,644
Patricia A. Maryland	100,000	201,745	2,137	303,882
John E. Maupin, Jr.	100,000	150,013	79,051	329,064
Nancy M. Schlichting	100,000	150,013	7,745	257,758
L. Edward Shaw, Jr.	120,000	150,013	79,051	349,064
Terrance Williams	100,000	201,745	2,137	303,882

(1) The amounts reflected in this column are the retainer and chairperson fees earned for service as a director for 2020, regardless of when such fees are paid.

(2) Each non-employee director received an award of restricted stock units, or RSUs, with a grant date fair value, computed in accordance with Accounting Standards Codification 718, *Compensation – Stock Compensation*, of $150,013 (2,304 units). In January 2020, the newly appointed directors, Mr. Carmichael, Ms. Maryland, and Mr. Williams, received RSU grants corresponding to their partial year of service from January through the 2020 annual meeting with a grant date fair value of $51,732 (748 units). RSU awards are fully vested in that they are not subject to forfeiture; however, no shares underlying a particular award will be issued until after the date the director ends his or her service on the board. As of December 31, 2020, each director held the following aggregate RSU awards: Mr. Carmichael - 3,086, Mr. Chidsey – 69,248, Mr. Correll –72,465, Ms. Curl – 72,465, Mr. Elson – 72,465, Ms. Herman – 28,200, Mr. Higdon – 72,465, Ms. Katz – 28,200, Ms. Maryland - 3,086, Dr. Maupin – 72,465, Ms. Schlichting – 8,145, Mr. Shaw – 72,465, and Mr. Williams - 3,086. There were no other outstanding stock awards.

(3) The amounts reflected in this column represent the value of additional RSUs granted as dividend equivalents in connection with the payment of dividends on our common stock during 2020 as required by the terms of the original grants.

Our non-employee directors received an annual base cash retainer of $100,000. We also paid the following chairperson fees to compensate for the enhanced responsibilities and time commitments associated with those positions:

Chair Position	Fees Earned or Paid in Cash ($)
Chairman of the Board	125,000
Audit Committee	25,000
Compensation and Human Capital Committee	20,000
Compliance/Quality of Care Committee	15,000
Finance Committee	15,000
Nominating/Corporate Governance Committee	20,000

Our non-employee directors may elect to defer all or part of their cash fees under our Directors' Deferred Stock Investment Plan. Elections must be made prior to the beginning of the applicable year. Under the plan, amounts deferred by non-employee directors are promptly invested in our common stock by the plan trustee at the market price at the time of the payment of the fees. Stock held in the deferred accounts is entitled to any dividends paid on our common stock, which dividends are promptly invested in our common stock by the plan trustee at the market price. Fees deferred under the plan and/or the acquired stock are held in a “rabbi trust” by the plan trustee. Accordingly, the plan is treated as unfunded for federal tax purposes. Amounts deferred and any dividends reinvested under the plan are distributed in the form of our common stock upon termination from board service for any reason. Distributions generally will commence within 30 days of leaving the board. As of December 31, 2020, the number of shares held in the plan were: Dr. Maupin’s 2,196 shares, Mr. Chidsey’s 50,465 shares, and Mr. Shaw’s 15,251 shares.

In addition, each non-employee member of the board of directors receives a grant of restricted stock units valued at approximately $150,000. When dividends are paid on our common stock, the directors receive the equivalent in restricted stock units based on the number of restricted stock units held and the value of the stock. The restricted stock units held by each director will be settled in shares of our common stock following the director’s departure from the board.

In furtherance of the goal to align the interests of our management with those of our stockholders, we have equity ownership guidelines for senior management and members of the board of directors. Each non-employee director should own equity equal in value to $500,000 within five years of appointment or election to the board. As of February 12, 2021, all of our non-employee directors with five or more years of service have attained the ownership levels under the guidelines.

Mr. Tarr received no additional compensation for serving on the board.

AUDIT COMMITTEE REPORT

The board of directors has the ultimate authority for effective corporate governance, including the role of oversight of the management of the Company. The Audit Committee's purpose is to assist the board of directors in fulfilling its responsibilities to the Company and its stockholders by overseeing the accounting and financial reporting processes, the qualifications and selection of the independent registered public accounting firm engaged by the Company, and the performance of the Company's Inspector General, internal auditors and independent registered public accounting firm. The Audit Committee members' functions are not intended to duplicate or to certify the activities of management or the Company's independent registered public accounting firm.

In its oversight role, the Audit Committee relies on the expertise, knowledge and assurances of management, the internal auditors, and the independent registered public accounting firm. Management has the primary responsibility for establishing and maintaining effective systems of internal and disclosure controls (including internal control over financial reporting), for preparing financial statements, and for the public reporting process. PricewaterhouseCoopers LLP, the Company's independent registered public accounting firm, is responsible for performing an independent audit of the Company's consolidated financial statements, for expressing an opinion on the conformity of the Company's audited financial statements with generally accepted accounting principles in the United States, and for expressing its own opinion on the effectiveness of the Company's internal control over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. In this context, the Audit Committee:

- reviewed and discussed with management and PricewaterhouseCoopers LLP the fair and complete presentation of the Company's consolidated financial statements and related periodic reports filed with the SEC (including the audited consolidated financial statements for the year ended December 31, 2020, and PricewaterhouseCoopers LLP's audit of the Company's internal control over financial reporting);
- discussed with PricewaterhouseCoopers LLP the matters required to be discussed by Statement on Auditing Standards No. 61, as amended (AICPA, Professional Standards, Vol. 1, AU Section 380), as adopted by the Public Company Accounting Oversight Board (the "PCAOB") in Rule 3200T; and
- received the written disclosures and the letter from PricewaterhouseCoopers LLP required by PCAOB Rule 3526 (Communication with Audit Committees Concerning Independence) and discussed with PricewaterhouseCoopers LLP its independence from the Company and its management.

The Audit Committee also discussed with the Company's internal auditors and PricewaterhouseCoopers LLP the overall scope and plans for their respective audits; reviewed and discussed with management, the internal auditors, and PricewaterhouseCoopers LLP the significant accounting policies applied by the Company in its financial statements, as well as alternative treatments and risk assessment; and met periodically in executive sessions with each of management, the internal auditors, and PricewaterhouseCoopers LLP.

The Audit Committee was kept apprised of the progress of management's assessment of the Company's internal control over financial reporting and provided oversight to management during the process.

Based on the reviews and discussions described above, the Audit Committee recommended to the board of directors, and the board of directors approved, that the audited consolidated financial statements for the year ended December 31, 2020, and management's assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2020, be included in our Annual Report on Form 10-K for the fiscal year ended December 31, 2020 for filing with the SEC. The Audit Committee has selected PricewaterhouseCoopers LLP as the Company's independent registered public accounting firm for 2021.

Audit Committee
John W. Chidsey (Chair)
Joan E. Herman
Nancy M. Schlichting
Terrance Williams

COMPENSATION AND HUMAN CAPITAL COMMITTEE MATTERS

Scope of Authority

The Compensation and Human Capital Committee acts on behalf of our board of directors to establish the compensation of our executive officers, other than the chief executive officer, and provides oversight of the Company's compensation philosophy for senior management. The Compensation and Human Capital Committee reviews and recommends to the board for final approval the compensation of the chief executive officer and the non-employee directors. The Compensation and Human Capital Committee also acts as the oversight committee and administrator with respect to our equity compensation, bonus and other compensation plans covering executive officers and other senior management. In overseeing those plans, the Compensation and Human Capital Committee may delegate authority for day-to-day administration and interpretation of the plans, including selection of participants, determination of award levels within plan parameters, and approval of award documents, to officers of the Company. However, the Compensation and Human Capital Committee may not delegate any authority under those plans for matters affecting the compensation and benefits of the executive officers. The Compensation and Human Capital Committee may also delegate other responsibilities to a subcommittee comprised of no fewer than two of its members, provided that it may not delegate any power or authority required by any applicable law or listing standard to be exercised by the committee as a whole. In addition to its compensation oversight authority, the Compensation and Human Capital Committee oversees assessment and management of human capital-related risks, such as those involving recruitment, retention, inclusion and diversity, employee engagement, and employment litigation.

Compensation Committee Interlocks and Insider Participation

No member of our Compensation and Human Capital Committee is an officer or employee of the Company. None of our current executive officers serves or has served as a member of the board of directors or compensation committee of any other company that had one or more executive officers serving as a member of our board of directors or Compensation and Human Capital Committee.

Compensation and Human Capital Committee Report

The Compensation and Human Capital Committee reviewed and discussed with management the Compensation Discussion and Analysis required by Item 402(b) of Regulation S-K, and, based upon such review and discussions, the Compensation and Human Capital Committee recommended to the board of directors that the Compensation Discussion and Analysis be included in this proxy statement and incorporated by reference in the Company's Annual Report on Form 10-K for the year ended December 31, 2020.

Compensation and Human Capital Committee
Yvonne M. Curl (Chair)
Greg D. Carmichael
Donald L. Correll
Leo I. Higdon, Jr.
Patricia A. Maryland
John E. Maupin, Jr.
L. Edward Shaw, Jr.

EXECUTIVE COMPENSATION

Compensation Discussion and Analysis

This section presents the key components of our executive compensation program. We explain why we compensate our executives in the manner we do and how these philosophies guide the individual compensation decisions for our named executive officers, or "NEOs." Our 2020 compensation decisions were directed by our board of directors and its Compensation and Human Capital Committee, which we refer to as the "Committee" in this section only. Our NEOs as of December 31, 2020 were:

Name	Title
Mark J. Tarr	President and Chief Executive Officer
Douglas E. Coltharp	Executive Vice President and Chief Financial Officer
Barbara A. Jacobsmeyer	Executive Vice President and President, Inpatient Hospitals
April K. Anthony	Chief Executive Officer, Home Health and Hospice
Patrick Darby	Executive Vice President, General Counsel and Secretary

EXECUTIVE SUMMARY

Strategy and Business Overview

Encompass Health is a leading provider of post-acute healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2020, our national footprint spans 39 states and Puerto Rico and includes 137 hospitals and 241 home health and 82 hospice locations. We are committed to delivering high-quality, cost effective integrated patient care. We manage our operations in two operating segments: (1) inpatient rehabilitation and (2) home health and hospice. On December 9, 2020, we announced a formal process to explore strategic alternatives for our home health and hospice business.

2020 Business Highlights and Recent Track Record

In 2020, we faced many challenges due to the COVID-19 pandemic yet continued to execute our business strategy. The impacts of COVID-19 on our business are highlighted in blue bordered boxes throughout this section of the proxy.

COVID-19 Business Impact Overview

Both of our business segments started 2020 on a positive note. For the two-month period of January and February 2020, year-over-year volume growth included increases of 7.7% for inpatient rehabilitation ("IRF") total discharges, 18.5% for home health episodic admissions, and 31.5% for hospice total admissions. However, in mid-March, the pandemic began to impact patient census and volume growth in both segments. The willingness and ability of patients to seek healthcare services were negatively affected by restrictive measures, such as travel bans, social distancing, quarantines, and shelter-in-place orders. Elective procedures were postponed by physicians and acute care hospitals and limited by governmental order to preserve capacity for the expected volume of COVID-19 patients and reduce the risk of the spread of COVID-19. At the same time, the healthcare industry experienced significant supply chain disruptions as a result of the pandemic. Beginning in March, we experienced increased supply expenses due to higher utilization of personal protective equipment, or "PPE," and increased purchasing of other medical supplies and cleaning and sanitization materials as well as higher prices for supplies in shortage.

COVID-19 Business Impact Overview (continued)

In this continuously changing operating environment, we took the following steps to ensure the safety and well-being of our patients and employees:

- Created COVID-19 Task Force to monitor and manage the frequently updated CDC recommendations and guidance on testing and the use of PPE
- Worked with our supply chain and secured secondary sources to ensure an adequate supply of PPE
- Acquired COVID testing devices for our hospitals
- Followed social distancing recommendations in our therapy gyms and performed therapy in patient rooms, as needed
- Changed hospital configurations to protect patients from potential exposure to the virus
- Maintained ample liquidity while returning all CARES Act relief funds
- Maintained patient satisfaction and quality outcomes in the face of patient census and case mix variability
- Modified bonus programs for non-executive plans to preserve the opportunity to earn target payouts
- Implemented COVID Incremental Time Off program for front line employees
- Modified employee benefit plans to waive fees for virus testing and treatment and extended coverage through furloughs
- Responded to numerous and sometimes conflicting legislative and regulatory mandates

While facing the challenges of the pandemic, we continued to focus on the execution of key business initiatives:

- Maintained growth momentum by opening new hospitals and completing bed expansions
- Continued marketing efforts while losing direct access to patients/families/referral sources
- Maintained implementation schedule for patient quality initiatives
- Continued to invest in inclusion and diversity initiatives to address both employee and patient relations
- Improved employee engagement scores

In 2020, we worked through the unprecedented challenges of the pandemic and furthered our long-term strategic objectives:

Operational Achievements

✓ We successfully transitioned to new Medicare payment systems in both the inpatient rehabilitation, or "IRF," and the home health businesses.

✓ We continued development and implementation of post-acute solutions.

✓ We grew total and "same store" hospice admissions by 23.2% and 8.1%, respectively.

✓ Our hospitals delivered high-quality outcomes in a cost-effective manner.

✓ We entered new IRF markets and enhanced our geographic coverage in existing markets in 2020 by adding four new hospitals, including one joint venture and expanded existing hospitals by 117 beds.

✓ We increased our participation in alternative payment models.

Quality of Care and Outcomes for Our Patients

✓ We continued to outperform the industry averages in most IRF and home health quality of care measures.

✓ We improved the patient experience, including through integrated care delivery in 89 overlap markets.

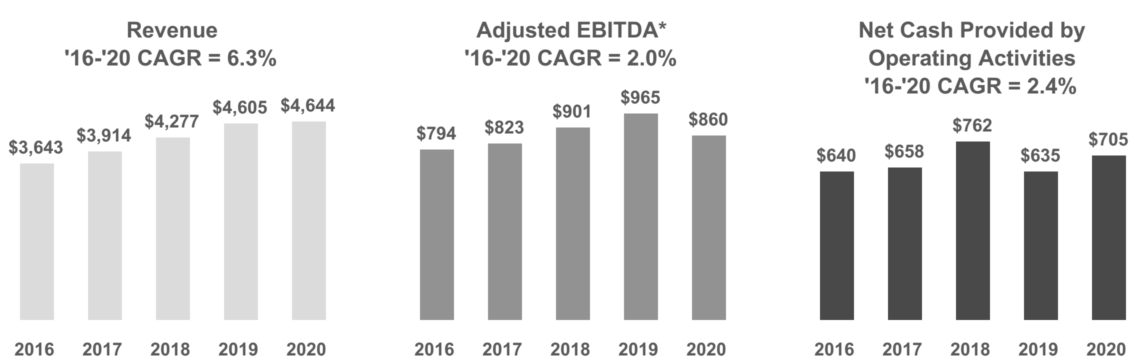
✓ We expanded our utilization of clinical data analytics designed to further improve patient outcomes.

Financial Strength and Success

✓ We increased *Net operating revenues* 0.9% over 2019.

✓ We retained our quarterly cash dividend at $0.28 per share and maintained ample liquidity.

✓ Our stockholders experienced a total return of 21.37%.



* Reconciliation to GAAP provided in Appendix A to this proxy statement.

Operating Performance and Executive Compensation

We utilize performance objectives in our compensation plans which we believe will, over time, lead to enhanced stockholder value. Over the past several years, we established a track record of strong results from operations, and we are proud of our 2020 financial performance in light of the unprecedented challenges posed by the pandemic.

Healthcare is a highly regulated industry. 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, capital structure, and human resource talent — to adapt to changes and continue to succeed in a highly regulated industry, and we have a proven track record of doing so.

COVID-19 Performance/Executive Compensation Note:

The Committee initiated discussions with management in the first half of 2020 regarding the pandemic's impacts on our incentive plan performance metrics and requested regular updates on those impacts as well as the impacts the pandemic could have on leadership retention and performance. Management provided the Committee with details of the Company's response to the challenges presented by the pandemic and highlighted operational activities (discussed above) related to future business growth and employee relations efforts. The Committee monitored the ongoing impact to performance under our incentive plans and, during the course of the year, considered appropriate adjustments while considering EHC's core values (*Set the Standard, Lead with Empathy, Do What's Right, Focus on the Positive, and Stronger Together*). The Committee made no guarantees to participants, and no incentive plans were revised. The Committee considered the discretion available to it and determined to exercise this discretion taking into account fairness, award achievement history, leadership retention, and our practice of incentivizing and rewarding overall performance.

Overview of Executive Compensation Actions in 2020

For 2020, our board of directors (for actions related to our President and Chief Executive Officer) and the Committee (for all other NEOs) considered the total compensation packages, both in whole and by component, of our NEOs to determine appropriateness in light of our executive compensation philosophy, 2019 accomplishments and 2020 anticipated challenges. We took the following actions:

2020 Executive Compensation Actions Summary

Compensation Component	Actions Related to Plans from Prior Years	Actions Related to 2020 Plans
Base Salary	Not applicable.	• Kept base salaries flat for the CEO and all NEOs with exception of Ms. Anthony ◦ Effective January 1, Ms. Anthony's base salary increased to $550,000 per her revised management agreement. • Executives voluntarily reduced base salaries in light of the economic uncertainty associated with the COVID-19 pandemic ◦ Effective April 26, Mr. Tarr and Mr. Coltharp voluntarily took 20% base salary reductions and Ms. Jacobsmeyer, Ms. Anthony, and Mr. Darby voluntarily took 10% base salary reductions which lasted for 24 weeks.
Senior Management Bonus Plan ("SMBP")	Approved 2019 SMBP awards based on performance compared to targets; awards equaled a weighted average of 143.4% of target opportunity.	• Kept the 2020 design unchanged from prior year with slight adjustments to target award opportunities ◦ Approved 2020 design with increases in target award opportunities for Mr. Tarr and Ms. Jacobsmeyer to 120% and 85% of base salary, respectively, to recognize performance and better align with the market and peer group medians. Ms. Anthony's target increased to 75% of base salary per her revised management agreement. ◦ Retained consolidated adjusted earnings before interest, tax, depreciation and amortization expenses, or "Adjusted EBITDA," and the "Quality Scorecard" (defined below) as the corporate performance metrics while eliminating the individual objectives component.
Long-Term Incentive Plan ("LTIP")	Approved 2018 PSU award payouts based on performance compared to targets for 2018-19 performance; awards equaled a weighted average of 138.5% of target opportunity.	• Kept the 2020 design unchanged from prior year with slight adjustments to target award opportunities ◦ Increased target award opportunities for Mr. Tarr, Mr. Coltharp, and Ms. Jacobsmeyer to $4,700,000, 250%, and 225% of base salary, respectively, to recognize performance and better align total direct compensation with the market and peer group medians. ◦ Retained PSU metrics of earnings per share, or "EPS," and return on invested capital, or "ROIC".

Response to 2020 Proxy Votes

The Committee believes the 97.4% affirmative vote on our 2020 "say-on-pay" vote indicates our stockholders support our current executive compensation program's alignment with our business strategy in the evolving healthcare industry. In 2020, in continuing to emphasize performance-based compensation, we made no material changes to our executive compensation program.

EXECUTIVE COMPENSATION PHILOSOPHY

Our Compensation Philosophy

- Provide a competitive rewards program for our senior management that aligns management's interests with those of our long-term stockholders
- Correlate compensation with corporate, regional and business unit outcomes by recognizing performance with appropriate levels and forms of awards
- Establish financial and operational goals to sustain strong performance over time
- Place 100% of annual cash incentives and a majority of equity incentive awards at risk by directly linking those incentive payments and awards to the Company's performance
- Provide limited executive benefits to members of senior management

We believe this philosophy will enable us to attract, motivate, and retain talented and engaged executives who will enhance long-term stockholder value.

Pay and Performance

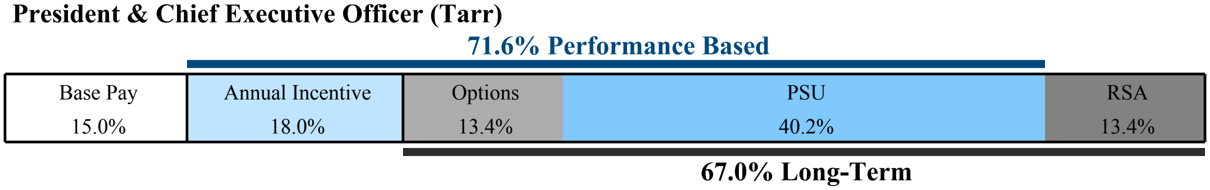
Our executive compensation program is designed to provide a strong correlation between pay and performance. Pay refers to the value of an executive's total direct compensation, or "TDC."	**Base Salary** + **Annual Cash Incentives** + **Long-Term Equity Incentives** **Total Direct Compensation**

NEO Target Total Direct Compensation

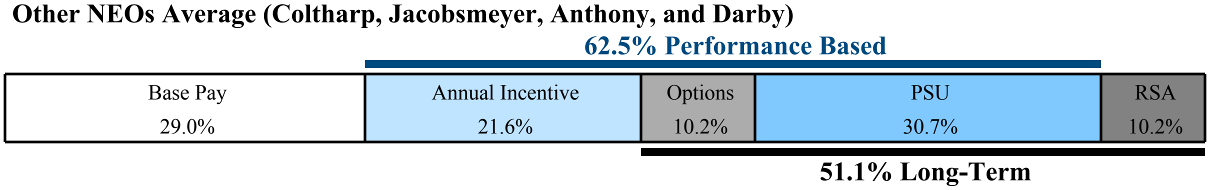
Named Executive Officer	Base Salary	Target Annual Cash Incentive (% of Base)	Target Long-Term Equity Incentive	Target Total Direct Compensation
Mark J. Tarr	1,050,000	120%	$4,700,000	7,010,000
Douglas E. Coltharp	700,000	85%	250 % of Base	3,045,000
Barbara A. Jacobsmeyer	650,000	85%	225 % of Base	2,665,000
April K. Anthony	550,000	75%	150 % of Base	1,787,500
Patrick Darby	550,000	75%	150 % of Base	1,787,500

In 2020, all cash incentive target amounts and a substantial majority of NEO equity award values were dependent on performance measured against predetermined, board-approved objectives. The graphs below approximately reflect: (i) the portion of our NEOs' 2020 target TDC that is performance-based and (ii) the time frame (i.e., annual vs. long-term) for our NEOs to realize the value of the various TDC components.

President & Chief Executive Officer (Tarr)



Other NEOs Average (Coltharp, Jacobsmeyer, Anthony, and Darby)



Note: Numbers may not sum to 100% due to rounding.

Annually, as a "checkup" of pay and performance, FW Cook prepares an analysis of the prior year TDC for the NEOs and the reported prior year TDC for the NEOs of our peer companies for the "Healthcare Peer Group" (as identified below). This analysis includes our rankings against the peer group for key financial and operating performance metrics for one-, three-, and five-year periods. These metrics are grouped into four categories: "growth," "operating performance," "returns," and "investor experience." The Committee has not taken any specific action in response to this information but does consider it in assessing whether the Company is paying for performance – both absolute and relative to peers. During the December 2020 review, for periods ending in 2019, Encompass Health's performance was at, or above median for 27 of these metrics while falling below median for 3 of these metrics.

Other Best Practices

To ensure the Company has strong corporate governance and risk mitigation, the board of directors also adopted the following best practices related to executive compensation:

- ✓ Annual and long-term incentive plans have capped, maximum award opportunities.
- ✓ Annual and long-term incentive plans are designed with multiple measures of performance.
- ✓ Annual incentive plan includes both financial and quality of care metrics.
- ✓ Compensation recoupment, or "claw-back," policy applies to both cash and equity incentives and covers misconduct in some cases where a financial restatement has not occurred.
- ✓ Equity ownership guidelines for senior executives require retention of 50% of net shares at the time of exercise/vest until ownership multiple is met.
- ✓ Insider trading policy expressly prohibits hedging or pledging of our stock by executives and directors.
- ✓ Supplemental executive benefits or perquisites are substantially limited to a nonqualified 401(k) plan and optional executive physical examinations.
- ✓ The Committee's independent consultant, FW Cook, is retained directly by the Committee and performs no other work for the Company.
- ✓ Independent sessions are scheduled at every regular meeting of our board and the Committee (no members of management are present at these independent sessions).
- ✓ Change-of-control compensation arrangements include a "double trigger" requiring generally both a change in control and termination of employment to receive cash benefits and accelerated vesting of equity and do not provide tax gross-ups.

DETERMINATION OF COMPENSATION

Key Participants	Roles and Responsibilities
Compensation and Human Capital Committee	Oversees our compensation and employee, benefit and human capital objectives, plans, and policies. Reviews and approves (or recommends for approval of the independent directors of our board in the case of the Chief Executive Officer) the individual compensation of the executive officers. The Committee is comprised solely of seven independent directors. Its responsibilities related to the compensation of our NEOs, include: • review and approve the Company's compensation programs and policies, including incentive compensation plans and equity-based plans; • review and approve corporate goals and objectives relevant to the compensation of our NEOs, then (i) evaluate their performance and (ii) determine and approve their base compensation levels and incentive compensation based on this evaluation; and, in the case of our Chief Executive Officer, recommend such to the board for approval. The Committee receives support from the Chief Human Resources Officer and the human resources staff and also engages its own executive compensation consultant as described below.
Chief Executive Officer	Makes recommendations to the Committee regarding our executive compensation plans and, for all other NEOs, proposes adjustments to base salaries and awards under our annual incentive compensation and long-term equity-based plans, establishes individual objectives, and reviews with the Committee the performance of the other NEOs on their individual objectives. The Chief Executive and Chief Human Resources Officers regularly attend meetings of the Committee.
Compensation Consultant	Throughout the year, the Committee relies on FW Cook for external executive compensation support. FW Cook is retained by, and works directly for, the Committee and attends meetings of the Committee, as requested by the Committee chair. FW Cook has no decision making authority regarding our executive compensation. Services provided include: • updates and advice to the Committee on the regulatory environment as it relates to executive compensation matters; • advice on trends and best practices in executive compensation and executive compensation plan design; • market data, analysis, evaluation, and advice in support of the Committee's role; and • commentary on our executive compensation disclosures. Management has separately engaged Mercer (US) Inc. The scope of that engagement includes providing data and analysis on competitive executive and non-executive compensation practices. Mercer data on executive compensation practices was provided to the Committee, subject to review by, and input from, FW Cook. Mercer also provides a diagnostic tool and support to our assessment of risk related to our compensation practices. Mercer does not directly advise the Committee in determining or recommending the amount or form of executive compensation.

Assessment of Competitive Compensation Practices

The Committee does not employ a strict formula in determining executive compensation. A number of factors are considered in determining executive base salaries, annual incentive opportunities, and long-term incentive awards, including:

- ✓ the executive's responsibilities
- ✓ the executive's experience
- ✓ the executive's performance
- ✓ aspects of the role that are unique to the Company
- ✓ internal equity within senior management
- ✓ competitive market data

To assess our NEOs' target total direct compensation, the Committee reviews competitive data from two sources:

- compensation survey data noted below, and
- healthcare peer group data - FW Cook, at the direction of the Committee, assembles data for a targeted group of healthcare industry peers.

The survey data provides a significant sample size, includes information for management positions below senior executives, and includes companies in healthcare and other industries from which we might recruit for executive positions.

Survey Sources

Mercer Benchmark Database	Aon Hewitt Executive
Mercer Integrated Health Networks	Willis Towers Watson Executive

For 2020, the Committee revised its Healthcare Provider Peer Group selection process to reduce subjectivity by making the selection criteria more formulaic and expanding the group by filtering the Russell 3000 index by Global Industry Classification Standard sub-industry codes to include only Health Care Services (35102015), Health Care Facilities (35102020), and Managed Health Care (35102030), with revenues between 33% and 300% of Encompass Health's and predominately operating in the continental United States.

2020 Healthcare Peer Group

- Acadia Healthcare
- Amedisys
- AMN Healthcare
- Brookdale Senior Living
- Chemed
- DaVita
- Diplomat Pharmacy*
- Ensign Group
- Genesis Healthcare
- LabCorp*
- LHC Group*
- Magellan Health*
- Mednax
- Premier*
- Quest Diagnostics*
- Quorum Health*
- Select Medical Holdings
- Surgery Partners
- Universal Health Systems

Note: Companies denoted with an asterisk were added to the peer group. Civitas Solutions (acquired), Envision Healthcare (acquired), and Lifepoint Health (acquired) were removed.

The Committee reviews competitive data on base salary levels, annual incentives, and long-term incentives for each executive and the NEO group as a whole. In preparation for 2020 compensation decisions, the Committee reviewed total direct compensation opportunities for our NEOs. Referencing the 50th percentile of both the Mercer survey data and the healthcare peer group data as well as the assessment factors discussed above, Target TDC for Mr. Tarr and Mr. Coltharp and Ms. Jacobsmeyer ranked below median for both the peer group and survey data comparisons. Ms. Anthony and Mr. Darby ranked above median for both comparator groups.

It is important to note the Committee, with input from FW Cook, recognizes the benchmark data changes from year to year, so the comparison against those benchmarks places emphasis on sustained compensation trends to avoid short-term anomalies. In general, the Committee views compensation 10% above or below the targeted market data point to be within a competitive range given year to year variability in the data.

The Committee has considered the appropriate competitive target range to attract and retain the kind of executive talent necessary to successfully achieve our strategic objectives. The Committee's objective is to establish target performance goals that will result in strong performance by the Company. Executives may achieve higher actual compensation for exceptional performance relative to these target performance goals and below-median levels of compensation for performance that is not as strong as expected.

ELEMENTS OF EXECUTIVE COMPENSATION

Elements of Annual Total Rewards at a Glance

Total Reward Component	Purpose	2020 Actions	2021 Actions
Base Salary	Provide our executives with a competitive level of regular income.	Increased base salary for Ms. Anthony; temporarily reduced base salaries for all NEOs in response to COVID.	No changes.
Annual Incentives	Intended to drive Company performance while focusing on annual objectives.	Increased target opportunities for Mr. Tarr, Ms. Jacobsmeyer, and Ms. Anthony; retained Adjusted EBITDA and Quality Scorecard as weighted metrics.	No changes.
Long-Term Incentives	Intended to focus executive attention on longer-term strength of the business and align their interests with our stockholders.	Increased target opportunities for Mr. Tarr, Mr. Coltharp, and Ms. Jacobsmeyer; retained EPS and ROIC as performance metrics for PSUs; retained time-based restricted stock and stock options.	One-time increase in target opportunities for all NEOs to address retention concerns.
Health and Welfare Benefits	Provide our executives with programs that promote health and financial security.	No changes.	No changes.
Other Benefits and Perquisites	Encourage supplemental tax deferral savings beyond 401(k) limitations and promote health awareness.	No changes.	No changes.
Change in Control and Severance	Provides business continuity during periods of transition.	No changes.	No changes.

The primary elements of our executive compensation program are:

Base Salary + Annual Cash Incentives + Long-Term Equity Incentives

Base Salary

We provide executives and other employees with base salaries to compensate them with regular income at competitive levels. Base salary considerations include the factors listed under “Assessment of Competitive Compensation Practices” above.

The base salaries of our NEOs are reviewed annually. As a result of the 2020 review the salaries for the NEOs were determined to be appropriate and competitive and maintained at 2019 levels to manage fixed expenses with the exception of Ms. Anthony who received a base salary increase for 2020 per her senior management agreement.[1]

2020 Annual Base Salaries

Mark J. Tarr	President and Chief Executive Officer	1,050,000
Douglas E. Coltharp	Executive Vice President and Chief Financial Officer	700,000
Barbara A. Jacobsmeyer	Executive Vice President and President, Inpatient Hospitals	650,000
April K. Anthony	Chief Executive Officer, Home Health and Hospice	550,000
Patrick Darby	Executive Vice President, General Counsel and Secretary	550,000

[1] Ms. Anthony has been employed in her current role since the acquisition of EHHI Holdings, Inc. of which she was the founder and CEO. Since 2015, her compensation has been in accordance with her senior management agreement. Both the acquisition and the terms of her senior management agreement executed in connection with the acquisition are described under “The Home Health and Hospice Segment Ownership Structure” beginning on page 65. In October 2019, we entered into a new management agreement with Ms. Anthony in anticipation of the expiration of her original agreement. The changes to her compensation for 2020 are described under “Employment Agreement with April Anthony” on page 54.

COVID-19 Base Salary Note:

To demonstrate alignment with our employees who faced employment uncertainties early in the pandemic, our NEOs voluntarily reduced their base salaries effective April 26, 2020 for a 24 week period. Mr. Tarr and Mr. Coltharp reduced their base salaries by 20% while Ms. Jacobsmeyer, Ms. Anthony, and Mr. Darby volunteered 10% reductions.

Annual Incentives

The 2020 Senior Management Bonus Plan, or "SMBP," was designed to incentivize and reward our NEOs and others for annual performance as measured against predetermined corporate and business segment quantitative objectives intended to improve the Company's performance and promote stockholder value. Mr. Tarr and Ms. Jacobsmeyer each received increases in the target value of their awards to align their compensation with the competitive market for similar experience and responsibilities. Ms. Anthony's 2020 annual incentive increased per her senior management agreement.

<u>Plan Objectives and Metrics</u>

For 2020, the Committee retained the corporate quantitative objectives of Adjusted EBITDA[2] and the "IRF Quality Scorecard"[3] to focus on quality of care metrics. The Committee added the "HHH Quality Scorecard" to Mr. Tarr's and Ms. Anthony's objectives to provide a similar focus in the HHH segment. The Quality Scorecard approach provides the flexibility to adjust the metrics year over year as our business and the healthcare operating environment evolve. For 2020, the IRF Quality Scorecard metrics were unchanged (see table below). Achievement of each of these metrics is measured by the percentage of hospitals meeting or exceeding their goals. Hospital-specific goals are established for each metric based on prior performance and relative performance to other hospitals. The HHH Quality Scorecard was new for 2020 with the metrics outlined below. Achievement for each of these metrics is the average of publicly reported ratings for all healthcare provider numbers.

The weightings and payout ranges for these metrics for all NEOs with the exception of Ms. Anthony are:

Base Salary	x	Annual Target Cash Incentive Opportunity	x	[EHC Adjusted EBITDA 70% Weighting	+	Quality Scorecard 30% Weighting]	=	SMBP Payout

For Ms. Anthony, the weightings and payout ranges are:

Base Salary	x	Annual Target Cash Incentive Opportunity	x	[EHC Adjusted EBITDA 20% Weighting	+	HHH Adjusted EBITDA 56% Weighting	+	Quality Scorecard 24% Weighting]	=	SMBP Payout

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[2] For purposes of the 2020 SMBP, Adjusted EBITDA on a consolidated basis is the same as the measure described in the 2020 Form 10-K, and the results for SMBP purposes may be adjusted further for certain unusual or nonrecurring unbudgeted items. Adjusted EBITDA is discussed in more detail, including reconciliations to corresponding GAAP financial measures, in Appendix A to this proxy statement. The Committee has established in advance the following four categories of adjustments for these unusual or nonrecurring unbudgeted items: acquisitions and divestitures, capital structure changes, litigation expenses and settlements, and material legislative changes. The Committee believes these pre-approved categories, along with the application of the same GAAP standards to the calculation of a metric during the life of the award, help the metric to more accurately reflect items within management's control while also minimizing unintended incentives and disincentives associated with the accounting treatment for or impacts of unbudgeted, discretionary transactions. For 2020, the adjustment for unbudgeted items included: acquisitions of home health and hospice assets and consolidation of a home health agency following a change in the partnership agreement.

[3] For purposes of the 2020 SMBP, the IRF Quality Scorecard is a compilation of quality metrics that track patient satisfaction and patient discharge status by hospital. Patient Satisfaction results are derived by NRC Health through their Customer Intelligence Platform, a standardized survey of hospital patients. Patient discharge statuses are tracked via internal systems.

2020 SMBP Quantitative Objectives

Objective	Not Eligible 0%	Threshold 50%	Target 100%	Maximum 200%
	Award Range			
EHC Adjusted EBITDA	<$882,516,000	$882,516,000	$954,071,000	≥$1,025,626,000
HHH Adjusted EBITDA	<$180,740,000	$180,740,000	$195,395,000	≥$210,050,000

IRF Quality Scorecard Sub-Objective	Sub-Weight	% of Hospitals Meeting or Beating Hospital-Specific Goal			
Discharge to Community	30%	<60%	60%	70%	80%
Acute Transfer	15%	<60%	60%	70%	80%
Discharge to Skilled Nursing Facility	30%	<60%	60%	70%	80%
Patient Satisfaction	25%	<60%	60%	70%	80%

HHH Quality Scorecard Sub-Objective	Sub-Weight	Consolidated Star/Hospice Rating			
Home Health Quality Stars	25%	<3.2	3.2	3.6	4.0
Home Health Patient Satisfaction Stars	25%	<3.0	3.0	3.5	4.0
Hospice HIS Measures	25%	<3.0	3.0	4.0	5.0
Hospice CAHPS	25%	<3.0	3.0	4.0	5.0

Effective for 2020, Mr. Tarr's Quality Scorecard was determined by weighting the Inpatient Rehabilitation Facilities ("IRF") Quality Scorecard outcome at 80% and the Home Health and Hospice ("HHH") Quality Scorecard outcome at 20%. Mr. Coltharp, Ms. Jacobsmeyer and Mr. Darby's Quality Scorecard outcome remained solely based on IRF results. Ms. Anthony's Quality Scorecard outcome was solely based on HHH results.

To reward exceptional performance, the NEOs have the opportunity to receive a maximum payout in the event actual results reach a predetermined level for each objective. Conversely, if attained results are less than threshold for a component of the corporate or regional quantitative objectives, then no payout for that component of the quantitative objectives occurs. It is important to note the following:

- performance measures can be achieved independently of each other; and
- as results increase above the threshold, a corresponding percentage of the target cash incentive will be awarded. In other words, levels listed are on a continuum, and straight-line interpolation is used to determine the payout multiple between two payout levels shown in the table above.

The structure of the 2020 SMBP removed the individual objectives component utilized in prior years to shift more emphasis to objective company performance. The Committee, and the board of directors in the case of our President and Chief Executive Officer, has the authority to recognize significant individual achievement or underperformance by modifying a final SMBP award up or down; however, no SMBP payout may exceed 200% of target.

Establishing the Target Cash Incentive Opportunity

Under the SMBP, the Committee first approves a target cash incentive opportunity for each NEO, based upon a percentage of his or her base salary, "Target Cash Incentive Opportunity as a % of Salary" in the table below. This target cash incentive opportunity is established as a result of the Committee's "Assessment of Competitive Compensation Practices" described above. The Committee then assigns relative weightings (as a percentage of total cash incentive opportunity) to the objectives. The relative weightings of the quantitative objectives take into account the executive's position.

The table below summarizes the target cash incentive opportunities and relative weightings of quantitative objectives for each NEO.

2020 Senior Management Bonus Plan Weightings

Named Executive Officer	Target Cash Incentive Opportunity as a % of Salary	Consolidated Adjusted EBITDA	IRF Quality Scorecard	HHH Segment Adjusted EBITDA	HHH Quality Scorecard
Mark J. Tarr	120%	70%	24%	N/A	6%
Douglas E. Coltharp	85%	70%	30%	N/A	N/A
Barbara A. Jacobsmeyer	85%	70%	30%	N/A	N/A
April K. Anthony	75%	20%	N/A	56%	24%
Patrick Darby	75%	70%	30%	N/A	N/A

Assessing and Rewarding 2020 Achievement of Objectives

After the close of the year, the Committee assesses performance against the quantitative objectives to determine a weighted average result, or the percentage of each NEO's target incentive that has been achieved, for each objective. The Committee has the discretion to alter awards and exercised this discretion for 2020 (see COVID-19 SMBP Note below). Actual 2020 Plan results for the quantitative objectives were as follows:

2020 EBITDA Results

Objective	Target	Result	% of Target Metric Achievement
EHC Adjusted EBITDA	$954,071,000	$859,965,000	— %
HHH Adjusted EBITDA	$195,395,000	$162,874,000	— %

2020 IRF Quality Scorecard Results

Objective	% of Target Metric Achievement	Weight	Weighted Metric Achievement
Discharge to Community	152.0%	30%	45.6%
Acute Transfer	—%	15%	—%
Discharge to Skilled Nursing Facility	200.0%	30%	60.0%
Patient Satisfaction	92.0%	25%	23.0%
Combined		**100%**	**128.6%**

2020 HHH Quality Scorecard Results

Objective	% of Target Metric Achievement	Weight	Weighted Metric Achievement
Home Health Quality Stars	175.0%	25%	43.8%
Home Health Patient Satisfaction Stars	200.0%	25%	50.0%
Hospice HIS Measures	200.0%	25%	50.0%
Hospice CAHPS	—%	25%	—%
Combined		**100%**	**143.8%**

2020 Senior Management Bonus Plan Awards - Calculated Actual

Named Executive Officer	EHC Adjusted EBITDA	HHH Segment Adjusted EBITDA	IRF Quality Scorecard	HHH Quality Scorecard	Total Payout	Result as % of Target
Mark J. Tarr	—	N/A	388,886	108,713	497,599	39.5%
Douglas E. Coltharp	—	N/A	229,551	N/A	229,551	38.6%
Barbara A. Jacobsmeyer	—	N/A	213,155	N/A	213,155	38.6%
April K. Anthony	—	—	N/A	142,362	142,362	34.5%
Patrick Darby	—	N/A	159,143	N/A	159,143	38.6%

COVID-19 SMBP Note:

The Committee believes the achievements outlined earlier in this section reflected exceptional performance in pandemic conditions and under these circumstances deserve recognition beyond the quantitative results described above. The Committee applied a holistic assessment of management's performance in 2020. Key areas that influenced the Committee's final determination of pay outcomes reflected the following principles derived from our core values:

- health and safety of our patients, employees, and the communities in which we operate
- management leadership during a pandemic
- alignment of rewards with outcomes
- long-term interests of the company
- financial and operational results as well as achievement of strategic priorities
- employee engagement and morale
- proper motivation and retention of our leaders

The Committee had multiple discussions throughout the year to evaluate management performance against core values and these principles as well as the original SMBP goals. The Committee determined that the achievements and actions taken by the NEOs and the rest of the leadership team strengthened our position in our industry, promoted the long-term interests of our stockholders, and were deserving of a payout higher than the formulaic results of the SMBP. Accordingly, the Committee approved the cash incentive payments for NEOs at 90% of target performance. The Committee believes this payout is a fair and accurate reflection of the excellent achievements of the management team despite the challenges associated with the pandemic. Other participants received a payout equal to the greater of 90% or their actual performance achievement, in the case of regional goals. These amounts were paid in March 2021 and are included in the 2020 compensation set out in the Summary Compensation Table on page 53.

2020 Senior Management Bonus Plan Payouts

Named Executive Officer	Total Payout	Result as % of Target
Mark J. Tarr	1,134,000	90.0%
Douglas E. Coltharp	535,500	90.0%
Barbara A. Jacobsmeyer	497,250	90.0%
April K. Anthony	371,250	90.0%
Patrick Darby	371,250	90.0%

Long-Term Incentives

To further align the interests of management and stockholders, a significant portion of each NEO's total direct compensation is in the form of long-term equity awards. We believe such awards promote strategic and operational decisions that align the long-term interests of management and the stockholders and help retain executives. In support of our performance-driven total compensation philosophy, earned equity values are driven by stock price and financial and operational performance.

For 2020, our equity incentive plan provided participants at all officer levels with the opportunity to earn performance-based restricted stock, or "PSUs," time-based restricted stock, or "RSAs," and, for the Chief Executive Officer and the Executive Vice Presidents, stock options. We believe these awards align all levels of management with stockholders and place a significant portion of TDC at risk. RSAs are included to enhance retention incentives.

The 2020 value of the long-term incentive awards to the NEOs was reviewed by the Committee. Mr. Tarr, Mr. Coltharp and Ms. Jacobsmeyer received increases in their target award values to align compensation with the competitive market for similar experience and responsibilities.

The following table summarizes the 2020 target equity award opportunity levels and forms of equity compensation for each of our NEOs as approved by the Committee and board. These amounts differ from the equity award values reported in the Summary Compensation Table on page 53 due to the utilization of a 20-day average stock price to determine the number of shares granted as opposed to the grant date values used for accounting and reporting purposes.

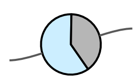
2020 Equity Incentive Plan Structure

Named Executive Officer	Total Target Equity Award Opportunity	Options as % of the Award	PSUs as a % of the Award	RSAs as a % of the Award
Mark J. Tarr	4,700,000	20%	60%	20%
Douglas E. Coltharp	1,750,000	20%	60%	20%
Barbara A. Jacobsmeyer	1,462,500	20%	60%	20%
April K. Anthony	825,000	20%	60%	20%
Patrick Darby	825,000	20%	60%	20%

PSU Awards in 2020

The Committee determined that performance-based vesting conditions for the majority of restricted stock granted to NEOs are appropriate to further align executives with the interests of stockholders and promote specific performance objectives while facilitating executive stock ownership. Under our equity incentive plan, NEOs may be awarded PSUs, which entitle them to receive a predetermined range of restricted shares upon achievement of specified performance objectives. PSU awards do not provide for voting rights unless and until restricted stock is earned after the measurement period. Dividends accrue when paid on unvested shares, but the holders of PSUs will not receive the cash payments related to these accrued dividends until the resulting restricted shares, if any, fully vest.

2020 PSU Objective Weightings



For the 2020 awards, the number of restricted shares earned will be determined at the end of a two-year performance period based on the level of achievement of Normalized Earnings Per Share ("EPS")[4] and Return on Invested Capital ("ROIC")[5]. The weighting of these metrics are outlined above. The Committee chose these metrics because the Committee believes they are directly aligned with our stockholders' interests. If restricted shares are earned at the end of the two-year

[4] For purposes of 2020 PSUs, normalized EPS is calculated on a weighted-average diluted shares outstanding basis by adjusting net income from continuing operations attributable to Encompass Health for the normalization of income tax expense, fair value adjustments to the value of stock appreciation rights ("SARs") and marketable securities, and certain unusual or nonrecurring unbudgeted items. The Committee has established in advance the following four categories for these unusual or nonrecurring unbudgeted items for Committee consideration: acquisitions and divestitures, changes in capital structure, litigation expenses and settlements, and material legislative changes. The Committee believes these pre-approved categories, along with the application of the same GAAP standards to the calculation of a metric during the life of the award, help the metric to more accurately reflect items within management's control while also minimizing unintended incentives or disincentives associated with the accounting treatment for unbudgeted, discretionary transactions.

For the 2019 PSU performance period ended December 31, 2020, those items included: acquisitions, divestiture, syndication and joint venture transactions; impact from debt refinancings; the put of the EHHI rollover shares; impact of Medicare payment system changes; and litigation and settlement reserves. The diluted share count for LTIP purposes includes, as is the case in our 2020 Form 10-K, the shares associated with restricted stock awards, performance share units, restricted stock units, and dilutive stock options. The diluted share count for the performance period ended December 31, 2020 was adjusted to eliminate the impact of common stock repurchases as noted above. The calculation of normalized earnings per share differs from that of basic and diluted earnings per share and adjusted earnings per share used in our earnings releases and publicly available financial guidance. We believe the calculation for compensation purposes for the associated performance period more accurately represents those matters within the control of management compared to that used in communications with the market.

[5] For purposes of 2020 PSUs, ROIC is defined as net operating profit after taxes ("NOPAT") divided by the average invested capital as of December 31, 2019, 2020, and 2021. Invested capital is calculated as total assets less right of use assets, deferred tax assets, assets from discontinued operations, current liabilities, noncontrolling interest and redeemable noncontrolling plus current portion of long-term debt. NOPAT is defined as income from continuing operations attributable to Encompass Health common shareholders, excluding interest expense, government, class action and related settlements, professional fees - accounting, tax, and legal, fair value adjustments to the value of SARs and marketable securities, and loss on early extinguishment of debt, as adjusted for a normalized income tax expense. Both the numerator and the denominator are then adjusted as described in the note above for the applicable unusual or nonrecurring unbudgeted items, including fair value adjustments related to the EHHI rollover shares, and the GAAP standards applied in the calculation of a metric are held constant during the life of the award.

performance period, the participant must remain employed until the end of the following year at which time the shares fully vest.

It is important to note:

- Management provides a report to the Committee that sets out the calculations of the actual results and engages an accounting firm to produce a report on the accuracy of the calculations;
- if results attained are less than the threshold, then no restricted shares are earned for that performance measure in that performance period; and
- as results increase above the threshold, a corresponding percentage of target equity value will be awarded. In other words, levels listed are on a continuum, and straight-line interpolation is used to determine the payout multiple between two payout levels.

Summary of 2019 PSU Award Results

The 2019 PSU awards completed their performance period on December 31, 2020. The EPS and ROIC objectives had the following achievement levels:

Objective	Target	Result	Target Metric Achievement	Weight	Weighted Metric Achievement
EPS	$7.99	$7.42	85.8%	60%	51.5 %
ROIC	12.03%	10.96%	55.4%	40%	22.2 %
Combined				100%	73.7 %

COVID-19 2019 PSU Note:

The Committee reviewed these results in light of the impact of COVID-19 on 2020 performance results and made no adjustment to the 2019 outstanding PSU awards after considering all relevant factors.

Time-Based Restricted Stock Awards in 2020

The Committee believes the portion of the 2020 award value denominated in RSAs provides retention incentives to our executives and facilitate stock ownership, which further links executives to our stockholders. Under our equity incentive plan, NEOs may be granted RSAs which entitle them to receive a predetermined number of restricted shares upon completion of a specified service period. The recipients of RSA awards have voting rights and rights to receive dividends. Dividends accrue when paid on outstanding shares, but the holders of RSAs will not receive the cash payments related to these accrued dividends until the restricted shares fully vest. As is our standard practice, one-third of the 2020 RSA award vests on each of the first three anniversaries of the grant date.

Stock Option Awards in 2020

The Committee believes nonqualified stock options also are an appropriate means to align the interests of our most senior executives with our stockholders since they provide an incentive to grow stock price.

Each stock option permits the holder, for a period of ten years, to purchase one share of our common stock at the exercise price, which is the closing market price on the date of issuance. Options generally vest ratably in equal annual increments over three years from the award date. In 2020, the number of options awarded equaled 20% of the total target equity award opportunity approved for the related officer divided by the individual option value determined using the Black-Scholes valuation model.

Equity Award Timing

Our practice is to have the independent members on our board of directors approve, based on recommendations of the Committee, equity awards at the February board meeting which allows time to review and consider our prior year's performance. The number of shares of common stock underlying the PSU, RSA, and stock option awards is determined using the average closing price for our common stock over the 20-day trading period preceding the February board meeting at which the awards are approved. The average of prices mitigates the risk of unintended consequences of using a single closing price that may reflect an anomalous price swing on that day. The strike price for the stock option awards is set at the closing price on the second trading day after the filing of our Form 10-K, which is also the date of issuance. This timing for the pricing and issuance of stock options allows for the exercise price to reflect a broad dissemination of our financial results from the prior year.

Executive Compensation Program Changes for 2021

No changes were made to the base salaries and SMBP targets for any of our NEOs for 2021. This decision was made based on a review of their TDC alignment with market and peer group medians.

Target award values for the 2021 LTIP included a one-time 10% increase for all participants, including NEOs, to address retention concerns stemming from COVID-19's negative impact on prior PSU awards.

For 2021 SMBP and PSU awards, a fifth adjustment category, "Public Health Emergencies", was added to adjust for the quantifiable impact of a pandemic or comparable public health emergency on incentive plans. A Public Health Emergency-related adjustment must meet the following criteria: internationally or nationally declared, sustained, unbudgeted, and material.

Benefits

In 2020, our NEOs were eligible for the same benefits offered to other employees, including medical and dental coverage. NEOs are also eligible to participate in a qualified 401(k) plan, subject to the limits on contributions imposed by the Internal Revenue Service. In order to allow deferrals above the amounts provided by the IRS, executives and certain other officers are eligible to participate in a nonqualified deferred 401(k) plan that closely mirrors the current qualified 401(k) plan. Other than the nonqualified deferred 401(k) plan referenced here, we did not provide our executives with compensation in the form of a pension plan or a retirement plan.

Perquisite Practices

We do not have any perquisite plans or policies in place for our executive officers. In general, we do not believe such personal benefit plans are necessary for us to attract and retain executive talent. We do not provide tax payment reimbursements, gross ups, or any other tax payments to any of our executive officers. We do offer to pay for optional executive physical examinations (historically at a cost of less than $3,000 each) that we believe encourage proactive health management by our executives, which in turn benefits the business. On occasion, there may be incidental perquisites arising from important business activities that have, in part, a direct or indirect personal benefit for the executives involved, such as entertainment associated with stockholder engagement or employee retreat functions. Additionally, from time to time, officers and directors may be allowed, if space permits, to have family members accompany them on business flights on our aircraft, at no material incremental cost to us.

OTHER COMPENSATION POLICIES & PRACTICES

Equity Ownership Guidelines for Management and Non-Employee Directors

To further align the interests of our management with those of our stockholders, we have adopted equity ownership guidelines for senior management and members of our board of directors.

Executive officers and outside directors have five years to reach their ownership level and upon each tax recognition or option exercise event, a covered officer must hold at least 50% of the after-tax value of the related equity award until ownership levels are achieved. Equity grants to our non-employee directors must be held until the director leaves the board. All of our NEOs and non-employee directors with five or more years of service have attained the ownership levels under the guidelines and all of our NEOs and non-employee directors with less than five years of tenure are on track to meet the guidelines. Outlined in the table below were the ownership guidelines for 2020:

Position	Required Value of Equity Owned
Chief Executive Officer	5 times annual base salary
Executive Vice President	3 times annual base salary
other executive officer	1.5 times annual base salary
outside director	$500,000

Compensation Recoupment Policy

Our board of directors has approved and adopted a senior management compensation recoupment policy. The policy provides that if the board has, in its sole discretion, determined that any fraud, illegal conduct, intentional misconduct, or gross neglect by any officer was a significant contributing factor to our having to restate all or a portion of our financial statements, the board may:

- require reimbursement of any incentive compensation paid to that officer,
- cause the cancellation of that officer's restricted or deferred stock awards and outstanding stock options, and
- require reimbursement of any gains realized on the exercise of stock options attributable to incentive awards,

if and to the extent (i) the amount of that compensation was calculated based upon the achievement of the financial results that were subsequently reduced due to that restatement and (ii) the amount of the compensation that would have been awarded to that officer had the financial results been properly reported would have been lower than the amount actually awarded.

Additionally, if an officer is found to have committed fraud or engaged in intentional misconduct in the performance of his or her duties, as determined by a final, non-appealable judgment of a court of competent jurisdiction, and the board determines the action caused substantial harm to Encompass Health, the board may, in its sole discretion, utilize the remedies described above.

Anti-Hedging Policy

The Company prohibits the following transactions for all employees and directors:

- short-term trading of our securities,
- short sales of our securities, and
- hedging or monetization transactions, such as zero-cost collars and forward sale contracts.

The Company also prohibits executive officers and directors from pledging our securities as collateral, including as part of a margin account.

Severance Arrangements

It is not our common practice to enter into individual employment agreements with our senior executives. However, in connection with the acquisition of EHHI Holdings, Inc., we executed a senior management agreement with Ms. Anthony, the founder and CEO of that home health business (see "Employment Agreement with April Anthony" on page 54 for additional details). To provide the balance of our senior executives with competitive levels of certainty as a retention tool, potential benefits are provided to our senior executives under our change of control and severance plans. The Committee determined the value of benefits were reasonable, appropriate, and competitive with our healthcare provider peer group. As a condition to receipt of any payment or benefits under either plan, participating employees must enter into a noncompetition, nonsolicitation, nondisclosure, nondisparagement and release agreement. The duration of the restrictive covenants would be equal to the benefit continuation periods described below for each plan. As a matter of policy, payments under either plan do not include "gross ups" for taxes payable on amounts paid. Definitions of "cause," "retirement," "change in control," and "good reason" are provided on page 58.

<u>Executive Severance Plan</u>

The goal of the Executive Severance Plan is to help retain qualified, senior officers whose employment is subject to termination under circumstances beyond their control. Our NEOs, with the exception of Ms. Anthony, are participants in the plan, which is an exhibit to our 2020 Form 10-K. Under the plan, if a participant's employment is terminated by the participant for good reason or by Encompass Health other than for cause (as defined in the plan), then the participant is entitled to receive a cash severance payment, health benefits, and the other benefits described below. Voluntary retirement, death, and disability are not payment triggering events. The terms of the plan, including the payment triggering events, were determined by the Committee to be consistent with healthcare industry market data from the Committee's and management's consultants.

The cash severance payment for participants is the multiple (shown in the table below) of annual base salary in effect at the time of the event plus any accrued, but unused, paid time off, and accrued, but unpaid, salary. This amount is to be paid in a lump sum within 60 days following the participant's termination date. In addition, except in the event of termination for cause or resignation for lack of good reason, the participants and their dependents continue to be covered by all life, healthcare, medical and dental insurance plans and programs, excluding disability, for a period of time set forth in the following table.

Position	Severance as Multiple of Annual Base Salary	Benefit Plan Continuation Period
Chief Executive Officer	3x	36 months
Executive Vice Presidents	2x	24 months
other executive officers	1x	12 months

Amounts paid under the plan are in lieu of, and not in addition to, any other severance or termination payments under any other plan or agreement with Encompass Health. As a condition to receipt of any payment under the plan, the participant must waive any entitlement to any other severance or termination payment by us, including any severance or termination payment set forth in any employment arrangement with us.

Upon termination of a participant without cause, or his or her resignation for good reason, a prorated portion of any equity award subject to time-based vesting only that is unvested as of the effective date of the termination or resignation will automatically vest. If any restricted stock awards are performance-based, the Committee will determine the extent to which the performance goals for such restricted stock have been met and what awards have been earned.

Ms. Anthony's senior management agreement, in the event the company terminates her employment without cause or she terminates her employment for good reason, provides twelve months of base salary continuation and COBRA premium payments in addition to any unpaid annual bonus for any fiscal year completed prior to termination.

Change in Control Benefits Plan

The goal of the Change in Control Benefits Plan is to help retain certain qualified senior officers, maintain a stable work environment, and encourage officers to act in the best interest of stockholders if presented with decisions regarding change in control transactions. Our NEOs, with the exception of Ms. Anthony, and other officers are participants in the plan, which is an exhibit to our 2020 Form 10-K. The terms of the plan, including the definition of a change in control event, were reviewed and determined to be consistent with healthcare industry market data from the Committee's and management's consultants. The plan includes a "double trigger" for the vesting of equity in the event of a change in control for all future awards to executives. The plan is reviewed annually for market competitiveness but no material benefit changes have been made since 2014.

Under the Change in Control Benefits Plan, participants are divided into tiers as designated by the Committee. Our current President and Chief Executive Officer and our Executive Vice Presidents are Tier 1 participants; Senior Vice Presidents are Tier 2 participants. Effective January 1, 2021, persons newly appointed as Executive Vice Presidents will participate at the Tier 2 level.

If a participant's employment is terminated within 24 months following a change in control or during a potential change in control, either by the participant for good reason (as defined in the plan) or by Encompass Health without cause, then the participant shall receive a lump sum severance payment. Voluntary retirement is not a payment triggering event. For Tier 1 and 2 participants, the lump sum severance is 2.99 times and 2.0 times, respectively, the sum of the highest base salary in the prior three years and the average of actual annual incentives for the prior three years for the participant, plus a prorated annual incentive award for any incomplete performance period. In addition, except in the event of termination for cause or resignation for lack of good reason, the participant and the participant's dependents continue to be covered by all life, healthcare, medical and dental insurance plans and programs, excluding disability, for a period of 36 months for Tier 1 participants and 24 months for Tier 2 participants.

Ms. Anthony's senior management agreement does not contain change-in-control protections.

If a change in control occurs as defined in the plan, outstanding equity awards vest as follows:

Stock Options	Restricted Stock
Outstanding options will only vest if the participant is terminated for good reason or without cause within 24 months of a change in control or if not assumed or substituted and, for Tier 1 and 2 participants, all options will remain exercisable for three and two years, respectively.	Restricted stock will only vest if the participant is terminated for good reason or without cause within 24 months of a change in control or if not assumed or substituted.

Note: For performance-based restricted stock, the Committee will determine the extent to which the performance goals have been met and vesting of the resulting restricted stock will only accelerate as provided above.

The Committee has the authority to cancel an award in exchange for a cash payment in an amount equal to the excess of the fair market value of the same number of shares of the common stock subject to the award immediately prior to the change in control over the aggregate exercise or base price (if any) of the award.

Tax Implications of Executive Compensation

Section 162(m) of the Internal Revenue Code of 1986, as amended ("Section 162(m)"), generally limits to $1 million per year income tax deductions available to publicly held corporations for compensation paid in years beginning after December 31, 2017 to the corporation's CEO, CFO, certain other NEOs, and certain former NEOs (each a "Covered Executive"). Prior to 2018, this limitation on deductibility did not apply to qualifying "performance-based compensation" and did not apply to our CFO or former NEOs. In December 2017, the Tax Cuts and Jobs Act ("Tax Act") was signed into law. Under the Tax Act, the exemption from Section 162(m)'s deduction limit for "performance-based compensation" was repealed, effective for taxable years beginning after December 31, 2017, and the limitation was extended to compensation paid to CFOs and certain former NEOs. As a result, most compensation in excess of $1 million paid to our Covered Executives is not deductible.

The Compensation Committee has considered the effect of Section 162(m) on the Company's executive compensation program. The Compensation Committee exercises discretion in setting base salaries, structuring incentive compensation awards and in determining payments in relation to levels of achievement of performance goals. The Compensation Committee believes that the total compensation program for Covered Executives should be managed in accordance with the objectives outlined in the Company's compensation philosophy and in the best overall interests of the Company's stockholders. Accordingly, compensation paid by the Company may not be deductible because such compensation exceeds the limitations for deductibility under Section 162(m).

Summary Compensation Table

The table below shows the compensation of our named executive officers for services in all capacities in 2020, 2019, and 2018. For a discussion of the various elements of compensation and the related compensation decisions and policies, including the amount of salary and bonus in proportion to total compensation and the material terms of awards reported below, see "Compensation Discussion and Analysis" beginning on page 34 Except as discussed under "Severance Arrangements" and "Employment Agreement with April Anthony" on pages 50 and 54, respectively, the Company had no employment agreements or compensation arrangements in effect with its named executive officers in 2020, and there are no additional material terms, if any, of each NEO's employment arrangement.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)[(1)]	Option Awards ($)[(2)]	Non-Equity Incentive Plan Compensation ($)[(3)]	All Other Compensation ($)[(4)]	Total ($)
Mark J. Tarr	2020	953,077	—	3,893,034	857,191	1,134,000	87,825	6,925,127
President and Chief Executive Officer	2019	1,050,000	—	3,607,305	889,480	1,626,744	96,758	7,270,287
	2018	962,500	—	2,833,177	750,865	1,770,678	71,007	6,388,227
Douglas E. Coltharp	2020	635,385	—	1,449,671	319,170	535,500	47,411	2,987,137
Executive Vice President and Chief Financial Officer	2019	700,000	—	1,097,963	270,713	801,584	54,869	2,925,129
	2018	700,000	—	1,133,356	300,349	939,624	48,835	3,122,164
Barbara A. Jacobsmeyer	2020	620,000	—	1,211,485	266,742	497,250	26,963	2,622,440
Executive Vice President and President, Inpatient Hospitals	2019	650,000	—	892,115	219,960	700,544	26,206	2,488,825
	2018	550,000	—	667,840	176,999	651,420	17,900	2,064,159
April K. Anthony	2020	524,615	—	683,514	150,473	371,250	3,762	1,733,614
Chief Executive Officer, Home Health and Hospice	2019	347,006	—	1,908,293	100,656	173,503	2,898	2,532,356
	—	—	—	—	—	—	—	—
Patrick Darby	2020	524,615	—	683,514	150,473	371,250	1,828	1,731,680
Executive Vice President, General Counsel and Secretary	2019	550,000	—	647,100	159,535	555,720	2,905	1,915,260
	2018	475,000	—	576,858	152,862	507,072	3,046	1,714,838

(1) The stock awards for each year consist of performance-based restricted stock, or "PSUs," and time-based restricted stock, or "RSAs," as part of the long-term incentive plan for the given year. The amounts shown in this column are the grant date fair values computed in accordance with Accounting Standards Codification Topic 718, *Compensation - Stock Compensation* ("ASC 718"), assuming the most probable outcome of the performance conditions as of the grant dates (i.e., target performance). All of the values in this column are consistent with the estimate of aggregate compensation expense to be recognized over the applicable vesting period, excluding any adjustment for forfeitures. The assumptions used in the valuations are discussed in Note 14, *Share-Based Payments*, to the consolidated financial statements in our 2020 Form 10-K.

The values of the PSU awards at the varying performance levels for our current NEOs are set forth in the table below.

Name	Year	Threshold Performance Value ($)	Target Performance Value ($)	Maximum Performance Value ($)
Mark J. Tarr	2020	1,459,867	2,919,734	5,839,468
	2019	1,352,723	2,705,446	5,410,892
	2018	1,062,468	2,124,883	4,249,765
Douglas E. Coltharp	2020	543,617	1,087,233	2,174,466
	2019	411,761	823,456	1,646,913
	2018	425,061	850,017	1,700,033
Barbara A. Jacobsmeyer	2020	454,287	908,573	1,817,146
	2019	334,535	669,070	1,338,141
	2018	250,466	500,880	1,001,760
April K. Anthony	2020	256,308	512,615	1,025,230
	2019	153,078	306,156	612,312
Patrick Darby	2020	256,308	512,615	1,025,230
	2019	242,662	485,325	970,649
	2018	216,322	432,643	865,286

(2) The values of option awards listed in this column are the grant date fair values computed in accordance with ASC 718 as of the grant date. All of the values in this column are consistent with the estimate of aggregate compensation expense to be recognized over the three-year vesting period, excluding any adjustment for forfeitures. The assumptions used in the valuations are discussed in Note 14, *Share-Based Payments*, to the consolidated financial statements in our 2020 Form 10-K.

(3) The amounts shown in this column are bonuses earned under our senior management bonus plan in the corresponding year but paid in the first quarter of the following year.

(4) The items reported in this column for 2020 are described as set forth below. The amounts reflected in the "Dividend Rights" column are the aggregate values of dividends associated with outstanding restricted stock awards to the extent that the per share dividend rate increased beyond the rate in existence on the grant date of the awards. That is, the grant date fair values for awards granted prior to the increases in the dividend

rate in October 2018 and 2019 may not have factored in those incremental dividend rights, so the aggregate amount of dividend rights equal to those incremental increases is included in this column. Both RSA and PSU awards accrue rights to cash dividends that are only paid if the awards vest. The dividend rights paid on or accruing to our equity awards are equivalent in value to the rights of common stockholders generally and are not preferential.

Name	Qualified 401(k) Match ($)	Nonqualified 401(k) Match ($)	Dividend Rights ($)	Other ($)
Mark J. Tarr	—	78,606	9,219	—
Douglas E. Coltharp	7,058	36,859	3,494	—
Barbara A. Jacobsmeyer	7,250	17,516	2,197	—
April Anthony	2,603	—	1,159	—
Patrick Darby	—	—	1,828	—

For SEC purposes, the cost of personal use of the Company aircraft, if any, is calculated based on the incremental cost to us. To determine the incremental cost, we calculate the variable costs based on usage which include fuel costs on a per hour basis, plus any direct trip expenses such as on-board catering, landing/ramp fees, crew hotel and meal expenses, and other miscellaneous variable costs. Since Company-owned aircraft are only used when there is a primary business purpose, the calculation method excludes the costs which do not change based on incremental non-business usage, such as pilots' salaries, aircraft leasing expenses and the cost of maintenance not related specifically to trips.

Occasionally, our executives are accompanied by guests on the corporate aircraft for personal reasons when there is available space on a flight being made for business reasons. There is no incremental cost associated with that use of the aircraft when the guests do not comprise 50% or more of the passengers, except for a pro rata portion of catering expenses and our portion of employment taxes attributable to the income imputed to that executive for tax purposes.

Employment Agreement with April Anthony

Other than the compensation plans and programs described under "Compensation Discussion and Analysis," the Company had only one agreement or arrangement in effect with its executives in 2020. On December 31, 2014, we entered into a management agreement with Ms. Anthony governing the terms of her employment as president and chief executive officer of our home health and hospice segment. As part of the acquisition of that business, Ms. Anthony and certain other members of that management team agreed to and did enter into amended and restated management agreements, each with an initial term of three years and subsequent one year automatic renewals, and related noncompetition/nonsolicitation agreements, pursuant to which they agreed not to compete in the business of providing home health or hospice care services or acquire any companies operating in those businesses during the two years following termination of employment. Ms. Anthony's agreement, previously filed as an exhibit to our Annual Report on Form 10-K, provided for her salary, bonus and benefit terms as well as severance benefits, including continuation of base salary and payment of COBRA premiums for up to one year upon termination for good reason or without cause, subject to a release of claims.

In October 2019, Ms. Anthony and Encompass Health entered into a new amended and restated management agreement to replace the 2014 agreement effective as of January 1, 2020. This latest agreement is an exhibit to our 2020 Form 10-K. Pursuant to this agreement, Ms. Anthony receives an annual base salary of no less than $550,000, subject to annual adjustments as determined by the Committee, and an annual bonus based on both the performance of the Company and her personal performance. It also provides that she will participate in the long-term incentive awards and programs and participate in and receive benefits under certain insurance, benefit and other plans. Under the terms of the agreement, Ms. Anthony's target annual cash bonus opportunity is 75% of her base salary and target long-term incentive plan award value is 150% of her base salary. In the event we terminate her employment without cause or she terminates her employment for good reason, the agreement provides 12 months of base salary continuation and COBRA premium payments in addition to any unpaid annual bonus for any fiscal year completed prior to termination. This agreement has an initial term of three years and subsequent one year automatic renewals, and related noncompetition/nonsolicitation agreements, pursuant to which Ms. Anthony agreed not to compete with Encompass Health or acquire any companies operating in our businesses for a period of 12 months from the date of termination.

Grants of Plan-Based Awards During 2020

Name	Grant Date	Date of Board Approval of Grant	Estimated Possible Payouts Under Non-Equity Incentive Plan Awards[1]			Estimated Future Payouts Under Equity Incentive Plan Awards[2]			All Other Stock Awards: Number of Shares of Stock or Unit[6] (#)	All Other Option Awards: Number of Securities Underlying Options[7] (#)	Exercise or Base Price of Option Awards ($/SH)	Grant Date Fair Value of Stock and Option Awards ($)
			Threshold[3] ($)	Target[4] ($)	Maximum[5] ($)	Threshold (#)	Target (#)	Maximum (#)				
Mark J. Tarr												
Annual Incentive			630,000	1,260,000	2,520,000	—	—	—	—	—	—	—
PSU	2/20/2020	2/20/2020	—	—	—	17,683	35,365	70,730	—	—	—	2,919,734
Stock options	3/2/2020	2/20/2020	—	—	—	—	—	—	—	55,360	76.54	857,191
RSA	2/20/2020	2/20/2020	—	—	—	—	—	—	11,789	—	—	973,300
Douglas E. Coltharp												
Annual Incentive			297,500	595,000	1,190,000	—	—	—	—	—	—	—
PSU	2/20/2020	2/20/2020	—	—	—	6,585	13,169	26,338	—	—	—	1,087,233
Stock options	3/2/2020	2/20/2020	—	—	—	—	—	—	—	20,613	76.54	319,170
RSA	2/20/2020	2/20/2020	—	—	—	—	—	—	4,390	—	—	362,438
Barbara A. Jacobsmeyer												
Annual Incentive			276,250	552,500	1,105,000	—	—	—	—	—	—	—
PSU	2/20/2020	2/20/2020	—	—	—	5,503	11,005	22,010	—	—	—	908,573
Stock Options	3/2/2020	2/20/2020	—	—	—	—	—	—	—	17,227	76.54	266,742
RSA	2/20/2020	2/20/2020	—	—	—	—	—	—	3,669	—	—	302,913
April Anthony												
Annual Incentive			206,250	412,500	825,000	—	—	—	—	—	—	—
PSU	2/20/2020	2/20/2020	—	—	—	3,105	6,209	12,418	—	—	—	512,615
Stock options	3/2/2020	2/20/2020	—	—	—	—	—	—	—	9,718	76.54	150,473
RSA	2/20/2020	2/20/2020	—	—	—	—	—	—	2,070	—	—	170,899
Patrick Darby												
Annual Incentive			206,250	412,500	825,000	—	—	—	—	—	—	—
PSU	2/20/2020	2/20/2020	—	—	—	3,105	6,209	12,418	—	—	—	512,615
Stock options	3/2/2020	2/20/2020	—	—	—	—	—	—	—	9,718	76.54	150,473
RSA	2/20/2020	2/20/2020	—	—	—	—	—	—	2,070	—	—	170,899

Footnotes found on next page.

(1) The possible payments described in these three columns are cash amounts provided for by our 2020 Senior Management Bonus Plan as discussed under "Annual Incentives" beginning on page 43. Final payments under the 2020 program were calculated and paid in the first quarter of 2021 and are reflected in the Summary Compensation Table under the heading "Non-Equity Incentive Plan Compensation."

(2) Awards which are designated as "PSU" are performance share units. As described in "PSU Awards in 2020" beginning on page 47, these awards vest and shares are earned based upon the level of attainment of performance objectives for the two-year period from January 1, 2020 ending December 31, 2021 and a one-year time-vesting requirement ending December 31, 2022. Each of the threshold, target and maximum share numbers reported in these three columns assume the performance objectives are each achieved at that respective level. Upon a change in control, the Compensation and Human Capital Committee will determine the extent to which the performance goals for PSUs have been met and what awards have been earned or if the goals should be modified on account of the change in control. The PSUs, and resulting restricted stock, accrue ordinary dividends during the service period, to the extent paid on our common stock, but the holders will not receive the cash payments related to these accrued dividends until the restricted stock resulting from performance attainment vests. The Compensation and Human Capital Committee will determine whether the restricted stock will be entitled to any extraordinary dividends, if any are declared and paid.

(3) The threshold amounts in this column assume: (i) the Company reached only threshold achievement on each of the quantitative objectives and (ii) the Compensation and Human Capital Committee, or board in the case of the CEO, exercised no discretion based on performance, resulting in payment of the minimum quantitative portion of the bonus. Then, following the procedures discussed under "Assessing and Rewarding 2020 Achievement of Objectives" beginning on page 45, we would multiply this amount by 50% (the threshold payout multiple) to arrive at the amount payable for threshold achievement of the quantitative objectives.

(4) The target payment amounts in this column assume: (i) the Company achieved exactly 100% of each of the quantitative objectives and (ii) the Compensation and Human Capital Committee, or board in the case of the CEO, exercised no discretion based on an individual's performance. The target amount payable for each NEO is his or her base salary multiplied by the target cash incentive opportunity percentage set out in the table under "Establishing the Target Cash Incentive Opportunity" on page 45.

(5) The maximum payment amounts in this column assume the Company achieved at or above the maximum achievement level of each of the quantitative objectives, at which level no discretion can be applied to increase the payment. Thus, following the procedures discussed under "Assessing and Rewarding 2020 Achievement of Objectives" beginning on page 45, we would multiply the target amount by 200% (the maximum payout multiple) to arrive at the amount payable for maximum achievement.

(6) Awards which are designated as "RSA" are time-vesting restricted stock awards. The number of shares of restricted stock set forth will vest in three equal annual installments beginning on the first anniversary of the grant, provided that the officer is still employed. A change in control of the Company will also cause these awards to immediately vest. This restricted stock accrues ordinary dividends to the extent paid on our common stock, but the holders will not receive the cash payments related to these accrued dividends until the restricted stock vests. The Compensation and Human Capital Committee will determine whether the restricted stock will be entitled to any extraordinary dividends, if any are declared and paid.

(7) All stock option grants will vest, subject to the officer's continued employment, in three equal annual installments beginning on the first anniversary of grant. A change in control of the Company will also cause options to immediately vest.

Potential Payments upon Termination of Employment

The following table describes the potential payments and benefits under the Company's compensation and benefit plans and arrangements to which the named executive officers currently employed with us would be entitled upon termination of employment by us without "cause" or by the executive for "good reason" or "retirement," as those terms are defined below. There are no payments or benefits due in the event of a termination of employment by us for cause. As previously discussed, our Change in Control Benefits Plan does not provide cash benefits unless there is an associated termination of employment. Due to the numerous factors involved in estimating these amounts, the actual value of benefits and amounts to be paid can only be determined upon termination of employment. In the event an NEO breaches or violates the restrictive covenants contained in the awards under our 2008 Equity Incentive Plan, 2016 Omnibus Performance Incentive Plan, Executive Severance Plan, or the Changes in Control Benefits Plan or, in the case of Ms. Anthony, her employment agreement, certain of the amounts described below may be subject to forfeiture and/or repayment.

For additional discussion of the material terms and conditions, including payment triggers, see "Severance Arrangements" beginning on page 50 and "Employment Agreement with April Anthony" on page 54. An executive cannot receive termination benefits under more than one of the plans or arrangements identified below. Retirement benefits are governed by the terms of the awards under our 2008 Equity Incentive and 2016 Omnibus Performance Incentive Plans. The following table assumes the listed triggering events occurred on December 31, 2020.

Name/Triggering Event	Lump Sum Payments ($)(1)	Continuation of Insurance Benefits ($)	Accelerated Vesting of Equity Awards ($)(2)	Total Termination Benefits ($)
Mark J. Tarr				
Executive Severance Plan				
Without Cause/For Good Reason	3,150,000	47,919	9,335,375	12,533,294
Disability or Death	—	—	13,144,885	13,144,885
Change in Control Benefits Plan	8,824,980	47,919	13,700,761	22,573,660
Douglas E. Coltharp				
Executive Severance Plan				
Without Cause/For Good Reason	1,400,000	25,094	3,449,926	4,875,020
Disability or Death	—	—	4,791,870	4,791,870
Change in Control Benefits Plan	5,134,351	37,641	4,980,407	10,152,399
Barbara A. Jacobsmeyer				
Executive Severance Plan				
Without Cause/For Good Reason	1,300,000	34,920	2,331,829	3,666,749
Disability or Death	—	—	3,443,279	3,443,279
Change in Control Benefits Plan	4,196,091	52,380	3,596,131	7,844,602
April Anthony				
Employment Agreement				
Without Cause/For Good Reason	550,000	11,303	1,543,476	2,104,779
Disability or Death	—	—	3,046,302	3,046,302
Equity Incentive Plan	—	—	3,121,421	3,121,421
Patrick Darby				
Executive Severance Plan				
Without Cause/For Good Reason	1,100,000	31,854	1,800,571	2,932,425
Disability or Death	—	—	2,474,329	2,474,329
Change in Control Benefits Plan	3,442,333	47,780	2,573,761	6,063,874

(1) The Company automatically reduces payments under the Change in Control Benefits Plan to the extent necessary to prevent such payments being subject to "golden parachute" excise tax under Section 280G and Section 4999 of the Internal Revenue Code, but only to the extent the after-tax benefit of the reduced payments exceeds the after-tax benefit if such reduction were not made ("best payment method"). The lump sum payments shown may be subject to reduction under this best payment method.

(2) The amounts reported in this column reflect outstanding equity awards, the grant date value of which along with accrued dividends and dividend equivalents has been reported as compensation in 2020 or prior years. The value of the accelerated vesting of equity awards listed in this column has been determined based on the $82.69 closing price of our common stock on the last trading day of 2020. The Committee may, in its discretion, provide that upon a change in control: (x) equity awards be canceled in exchange for a payment in an amount equal to the fair market value of our stock immediately prior to the change in control over the exercise or base price (if any) per share of the award, and (y) each award be canceled without payment therefore if the fair market value of our stock is less than the exercise or purchase price (if any) of the award.

The amounts shown in the preceding table do not include payments and benefits to the extent they are provided on a nondiscriminatory basis to salaried employees generally upon termination of employment. The "Lump Sum Payments" column in the above table includes the estimated payments provided for under the plans described under "Severance Arrangements" beginning on page 50 and "Employment Agreement with April Anthony" on page 54. Additionally, the Executive Severance Plan and the Change in Control Benefits Plan provide that as a condition to receipt of any payment or benefits all participants must enter into a nonsolicitation, noncompete, nondisclosure, nondisparagement and release agreement.

As of December 31, 2020, none of our named executive officers qualified for retirement as defined below. However, the potential equity value accelerated upon retirement had each NEO been retirement eligible on December 31, 2020 is outlined in the table below.

Named Executive Officer	Accelerated Vesting of Equity Awards Due to Retirement (Assuming Retirement Eligible)($)
Mark J. Tarr	9,335,375
Douglas E. Coltharp	3,449,926
Barbara A. Jacobsmeyer	2,331,829
April Anthony	1,543,476
Patrick Darby	1,800,571

Definitions

"*Cause*" means, in general terms:

(i) evidence of fraud or similar offenses affecting the Company;

(ii) indictment for, conviction of, or plea of guilty or no contest to, any felony;

(iii) suspension or debarment from participation in any federal or state health care program;

(iv) an admission of liability, or finding, of a violation of any securities laws, excluding any that are noncriminal;

(v) a formal indication that the person is a target or the subject of any investigation or proceeding for a violation of any securities laws in connection with his employment by the Company, excluding any that are noncriminal; and

(vi) breach of any material provision of any employment agreement or other duties.

"*Change in Control*" means, in general terms:

(i) the acquisition of 30% or more of either the then-outstanding shares of common stock or the combined voting power of the Company's then-outstanding voting securities; or

(ii) the individuals who currently constitute the board of directors, or the "Incumbent Board," cease for any reason to constitute at least a majority of the board (any person becoming a director in the future whose election, or nomination for election, was approved by a vote of at least a majority of the directors then constituting the Incumbent Board shall be considered as though such person were a member of the Incumbent Board); or

(iii) a consummation of a reorganization, merger, consolidation or share exchange, where persons who were the stockholders of the Company immediately prior to such reorganization, merger, consolidation or share exchange do not own at least 50% of the combined voting power; or

(iv) a liquidation or dissolution of the Company or the sale of all or substantially all of its assets.

"*Good Reason*" means, in general terms:

(i) an assignment of a position that is of a lesser rank and that results in a material adverse change in reporting position, duties or responsibilities or title or elected or appointed offices as in effect immediately prior to the change, or in the case of a Change in Control ceasing to be an executive officer of a company with registered securities;

(ii) a material reduction in compensation from that in effect immediately prior to the Change in Control; or

(iii) any change in benefit level under a benefit plan if such change in status occurs during the period beginning 6 months prior to a Change in Control and ending 24 months after it; or

(iv) any change of more than 50 miles in the location of the principal place of employment.

"*Retirement*" means the voluntary termination of employment after attaining (a) age 65 or (b) in the event that person has been employed for 10 or more years on the date of termination, age 60.

Outstanding Equity Awards at December 31, 2020

	Option Awards[1]				Stock Awards			
	Number of Securities Underlying Unexercised Options (#) Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Option Exercise Price ($)	Option Expiration Date[2]	Number of Shares or Units of Stock That Have Not Vested (#)[3]	Market Value of Shares or Units of Stock That Have Not Vested ($)[4]	Equity Incentive Plan Awards: Number of Unearned Shares, Units or Other Rights That Have Not Vested (#)[5]	Equity Incentive Plan Awards: Market or Payout Value of Unearned Shares, Units or Other Rights That Have Not Vested ($)[6]
Mark J. Tarr								
	16,981	—	24.17	2/21/2023	55,515	4,590,535	30,468	2,519,399
	21,034	—	31.97	2/24/2024	4,453	368,219	70,730	5,848,664
	16,160	—	43.14	3/3/2025	9,194	760,252	—	—
	21,187	—	34.99	2/26/2026	11,789	974,832	—	—
	46,754	—	42.22	2/24/2027	—	—	—	—
	34,365	17,182	53.79	3/1/2028	—	—	—	—
	19,191	38,381	63.77	3/1/2029	—	—	—	—
	—	55,360	76.54	3/2/2030	—	—	—	—
Douglas E. Coltharp								
	26,132	—	21.02	2/27/2022	22,209	1,836,462	9,275	766,950
	14,859	—	24.17	2/21/2023	1,781	147,271	26,338	2,177,889
	13,803	—	31.97	2/24/2024	2,798	231,367	—	—
	10,181	—	43.14	3/3/2025	4,390	363,009	—	—
	13,348	—	34.99	2/26/2026	—	—	—	—
	45,830	—	39.67	10/28/2026	—	—	—	—
	24,243	—	42.22	2/24/2027	—	—	—	—
	13,746	6,873	53.79	3/1/2028	—	—	—	—
	5,841	11,681	63.77	3/1/2029	—	—	—	—
	—	20,613	76.54	3/2/2030	—	—	—	—
Barbara A. Jacobsmeyer								
	7,792	—	42.22	2/24/2027	13,087	1,082,164	7,536	623,152
	8,101	4,050	53.79	3/1/2028	1,050	86,825	22,010	1,820,007
	4,746	9,491	63.77	3/1/2029	2,274	188,037	—	—
	—	17,227	76.54	3/2/2030	3,669	303,390	—	—
April Anthony								
	2,172	4,343	63.77	3/1/2029	1,040	85,998	3,449	285,198
	—	9,718	76.54	3/2/2030	2,070	171,168	12,418	1,026,844
	—	—	—	—	23,264	1,923,700	—	—
Patrick Darby								
	12,077	—	34.99	2/26/2026	11,304	934,728	5,466	451,984
	12,338	—	42.22	2/24/2027	907	75,000	12,418	1,026,844
	6,996	3,498	53.79	3/1/2028	1,649	136,356	—	—
	3,442	6,884	63.77	3/1/2029	2,070	171,168	—	—
	—	9,718	76.54	3/2/2030	—	—	—	—

(1) All options shown above vest in three equal annual installments beginning on the first anniversary of the grant date, except for those options granted to Mr. Coltharp on October 28, 2016 as a special retention grant. The special grant vested in its entirety on the third anniversary of the grant date.

(2) The expiration date of each option occurs 10 years after the grant date of each option.

(3) Except for Ms. Anthony, the first amount shown in this column is restricted stock awards resulting from the attainment of the related PSU awards' performance objectives during the 2018-2019 performance period, and the second, third, and fourth amounts represent the annual grants of time-based restricted stock in February 2018, 2019, and 2020, respectively, each of which vest in three equal annual installments beginning on the first anniversary of the grant date. For Ms. Anthony, the first and second amounts shown in this column are the annual grants of time-based restricted stock in February 2019 and 2020 which vest in three equal annual installments beginning on the first anniversary of the grant date and the third amount shown in this column is a special retention grant of time-based restricted stock on May 3, 2019 which vests 50% on the second anniversary of the grant date and 50% on the third anniversary.

(4) The market value reported was calculated by multiplying the closing price of our common stock on the last trading day of 2020, $82.69, by the number of shares set forth in the preceding column.

(5) The PSU awards shown in this column are contingent upon the level of attainment of performance goals for the two-year period from January 1 of the year in which the grant is made. The determination of whether and to what extent the PSU awards are achieved will be made following the close of the two-year period. The first amount for each officer in this column represents the actual number of shares earned over the 2019-2020 performance period as officially determined by the board of directors in February 2021, which shares shall be restricted through December 31,

2021. The second amount for each officer in this column represents the number of shares to be earned assuming achievement of maximum performance during the 2020-2021 performance period on the normalized earnings per share and return on invested capital objectives. The actual number of restricted shares earned at the end of that performance period may be lower.

(6) The market value reported was calculated by multiplying the closing price of our common stock on the last trading day of 2020, $82.69, by the number of shares set forth in the preceding column.

Options Exercised and Stock Vested in 2020

The following table sets forth information concerning the exercise of options and the vesting of shares for our named executive officers in 2020.

	Option Awards		Stock Awards	
Name	Number of Shares Acquired on Exercise	Value Realized on Exercise ($)	Number of Shares Acquired on Vesting	Value Realized on Vesting ($)
Mark J. Tarr	26,132	1,068,861	64,666	4,651,658
Douglas E. Coltharp	23,501	1,211,001	32,018	2,288,491
Barbara A. Jacobsmeyer	*	*	16,091	1,156,739
April Anthony	*	*	521	42,534
Patrick Darby	*	*	16,409	1,173,979

* No stock option exercises or stock award vestings in 2020.

Equity Compensation Plans

The following table sets forth, as of December 31, 2020, 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.

Equity Plans	Securities to be Issued Upon Exercise	Weighted Average Exercise Price(1)	Securities Available for Future Issuance
Approved by stockholders	2,532,030 (2)	$50.65	8,445,724 (3)
Not approved by stockholders	86,830 (4)		—
Total	2,618,860	$50.65	8,445,724

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

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

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

(4) This amount represents 86,830 restricted stock units issued under the 2004 Amended and Restated Director Incentive Plan.

2004 Amended and Restated Director Incentive Plan

The 2004 Amended and Restated Director Incentive Plan, or 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.

2008 Equity Incentive Plan

Originally approved in May 2008 by our stockholders, the 2008 Equity Incentive Plan, or the "2008 Plan," provided for the grant of stock options, restricted stock, stock appreciation rights, deferred stock, other stock-based awards and cash-settled awards, including our senior management bonus plan awards, to our directors, executives and other key employees as determined by our board of directors or its Compensation and Human Capital Committee in accordance with the terms of the plan and evidenced by an award agreement with each participant. In May 2011, our stockholders approved the amendment and restatement of the 2008 Plan.

No additional awards will be made under the 2008 Plan. However, the awards outstanding under the 2008 Plan will remain 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. Notwithstanding the foregoing, no option may be exercised and no shares of stock may be issuable pursuant to other awards under the 2008 Plan until we comply with our reporting and registration obligations under the federal securities laws, unless an exemption from registration is available with respect to such shares.

2016 Omnibus Performance Incentive Plan

In May 2016, our stockholders approved the 2016 Omnibus Performance Incentive Plan, or the "2016 Plan," to provide for the grant of stock options, restricted stock, stock appreciation rights, deferred stock, other stock-based awards and cash-settled awards, including our senior management bonus plan awards, to our directors, executives and other key employees as determined by our board of directors or its Compensation and Human Capital Committee in accordance with the terms of the plan and evidenced by an award agreement with each participant. The 2016 Plan has an expiration date of May 9, 2026. Any awards outstanding under the 2016 Plan at the time of its termination will remain in effect in accordance with their terms. The aggregate number of shares of common stock available for issuance in connection with new awards under the 2016 Plan shown above is subject to equitable adjustment upon a change in capitalization of the Company or the occurrence of certain transactions affecting the common stock reserved for issuance under the plan. Any awards under the 2016 Plan must have a purchase price or an exercise price not less than the fair market value of such shares of common stock on the date of grant.

Deferred Compensation

Our board of directors has designated a benefits committee comprised of members of management as the plan administrator and “named fiduciary” within the meaning of section 402(a) of the Employee Retirement Income Security Act of 1974, as amended, for the following deferred compensation plans.

Retirement Investment Plans

Each of our named executive officers participates in one of two qualified 401(k) savings plans, the Encompass Health Retirement Investment Plan (the “RIP”) or the Encompass Home Health Savings Plan (the “HHSP”). The RIP allows eligible employees to contribute up to 100% of their their annual compensation (W-2 compensation excluding certain reimbursements, stock awards, and perquisites) on a pre-tax basis into their individual retirement accounts in the plan, subject to nondiscrimination rules and annual contribution limits. Inpatient rehabilitation employees who are at least 21 years of age are eligible to participate in the RIP and all contributions to the plan are in the form of cash. The employer matching contribution under the RIP is 50% of the first 6% of each participant’s elective deferrals, which vest 100% after three years of service. Participants are always fully vested in their own contributions.

The HHSP allows eligible employees to contribute up to 60% of their annual compensation on a pre-tax basis into their individual retirement accounts in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. All home health and hospice full-time and part-time employees, unless eligible under an acquired plan, are eligible to participate in the HHSP and all contributions to the plan are in the form of cash. The employer matching contribution under the HHSP is 25% of the first 3% of each participant’s elective deferrals, which vest gradually over a six-year service period. Participants are always fully vested in their own contributions.

Participants may invest the amounts contributed to these plans in various investment vehicles, which do not include our common stock, managed by unrelated third parties. Generally, amounts contributed to these plans will be paid upon termination of employment, although in-service withdrawals may be made upon the occurrence of a hardship or the attainment of age 59.5. Distributions will be made in the form of a lump sum cash payment unless the participant is eligible for and elects a direct rollover to an eligible retirement plan.

Nonqualified Deferred Compensation Plan

We adopted a nonqualified deferred compensation plan, the Encompass Health Corporation Nonqualified 401(k) Plan, or the “NQ Plan,” in order to allow deferrals above what is limited by the IRS. Our named executive officers, except for Ms. Anthony, are eligible to participate in the NQ Plan, the provisions of which follow the 401(k) Plan. Participants may request, on a daily basis, to have amounts credited to their NQ Plan accounts track the rate of return based on one or more benchmark mutual funds, which are substantially the same funds as those offered under our 401(k) Plan.

Our eligible employees may elect to defer from 1% to 100% of compensation (W-2 compensation excluding certain reimbursements, stock awards, and perquisites) to the NQ Plan. We will make an employer matching contribution to the NQ Plan equal to 50% of the participant’s deferral contributions, up to 6% of such participant’s total compensation, less any employer matching contributions made on the participant’s behalf to the 401(k) Plan. In addition, we may elect to make a discretionary contribution to the NQ Plan with respect to any participant. We did not elect to make any discretionary contributions to the NQ Plan for 2020. All deferral contributions made to the NQ Plan are fully vested when made and are credited to a separate bookkeeping account on behalf of each participant. Employer matching contributions vest once the participant has completed three years of service.

Deferral contributions will generally be distributed, as directed by the participant, upon either a termination of service or the occurrence of a specified date. Matching and discretionary contributions are distributed upon termination of service. Distributions may also be elected by a participant in the event of an unforeseen emergency in which case participation in the NQ Plan will be suspended. Distributions will be made in cash in the form of a lump sum payment or annual installments over a two to fifteen year period, as elected by the participant. Any amounts that are payable from the NQ Plan upon a termination of employment are subject to the six month delay applicable to specified employees under section 409A of the Code.

The following table sets forth information as of December 31, 2020 with respect to the NQ Plan.

Name	Executive Contributions in Last Fiscal Year ($)[1]	Registrant Contributions in Last Fiscal Year ($)[2]	Aggregate Earnings in Last Fiscal Year ($)[3]	Aggregate Withdrawals/ Distributions ($)	Aggregate Balance at Last Fiscal Year-End ($)[4]
Mark J. Tarr	262,021	78,606	463,999 [5]	—	4,221,386
Douglas E. Coltharp	219,584	36,859	211,802 [6]	—	2,136,481
Barbara A. Jacobsmeyer	105,082	17,516	49,352 [7]	—	352,659
Patrick Darby	—	—	—	—	—

(1) All amounts in this column are included in the 2020 amounts represented as "Salary" and "Non-Equity Incentive Plan Compensation," except $162,674 for Mr. Tarr, $120,238 for Mr. Coltharp, and $105,082 for Ms. Jacobsmeyer included in the 2019 amounts, in the Summary Compensation Table.

(2) All amounts in this column are included in the 2020 amounts represented as "All Other Compensation" except $48,802 for Mr. Tarr, $21,028 for Mr. Coltharp, and $17,516 for Ms. Jacobsmeyer included in the 2019 amounts, in the Summary Compensation Table.

(3) No amounts in this column are included, or are required to be included in the Summary Compensation Table.

(4) Other than the amounts reported in this table for 2020, the balances in this column were previously reported as "Salary," "Non-Equity Incentive Plan Compensation" and "All Other Compensation" in our Summary Compensation Tables in previous years, except for the following amounts which represent the aggregate earnings, all of which are non-preferential and not required to be reported in the Summary Compensation Table: $1,160,741 for Mr. Tarr, $497,127 for Mr. Coltharp, and $77,452 for Ms. Jacobsmeyer.

(5) Represents earnings and (losses) from amounts invested in the following mutual funds: Vanguard Wellington Admiral Shares, Vanguard Total Bond Market Index Inst, Dodge & Cox Income, Vanguard Fed Money Market Fund, EuroPacific Growth R6, and Vanguard Inst Index.

(6) Represents earnings and (losses) from amounts invested in the following mutual funds: Vanguard Wellington Admiral Shares, Vanguard Total Bond Market Index Inst, Dodge & Cox Income, Vanguard MDCP Growth Index ADM, Vanguard Fed Money Market Fund, EuroPacific Growth R6, and Vanguard Inst Index.

(7) Represents earnings and (losses) from amounts invested in the following mutual funds: Vanguard Midcap Index Instl, Vanguard Wellington Admiral Shares, Vanguard Sm Cap Index Inst, Vanguard Equity Income Admiral, EuroPacific Growth R6, and Vanguard Inst Index.

CEO Pay Ratio

Mr. Tarr's 2020 Summary Compensation Table ("SCT") Total Compensation was $6,925,127. We used the 2020 Form W-2 Box 1 "Wages, Tips and Other Compensation" for employees to determine our median employee. We annualized pay amount for those who started employment with us during 2020. Our median employee's 2020 SCT Total Compensation was $44,131. The ratio of CEO pay to median worker pay is 157:1.

The composition of our workforce greatly impacts this ratio. Approximately 35.4% of our workforce consists of employees working less than full-time, which is a common employment arrangement in the healthcare services sector. Flexible staffing arrangements that fit employees' needs allow us to attract and retain well-qualified employees.

CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Review and Approval of Transactions with Related Persons

For purposes of this section, an executive officer or a member of the board of directors or any family member of an executive officer or board member is referred to as a "related party." The board considers, in consultation with the Nominating/Corporate Governance Committee, whether a transaction between a related party and the Company presents any inappropriate conflicts of interest or impairs the "independence" of any director, or both. Additionally, the following are prohibited unless expressly approved by the disinterested members of the board of directors:

- transactions between the Company and any related party in which the related party has a material direct or indirect interest;
- employment by the Company of any sibling, spouse or child of an executive officer or a member of the board of directors, other than as expressly allowed under our employment policies; and
- any direct or indirect investment or other economic participation by a related party in any entity not publicly traded in which the Company has any direct or indirect investment or other economic interest.

Each independent director is required to promptly notify the chairman of the board of directors if any actual or potential conflict of interest arises between such member and the Company which may impair such member's independence. If a conflict exists and cannot be resolved, such member is required to submit to the board of directors written notification of such conflict of interest and an offer of resignation from the board of directors and each of the committees on which such member serves. The board need not accept such offer of resignation; however, the submission of such offer of resignation provides the opportunity for the board to review the appropriateness of the continuation of such individual's membership on the board.

Members of the board of directors must recuse themselves from any discussion or decision that affects their personal, business, or professional interest. The non-interested members of the board will consider and resolve any issues involving conflicts of interest of other members.

Transactions with Related Persons

Our policies regarding transactions with related persons and other matters constituting potential conflicts of interest are contained in our Corporate Governance Guidelines and our Standards of Business Ethics and Conduct which can be found on our website at https://investor.encompasshealth.com.

Since January 1, 2020, there has not been, nor is there currently proposed, any transaction or series of similar transactions to which we were or are to be a party in which the amount involved exceeds $120,000 and in which any director, executive officer or holder of more than 5% of our voting securities, or an immediate family member of any of the foregoing, had or will have a direct or indirect material interest, except as described below. Additionally, none of our directors, nominees or executive officers is a party to any material proceedings adverse to us or any of our subsidiaries or has a material interest adverse to us or any of our subsidiaries.

The Home Health and Hospice Segment Ownership Structure

On December 31, 2014, we completed the previously announced acquisition of EHHI Holdings, Inc. ("EHHI") and its home health and hospice business. In the acquisition, we acquired, for cash, all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Encompass Health Home Health Holdings, Inc. ("Holdings"), a subsidiary of Encompass Health and now indirect parent of EHHI, by individual sellers in exchange for shares of common stock of Holdings. Those sellers were members of EHHI management, including April Anthony, the chief executive officer, who is now an executive officer of Encompass Health. They contributed a portion of their shares of common stock of EHHI in exchange for shares of common stock of Holdings. As a result of that contribution, they acquired approximately 16.7% of the outstanding common stock of Holdings. At the time of this acquisition, we capitalized Holdings with a revolving intercompany note payable to Encompass Health in the amount of $385 million. The balance of the intercompany debt with Holdings changes from time to time based on principal repayments and borrowings to fund certain operational cash flow uses, including acquisitions, by Holdings.

Encompass Health and the employee stockholders of Holdings, including Ms. Anthony, were parties to a stockholders' agreement (the "Stockholders' Agreement") that provided for, among other things, restrictions on share transfers, preemptive rights in connection with proposed transfers of shares, customary tag-along and drag-along rights, rights of the employee stockholders to require, in certain circumstances, Encompass Health or its designee to purchase the shares of stock held by them, and the right of Encompass Health to purchase the shares of stock held by those stockholders. Specifically, at any time after December 31, 2017, each employee stockholder had the right (but not the obligation) to have his or her shares of Holdings stock purchased by Encompass Health for a cash purchase price equal to the fair value. The Stockholders' Agreement required the fair value of Holdings stock to be determined using the product of the trailing twelve-month Adjusted EBITDA measure for Holdings and a specified median market price multiple based on a basket of public home health companies and transactions with a value of $400 million or more, after adding cash and deducting indebtedness including the outstanding principal balance under any intercompany notes.

In February 2018 and again in July 2019, each employee stockholder exercised the right to sell one-third of his or her shares to Encompass Health, and Encompass Health settled the acquisition of those shares in cash, including an aggregate of $186.5 million of stock owned by Ms. Anthony. In January 2020, the Company received exercise notices for all remaining management owned shares, except for a portion of the shares owned by Ms. Anthony and another management investor. On February 18, 2020, Encompass Health settled the acquisition of those shares upon payment of approximately $162 million in cash, including $125.1 million payment to Ms. Anthony.

On February 20, 2020, we entered into an exchange agreement with Ms. Anthony, pursuant to which she had the right to exchange all of her remaining shares of Holdings stock, valued at approximately $45 million, for shares of common stock of Encompass Health by delivering notice to us. The other remaining management investor entered into the same form of exchange agreement. The exchange agreements provided that the number of Encompass Health shares to be delivered equaled the fair value of the shares of Holdings stock on the date of the exchange agreements divided by the last reported sales price of Encompass Health's common stock on the date of delivery of the exchange notice.

On February 20, 2020, we also received the exchange notices from Ms. Anthony and the other remaining management investor. Based on the last sales price of our common stock on the NYSE on February 20, 2020 and the balance of the intercompany notes, the Company delivered an aggregate of approximately 561,000 Encompass Health shares, including 548,842 shares to Ms. Anthony, in exchange for all of the remaining management-owned Holdings stock. The total number of Encompass Health shares issued pursuant to the exchange agreements on March 6, 2020 represented less than 0.6% of the outstanding shares of Encompass Health common stock. Encompass Health now owns 100% of Holdings and EHHI, and the Stockholders' Agreement is no longer in effect.

Employment Agreements

As part of the acquisition negotiation, Ms. Anthony and certain other employees of EHHI agreed to and did enter into amended and restated employment agreements, each with an initial term of three years and subsequent one year automatic renewals, and related noncompetition/nonsolicitation agreements, pursuant to which they agreed not to compete in the business of providing home health or hospice care services or acquire any companies operating in those businesses during the two years following termination of employment. Those agreements expired at the end of 2019, but in the fourth quarter of 2019, we executed updated forms of the agreements with terms of three years. Ms. Anthony's updated agreement is described further under "Employment Agreement with April Anthony" on page 54 and is an exhibit to our Annual Report on Form 10-K for the year ended December 31, 2020.

Pre-existing Agreement with an Affiliate

At the time of the acquisition, EHHI was party to a client service and license agreement (the "HCHB Agreement") with Homecare Homebase, LLC ("HCHB") for a home care management software product that includes multiple modules for collecting, storing, retrieving and disseminating home care patient health and health-related information by and on behalf of home health care agencies, point of care staff, physicians, patients and patient family members via hand-held mobile computing devices and desktop computers linked with a website hosted by HCHB. Ms. Anthony along with others created this software product and eventually sold it to HCHB. She currently serves as that company's executive chairman. A term of our negotiated acquisition of EHHI was that Ms. Anthony be allowed to continue to dedicate a portion of her time to her duties with HCHB, which portion may not exceed that time commitment provided for in her pre-existing employment agreement with EHHI and may not materially interfere with her duties and responsibilities to the Encompass Health subsidiary going forward.

The HCHB Agreement continues until terminated by either party. Either party may terminate for a material breach or an insolvency event. We may terminate the HCHB Agreement for convenience upon 90-days notice. Beginning on December 19, 2026, HCHB may terminate the HCHB Agreement for convenience upon two-years notice.

Pursuant to the HCHB Agreement, we pay fees to HCHB based on, among other things, the software modules in use, the training programs, and the number of licensed users. In 2020, the aggregate fees paid to HCHB were approximately $5.8 million.

Our board of directors reviewed and approved, as part of the acquisition negotiation and approval, the terms of the HCHB Agreement, the Stockholders' Agreement and Ms. Anthony's continuing employment with HCHB. The board found the terms of the HCHB Agreement are no less favorable to Encompass Health than those that could be obtained in arm's-length dealings by a third party.

On May 3, 2019, the board reviewed and approved an Innovation Project Development Agreement (the "IPDA") with HCHB, as a supplement to the HCHB Agreement. Under the IPDA, HCHB will develop a scheduling tool and license it to us as part of the existing HCHB software. We will transfer to HCHB certain home health related technical and algorithmic data to aid development of the scheduling tool. In consideration of this transfer, we will receive a reduced licensing charge for the new scheduling tool and payments of royalty fees over the next seven years in the event HCHB licenses the scheduling tool to other providers. The value of the data and the licensing fees are not material to us.

DELINQUENT SECTION 16(a) REPORTS

In 2020, there was one late filing of a Form 4. The acquisition on March 6, 2020 of 548,842 shares of the Company's common stock by Ms. Anthony in a single exchange transaction described above on page 65 was reported on a Form 4 filed with the SEC after that form's due date. The transaction, however, was disclosed in advance by the Company on its Form 8-K, Item 8.01, filed with the SEC on February 21, 2020, and also disclosed in its Quarterly Report on Form 10-Q, Part II, Item 2, for the quarter ended March 31, 2020, and its Definitive Proxy Statement filed with the SEC on March 27, 2020.

SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The following table sets forth information regarding the beneficial ownership of our common stock as of February 12, 2021 (unless otherwise noted), for (1) each person who is known by us to own beneficially more than 5% of the outstanding shares of our common stock, (2) each director, (3) each executive officer named in the Summary Compensation Table, and (4) all of our current directors and executive officers as a group. The address of our directors and executive officers is c/o Encompass Health Corporation, 9001 Liberty Parkway, Birmingham, Alabama 35242. We know of no arrangements, the operation of which may at a subsequent date result in the change of control of Encompass Health.

Name	Common Shares Beneficially Owned[(1)]		Percent of Class[(2)]
Greater Than 5% Beneficial Owners			
Wellington Management Group LLP	10,690,467	(3)	10.8%
BlackRock, Inc.	10,638,887	(4)	10.7%
The Vanguard Group	8,998,232	(5)	9.1%
Directors and Executive Officers			
April Anthony	748,165	(6)	*
Greg Carmichael	3,097		*
John W. Chidsey	120,118		*
Douglas E. Coltharp	334,916	(7)	*
Donald L. Correll	74,002		*
Yvonne M. Curl	75,239		*
Patrick Darby	82,329	(8)	*
Charles M. Elson	79,762		*
Joan E. Herman	29,295		*
Leo I. Higdon, Jr.	77,172		*
Barbara A. Jacobsmeyer	74,066	(9)	*
Leslye G. Katz	29,295		*
Patricia Maryland	3,097		*
John E. Maupin, Jr.	78,005		*
Nancy M. Schlichting	8,173		*
L. Edward Shaw, Jr.	95,871		*
Mark J. Tarr	590,669	(10)	*
Terrance Williams	3,097		*
All directors and executive officers as a group	2,680,096	(11)	2.7%

* Less than 1%.

(1) According to the rules adopted by the SEC, a person is a beneficial owner of securities if the person or entity has or shares the power to vote them or to direct their investment or has the right to acquire beneficial ownership of such securities within 60 days through the exercise of an option, warrant or right, conversion of a security or otherwise. Unless otherwise indicated, each person or entity named in the table has sole voting and investment power, or shares voting and investment power, with respect to all shares of stock listed as owned by that person.

(2) The percentage of beneficial ownership is based upon 99,265,706 shares of common stock outstanding as of February 12, 2021.

(3) Based on a Schedule 13G/A filed with the SEC on February 3, 2021, Wellington Management Group LLP (parent holding company/control person), Wellington Group Holdings LLP (parent holding company/control person), Wellington Investment Advisors Holdings LLP (parenting holding company/control person), and Wellington Management Company LLP (investment advisor)(the "IA") reported, as of December 31, 2020, beneficial ownership of 10,690,467 shares, including shared voting power for up to 9,602,137 shares and shared investment power for up to 10,690,467 shares, except that the IA reported shared voting power for up to 9,300,128 shares and shared investment power for up to 9,978,818 shares. These holders are located at 280 Congress Street Boston, MA 02210.

(4) Based on a Schedule 13G/A filed with the SEC on January 27, 2021, BlackRock, Inc. (parent holding company/control person) reported, as of December 31, 2020, beneficial ownership of 10,638,887 shares, with sole voting for 10,303,856 shares and sole investment power for 10,638,887 shares. This holder is located at 55 East 52nd Street, New York, NY 10055.

(5) Based on a Schedule 13G/A filed with the SEC on February 10, 2021, The Vanguard Group (investment adviser) reported, as of December 31, 2020, beneficial ownership of 8,998,232 shares, with shared voting power for 71,402 shares, sole investment power for 8,846,236 shares, and shared investment power for 151,996 shares. This holder is located at 100 Vanguard Blvd., Malvern, PA 19355.

(6) Includes 7,583 shares issuable upon exercise of options.

(7) Includes 187,567 shares issuable upon exercise of options.

(8) Includes 45,033 shares issuable upon exercise of options.

(9) Includes 35,177 shares issuable upon exercise of options.

(10) Includes 230,498 shares issuable upon exercise of options.

(11) Includes 505,858 shares issuable upon exercise of options.

PROXY

EXECUTIVE OFFICERS

The following table lists all of our executive officers. Each of our executive officers will hold office until his or her successor is elected and qualified, or until his earlier resignation or removal.

Name	Age	Position	Since
Mark J. Tarr	59	President and Chief Executive Officer; Director	12/29/2016
Douglas E. Coltharp	59	Executive Vice President and Chief Financial Officer	5/6/2010
Barbara A. Jacobsmeyer	55	Executive Vice President and President, Inpatient Hospitals	12/29/2016
April Anthony	54	Chief Executive Officer, Home Health and Hospice	12/31/2014
Patrick Darby	56	Executive Vice President, General Counsel and Secretary	2/18/2016
Elissa J. Charbonneau, D.O.	61	Chief Medical Officer	7/1/2015
Andrew L. Price	54	Chief Accounting Officer	10/22/2009
Edmund M. Fay	54	Senior Vice President and Treasurer	3/1/2008

There are no family relationships or other arrangements or understandings known to us between any of the executive officers listed above and any other person pursuant to which he or she was or is to be selected as an officer, other than any arrangements or understandings with persons acting solely as officers of Encompass Health.

Executive Officers Who Are Not Also Directors

Douglas E. Coltharp—Executive Vice President and Chief Financial Officer

Mr. Coltharp was named Executive Vice President and Chief Financial Officer on May 6, 2010. Prior to joining us, Mr. Coltharp served as a partner at Arlington Capital Advisors and Arlington Investment Partners, LLC, a boutique investment banking firm and private equity firm, from May 2007 to May 2010. Prior to that, he served 11 years as executive vice president and chief financial officer for Saks Incorporated and its predecessor organization. Prior to joining Saks in November 1996, Mr. Coltharp spent approximately 10 years with Nations Bank, N.A. and its predecessors in various positions of increasing responsibilities culminating in senior vice president and head of southeast corporate banking. He currently serves as a member of the board of directors of Under Armour, Inc.

Barbara A. Jacobsmeyer—Executive Vice President and President, Inpatient Hospitals

Ms. Jacobsmeyer was promoted to Executive Vice President of Operations, now titled as President, Inpatient Hospitals, on December 29, 2016 when Mr. Tarr was promoted to President and Chief Executive Officer. Previously, she served as a Regional President for our inpatient rehabilitation business since 2012 and prior to that held various management positions with us since joining Encompass Health in April 2007. In that time her roles included Regional Vice President and hospital chief executive officer. Prior to joining us, Ms. Jacobsmeyer served as chief operating officer for Des Peres Hospital in St. Louis, Missouri.

April Anthony—Chief Executive Officer, Home Health and Hospice

Ms. Anthony became an executive officer effective December 31, 2014 upon the acquisition of Encompass Home Health and Hospice by Encompass Health. Ms. Anthony has 28 years of experience in the home health industry. In 1992, she acquired and became chief executive officer of Liberty Health Services. She sold Liberty in 1996 and founded Encompass in 1998, where she has served as chief executive officer since. During her time in the home health industry, Ms. Anthony has overseen the design and development of an industry-leading, comprehensive information platform that allows home health providers, including Encompass, to process clinical, compliance, financial, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. Ms. Anthony founded Homecare Homebase, LLC in 2001 and served as its chief executive officer until January 2020 when she assumed the role of executive chairman of the board. See "Pre-existing Agreement with an Affiliate" beginning on page 65 for additional detail. She practiced as a certified public accountant with Price Waterhouse LLP prior to entering the home health industry. Mrs. Anthony serves as a director of First Financial Bankshares, Inc. In addition, Ms. Anthony serves on the boards of a privately-held company, Celtic Holdings CB, L.P., and two non-profit organizations, Encompass Cares Foundation and Abilene Christian University.

Patrick Darby—Executive Vice President, General Counsel and Secretary

Mr. Darby was named Executive Vice President, General Counsel and Secretary effective February 18, 2016. Before joining us, Mr. Darby was a partner at the law firm Bradley Arant Boult Cummings LLP in Birmingham, Alabama, where he practiced from 1990 to 2016, and an adjunct professor at Cumberland School of Law, in Birmingham, Alabama.

Elissa J. Charbonneau, D.O.—Chief Medical Officer

Dr. Charbonneau, a board-certified physical medicine and rehabilitation physician, was named Chief Medical Officer on July 1, 2015. From January 2015 to June 2015, she served as Vice President of Medical Services at Encompass Health. From 2001 to 2014, she served as Medical Director of New England Rehabilitation Hospital of Portland, a joint venture between Maine Medical Center and Encompass Health, where she was a staff physician for several years. Dr. Charbonneau received her doctor of osteopathic medicine from New York College of Osteopathic Medicine, a master's degree in natural sciences/epidemiology from the State University of New York at Buffalo, and a bachelor's degree from Cornell University. She is a diplomat of the American Board of Physical Medicine and Rehabilitation and of the American Osteopathic Board of Rehabilitation Medicine.

Andrew L. Price—Chief Accounting Officer

Mr. Price was named Chief Accounting Officer in October 2009 and has held various management positions with us since joining Encompass Health in June 2004 including Senior Vice President of Accounting and Vice President of Operations Accounting. Prior to joining us, Mr. Price served as senior vice president and corporate controller of Centennial HealthCare Corp, an Atlanta-based operator of skilled nursing centers and home health agencies, from 1996 to 2004, and as a manager in the Atlanta audit practice of BDO Seidman, LLC. Mr. Price is a certified public accountant and member of the American Institute of Certified Public Accountants.

Edmund M. Fay—Senior Vice President and Treasurer

Mr. Fay joined Encompass Health in 2008 as Senior Vice President and Treasurer. Mr. Fay has more than 16 years of experience in financial services specializing in corporate development, mergers and acquisitions, bank treasury management, fixed income and capital markets products. Prior to joining us, he served in various positions at Regions Financial Corporation, including executive vice president of strategic planning/mergers and acquisitions. Previously, he held vice president positions at Wachovia Corporation and at J.P. Morgan & Company, Inc.

GENERAL INFORMATION

Other Business

We know of no other matters to be submitted at the annual meeting. By submitting the proxy, the stockholder authorizes the persons named on the proxy to use their discretion in voting on any matter brought before the annual meeting.

Notice of Internet Availability of Proxy Materials

To conserve resources and save expense, we have elected to make our proxy materials available to our stockholders over the internet rather than mailing paper copies of those materials to each stockholder. However, we mail hard copies of proxy materials in the event a stockholder requests that we do so, as described below. On March 26, 2021, we began mailing to our stockholders, and also made available online at www.proxyvote.com, a Notice of Internet Availability of Proxy Materials directing stockholders to a website for access to this Proxy Statement, our 2020 Form 10-K, and instructions on how to vote via the internet or by telephone. If you received the Notice of Internet Availability only and would like to receive a paper copy of the proxy materials, please follow the instructions printed on the Notice of Internet Availability to request that a paper copy be mailed to you. Stockholders who do not receive the Notice of Internet Availability will receive a paper or electronic copy of our proxy materials.

Annual Report to Stockholders

A copy of our 2020 Form 10-K is being mailed concurrently with this proxy statement to stockholders who have requested hard copies previously and are entitled to notice of and to vote at the annual meeting. Our annual report to stockholders is not incorporated into this proxy statement and will not be deemed to be solicitation material. A copy of our 2020 Form 10-K is available without charge from the “Investors” section of our website at https://investor.encompasshealth.com. Our 2020 Form 10-K is also available in print to stockholders without charge and upon request, addressed to Encompass Health Corporation, 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Investor Relations.

Proposals for 2022 Annual Meeting of Stockholders

All stockholder proposals must be sent by mail or courier service and addressed to Encompass Health Corporation, 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Corporate Secretary. Electronic mail and facsimile delivery are not monitored routinely for stockholder submissions, so timely delivery cannot be insured.

Any proposals that our stockholders wish to have included in our proxy statement and form of proxy for the 2022 annual meeting of stockholders must be received by us no later than the close of business on November 26, 2021, and must otherwise comply with the requirements of Rule 14a-8 of the Exchange Act in order to be considered for inclusion in the 2022 proxy statement and form of proxy.

You may also submit a proposal without having it included in our proxy statement and form of proxy, but we need not submit such a proposal for consideration at the annual meeting if it is considered untimely or does not include the information required by Section 2.9 of our Bylaws. In accordance with Section 2.9, to be timely your proposal must be delivered to or mailed and received at our principal executive offices on or after January 6, 2022 and not later than February 7, 2022; provided, however, that in the event that the annual meeting is called for a date that is not within 30 days before or after anniversary date of this year’s annual meeting, your proposal, in order to be timely, must be received not later than the close of business on the tenth day following the day on which such notice of the date of the annual meeting was mailed or such public disclosure of the date of the annual meeting was made, whichever first occurs. Section 2.9 also requires, among other things, that the proposal must set forth a brief description of the business to be brought before the annual meeting and the reasons for conducting that business. A stockholder proposing business for the annual meeting must update and supplement the notice information required by Section 2.9 of our Bylaws so that it is true and correct as of the record date(s) for determining the stockholders entitled to receive notice of and to vote at the annual meeting. Any stockholder that intends to submit a proposal should read the entirety of the requirements in Section 2.9 of our Bylaws which can be found in the “Corporate Governance” section of our website at https://investor.encompasshealth.com.

Reconciliations of Non-GAAP Financial Measures to GAAP Results

To help our readers understand our past financial performance, our future operating results, and our liquidity, we supplement the financial results we provide in accordance with generally accepted accounting principles in the United States of America ("GAAP") with certain non-GAAP financial measures, including our leverage ratio and Adjusted EBITDA. Our management regularly uses our supplemental non-GAAP financial measures to understand, manage, and evaluate our business and make operating decisions. We believe our leverage ratio and Adjusted EBITDA, as defined in our credit agreement, are measures of our ability to service our debt and our ability to make capital expenditures.

The leverage ratio is defined as the ratio of consolidated total debt to Adjusted EBITDA for the trailing four quarters. Additionally, the leverage ratio is a standard measurement used by investors to gauge the creditworthiness of an institution. Our credit agreement also includes a maximum leverage ratio financial covenant which allows us to deduct up to $300 million of cash on hand from consolidated total debt.

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 Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Liquidity and Capital Resources," and Note 10, *Long-term Debt*, to the consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2020 (the "2020 Form 10-K"). These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under the credit agreement — its interest coverage ratio and its 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 those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under the credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA therein, referred to as "Adjusted Consolidated EBITDA," allows us to add back to consolidated net income interest expense, income taxes, and depreciation and amortization and then add back to consolidated net income (1) all unusual or nonrecurring items reducing consolidated net income (of which only up to $10 million in a year may be cash expenditures), (2) any losses from discontinued operations, (3) non-ordinary course fees, costs and expenses incurred with respect to any litigation or settlement, (4) share-based compensation expense, (5) costs and expenses associated with changes in the fair value of marketable securities, (6) costs and expenses associated with the issuance or prepayment debt and acquisitions, and (7) any restructuring charges not in excess of 20% of Adjusted Consolidated EBITDA. We also subtract from consolidated net income all unusual or nonrecurring items to the extent they increase consolidated net income.

The calculation of Adjusted EBITDA under the credit agreement does not require us to deduct net income attributable to noncontrolling interests or gains on fair value adjustments of hedging and equity instruments, disposal of assets and development activities. It also does not allow us to add back losses on fair value adjustments of hedging instruments or unusual or nonrecurring cash expenditures in excess of $10 million. These items and amounts, in addition to the items falling within the credit agreement's "unusual or nonrecurring" classification, may occur in future periods, but can vary significantly from period to period and may not directly relate to, or be indicative of, our ongoing liquidity or operating performance. Accordingly, the Adjusted EBITDA calculation presented here includes adjustments for them.

Adjusted EBITDA is not a measure of financial performance under GAAP, 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 consolidated financial statements accompanying the 2020 Form 10-K.

PROXY

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,				
	2020	2019	2018	2017	2016
	(In Millions)				
Net income	$368.8	$445.8	$375.4	$350.2	$318.1
Loss (income) from discontinued operations, net of tax, attributable to Encompass Health	—	0.6	(1.1)	0.4	—
Provision for income tax expense	103.8	115.9	118.9	145.8	163.9
Interest expense and amortization of debt discounts and fees	184.2	159.7	147.3	154.4	172.1
Loss on early extinguishment of debt	2.3	7.7	—	10.7	7.4
Professional fees—accounting, tax, and legal	—	—	—	—	1.9
Government, class action, and related settlements	2.8	—	52.0	—	—
Loss on disposal or impairment of assets	11.6	11.1	5.7	4.6	0.7
Depreciation and amortization	243.0	218.7	199.7	183.8	172.6
Stock-based compensation expense	29.5	114.4	85.9	47.7	27.4
Net income attributable to noncontrolling interests	(84.6)	(87.1)	(83.1)	(79.1)	(70.5)
Transaction costs	—	2.1	1.0	—	—
Gain on consolidation of joint venture formerly accounted for under the equity method of accounting	(2.2)	(19.2)	—	—	—
SARs mark-to-market impact on noncontrolling interests	—	(5.0)	(2.6)	—	—
Change in fair market value of equity securities	(0.4)	(0.8)	1.9	—	—
Tax reform impact of noncontrolling interests	—	—	—	4.6	—
Payroll taxes on SARs exercise	1.5	1.0	—	—	—
Adjusted EBITDA	$860.3	$964.9	$901.0	$823.1	$793.6

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,				
	2020	2019	2018	2017	2016
	(In Millions)				
Net cash provided by operating activities	$ 704.7	$ 635.3	$ 762.4	$ 658.3	$ 640.2
Professional fees—accounting, tax, and legal	—	—	—	—	1.9
Interest expense and amortization of debt discounts and fees	184.2	159.7	147.3	154.4	172.1
Equity in net income of nonconsolidated affiliates	3.5	6.7	8.7	8.0	9.8
Net income attributable to noncontrolling interests in continuing operations	(84.6)	(87.1)	(83.1)	(79.1)	(70.5)
Amortization of debt-related items	(7.2)	(4.5)	(4.0)	(8.7)	(13.8)
Distributions from nonconsolidated affiliates	(3.8)	(6.6)	(8.3)	(8.6)	(8.5)
Current portion of income tax expense	51.4	75.9	128.0	85.0	31.0
Change in assets and liabilities	7.3	180.1	(46.0)	7.4	30.1
Tax reform impact of noncontrolling interests	—	—	—	4.6	—
Cash used in (provided by) operating activities of discontinued operations	0.2	4.4	(0.8)	0.6	0.7
Transaction costs	—	2.1	1.0	—	—
SARs mark-to-market impact on noncontrolling interests	—	(5.0)	(2.6)	—	—
Change in fair market value of equity securities	(0.4)	(0.8)	1.9	—	—
Payroll taxes on SARs exercise	1.5	1.0	—	—	—
Other	3.5	3.7	(3.5)	1.2	0.6
Adjusted EBITDA	$ 860.3	$ 964.9	$ 901.0	$ 823.1	$ 793.6

For the year ended December 31, 2020, net cash used in investing activities was $407.5 million and primarily resulted from capital expenditures. Net cash used in financing activities during the year ended December 31, 2020 was $145.9 million and primarily resulted from the issuance of senior notes in May and October 2020 offset by the redemption of the Company's 5.75% Senior Notes due 2024, the purchase of one-third of the rollover shares held by members of the home health and hospice management team, dividends paid common stock, and distributions paid to noncontrolling interests of consolidated affiliates.

For the year ended December 31, 2019, net cash used in investing activities was $657.4 million and primarily resulted from the acquisition of Alacare and capital expenditures. Net cash provided by financing activities during the year ended December 31, 2019 was $48.2 million and primarily resulted from the issuance of $1.0 billion of senior notes offset by repayments on the Company’s revolving credit facility and 5.75% Senior Notes due 2024, the purchase of one-third of the rollover shares held by members of the home health and hospice management team, dividends paid common stock, distributions paid to noncontrolling interests of consolidated affiliates, and repurchases of common stock.

For the year ended December 31, 2018, net cash used in investing activities was $424.5 million and resulted primarily from capital expenditures and the acquisition of Camellia Healthcare. Net cash used in financing activities during the year ended December 31, 2018 was $321.2 million and resulted primarily from cash dividends paid on common stock, net debt payments, distributions to noncontrolling interests of consolidated affiliates, and purchasing one-third of the Rollover Shares held by members of the home health and hospice management team.

For the year ended December 31, 2017, net cash used in investing activities was $283.0 million and resulted primarily from capital expenditures and acquisitions of businesses. Net cash used in financing activities during the year ended December 31, 2017 was $359.9 million and resulted primarily from net debt repayments associated with the Company’s credit agreement, cash dividends paid on common stock, distributions to noncontrolling interests of consolidated affiliates, and repurchases of common stock in the open market.

For the year ended December 31, 2016, net cash used in investing activities was $229.9 million and resulted primarily from capital expenditures and acquisitions of businesses offset by the proceeds from the disposal of the home health pediatric assets. Net cash used in financing activities during the year ended December 31, 2016 was $416.4 million and resulted primarily from the redemption of the Company’s 7.75% Senior Notes due 2022, cash dividends paid on common stock, repurchases of common stock in the open market, and distributions to noncontrolling interests of consolidated affiliates.

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, 2020

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 001-10315

Encompass Health Corporation

(Exact Name of Registrant as Specified in its Charter)

Delaware	**63-0860407**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

9001 Liberty Parkway
Birmingham, Alabama 35242
(Address of Principal Executive Offices)

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

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

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

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $6.0 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 99,265,706 shares of common stock of the registrant outstanding, net of treasury shares, as of February 12, 2021.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2021 annual meeting of stockholders is incorporated by reference in Part III to the extent described therein.

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NOTE TO READERS

As used in this report, the terms "Encompass Health," "we," "us," "our," and the "Company" refer to Encompass Health Corporation and its consolidated subsidiaries, unless otherwise stated or indicated by context. This drafting style is suggested by the Securities and Exchange Commission and is not meant to imply that Encompass Health Corporation, the publicly traded parent company, owns or operates any specific asset, business, or property. The hospitals, operations, and businesses described in this filing are primarily owned and operated by subsidiaries of the parent company. In addition, we use the term "Encompass Health Corporation" to refer to Encompass Health Corporation alone wherever a distinction between Encompass Health Corporation and its subsidiaries is required or aids in the understanding of this filing. We may refer to our consolidated subsidiary, EHHI Holdings, Inc. and its subsidiaries, which collectively operate our home health and hospice business, as "EHHI."

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS AND SUMMARY OF RISK FACTORS

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, the spread and impact of the COVID-19 pandemic, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy and ongoing strategic review, 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, and in the case of the COVID-19 pandemic has already caused, actual results to differ materially from those estimated by us include, but are not limited to, each of the factors discussed in Item 1A, *Risk Factors*, summarized in the list below, as well as uncertainties and factors, if any, discussed elsewhere in this Form 10-K, in our other SEC filings from time to time, or in materials incorporated therein by reference.

Risks Related to the Strategic Review of Our Home Health and Hospice Business

- Our ongoing strategic review exposes us to a number of risks and uncertainties, including diversion of management’s time to the process; the incurrence of significant expenses associated with the review and pursuit of any transaction; increased difficulties in attracting, retaining or motivating key management personnel; exposure to potential litigation; and inability to realize anticipated benefits from a potential transaction or other strategic alternative involving our home health and hospice business, any of which could adversely affect our business, financial results or condition, or stock price.

Novel Coronavirus Disease 2019 (“COVID-19”) Pandemic Risks

- A pandemic, epidemic, or other widespread outbreak of an infectious disease or other public health crisis could decrease our patient volumes, pricing, and revenues, lead to staffing and supply shortages and associated cost increases, otherwise interrupt operations, or lead to increased litigation risk and, in the case of the COVID-19 pandemic, has already done so in many instances.
- Governmental actions in response to the COVID-19 pandemic, such as shelter-in-place orders, new workplace regulations, facility closures and quarantines, could reduce volumes and otherwise impair our ability to operate and provide care and in many instances already have done so.
- Our ability to maintain infectious disease prevention and control efforts that are required and effectively minimize the spread of COVID-19 among patients and employees could decrease our patient volumes and revenues, lead to staffing shortages or otherwise interrupt operations, or lead to increased litigation risk.

Reimbursement Risks

- Reductions or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our inability to obtain and retain favorable arrangements with third-party payors, could decrease our revenues and adversely affect other operating results.
- Restrictive interpretations of the regulations governing the claims that are reimbursable by Medicare could decrease our revenues and adversely affect other operating results.
- New or changing Medicare quality reporting requirements could adversely affect our operating costs or Medicare reimbursement.
- Reimbursement claims are subject to various audits from time to time and such audits may lead to assertions that we have been overpaid or have submitted improper claims, and such assertions may require us to incur additional costs to respond to requests for records and defend the validity of payments and claims and may ultimately require us to refund any amounts determined to have been overpaid.
- Delays and other substantive and procedural deficiencies in the administrative appeals process associated with denied Medicare reimbursement claims, including from various Medicare audit programs, could delay or reduce our reimbursement for services previously provided, including through recoupment from other claims due to us from Medicare.

- Efforts to reduce payments to healthcare providers undertaken by third-party payors, conveners, and referral sources could adversely affect our revenues or profitability.
- Changes in our payor mix or the acuity of our patients could reduce our revenues or profitability.

Other Regulatory Risks

- Changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction (such as the re-basing of payment systems, the introduction of site neutral payments or case-mix weightings across post-acute settings, and other payment system reforms, including the Patient-Driven Groupings Model for home health) could decrease revenues and increase the costs of complying with the rules and regulations.
- The ongoing evolution of the healthcare delivery system, including alternative payment models and value-based purchasing initiatives, could decrease our reimbursement rate or increase costs associated with our operations.
- Compliance with the extensive and frequently changing laws and regulations applicable to healthcare providers requires substantial time, effort and expense, and if we fail to comply, we could incur penalties and significant costs of investigating and defending asserted claims, whether meritorious or not, or be required to make significant changes to our operations.
- Our inability to maintain proper local, state and federal licensing, including compliance with the Medicare conditions of participation and provider enrollment requirements, could decrease our revenues.

Other Operational and Financial Risks

- Incidents affecting the proper operation, availability, or security of our or our vendors' or partners' information systems, including the patient information stored there, could cause substantial losses and adversely affect our operations and governmental mandates to increase use of electronic records and interoperability exacerbate that risk.
- Any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including disclosed and undisclosed *qui tam* suits could be difficult to predict and could adversely affect our financial results or condition or our operations, and we could experience increased costs of defending and insuring against alleged professional liability and other claims.
- Our inability 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 could adversely affect our financial results or condition.
- Our inability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and potential union activity could increase labor expenses and adversely affect other financial and operating results.
- 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 could adversely affect our revenues or other financial results.
- Our inability to maintain or develop relationships with patient referral sources could decrease our revenues.
- Our debt and the associated restrictive covenants could have negative consequences for our business and limit our ability to execute aspects of our business plan successfully.
- The price of our common stock could adversely affect our willingness and ability to repurchase shares.
- We may be unable or unwilling to continue to declare and pay dividends on our common stock.
- General conditions in the economy and capital markets, including any disruption, instability, or uncertainty related to armed conflict or an act of terrorism, a governmental impasse over approval of the United States federal budget, an increase to the debt ceiling, an international trade war, or a sovereign debt crisis could adversely affect our financial results or condition, including access to the capital markets.

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

PART I

Item 1. Business.

Overview of the Company

General

We are a leading provider of post-acute healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2020, our national footprint spans 39 states and Puerto Rico and includes 137 hospitals and 241 home health and 82 hospice locations. We are committed to delivering high-quality, cost-effective integrated patient care.

Effective January 1, 2018, we changed our corporate name from HealthSouth Corporation to Encompass Health Corporation and the NYSE ticker symbol for our common stock from "HLS" to "EHC." Our principal executive offices are located at 9001 Liberty Parkway, Birmingham, Alabama 35242, and the telephone number of the principal executive offices is (205) 967-7116. Our website address is www.encompasshealth.com.

On December 9, 2020, we announced a formal process to explore strategic alternatives for our home health and hospice business. A range of options are under consideration, including the full or partial separation of the home health and hospice business from Encompass Health through an initial public offering, spin-off, merger, sale or other transaction. No timetable has been established for the completion of the strategic review.

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

We manage our operations in two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. The table below provides selected operating and financial data for our inpatient rehabilitation hospitals, home health agencies, and hospice agencies. See Note 19, *Segment Reporting,* to the accompanying consolidated financial statements for detailed financial information for each of our segments.

	As of or for the Year Ended December 31,		
	2020	2019	2018
Consolidated data:		(Actual Amounts)	
Inpatient rehabilitation:			
Number of hospitals [1]	137	133	130
Discharges	181,897	186,842	179,846
Number of licensed beds	9,505	9,249	8,966
Home health and hospice:			
Number of home health locations [2]	241	245	220
Home health episodic admissions	158,912	159,727	137,396
Number of hospice locations	82	83	58
Hospice admissions	12,878	10,452	7,474
Net operating revenues:		(In Millions)	
Inpatient	$ 3,496.1	$ 3,423.5	$ 3,247.9
Outpatient and other	70.1	89.5	98.3
Total inpatient rehabilitation	3,566.2	3,513.0	3,346.2
Home health	877.6	918.0	814.6
Hospice	200.6	174.0	116.5
Total home health and hospice	1,078.2	1,092.0	931.1
Net operating revenues	$ 4,644.4	$ 4,605.0	$ 4,277.3

(1) The amounts as of December 31, 2018 include one hospital operating as a joint venture, which we accounted for using the equity method of accounting. As a result of an amendment to the joint venture agreement related to this hospital, the accounting for it changed from the equity method to consolidated effective July 1, 2019.

(2) These amounts include one, two and two locations as of December 31, 2020, 2019, and 2018, respectively, which we account for using the equity method of accounting.

Inpatient Rehabilitation

We are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated, revenues, and number of hospitals. We provide specialized rehabilitative treatment on predominantly an inpatient basis. We operate hospitals in 35 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. In addition to our hospitals, we manage four inpatient rehabilitation units through management contracts.

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across an array of diagnoses and deliver comprehensive, high-quality, cost-effective patient care services. As participants in the Medicare program, our hospitals must be licensed and certified and otherwise comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Inpatient Rehabilitation" section. Substantially all (91%) of the patients we serve are admitted from acute care hospitals following physician referrals for specific acute inpatient rehabilitative care. Most of those patients have experienced significant physical and cognitive disabilities or injuries due to medical conditions, such as strokes, hip fractures, and a variety of debilitating neurological conditions, that are generally nondiscretionary in nature and require rehabilitative healthcare services in a facility-based setting. During the COVID-19 Pandemic (the "pandemic"), our hospitals have treated thousands of patients suffering or recovering from the COVID-19 virus. Our focus on specialized rehabilitative care also means that in many cases our hospitals are ideal settings for treating the debilitating effects of the COVID-19 virus, such as significant muscle weakness, cognitive impairments, shortness of breath with activity, and malnutrition. Our teams of highly skilled nurses and physical, occupational, and speech therapists utilize proven technology and clinical protocols with the objective of restoring our patients' physical and cognitive abilities. Patient care is provided by nursing and therapy staff as directed by physician orders while case managers monitor each patient's progress and provide documentation and oversight of patient status, achievement of goals, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leverages innovative technologies and advanced therapies and leads to superior outcomes.

Home Health and Hospice

Our home health business is the nation's fourth largest provider of Medicare-certified skilled home health services in terms of revenues. Our hospice business is the nation's eighth largest provider of Medicare-certified hospice services in terms of revenues. We operate home health and hospice agencies in 31 states, with a concentration in the southern half of the United States. As participants in the Medicare program, our agencies must comply with various requirements that are discussed below in the "Sources of Revenues—Medicare Reimbursement—Home Health" and "—Hospice" sections. We acquired a significant portion of our home health and hospice business when we purchased EHHI Holdings, Inc. ("EHHI") on December 31, 2014. In the acquisition, we acquired 83.3% of the issued and outstanding equity interests of EHHI, and certain members of EHHI management, including April Anthony, its chief executive officer, acquired the remaining interests. In March 2020, we acquired 100% ownership of EHHI. See Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Liquidity and Capital Resources" for further discussion of the history of the ownership structure of our home health and hospice business.

Our home health agencies provide a comprehensive range of Medicare-certified skilled home health services. These services include, among others, skilled nursing, physical, occupational and speech therapy, medical social work, and home health aide services. We also offer evidence-based specialty programs related to post-operative care, fall prevention, chronic disease management, and transitional care. Home health patients are frequently referred to us following a stay in an acute care or inpatient rehabilitation hospital or other facility, but many patients are referred from primary care settings and specialty physicians without a preceding inpatient stay. Our patients are typically older adults with three or more chronic conditions and significant functional limitations, and require greater than ten medications. As with our inpatient rehabilitation hospitals, our home health agencies have treated thousands of patients suffering or recovering from COVID-19. Our teams of registered nurses, licensed practical nurses, physical, speech and occupational therapists, medical social workers, and home health aides work closely with patients and their families and physicians to deliver patient-centered care plans focused on their needs and their goals.

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

COVID-19 Pandemic

The rapid onset of the pandemic in the United States has resulted in significant changes to our operating environment. The willingness and ability of patients to seek healthcare services have been negatively affected by restrictive measures, such as travel bans, social distancing, quarantines, and shelter-in-place orders. Elective procedures have been postponed by physicians and acute care hospitals and limited by governmental order to preserve capacity for the expected volume of COVID-19 patients and reduce the risk of the spread of COVID-19. Patients recovering from elective surgeries have historically represented approximately 15% of our home health admissions. While not a significant percentage of our inpatient rehabilitation population, we treat patients who are recovering from elective surgery with multiple comorbidities and qualify for inpatient rehabilitation care. Additionally, many in need of treatment for more severe medical conditions have chosen not to seek care because of fear of infection. We are also experiencing supply chain disruptions as a result of the pandemic, including increased time between ordering and receiving supplies. We have experienced and are likely to continue to experience significant price increases in medical supplies, particularly personal protective equipment ("PPE"). The federal government began to undertake numerous legislative and regulatory initiatives designed to provide relief to the healthcare industry during the pandemic as described below in the "Sources of Revenue—Medicare Reimbursement" section. These initiatives have provided enhanced flexibility to our hospitals and agencies to care for our patients and assist acute care hospitals in maintaining hospital capacity in the current environment. The pandemic is still rapidly evolving and much of its impact remains unknown and difficult to predict, with the impact on our operations and financial performance being dependent on numerous factors, including the ongoing nature of the pandemic, such as its rate of spread, duration, and geographic coverage; the rate and extent to which the virus mutates; the status of testing capabilities; the development, distribution, and administration of effective vaccines and other therapeutic remedies; the legal, regulatory, and administrative developments related to the pandemic at federal, state, and local levels, such as shelter-in-place orders, suspended services, and quarantines; and our infectious disease prevention and control efforts. For discussion of the financial and operational impacts we have experienced as a result the pandemic, see Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*.

In the continuously changing operating environment during the pandemic, we have taken the following steps to ensure the safety and well-being of our patients and employees:

- ✓ staying current with the Centers for Disease Control and Prevention's (the "CDC") guidance on testing and the use of PPE, which is frequently updated;
- ✓ working with our supply chain and securing secondary sources to ensure an adequate supply of PPE to protect our staff and patients;
- ✓ acquiring testing devices;
- ✓ limiting visitors in our hospitals;
- ✓ screening everyone entering our hospitals and self-screening all home health and hospice employees;
- ✓ performing pre-visit telephone calls to assess risk factors within the home, including patient and caregiver health status;
- ✓ following social distancing recommendations in our therapy gyms and performing therapy in patient rooms, if needed;
- ✓ changing hospital configurations to protect patients from potential exposure to the virus;
- ✓ suspending most of the hospital-based outpatient services (we have resumed these services at some locations);
- ✓ implementing work-at-home policies for many home office employees; and
- ✓ halting all non-essential travel.

We have also taken actions to enhance our operational and financial flexibility and ensure our long-term sustainability. Members of our executive team voluntarily reduced their base compensation for six months. In addition, we:

- ✓ amended our senior credit facility in April 2020 (primarily provided covenant relief due to disruptions from the COVID-19 pandemic);
- ✓ issued an additional $300 million of our 4.50% Senior Notes due 2028 and an additional $300 million of our 4.75% Senior Notes due 2030 in May 2020;
- ✓ issued $400 million of 4.625% Senior Notes due 2031 in October 2020;
- ✓ redeemed all $700 million in outstanding principal amount of the 5.75% Senior Notes due 2024 in November 2020; and
- ✓ developed plans for reducing capital expenditures in the event liquidity concerns arise.

Competitive Strengths

We believe we differentiate ourselves from our competitors based on, among other things, the quality of our clinical outcomes, our cost-effectiveness, our financial strength, and our extensive application of technology. We also believe our competitive strengths discussed below give us the ability to adapt and succeed in a healthcare industry facing regulatory uncertainty around attempts to improve outcomes and reduce costs.

- People. We believe our employees share a steadfast commitment to providing outstanding care to our patients. We undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality care in the most cost-effective manner. We also have hospital staff trained for all patient acuity levels faced in the post-acute setting. We embrace the Encompass Health Way, our core set of values developed through input from a broad cross section of our employees. The Encompass Health Way calls on each of our employees to set the standard, lead with empathy, do what's right, focus on the positive, and ensure we are stronger together. For further discussion of our human capital management, see the section titled "Human Capital Management" below.

- Change Agility. We have a demonstrated ability to adapt in the face of numerous and significant regulatory and legislative changes. In 2020, we rapidly moved to adapt our operations to the unprecedented pandemic. Additionally, while addressing the urgent challenges presented by the pandemic, both operating segments successfully managed through significant changes in their respective Medicare reimbursement systems in 2020.

- Strategic Relationships. We have a long and successful history of building strategic relationships with major healthcare systems. Approximately one-third of our inpatient rehabilitation hospitals currently operate as joint ventures with acute care hospitals or systems. Joint ventures with market leading acute care hospitals establish a solid foundation for providing integrated patient care that can improve the quality of outcomes and reduce the total cost of care.

  Clinical collaboration between our hospitals and home health agencies in overlap markets offers an excellent means to improve patient experience and outcomes and reduce the total cost of care across a post-acute episode. We believe the benefits of collaboration are available in non-overlap markets as well. In 2020, we deployed a home health agency quality reporting tool to identify the highest quality clinical partners in all of our markets.

  The post-acute innovation tools we have developed, and will continue to develop, support our strategic relationship initiatives by enhancing the effective and efficient management of patients across multiple post-acute care settings and facilitating high-quality patient care, improved care coordination, and network provider performance and cost management.

  Additionally, we have a strategic sponsorship with the American Heart Association/American Stroke Association on a nationwide basis to increase patient independence after a stroke and reduce stroke mortality through community outreach and information campaigns.

- Clinical Expertise and High-Quality Outcomes. We have extensive facility-based and home-based clinical experience from which we have developed standardized best practices and protocols. We believe these clinical best practices and protocols, particularly as leveraged with industry-leading technology, help ensure the delivery of consistently high-quality healthcare services, reduced inefficiencies, and improved performance across a spectrum of operational areas.

- Cost Effectiveness. Our size, data-driven business practices, and culture help us provide facility-based and home-based healthcare services on a cost-effective basis. We leverage our comprehensive IT capabilities and centralized administrative functions, identify best practices, utilize proven staffing models, and take advantage of supply chain efficiencies across our extensive platform of operations. Our information systems allow users to analyze data and trends and create custom reports on a timely basis. Additionally, our home-based healthcare services are part of the broader industry focus on reducing costs by delivering care, when clinically appropriate, in the significantly lower cost home setting.

- Financial Resources. We have a proven track record of generating strong cash flows from operations that have allowed us to successfully pursue our growth strategy, manage our financial leverage, and make significant shareholder distributions. As of December 31, 2020, we have a strong, well-capitalized balance sheet, including ownership of approximately 70% of our hospital real estate, no significant debt maturities prior to 2023, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide sufficient support for our business strategy.

- Advanced Technology and Innovation. We are focused on developing technology-enabled real-time strategies for the next generation of integrated healthcare. Our post-acute innovation strategy is based on using our clinical expertise, our large post-acute datasets, and our proven capabilities in enterprise-level electronic medical record technologies, data analytics, data integration, and predictive analytics to drive value-based performance across the healthcare continuum for our patients, our partners, and our payors. We believe our information systems and post-acute innovation solutions, in addition to improving patient care and operating efficiencies, allow us to collect, analyze, and share information on a timely basis making us an ideal partner for other healthcare providers in a coordinated care delivery environment. Our systems also emphasize interoperability with referral sources and other providers coordinating care. We have devoted substantial resources, effort and expertise to leveraging technology to create post-acute solutions that improve patient care and operating efficiencies.

Patients and Demographic Trends

Demographic trends, such as population aging, should continue to increase long-term demand for the services we provide. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. Even more specifically, the average age of our patients is approximately 76, and the population group ranging in ages from 75 to 79 is expected to grow at approximately 5% per year through 2026. We believe the demand for the services we provide will continue to increase as the U.S. population ages. We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute care services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring or opening home health and hospice agencies in those fragmented industries.

Strategy and 2021 Strategic Priorities

The following discussion of strategy and strategic priorities assumes the continuation of operations under a single ownership structure. If any change in our structure results from the ongoing strategic review, we will update our strategic priorities.

Our strategy is to expand our network of inpatient rehabilitation hospitals and home health and hospice locations, further strengthen our relationships with healthcare systems, provider networks, and payors in order to connect patient care across the healthcare continuum, and to deliver superior patient outcomes. We believe this strategy, along with our demonstrated ability to adapt to changes in healthcare, will position us for success in the evolving healthcare delivery system. In pursuit of our strategy, we established the following strategic priorities for 2021.

Growth. We will be targeting the addition of six to ten new inpatient rehabilitation hospitals and $50 million to $100 million in home health and hospice acquisitions per year. We also believe we will continue to have organic growth opportunities in our inpatient rehabilitation and home health and hospice segments based on our pre-pandemic track record of consistent growth in both segments, planned bed additions at a number of existing hospitals, and the maturation of acquired home health and hospice locations.

Operational Initiatives. Our priorities include operational initiatives that build on momentum from recent years. We will seek to continue to increase clinical collaboration in both overlap and non-overlap markets. We believe our clinical collaboration efforts have and will continue to contribute to reductions in discharges to skilled nursing facilities, higher discharges to community, and improved patient experience.

Given the significant number of stroke patients in need of post-acute care, we will continue working to build our stroke market share by leveraging our strategic sponsorship of the American Heart Association/American Stroke Association, the inpatient rehabilitation facility ("IRF") treatment recommendations published by the Department of Veterans' Affairs and the Journal of the American Medical Association, our clinical collaboration, and our hospitals' participation in The Joint Commission's Disease-Specific Care Certification Program. As of December 31, 2020, 124 of our 137 hospitals held stroke-specific certifications that required us to demonstrate effective use of evidence-based clinical practice guidelines to manage and optimize stroke care and an organized approach to performance measurement and evaluation of clinical outcomes.

We will also continue to develop and implement post-acute solutions that allow us to apply our clinical expertise, large post-acute datasets, electronic medical record technologies, and strategic partnerships to drive improved patient outcomes and lower the cost of care across the entire post-acute episode.

Capital Structure. We will seek to maintain balance sheet flexibility, consider opportunistic refinancings and augment returns from investments in operations with shareholder distributions via common stock dividends and repurchases of our common stock.

For additional discussion of our strategic priorities as well as our progress toward our priorities in 2021, including operating results, growth, and shareholder distributions, and our business outlook, see Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview," "Results of Operations," and "Liquidity and Capital Resources."

Human Capital Management

Overview of Our Employees. In 2020, our employees made inspiring sacrifices and showed extraordinary dedication to providing outstanding patient care in our hospitals and in our patients' homes across the country during the pandemic. As of December 31, 2020, we employed approximately 43,000 individuals. In the healthcare services sector, many professionals, such as nurses, desire flexible work arrangements. Accordingly, part-time and per diem employees represent a large percentage of our employee population. Except for 58 employees at one hospital (approximately 17% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2020. The chart below includes a breakdown of our employees by segment.

	Inpatient Rehabilitation	Home Health and Hospice
Total Employees	31,837	11,341
Full-time Employees	19,560	8,334
Part-time Employees	2,274	182
Pool/Per-diem Employees	10,003	2,825

In some markets, the shortage of clinical personnel is a significant operating issue facing healthcare providers. Shortages of nurses and other clinical personnel, including therapists, may, from time to time, require us to increase use of more costly temporary personnel, which we refer to as "contract labor," and other types of premium pay programs. In order to recruit and retain those clinical employees, we maintain a total rewards program that we view as a combination of the tangible components of pay and benefits with the intangible components of a culture that encourages learning, development, and a supportive work environment. We believe our outstanding employee engagement scores, discussed below, evidence that our human capital management efforts have been successful. We also believe our recognition as one of Fortune Magazine's "100 Best Companies to Work For" and the recognition of both our segments in Modern Healthcare's "Best Places to Work" is further evidence of that success. We focus on the following strategic human capital imperatives:

- Maintaining competitive compensation and benefit programs that reward and recognize employee performance;
- Fostering a strong culture that values inclusion, diversity, and equity; and
- Emphasizing employee development and engagement to attract talent and reduce turnover.

Compensation and Benefits. Maintaining competitive compensation and benefit programs that reward and recognize employee performance furthers our goal to attract, retain, and motivate employees who will help us deliver high-quality patient care. We are also committed to providing comprehensive benefit options that will allow our employees and their families to live healthier and more secure lives. In our compensation and benefit programs:

- we provide employee wages that are competitive and consistent with employee positions, skill levels, experience, knowledge and geographic location.
- we engage nationally recognized outside compensation and benefits consulting firms to independently evaluate the effectiveness of our compensation and benefit programs and to provide benchmarking against our peers within the industry and by specific market.

- we base annual increases and incentive compensation on merit, which is communicated to employees through our talent management process as part of our annual review procedures.

- all full-time and most part-time employees are eligible for health insurance, paid and unpaid leaves, a retirement plan, a wellness program, telemedicine, tuition reimbursement, an employee assistance program, and life and disability/ accident coverage.

- we provide an employer match on retirement plan contributions.

- we also offer a wide variety of voluntary benefits that allow employees to select the options that meet their needs, including pre-paid legal services, dental insurance, vision insurance, hospital indemnity insurance, accident insurance, critical illness insurance, supplemental life insurance, disability insurance, health savings accounts, flexible spending accounts, auto/home insurance, and identity theft insurance.

- we have various short-term incentive plans for field leadership, most marketing/sales employees, and executives.

- we make annual grants of restricted stock to employees (approximately 340 in 2020) at various levels of non-executive management to foster a strong sense of ownership and align the interests of members of management with those of our stockholders.

In early April 2020, we initiated a program for eligible frontline employees to earn additional paid time off in recognition of their outstanding efforts during the pandemic. With more than 21,000 employees potentially benefiting from this additional paid time off, we accrued approximately $43 million in salary and benefits expense in the second quarter of 2020 in connection with this award. This program provided for cash-out at the end of the year for any unused balance of paid time off. Additionally, we waived the employee cost-share for COVID-19 testing and telehealth/telemedicine for any illness and allowed frontline employees to continue working and accrue paid time off without a maximum.

Inclusion, Diversity, and Equity. We believe fostering a strong culture that values inclusion, diversity, and equity allows us to maintain a competitive advantage with recruiting and retaining employees. We maintain an inclusion and diversity program that is overseen by our human resources team at the home office. The program is also supported by an employee-led inclusion and diversity council that is comprised of a broad, cross-functional segment of our management and administration. The four components of our inclusion and diversity program are:

- **Workforce development**. Specific initiatives we are pursuing include, but are not limited to, a recruiting program that targets historically black colleges; funding nursing scholarships for diverse candidates; the launch of a new Encompass Health career site tool to help veterans find jobs that closely align with their specific skills; inclusion and diversity competency training for our employees; and policy reviews to incorporate language that supports inclusion and diversity.

- **Patient experience**. Specific initiatives we are pursuing include, but are not limited to, completion of a language assessment process to evaluate oral and written skills of employees who elect to serve as language translators and the addition of diversity questions to our annual employee engagement survey to assess our ability to provide culturally competent care to patients.

- **Community partnership**. Specific initiatives we are pursuing include, but are not limited to, launching a quarterly inclusion and diversity digest to better communicate our inclusion and diversity initiatives across our company; joining the National Association of Health Service Executives ("NAHSE"), an organization that promotes the advancement and development of minority healthcare leaders; participating in NAHSE's minority male leadership academy; and participating in a regional working group of Alabama-based businesses convened to discuss and share diversity and recruiting best practices.

- **Supplier diversity**. We maintain a supplier base program that offers contracting opportunities with manufacturers, distributors and service providers that are certified as minority-owned, veteran-owned and small disadvantage-owned businesses, and we are researching diverse supplier certifying organizations.

We have undertaken other initiatives to emphasize the importance of inclusion and diversity. We participate in the CEO Action for Diversity and Inclusion Pledge. This coalition of more than 1,000 chief executive officers is dedicated to advancing diversity, equity, and inclusion in the workplace. Every three to five years, we engage a third party consulting agency to help us evaluate our program and explore possible enhancements. We then provide the feedback to our board of directors. In response to societal concerns regarding systemic racism and social injustice in 2020, we produced and published a series of video conversations with various employees and members of executive management in order to highlight personal experience with prejudice and injustice and to promote diversity, inclusion, and equity.

Employee Development and Engagement. We believe promoting employee development and engagement furthers our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment where staffing shortages are not uncommon. We track and measure therapist and nurse turnover in our inpatient rehabilitation segment and overall turnover for our full-time employees in our home health and hospice segment (excluding those at new stores and most at the corporate office) on a quarterly and annual basis for significant trends and outliers, but we do not believe comparisons to benchmarks are material given the variations in survey data across markets, hospital sizes, practice settings, and practice specialties. The table below shows those turnover rates for 2020 and 2019.

	2020	2019
Therapist (IRF)	5.3%	7.2%
Nurse (IRF)	23.0%	22.8%
Overall (HH&H)	26.7%	24.7%

We support the long-term career aspirations of our employees through education and personal development.

- **Education opportunities.** We offer our nurses an opportunity to advance their academic degrees at a reduced tuition rate of 20% to 50% of the total program cost. To date, approximately 850 of our nurses have taken advantage of this opportunity.

- **Tuition reimbursement/scholarship programs.** Employees also have the opportunity to advance their education through our tuition reimbursement and scholarship programs. We reimbursed over $1 million in tuition and paid over $3 million toward employees' student loan debt in 2020.

- **Academic endowments.** We endowed five scholarships for deserving students from underrepresented groups pursuing degrees in nursing and allied health fields.

- **Therapy grants.** We fund research projects to investigate the impact and effectiveness of therapy in the inpatient rehabilitation and home health settings. In recent years, we have funded studies and research on topics ranging from caregiver education to the effectiveness of occupation-centered interventions. The program is open to qualified candidates, including employees.

- **Other employee development programs:**

    * career ladders that offer paths to develop, demonstrate, and be rewarded for expanded responsibility in nursing, therapy and case management;

    * online development library that provides access to a wide range of readily available internal and external content on many topics important for success in current or desired jobs;

    * developing future leaders program that develops nurses and therapists for supervisory positions and develops nurse and therapy supervisors for higher level positions;

    * leadership precepting that provides new leaders 6-12 months of structured mentoring from experienced, high-performing peers;

    * leadership coaching that provides six months of executive coaching to high performing leaders;

    * developing future chief nursing officers program that provides 12-18 months of intensive on-the-job experience to develop participants for future chief nursing officer job openings; and

    * developing future chief executive officers program that provides 18-24 months of intensive on-the-job experience to develop participants for future hospital chief executive officer openings.

To further aid in employee development, we have invested money in best-in-class technology to offer on-demand learning and development programs, podcasts for our home health and hospice segment, and leadership coaching programs. Another important aspect of employee development is succession planning. We annually review our talent to identify potential successors for key positions and to identify candidates for accelerated development based on their performance and potential.

The annual process includes an assessment of each employee's promotability based on a set of leadership core competencies defined as part of the company's talent strategy.

We believe employee engagement is another important driver of employee retention. We conduct an annual employee engagement survey open to all of our employees. In 2020, 78% of our employees participated in the survey, which measures perceptions based on responses to 59 questions. In 2020, the average response to 93% of engagement questions surveyed exceeded healthcare benchmarks.

Competition

Inpatient Rehabilitation. The inpatient rehabilitation industry, outside of our leading position, is highly fragmented. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units, most of which are within acute care hospitals, in the markets we serve. An acute care hospital, particularly one owned or operated by a large public company or not-for-profit that has a dominant position in the local market, can be a formidable competitor because 91% of our patients come from acute care hospitals. There are several privately held companies offering post-acute rehabilitation services that compete with us primarily in select geographic markets. In addition, there is a public company that is primarily focused on other post-acute care services, including approximately 1,700 outpatient clinics, but also operates approximately 29 freestanding inpatient rehabilitation hospitals. Other providers of post-acute care services compete for some rehabilitation patients. For example, nursing homes may market themselves as offering certain rehabilitation services, particularly to patients not in need of intensive rehabilitation therapy, even though those nursing homes are not required to offer the same level of care, and are not licensed, as hospitals. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, the relationship and reputation with managed care and other private payors and the acute care hospitals, physicians, or other referral sources in the market, and the regulatory barriers to entry in certificate of need states. The ability to work as part of an integrated delivery payment model with other providers, including the ability to deliver quality patient outcomes and cost-effective care, could become an increasingly important factor in competition if a significant number of people in a market are participants in one or more of these models. See the "Regulation—Relationships with Physicians and Other Providers" and "Regulation—Certificates of Need" sections below for further discussion of some of these factors. For a list of our inpatient rehabilitation markets by state, see the table in Item 2, *Properties.*

Home Health and Hospice. The home health and hospice services industries are also highly competitive and fragmented. There are more than 11,300 home health agencies and more than 4,800 hospice agencies nationwide certified to participate in Medicare. We are the fourth largest provider of Medicare-certified skilled home health services in the United States in terms of Medicare revenues. Our primary competition varies from market to market. Providers of home health and hospice services include both not-for-profit and for-profit organizations. There are three other public healthcare companies with significant presences in the Medicare-certified home health industry, and one insurance company with a minority interest in the largest provider of Medicare-certified skilled home health services. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, the relationship and reputation with managed care and other private payors and the acute care hospitals, physicians, or other referral sources in the market, and the regulatory barriers to entry in certificate of need states. The ability to work as part of an integrated care delivery model with other providers could become an increasingly important factor in competition if a significant number of people in a market are participants in one or more of these models. As of January 1, 2021, our home health and hospice segment is collaborating with approximately 140 alternative payment models, including Next Generation Accountable Care Organizations ("ACOs"), MSSP ACOs, and Direct Contracting Models. Home health providers with scale, which include the other public companies, may have competitive advantages, including professional management, efficient operations, sophisticated information systems, brand recognition, and large referral bases. For a list of our home health and hospice markets by state, see the table in Item 2, *Properties.*

Regulatory and Reimbursement Challenges

Healthcare is a highly regulated industry facing many well-publicized regulatory and reimbursement challenges driven by escalating costs and the pursuit of better quality of care. The Medicare reimbursement systems for both inpatient rehabilitation and home health have recently undergone significant changes. The future of many aspects of healthcare regulation remains uncertain. Any regulatory or legislative changes impacting the healthcare industry ultimately may affect, among other things, reimbursement of healthcare providers, consumers' access to coverage of health services, including among non-Medicare aged population segments within commercial insurance markets and Medicaid enrollees, and competition among providers. Changes may also affect the delivery of healthcare services to patients by providers and the regulatory compliance obligations associated with those services.

Successful healthcare providers are those able to adapt to changes in the regulatory and operating environments, build strategic relationships across the healthcare continuum, and consistently provide high-quality, cost-effective care. We believe we have the necessary capabilities — change agility, strategic relationships, quality of patient outcomes, cost effectiveness, and ability to capitalize on growth opportunities — to adapt to and succeed in a dynamic, highly regulated industry, and we have a proven track record of doing so. For more in-depth discussion of the primary challenges and risks related to our business, particularly the changes in Medicare reimbursement, increased compliance and enforcement burdens, and changes to our operating environment resulting from healthcare reform, see "Sources of Revenues—Medicare Reimbursement" and "Regulation" below in this section as well as Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), managed care plans and private insurers, and, to a considerably lesser degree, state governments (under their respective Medicaid or similar programs) and directly from patients. Revenues and receivables from Medicare are significant to our operations. The federal and state governments establish payment rates as described in more detail below. We negotiate the payment rates with non-governmental group purchasers of healthcare services that are included in "Managed care" in the tables below, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and other managed care plans. Patients are generally not responsible for the difference between established gross charges and amounts reimbursed for such services under Medicare, Medicaid, and other private insurance plans, HMOs, or PPOs but are responsible to the extent of any exclusions, deductibles, copayments, or coinsurance features of their coverage. Medicare, through its Medicare Advantage program, offers Medicare-eligible individuals an opportunity to participate in managed care plans. Revenues from Medicare and Medicare Advantage represent approximately 85% of total revenues.

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

Inpatient Rehabilitation

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Medicare	66.7 %	72.2 %	73.2 %
Medicare Advantage	15.3 %	10.7 %	9.2 %
Managed care	10.4 %	9.8 %	10.3 %
Medicaid	3.9 %	3.1 %	3.0 %
Other third-party payors	1.2 %	1.2 %	1.5 %
Workers' compensation	0.6 %	0.8 %	0.8 %
Patients	0.5 %	0.7 %	0.6 %
Other income	1.4 %	1.5 %	1.4 %
Total	100.0 %	100.0 %	100.0 %

Home Health and Hospice

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Medicare	83.1 %	84.2 %	85.3 %
Medicare Advantage	10.8 %	10.2 %	9.5 %
Managed care	4.4 %	3.6 %	3.6 %
Medicaid	1.4 %	1.7 %	1.2 %
Workers' compensation	0.1 %	0.1 %	0.2 %
Patients	0.1 %	0.1 %	0.1 %
Other income	0.1 %	0.1 %	0.1 %
Total	100.0 %	100.0 %	100.0 %

Medicare Reimbursement

Medicare is a federal program that provides hospital and medical insurance benefits to persons aged 65 and over, qualified disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare providers, facilities, and services. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises the United States Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility prospective payment system (the "IRF-PPS"), the home health prospective payment system (the "HH-PPS"), and the hospice payment system (the "Hospice-PPS"). Congress is not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. However, MedPAC's recommendations have, and could in the future, become the basis for subsequent legislative or, as discussed below, regulatory action.

The Medicare statutes are subject to change from time to time. For example, in March 2010, President Obama signed the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). In December 2018, a federal district court in Texas invalidated the 2010 Healthcare Reform Laws in their entirety but postponed enforcement of that decision pending appeal. On December 18, 2019, the United States Court of Appeals for the Fifth Circuit affirmed the district court decision but remanded the case for additional analysis on the question of severability. A group of state attorneys general subsequently appealed the case to the Supreme Court of the United States, which heard oral arguments in November 2020 but has yet to rule. With respect to Medicare reimbursement, the 2010 Healthcare Reform Laws provided for specific reductions to healthcare providers' annual market basket updates and other payment policy changes. In August 2011, President Obama signed into law the Budget Control Act of 2011 providing for an automatic 2% reduction, or "sequestration," of Medicare program payments for all healthcare providers. Sequestration took effect April 1, 2013 and, as a result of subsequent legislation, will continue through fiscal year 2029 unless Congress and the President take further action. In response to the public health emergency associated with the pandemic, Congress and the President suspended sequestration through March 31, 2021, as discussed further below.

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (the "2018 Budget Act"), which includes several provisions affecting Medicare reimbursement. Among those changes, the 2018 Budget Act mandated the adoption of a new Medicare payment model for home health providers which went into effect January 1, 2020. In the future, concerns about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both. The future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain. Healthcare will almost certainly be the subject of significant regulatory and legislative changes under the Biden administration and a Democratic-controlled Congress.

From time to time, Medicare regulations, including reimbursement methodologies and rates, can be further modified by the Centers for Medicare & Medicaid Services ("CMS"). CMS, subject to its statutory authority, may make some prospective payment system changes, including in response to MedPAC recommendations. For example, CMS instituted a rebasing adjustment in the HH-PPS consistent with a MedPAC recommendation. In some instances, CMS's modifications can have a substantial impact on healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in prospective payment systems, including the IRF-PPS and HH-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS requires IRFs to submit data on certain quality of care measures for the IRF quality reporting program. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in a subsequent Medicare fiscal year. IRFs began submitting quality data to CMS in October 2012. All of our inpatient rehabilitation hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions. Similarly, home health and hospice agencies are required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update. For 2021, we expect four of our home health and hospice agencies will incur a reduction in their reimbursement rates.

We cannot predict the adjustments to Medicare payment rates Congress or CMS may make in the future. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. Any additional downward adjustment to rates or limitations on reimbursement for the types of facilities we operate and services we provide could have a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of the risks associated with our concentration of revenues from the federal government or with potential changes to the statutes or regulations governing Medicare reimbursement, including the 2018 Budget Act, see Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Although reductions or changes in reimbursement from governmental or third-party payors and regulatory changes affecting our business represent one of the most significant challenges to our business, our operations are also affected by other rules and regulations that indirectly affect reimbursement for our services, such as data coding rules and patient coverage rules and determinations. For example, Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable and necessary. Current CMS coverage rules require inpatient rehabilitation services to be ordered by a physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide the rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services that may be needed. Medicare contractors processing claims for CMS make coverage determinations regarding medical necessity that can represent restrictive interpretations of the CMS coverage rules. Those interpretations are not made through a notice and comment review process. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

In the ordinary course, Medicare reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors (“MACs”) that act as fiscal intermediaries for all Medicare billings, as well as the United States Department of Health and Human Services Office of Inspector General (the “HHS-OIG”), CMS, and state Medicaid programs. In addition to those audits conducted by existing MACs, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. Some contractors are paid a percentage of the overpayments recovered. The Recovery Audit Contractors (“RACs”) conduct payment reviews of claims, which can examine coding, overall billing accuracy, and medical necessity. When conducting an audit, the RACs receive claims data directly from MACs on a monthly or quarterly basis.

CMS has also established Unified Program Integrity Contractors (“UPICs”), previously known as Zone Program Integrity Contractors, to perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the United States Department of Justice (“DOJ”). Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the payment errors they identify.

As a matter of course, we undertake significant efforts through training, education, and documentation to ensure compliance with coding and medical necessity coverage rules. Despite our belief that our coding and assessment of patients are accurate, audits may lead to assertions that we have been underpaid or overpaid by Medicare or that we have submitted improper claims in some instances. Audits may also require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these audit programs will affect us. Any denial of a claim for payment, either as a result of an audit or ordinary course payment review by the MAC, is subject to an appeals process that is currently taking numerous years to complete. For additional discussion of these audits and the risks associated with them, see Item 1A, *Risk Factors*, and Item 7, *Management’s Discussion and Analysis of Financial Condition and Results of Operations*, “Executive Overview—Key Challenges.”

In response to the public health emergency associated with the pandemic, Congress and CMS adopted several statutory and regulatory measures intended to provide relief to healthcare providers in order to ensure patients would continue to have adequate access to care. On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the “CARES Act”), which temporarily suspended sequestration for the period of May 1 through December 31, 2020. The CARES Act also authorized the cash distribution of relief funds from the United States Department of Health and Human Services (“HHS”) to healthcare providers. We did not request any relief funds. However, on April 10, 2020, HHS began distributing CARES Act relief funds to various of our bank accounts. We refused the CARES Act relief funds, and our banks returned all the funds to HHS. The Consolidated Appropriations Act, 2021 (the “2021 Budget Act”), signed into law on December 27, 2020, extends the sequestration suspension through March 31, 2021 and provides for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the CARES Act or the 2021 Budget Act. The CARES Act, the 2021 Budget Act, and CMS regulatory actions include a number of other provisions, which are discussed below, affecting our reimbursement and operations in both segments.

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

Inpatient Rehabilitation. As discussed above, our inpatient rehabilitation hospitals receive a fixed payment reimbursement amount per discharge under the IRF-PPS based on the patient’s rehabilitation impairment category and other characteristics and conditions identified by the attending clinicians. In order to qualify for reimbursement under the IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, pre-admission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. For example, a physician must admit each patient and in doing so determine that the treatment of the patient in an IRF setting is reasonable and necessary. In addition, to qualify as an IRF under Medicare rules, a facility must be primarily focused on treating patients with one of 13 specified medical conditions that typically require intensive therapy and supervision, such as stroke, brain injury, hip fracture, certain neurological conditions, and spinal cord injury. Specifically, at least 60% of a facility's patients must have a diagnosis or qualifying comorbidity from at least one of these 13 conditions, which requirement is known as the "60% Rule." Also, each patient admitted to an IRF must be able to tolerate a minimum of three hours of therapy per day for five days per week and must have a registered nurse available 24 hours, each day of the week.

The CARES Act temporarily suspends the requirement that patients must be able to tolerate a minimum of three hours of therapy per day for five days per week. Additionally, CMS has waived certain of the requirements that at least 60% of a facility's patients must have a diagnosis from at least 1 of 13 specified medical conditions and the requirement for a physician to conduct and document a post-admission evaluation (as discussed below, the 2021 IRF Rule permanently removed the post-admission evaluation requirement effective October 1, 2020). CMS has also issued a waiver to permit the rehabilitation physician to conduct face-to-face visits using telehealth.

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

On July 31, 2019, CMS released its notice of final rulemaking for fiscal year 2020 IRF-PPS (the "2020 IRF Rule"). The 2020 IRF Rule implemented a 2.9% market basket update effective for discharges between October 1, 2019 and September 30, 2020. The 2010 Healthcare Reform Laws require the annual market basket update to be reduced by a productivity adjustment. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective October 1, 2019 decreased the market basket update by 40 basis points. The 2020 IRF Rule also included a change to the IRF-PPS, effective October 1, 2019, that replaced the FIM™ assessment instrument with new patient assessment measures, which we refer to as "Section GG functional measures" or "Section GG" based on the designation CMS assigned to them. Section GG affects patients' classification into case-mix groupings, relative weights, and length-of-stay values under the IRF-PPS, which in turn affect our reimbursement amounts.

On August 4, 2020, CMS released its notice of final rulemaking for fiscal year 2021 IRF-PPS (the "2021 IRF Rule"). The 2021 IRF Rule implements a net 2.4% market basket increase effective for discharges between October 1, 2020 and September 30, 2021. The 2021 IRF Rule also includes changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, revisions to the wage index and labor-related share values and updates to the case-mix group relative weights and average lengths of stay values. Additionally, the 2021 IRF Rule removes the post-admission physician evaluation requirement for all IRF discharges beginning on or after October 1, 2020, codifies certain inpatient rehabilitation coverage documentation requirements, and, under certain conditions, allows the use of non-physician practitioners to perform the service and documentation requirements for one of the three required face-to-face physician visits in a patient's second and subsequent weeks in an IRF stay.

Unlike our inpatient services, our outpatient services are primarily reimbursed under the Medicare Part B physician fee schedule. On December 1, 2020, CMS released its final notice of rulemaking for the payment policies under the physician fee schedule and other revisions to Part B policies for calendar year 2021. The updates to the fee schedule are not expected to be material to us. The 2021 Budget Act includes a 3.75% increase to payments under the physician fee schedule for services furnished during calendar year 2021.

Home Health. Medicare pays home health benefits for patients discharged from a hospital or patients otherwise suffering from chronic conditions that require ongoing but intermittent skilled care. As a condition of participation under Medicare, patients must be homebound (meaning unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, or have a continuing need for occupational therapy, and receive treatment under a plan of care established and periodically reviewed by a physician. A physician must document that he or she or a qualifying nurse practitioner has had a face-to-face encounter with the patient and then certify to CMS that a patient meets the eligibility requirements for the home health benefit. The CARES Act temporarily allows nurse practitioners and physician assistants under certain conditions to certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries and expands the use of telehealth. For regulatory relief during the pandemic, CMS adopted a series of waivers, including expanding the definition of "homebound" to include patients needing skilled services who are homebound due solely to their COVID-19 diagnosis or patients susceptible to contract COVID-19 and limiting and delaying certain quality reporting requirements.

The initial certification of Medicare patient eligibility, plan of care, and comprehensive assessment is valid for a 60-day episode of care. Prior to January 1, 2020, Medicare paid home health providers under the HH-PPS for each 60-day episode of care for each patient. Providers typically received either 50% or 60% of the estimated base payment for the full 60 days for each patient upon submission of the initial claim at the beginning of the episode of care based on the patient's condition and treatment needs. The provider received the remaining portion of the payment after the 60-day treatment period, subject to any applicable adjustments. This partial early payment process is referred to as the Request for Anticipated Payment or "RAP."

As of January 1, 2020, Medicare reimburses home health providers under a new payment system, referred to as the Patient-Driven Groupings Model ("PDGM"). PDGM replaced a 60-day episode of payment methodology with a 30-day payment period and relies more heavily on clinical characteristics and other patient information (such as principal diagnosis, functional level, referral source, and timing), rather than the therapy service-use thresholds under the prior system, to determine payments. Under PDGM, the initial certification remains valid for 60 days. If a patient remains eligible for care after the initial period as certified by a physician, a new treatment period may begin. There are currently no limits to the number of home health treatment periods a Medicare patient may receive assuming there is eligibility for each successive period. PDGM also reduced the early payment opportunity available through RAP in 2020. Beginning in 2021, providers no longer have the opportunity to receive early payment through the RAP process. However, providers are required to submit certain RAP documentation components within five days of the start of each payment period and are subject to reimbursement penalties if not timely filed. Beginning in 2022, home health providers will be required to submit a Notice of Admission, or "NOA," within five days of the start of the initial treatment period. CMS will reduce reimbursement for agencies that fail to submit a NOA timely.

Home health Medicare payments are adjusted based on each patient's condition and clinical treatment. This is referred to as the case-mix adjustment. In addition to the case-mix adjustment, payments for periods of care may be adjusted for other reasons, including unusually large (outlier) costs, low-utilization patients (such as those requiring one to five visits based on the case-mix group), and geographic differences in wages. Payments are also made for non-routine medical supplies that are used in treatment.

On October 31, 2019, CMS released its notice of final rulemaking for calendar year 2020 for home health agencies under the HH-PPS (the "2020 HH Rule"). Pursuant to the requirements of the 2018 Budget Act, the 2020 HH Rule finalized the implementation of PDGM for 2020. In addition to the significant changes to the home health reimbursement model related to PDGM, the 2020 HH Rule required additional quality reporting measures and significantly increased the standardized patient assessment data elements to be collected by providers beginning in 2022. With respect to Medicare reimbursement rates, the 2020 HH Rule implemented a net 1.3% market basket increase (market basket update of 1.5% reduced by 0.2% for an extension of the rural payment add-on factor) in 2020. The 2020 HH Rule then reduced the base payment rate by 4.4% to offset the provider behavioral changes that CMS assumed PDGM would drive.

On October 29, 2020, CMS released its notice of final rulemaking for calendar year 2021 for home health agencies under the home health prospective payment system (the "2021 HH Rule"). The 2021 HH Rule implements a net 2.0% market basket increase (market basket update of 2.3% reduced by a productivity adjustment of 0.3%) and makes changes to the underlying wage index system. Making the previously temporary pandemic-related relief permanent, the 2021 HH Rule authorizes the use of telecommunications technologies in providing care to beneficiaries under the Medicare home health benefit as long as the telecommunications technology meets certain criteria and does not replace in-person visits.

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. Medicare hospice reimbursements are subject to a number of conditions of participation, including the use of volunteers and onsite visits to evaluate aides. Volunteers provide day-to-day administrative and direct patient care services in an amount that, at a minimum, equals five percent of the total patient care hours of all paid hospice employees and contract staff. A nurse or other professional conducts an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan. The CARES Act includes the temporary waiver of the requirement to use volunteers and to conduct a nurse visit every two weeks to evaluate aides and allows for the expanded use of telehealth. The 2021 Budget Act creates a new Medicare survey program for hospice agencies which will require a survey at least once every three years. Hospices that are found to be out of compliance could be subjected to new civil monetary penalties that accrue according to days out of compliance, as well as other forms of corrective action.

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 31, 2019, CMS released its notice of final rulemaking for fiscal year 2020 for hospice agencies under the Hospice-PPS (the “2020 Hospice Rule”). The 2020 Hospice Rule provided for various pricing updates, including a net market basket update of 2.6% (market basket update of 3.0% reduced by a productivity adjustment of 0.4%), for hospice payments from October 1, 2019 through September 30, 2020 and made other policy updates, including adding a requirement to provide additional cost sharing information to beneficiaries if there are services not covered by the hospice agency.

On July 31, 2020, CMS released its notice of final rulemaking for fiscal year 2021 for hospice agencies under the Hospice-PPS (the “2021 Hospice Rule”). The 2021 Hospice Rule implements a net 2.4% market basket increase from October 1, 2020 through September 30, 2021.

For additional discussion of the 2021 Medicare payment rules and other regulatory and legislative initiatives affecting Medicare reimbursement, including relief measures associated with the pandemic, that could impact our businesses, see Item 1A, *Risk Factors*, and Item 7, *Management’s Discussion and Analysis of Financial Condition and Results of Operations*, “Executive Overview—Key Challenges.”

Managed Care and Other Discount Plans

We negotiate payment rates with certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms between one and three years, although we have a number of managed care contracts that automatically renew each year (with pre-defined rate increases) unless a party elects to terminate the contract. In 2020, typical rate increases for our inpatient rehabilitation contracts ranged from 2-4% and for our home health and hospice contracts ranged from 0-3%. We cannot provide any assurance we will continue to receive increases in the future. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed unable to afford healthcare. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of some services. Continuing downward pressure on Medicaid payment rates could cause a decline in that portion of our *Net operating revenues*. However, for the year ended December 31, 2020, Medicaid payments represented only 3.4% of our consolidated *Net operating revenues*. In certain states in which we operate, we are experiencing an increase in Medicaid patients, partially the result of expanded coverage consistent with the intent of the 2010 Healthcare Reform Laws. For additional discussion, see Item 1A, *Risk Factors*, “Changes in our payor mix or the acuity of our patients could adversely affect our *Net operating revenues* or our profitability.”

Cost Reports

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

Regulation

The healthcare industry is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our operations, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth. State and local healthcare regulation may cover additional matters such as nurse staffing ratios, healthcare worker safety, marijuana legalization, and assisted suicide. We are also subject to the broader federal and state regulations that prohibit fraud and abuse in the delivery of healthcare services. Congress, HHS-OIG, and the DOJ have historically focused on fraud and abuse in healthcare. Since the 1980s, a steady stream of changes have stiffened penalties or made it easier for DOJ to impose liability on companies and individuals, and the pace of these changes has only been increasing. The 2018 Budget Act continues this emphasis by increasing the criminal and civil penalties that can be imposed for violating federal health care laws. As a healthcare provider, we are subject to periodic audits, examinations and investigations conducted by, or at the direction of, government investigative and oversight agencies. Failure to comply with applicable federal and state healthcare regulations can result in a provider's exclusion from participation in government reimbursement programs and in substantial civil and criminal penalties.

We undertake significant effort and expense to provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as, for most facilities, accreditation standards of The Joint Commission and, for some facilities, the Commission on Accreditation of Rehabilitation Facilities. We also maintain accreditation for our home health and hospice agencies where required and in other instances where it facilitates more efficient Medicare enrollment. The Community Health Accreditation Program is the most common accrediting organization for our agencies. Accredited facilities and agencies are subject to periodic resurvey to ensure the standards are being met.

Beyond healthcare specific regulations, we face increasing state and local regulation in areas, such as labor and employment and data privacy, traditionally subject to only or primarily federal regulation. In addition to the risk and burden of new, additional, or more stringent regulatory standards, these state and local regulations often conflict with federal regulation, and with each other. Given the number of locations in which we operate, increasing state and local regulation, which may be more stringent than federal regulation and may even conflict with federal or other state or local regulation, represents a significant burden and risk to us.

We maintain a comprehensive ethics and compliance program to promote conduct and business practices that meet or exceed requirements under laws, regulations, and industry standards. The program monitors the Company's performance on, and raises awareness of, various regulatory requirements among employees and emphasizes the importance of complying with governmental laws and regulations. As part of the compliance program, we provide annual compliance training to our employees, Board members, medical directors, vendors, and other non-employees that operate within our hospitals, and require all employees to report any violations to their supervisor or another person of authority or through a toll-free telephone hotline. Another integral part of our compliance program is a policy of non-retaliation against employees who report compliance concerns.

Licensure and Certification

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

In addition, inpatient rehabilitation hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. Certification and participation in these programs involve numerous regulatory obligations. For example, hospitals must treat at least 20 patients without reimbursement prior to certification and eligibility for Medicare reimbursement. Once certified by Medicare, hospitals undergo periodic on-site surveys and revalidations in order to maintain their certification. All of our inpatient hospitals participate in the Medicare program.

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

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

All Medicare providers are subject to employee screening requirements and associated fees. The screening of employees with patient access must include a licensure check and may include other procedures such as fingerprinting, criminal background checks, unscheduled and unannounced site visits, database checks, and other screening procedures prescribed by CMS. If a healthcare provider arranges or contracts with an individual or entity who is excluded by HHS-OIG from participation in a federal healthcare program, the provider may be subject to civil monetary penalties if the excluded person renders services reimbursed, directly or indirectly, by a program.

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

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities or agencies, or the introduction of new beds or inpatient, home health, and hospice services may be subject to review by and prior approval of state regulatory bodies under a "certificate of need," or "CON," law. As of December 31, 2020, approximately 40% of our licensed beds and 36% of our home health and hospice locations are in states or U.S. territories that have CON laws. CON laws require a reviewing authority or agency to determine the public need for additional or expanded healthcare facilities and services. These laws also generally require approvals for capital expenditures involving inpatient rehabilitation hospitals if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any instance where we are subject to a CON law, we must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility, starting a new healthcare program, or opening a new home health or hospice agency.

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

In an attempt to reduce regulation and increase competition, lawmakers in several states have recently proposed modification or even full repeal of CON laws. In 2019, Florida enacted legislation to repeal CON laws for several provider types, including IRFs, in two stages. Effective July 1, 2019, existing IRFs became eligible to expand without first obtaining a CON. Effective July 1, 2021, new IRFs may operate without first obtaining a CON. It appears likely other states will consider CON-related legislation and regulation changes, including in some cases expanding CON requirements.

False Claims

The federal False Claims Act (the "FCA") imposes liability for the knowing presentation of a false claim to the United States government and provides for penalties equal to three times the actual amount of any overpayments plus up to approximately $23,000 per claim. Federal civil penalties will be adjusted to account for inflation each year. In addition, the FCA allows private persons, known as "relators," to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. The government and relators may also allege violations of the FCA for the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. This is known as a "reverse false claim." The government deems identification of the overpayment to occur when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error, cost reporting error or disagreement over physician medical judgment could result in significant damages and civil and criminal penalties under the FCA. Many states have also adopted similar laws relating to state government payments for healthcare services. The 2010 Healthcare Reform Laws amended the FCA to expand the definition of false claim, to make it easier for the government to initiate and conduct investigations, to enhance the monetary reward to relators where prosecutions are ultimately successful, and to extend the statute of limitations on claims by the government. The federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent FCA violations and in challenging the medical judgment of independent physicians as the basis for FCA allegations. Furthermore, well-publicized enforcement actions indicate that the federal government has increasingly sought to use statistical sampling to extrapolate allegations to larger pools of claims or to infer liability without proving knowledge of falsity of individual claims. For additional discussion, see Item 1A, *Risk Factors*, and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

Anti-Kickback Law. Various state and federal laws regulate relationships between providers of healthcare services, including management or service contracts and investment relationships. Among the most important of these restrictions is a federal law prohibiting the offer, payment, solicitation, or receipt of remuneration by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs (the "Anti-Kickback Law"). The 2010 Healthcare Reform Laws amended the federal Anti-Kickback Law to provide that proving violations of this law does not require proving actual knowledge or specific intent to commit a violation. Another amendment made it clear that Anti-Kickback Law violations can be the basis for claims under the FCA. These changes and those described above related to the FCA, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. In addition to standard federal criminal and civil sanctions, including imprisonment and penalties of up to $100,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. Federal civil penalties will be adjusted to account for inflation each year. In 1991, 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 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.

On November 20, 2020, HHS-OIG finalized a rule to modernize the Anti-Kickback Law by reducing regulatory barriers to care coordination and accelerating adoption of value-based delivery and payment models (the "2020 AKL Rule"). The 2020 AKL Rule adds several new safe harbors for value-based arrangements and modifies several existing safe harbors with the goal of encouraging innovations that are beneficial to patients while maintaining necessary safeguards to protect against fraud and abuse. The 2020 AKL Rule also expands the safe harbor for cybersecurity technology by covering remuneration in the form of cybersecurity technology and services. The new and modified value-based safe harbors are available to inpatient rehabilitation and home health providers if the applicable conditions are met.

Failure to fall within a safe harbor does not constitute a violation of the Anti-Kickback Law, but HHS-OIG has indicated failure to fall within a safe harbor may subject an arrangement to increased scrutiny. A violation of the Anti-Kickback Law by us or one or more of our joint ventures could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

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

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

Physician Self-Referral Law. The federal law commonly known as the “Stark law” and CMS regulations promulgated under the Stark law prohibit physicians from making referrals for “designated health services” including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, and home health services, to an entity in which the physician (or an immediate family member) has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing Medicare for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $26,000 for each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $172,000 for a circumvention scheme. Federal civil penalties will be adjusted to account for inflation each year. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.

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

On November 20, 2020, CMS finalized a rule implementing various changes to the Stark law to provide better access and outcomes for patients by creating clearer paths for providers to serve patients through enhanced coordinated care agreements (the “2020 Stark Rule”). Notably, the 2020 Stark Rule creates permanent exceptions for value-based compensation arrangements that provide at least one value-based activity, which arrangements must further one value-based purpose, which may include: (1) coordinating and managing patient care; (2) improving quality of care for a target population; (3) reducing costs or expenditure growth without reducing quality of care; and (4) transitioning from health care delivery and payment mechanisms that are based on volume to outcome-based delivery and payment systems. In addition, the 2020 Stark Rule adopts a new exception regarding the provision of cybersecurity items to physicians and makes permanent the electronic health record exception under the Stark law.

The complexity of the Stark law and the associated regulations and their associated strict liability provisions are a challenge for healthcare providers, who do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet one or more exceptions to the Stark law, but the regulations implementing the exceptions are detailed and complex. Accordingly, we cannot assure that every relationship complies fully with the Stark law.

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA,” broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare or Medicaid beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive a monetary reward for providing information on Medicare fraud and abuse that leads to the recovery of at least Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties. The HHS Office of Civil Rights (“HHS-OCR”) implemented a permanent HIPAA audit program for healthcare providers nationwide in 2016. As of December 31, 2020, we have not been selected for audit.

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

The Health Information Technology for Economic and Clinical Health (“HITECH”) Act modifies and expands the privacy and security requirements of HIPAA. The HITECH Act applies certain of the HIPAA privacy and security requirements directly to business associates of covered entities. The modifications to existing HIPAA requirements include: expanded accounting requirements for electronic health records, tighter restrictions on marketing and fundraising, and heightened penalties and enforcement associated with noncompliance. Significantly, the HITECH Act also establishes new mandatory federal requirements for notification of breaches of security involving protected health information. HHS-OCR rules implementing the HITECH Act expand the potential liability for a breach involving protected health information to cover some instances where a subcontractor is responsible for the breaches and that individual or entity was acting within the scope of delegated authority under the related contract or engagement. These rules generally define “breach” to mean the acquisition, access, use or disclosure of protected health information in a manner not permitted by the HIPAA privacy standards, which compromises the security or privacy of protected health information. Under these rules, improper acquisition, access, use, or disclosure is presumed to be a reportable breach, unless the potentially breaching party can demonstrate a low probability that protected health information has been compromised.

In December 2020, HHS-OCR proposed a new rule that would modify HIPAA regulations. According to HHS-OCR, the proposed rule is intended to promote care coordination and value-based care. The proposed changes to the HIPAA rules also provide for strengthening individuals’ rights to access their own health information, including electronic information; improving information sharing for care coordination and case management for individuals; facilitating greater family and caregiver involvement in the care of individuals experiencing emergencies or health crises; enhancing flexibilities for disclosures in emergency or threatening circumstances, such as the opioid and COVID-19 public health emergencies; and reducing administrative burdens on HIPAA covered healthcare providers and health plans, while continuing to protect individuals’ health information privacy interests. Although one of the stated purposes of the proposed rules is to reduce healthcare providers burdens, providers would have to engage in a number of activities to come into compliance if the changes are finalized, including changing policies and procedures, changing patient privacy notices and business associate agreements and training workforce members in the new requirements.

HHS-OCR is responsible for enforcing the requirement that covered entities notify HHS and any individual whose protected health information has been improperly acquired, accessed, used, or disclosed. In certain cases, notice of a breach is required to be made to media outlets. The heightened penalties for noncompliance range from $100 to $50,000 per violation for most violations. In the event of violations due to willful neglect that are not corrected within 30 days, penalties start at $50,000 per violation and are not subject to a per violation statutory maximum. Penalties are also subject to an annual cap for multiple identical violations in a single calendar year. Pursuant to 2019 guidance from HHS-OCR, this enforcement cap ranges from a minimum of $25,000 per year to a maximum of $1,500,000 per year depending on an entity’s level of culpability. Importantly, HHS-OCR has indicated that the failure to conduct a security risk assessment or adequately implement HIPAA compliance policies could qualify as willful neglect.

In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Healthcare providers will continue to remain subject to any federal or state privacy-related laws, including but not limited to the California Consumer Privacy Act, that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. HHS-OIG and other regulators have also increasingly interpreted laws and regulations in a manner as to increase exposure of healthcare providers to allegations of noncompliance. Any actual or perceived violation of privacy-related laws and regulations, including HIPAA and the HITECH Act, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Civil Monetary Penalties Law

Under the Civil Monetary Penalties Law, HHS may impose civil monetary penalties on healthcare providers that present, or cause to be presented, ineligible reimbursement claims for services. The 2018 Budget Act increased the civil monetary penalties, which vary depending on the offense from $5,000 to $100,000 per violation, plus treble damages for the amount at issue and may include exclusion from federal health care programs such as Medicare and Medicaid. The penalties are adjusted annually to account for inflation. HHS may seek to impose monetary penalties under this law for, among other things, offering inducements to beneficiaries for program services and filing false or fraudulent claims.

Available Information

We make available through our website, www.encompasshealth.com, the following documents, free of charge: our annual reports (Form 10-K), our quarterly reports (Form 10-Q), our current reports (Form 8-K), and any amendments to those reports promptly after we electronically file such material with, or furnish it to, the United States Securities and Exchange Commission.

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and the reader should take such risks into account in evaluating Encompass Health or any investment decision involving Encompass Health. This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of material risk factors. More detailed information concerning other risks and uncertainties as well as those described below is contained in other sections of this annual report. Still other risks and uncertainties we have not or cannot foresee as material to us may also adversely affect us in the future. If any of the risks below or other risks or uncertainties discussed elsewhere in this annual report are actually realized, our business and financial condition, results of operations, and cash flows could be adversely affected. In the event the impact is materially adverse, the trading price of our common stock could decline.

Risks Related to the Strategic Review of Our Home Health and Hospice Business

We are reviewing strategic alternatives for our home health and hospice business, but there can be no assurance that we will be successful in identifying or consummating any strategic alternatives, that strategic alternatives will yield additional value for our stockholders, or that exploration of strategic alternatives for our home health and hospice business will not adversely impact our business, financial results or results of operations.

On December 9, 2020, we announced that our board of directors proceeded with a more formalized process for exploring strategic alternatives for our home health and hospice business. As part of this strategic review process, a number of options are under consideration, including the full or partial separation of the home health and hospice business from Encompass Health through an initial public offering, spin-off, merger, sale or other transaction. This strategic review is ongoing and may not result in the consummation of any transaction, on any particular timetable or at all. Speculation regarding any developments related to the review of strategic alternatives for our home health and hospice business and perceived uncertainties related to the future of such business or Encompass Health could cause our stock price to fluctuate significantly.

Our exploration of strategic alternatives for the home health and hospice business exposes us to a number of risks and uncertainties, including diversion of management's time to the process; the incurrence of significant expenses associated with the review and pursuit of any transaction; increased difficulties in attracting, retaining or motivating key management personnel; and exposure to potential litigation. Any of these factors could disrupt our business and could have a material adverse effect on our business, financial condition, results of operations, cash flows or stock price.

Additionally, we may not be able to realize the anticipated benefits from a potential transaction or other strategic alternative involving our home health and hospice business. There can be no assurance that any potential transaction or other strategic alternative, if identified, evaluated and consummated, will provide greater value to our stockholders than that reflected in our current stock price. Further, our board of directors may determine to suspend or terminate the exploration of strategic alternatives for our home health and hospice business at any time. Any potential transaction or other outcome of this review process is also dependent upon a number of factors that may be beyond our control, including among other factors, market conditions (including the impact of the COVID-19 pandemic), industry trends, regulatory developments, litigation, and the interest of third parties in our business.

Novel Coronavirus Disease 2019 ("COVID-19") Pandemic Risks

The COVID-19 pandemic (the "pandemic") has significantly affected and is expected to continue to significantly affect our operations, business and financial condition, and our liquidity could be negatively impacted, particularly if the operations of a significant number of acute-care hospitals and physician practices are disrupted for a lengthy period of time.

The pandemic has significantly affected and will continue to significantly affect our facilities, employees, business operations, and financial performance, as well as the United States economy and financial markets. The pandemic is still rapidly evolving and much of its impact remains unknown and difficult to predict, with the impact on our operations and financial performance being dependent on numerous factors, including the rate of spread, duration and geographic coverage of the pandemic; the rate and extent to which the virus mutates; the status of testing capabilities; the development, distribution, and administration of effective vaccines and therapeutic remedies for COVID-19 and any mutant strains; the legal, regulatory and administrative developments related to the pandemic at federal, state, and local levels, such as shelter-in-place orders, facility closures and quarantines; and the infectious disease prevention and control efforts of the Company, governments and third parties. We began experiencing a negative impact on our operations and financial results in March 2020. Although we experienced improvements in operations and financial performance in the third and fourth quarters, the ongoing nature of the pandemic means that new or recurring problems are likely to arise and may have significant negative effects on our business.

Patient Volumes and Related Risks

Beginning in mid-March 2020 and continuing through the end of the year, we have experienced decreased patient volumes in both of our operating segments, with the exception of our hospice business, when compared to prior year periods. We believe reduced patient volumes resulted, and may continue to result in specific markets, from a number of conditions related to the pandemic negatively affecting the willingness and ability of patients to seek and receive healthcare services, including: reductions in elective procedures by acute-care hospitals and physician practices; capacity and staffing constraints; restrictive governmental measures, such as travel bans, social distancing requirements, quarantines and shelter-in-place orders; and patient and caregiver fear of infection. In the home health and hospice segment, we also experienced decreases in visits per episode and institutional referrals because of the pandemic, both of which negatively affected pricing for home health.

We believe one of the primary drivers of our reduced volumes is the significant reduction in volumes of elective procedures by acute-care hospitals and physician practices. There is also reason to believe patients, because of fear of infection, have delayed or foregone treatment for conditions, such as stroke and heart attack, that are non-elective in nature. As a reminder, a large number of patients are referred to us following procedures or treatment at acute-care hospitals. Other factors related to the pandemic that have led to decreasing patient volumes include: lower acute-care hospital censuses due to shelter-in-place orders, restrictive visitation policies in place at acute-care hospitals that severely limit access to patients and caregivers by our clinical rehabilitation liaisons and care transition coordinators, lock downs of assisted living facilities that prevent our home care and hospice clinicians and other care providers from visiting patients, and heightened anxiety among patients and their family members regarding the risk of exposure to COVID-19 during acute-care and post-acute care treatment. Significant outbreaks of COVID-19 in our markets, hospitals or large acute-care referral sources could further increase patient anxiety and unwillingness to seek treatment from us or otherwise limit referrals. These factors have contributed, and could in the future contribute, to a decline in new patients for both of our operating segments as well as decreases in visits per episode and institutional referrals in our home health segment.

Supply Chain

Additionally, we experienced supply chain disruptions as a result of the pandemic, including shortages and delays, and we have experienced, and are likely to continue to experience, significant price increases in equipment, pharmaceuticals and medical supplies, particularly personal protective equipment, or “PPE.” Beginning in March 2020, we experienced increased supply expenses due to higher utilization of PPE and increased purchasing of other medical supplies and cleaning and sanitization materials as well as higher prices for supplies in shortage. Increased supply expenses are likely to continue into 2021. Shortages of essential PPE and pharmaceutical and medical supplies in the future may also limit our ability to admit and treat patients or lead to employee disputes.

Staffing and Related Risks

Our operations and financial results have been and may in the future be adversely affected by staffing shortages where employees must self-quarantine due to exposure to COVID-19 or where employees are unavailable due to a lack of childcare or care for elderly family members (social distancing, quarantines and shelter-in-place orders). Staffing shortages have limited, and may in the future limit, our ability to admit additional patients at a given facility or agency. Delays in obtaining COVID-19 test results may also adversely affect employee availability. In addition to staffing shortages, significant outbreaks or PPE shortages in our markets or hospitals may reduce employee morale or create labor unrest or other workforce disruptions. Staffing shortages or employee relations issues related to COVID-19 may lead to increased compensation expenses and limitations on the ability to admit new patients. In April 2020, we initiated a program for eligible frontline employees to earn additional paid time off in recognition of their outstanding efforts responding to the pandemic. With more than 21,000 employees potentially benefiting from this additional paid time off, we accrued approximately $43 million in salary and benefits expense during the second quarter in connection with this award. We may also experience additional benefit costs related to increased workers’ compensation claims and group health insurance expenses as a result of the pandemic. Additionally, as some employees work from home to comply with pandemic-mitigation protocols, they will rely on remote access to our information systems to a greater extent than normal, which could increase the likelihood and magnitude of a cyber attack on our information systems.

Legal and Regulatory Environment

Future federal, state or local laws, regulations, orders, or other governmental or regulatory actions addressing the pandemic could reduce the number of patients willing or able to seek care with us, potentially adversely affecting our financial condition, results of operations and cash flow. State and local executive actions in response to the pandemic, such as shelter-in-place orders, facility closures and quarantines, have in the past, and could in the future, impair our ability to operate or prevent people from seeking care from us. For example, local health departments have restricted our ability to take patients in specific markets for periods of time in reaction to perceived COVID-19 outbreaks. The imposition of a nationwide restriction on travel or other public activities by the federal government could have similar effects in all of our markets.

We may also be subject to lawsuits from patients, employees and others alleging exposure to COVID-19 at our facilities. For example, suits on behalf of two former patients alleging COVID-19 exposure have been brought against one of our hospitals. Such actions may involve large damage claims as well as substantial defense costs. Our professional and general liability insurance may not cover all claims against us.

Additionally, the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the “CARES Act”), signed into law on March 27, 2020, authorized the cash distribution of relief funds to healthcare providers in response to the pandemic. On April 10, 2020, the United States Department of Health and Human Services (“HHS”) began distributing CARES Act relief funds, for which we did not apply, to various of our bank accounts. We refused the CARES Act relief funds, and our banks returned all the funds to HHS. The Consolidated Appropriations Act, 2021 (the “2021 Budget Act”), signed into law on December 27, 2020, provides for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the CARES Act or the 2021 Budget Act.

The foregoing and other disruptions to our business as a result of the pandemic have had and are likely to continue to have an adverse effect on our business and could have a material adverse effect on our business, results of operations, financial condition and cash flows. Furthermore, assessing the CARES Act and numerous regulatory changes and formulating our response to the pandemic have required our management to devote extensive resources and are likely to continue to do so in the near future, which may negatively affect our ability to implement our business plan and respond to opportunities.

Other Factors

The situation relating to the pandemic, as well as its disruptions to and other potential effects on our business and financial results, remains dynamic. The broader implications for our business and results of operations remain uncertain and will depend on many factors outside our control, including, without limitation, the timing, extent, trajectory and duration of the pandemic, the development, distribution and administration of effective vaccines and treatments, the imposition of protective public safety measures, and the impact of the pandemic on the global economy and individual behaviors. Accordingly, the pandemic is expected to continue to have an adverse effect on our business and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Reimbursement Risks

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

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

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). Many provisions within the 2010 Healthcare Reform Laws have impacted or could in the future impact our business, including Medicare reimbursement reductions and promotion of alternative payment models, such as accountable care organizations ("ACOs") and bundled payment initiatives. The Trump administration and the United States Congress have previously attempted, and may in the future attempt, to change or repeal provisions of the 2010 Healthcare Reform Laws through both legislative and regulatory action. For example, on December 22, 2017, President Trump signed into law the Tax Cuts and Jobs Act, which eliminated the tax penalty for individuals for failing to enroll in health insurance beginning in 2019. On January 20, 2017, President Trump issued his first executive order titled "Minimizing the Economic Burden of the Patient Protection And Affordable Care Act Pending Repeal," that directs federal regulators to begin dismantling those laws through regulatory and policy-making processes and procedures, "to the maximum extent permitted by law." In December 2018, a federal district court in Texas invalidated the 2010 Healthcare Reform Laws in their entirety based on the elimination of the tax penalty but postponed enforcement of that decision pending appeal. On December 18, 2019, the United States Court of Appeals for the Fifth Circuit affirmed the district court decision but remanded the case for additional analysis on the question of severability. A group of state attorneys general subsequently appealed the case to the Supreme Court of the United States, which heard oral arguments in November 2020 but has yet to rule. The future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain. The Biden administration is likely to take a dramatically different approach to federal healthcare policy than the Trump administration. Any future changes may ultimately impact the provisions of the 2010 Healthcare Reform Laws discussed below or other laws or regulations that either currently affect, or may in the future affect, our business.

For Medicare providers like us, these laws include reductions in CMS's annual adjustments to Medicare reimbursement rates, commonly known as a "market basket update." In accordance with Medicare laws and statutes, CMS makes market basket updates by provider type in an effort to compensate providers for rising operating costs. The 2010 Healthcare Reform Laws required reductions, the last of which ended in 2019, in the annual market basket updates for hospital providers ranging from 10 to 75 basis points and for hospice agencies 30 basis points. For home health agencies, the 2010 Healthcare Reform Laws directed CMS to improve home health payment accuracy through rebasing home health payments over four years starting in 2014. In addition, the 2010 Healthcare Reform Laws require the market basket updates for hospital, home health, and hospice providers to be reduced by a productivity adjustment on an annual basis. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. To date, the productivity adjustments have typically resulted in decreases to the market basket updates ranging from 30 to 100 basis points. For fiscal year 2021, the IRF-PPS productivity adjustment resulted in no change to the market basket update.

Other federal legislation can also have a significant direct impact on our Medicare reimbursement. On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2% reduction of Medicare program payments. This automatic reduction, known as "sequestration," began affecting payments received after April 1, 2013. Sequestration has been extended by subsequent legislation, most recently by the Bipartisan Budget Act of 2019, which was signed into law on August 2, 2019. Under current law each year through fiscal year 2029, the reimbursement we receive from Medicare, after first taking into account all annual payment adjustments including the market basket update, will be reduced by sequestration unless it is repealed or modified before then. The CARES Act temporarily suspended sequestration for the period of May 1 through December 31, 2020. The 2021 Budget Act extends the sequestration suspension through March 31, 2021.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, or healthcare spending specifically could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. In October 2014, President Obama signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act"). The IMPACT Act directs HHS, in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the implementation of a new post-acute payment system, we believe this act lays the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided, also referred to as "site neutral" reimbursement. CMS has begun changing current post-acute payment systems to improve comparability of patient assessment data and clinical characteristics across settings, which will make it easier to create a unified payment system in the future. For example, CMS recently established new case-mix classification models for both home health, discussed further below, and skilled nursing facilities which rely on patient characteristics rather than the amount of therapy received to determine payments. Another example is CMS's implementation of the new patient assessment measures for IRFs discussed below. The IMPACT Act also creates additional data reporting requirements for our hospitals and home health agencies. The precise details of these new reporting requirements, including timing and content, are being developed and implemented by CMS through the regulatory process that we expect will continue to take place over the next several years. We cannot quantify the potential effects of the IMPACT Act on us.

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

In connection with CMS's final rulemaking for the IRF-PPS and the HH-PPS in each year since 2008, MedPAC has recommended either no updates to payments or reductions to payments. In a March 2020 report to Congress, MedPAC recommended, among other things, legislative changes to eliminate the update to the fiscal year 2020 Medicare base payment rates for hospice, reduce by 7% the base payment rate under the HH-PPS, and reduce by 5% the base payment rate under IRF-PPS. In the March 2020 report, MedPAC also reiterated a previous recommendation for Congress to increase the IRF 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. The March 2020 report also called on the HHS Secretary to conduct focused medical record reviews on IRFs. In an October 2020 report, MedPAC called for future research into Medicare hospice payments and expressed concerns that aggregate payments substantially exceed costs and that there are outlier utilization patterns in the industry.

In a June 2018 report mandated by the IMPACT Act, MedPAC reiterated its recommendation that Congress adopt a unified payment system for all post-acute care ("PAC-PPS") in lieu of separate systems for inpatient rehabilitation facilities ("IRFs"), skilled nursing facilities, long-term acute care hospitals, and home health agencies. A PAC-PPS would rely on "site neutral" reimbursement based on patients' medical conditions and other clinical factors rather than the care settings. MedPAC found a PAC-PPS to be feasible and desirable but also suggested many existing regulatory requirements, including the 60% rule discussed below and the requirement for a minimum of three hours of therapy per day, should be waived or modified as part of implementing a PAC-PPS. MedPAC previously estimated, although we cannot verify the methodology or the accuracy of that estimate, a PAC-PPS would result in 15% and 1% decreases to IRF and home health reimbursements, respectively. As a precursor to a unified PAC-PPS, MedPAC discussed in November 2017 a potential recommendation to change the case-mix weights in each post-acute setting for 2019 and 2020 to a blend of the current setting specific weight and the proposed unified PAC-PPS weight, which MedPAC suggested would shift money from for-profit and freestanding IRFs to non-profit and hospital-based IRFs. MedPAC has also called for aligning Medicare regulatory requirements across post-acute providers, although the agency has acknowledged it could take years to complete this effort. Additionally, MedPAC previously has suggested that Medicare should ultimately move from fee-for-service reimbursement to more integrated delivery payment models.

MedPAC also recommended significant changes to the HH-PPS, some of which CMS incorporated into the new payment system mandated by the Bipartisan Budget Act of 2018, referred to as the Patient-Driven Groupings Model ("PDGM"), and set out in the final rule for the 2019 HH-PPS. Beginning in 2020, PDGM replaced the prior 60-day episode of payment methodology with a 30-day payment period and eliminated therapy usage as a factor in setting payments (that is, more therapy visits led to higher reimbursement). CMS adopted a 4.4% reduction in the base payment rate for 2020 intended to offset the provider behavioral changes that CMS assumed PDGM would drive. The reimbursement and other changes associated with PDGM could have a significant impact on our home health agencies. Likewise, MedPAC's previously recommended changes to the Hospice-PS, including a wage adjustment and a reduction in the hospice aggregate cap by 20%, could have a significant impact on our hospice agencies.

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

There can be no assurance future governmental action will not result in substantial changes to, or material reductions in, our reimbursements. Similarly, we may experience material increases in our operating costs. For example, in 2021, we expect our wage and benefit costs to increase at a rate in excess of our aggregate Medicare reimbursement rate increase. In any given year, the net effect of statutory and regulatory changes may result in a decrease in our reimbursement rate, and that decrease may occur at a time when our expenses are increasing. As a result, there could be a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of how we are reimbursed by Medicare, see Item 1, *Business*, “Regulatory and Reimbursement Challenges” and “Sources of Revenues—Medicare Reimbursement.”

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

Quality reporting requirements could adversely affect the Medicare reimbursement we receive.

The focus on alternative payment models and value-based purchasing of healthcare services has, in turn, led to more extensive quality of care reporting requirements. In many cases, the new reporting requirements are linked to reimbursement incentives. For example, under the 2010 Healthcare Reform Laws, CMS established new quality data reporting, effective October 1, 2012, for all IRFs. A facility’s failure to submit the required quality data results in a two percentage point reduction to that facility’s annual market basket increase factor for payments made for discharges in the subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals have met the reporting deadlines to date resulting in no corresponding reimbursement reductions. Similarly, home health and hospice agencies are required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket updates. For 2021, we expect four of our home health and hospice agencies will incur a reduction in their reimbursement rates.

As noted above, the IMPACT Act mandated that CMS adopt several new quality reporting measures for the various post-acute provider types. The adoption of additional quality reporting measures to track and report will require additional time and expense and could affect reimbursement in the future. In healthcare generally, the burdens associated with collecting, recording, and reporting quality data are increasing. Currently, CMS requires IRF and home health providers to track and submit patient assessment data to support the calculation of 17 and 20 quality reporting measures, respectively.

In 2015, CMS established a five-year home health value-based purchasing model in nine states to test whether incentives for better care can improve outcomes in the delivery of home health services. The model, which began in 2016, applies a reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, made to agencies in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. CMS under the Trump administration approved the expansion of the model to be done through future rulemaking, but there can be no assurance of how, or if, CMS under the Biden administration will continue expansion. As of December 31, 2020, we have 45 home health locations in the states currently included in the model, which account for 22% of our home health Medicare revenue. Performance will be assessed based on several process, outcome, and care satisfaction measures, and the payment adjustments to be applied on an annual basis are set forth in the table below:

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

To date, we have not experienced a decrease in *Net operating revenues* in excess of $0.5 million in any year. Based on 2020 performance data, we anticipate almost no impact to our 2021 reimbursements. There can be no assurance all of our hospitals and agencies will meet quality reporting requirements or quality performance in the future which may result in one or more of our hospitals or agencies seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

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

We receive a substantial portion of our revenues from the Medicare program. Medicare reimbursement claims made by healthcare providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as MACs that act as fiscal intermediaries for all

Medicare billings, auditors contracted by CMS, and insurance carriers, as well as the HHS Office of Inspector General (the "HHS-OIG"), CMS and state Medicaid programs. As noted above, the clarity and completeness of each patient medical file, some of which is the work product of a physician not employed by us, is essential to successfully challenging any payment denials. If the physicians working with our patients do not adequately document, among other things, their diagnoses and plans of care, our risks related to audits and payment denials in general are greater. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material adverse effect in the aggregate on our financial position, results of operation and liquidity.

In the context of our inpatient rehabilitation business, one of the prevalent grounds for denying a claim or challenging a previously paid Medicare claim in an audit is that the patient's treatment in a hospital was not medically necessary. The medical record must support that both the documentation and coverage criteria requirements are met for the hospital stay to be considered medically reasonable and necessary. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. A Medicare claim may be denied or challenged based on an opinion of the auditor that the record did not evidence medical necessity for treatment in an IRF or lacked sufficient documentation to support the conclusion. In the past, we had a MAC that made determinations regarding medical necessity using its own uniquely restrictive interpretations of the CMS coverage rules or imposing otherwise arbitrary conditions not set out in the related rules, which resulted in a significant number of payment denials.

In some cases, we believe the reviewing party is not merely challenging the sufficiency of the medical record but is substituting its judgment of medical necessity for that of the attending physician or imposing documentation or other requirements that are not set out in the regulations. We argue that doing so is inappropriate and has no basis in law. When the government or its contractors reject the medical judgment of physicians or impose documentation and other requirements beyond the language of the statutes and regulations, patient access to inpatient rehabilitation as well as our Medicare reimbursement from the related claims may be adversely affected.

In August 2017, CMS announced the Targeted Probe and Educate ("TPE") initiative. Under the TPE initiative, MACs use data analysis to identify healthcare providers with high claim error rates and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE initiative includes up to three rounds of claims review with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action, which may include extrapolation of error rates to a broader universe of claims or referral to a UPIC or RAC (defined below). As of December 31, 2020, none of our hospitals or agencies have progressed beyond the third round of reviews, so it is unclear how the review process after TPE would proceed. We cannot predict whether the TPE initiative or similar probes or reviews will materially impact our reimbursement or the timeliness of collections from Medicare in the future.

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

RAC audits of IRFs initially focused on coding errors but subsequently expanded to include medical necessity and billing accuracy reviews. To date, the Medicare payments subject to RAC audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2020. We have appealed substantially all RAC denials arising from these audits using the same process we follow for appealing pre-payment denials by MACs. CMS has authorized RACs to conduct complex reviews of the medical records associated with both IRF and home health reimbursement claims.

CMS has also established contractors known as the Uniform Program Integrity Contractors ("UPICs," formerly known as "ZPICs"). These contractors are successors to the Program Safeguard Contractors and conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the United States Department of Justice ("DOJ"). Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the error. We have, from time to time, received UPIC record requests which have resulted in claim denials on paid claims. In some cases, the UPICs have extrapolated error rates to larger pools of our claims. In the most significant example to date, a UPIC denied less than $2 million in claims but recouped an extrapolated amount of approximately $30 million. We have appealed substantially all UPIC denials, including the recoupment noted above, arising from these audits using the same process we follow for appealing other denials by contractors and will continue to contest the use of extrapolation in any context.

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

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations. Similarly, there can be no assurance that our current or future MACs will not take restrictive interpretations of Medicare coverage rules. Because one MAC has jurisdiction over a significant number of our hospitals and our hospitals derive a substantial portion of their revenue from Medicare, the adoption of restrictive interpretations of coverage rules by that MAC could result in a large number of payment denials and materially and adversely affect our financial position, results of operations, and cash flows.

Delays in the administrative appeals process associated with denied Medicare reimbursement claims could delay or reduce our reimbursement 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. Due to the sheer number of appeals and various administrative inefficiencies, including a shortage of judges, appeals that are due to be resolved in a matter of months commonly take years to complete. For example, most of our appeals heard in 2020 related to denials received in 2014 and 2015. We believe the process for resolving individual Medicare payment claims that are denied will continue to take several years. Additionally, the number of new denials far exceeds the number of appeals resolved in recent years (except 2020 in which CMS suspended payment reviews for several months because of the public health emergency and 2018) as shown in the following summary of our inpatient rehabilitation segment activity:

	New Denials	Collections of Previously Denied Claims	Revenue Reserve for New Denials
		(In Millions)	
2020	$1.7	$22.0	$1.3
2019	20.2	14.9	6.1
2018	10.2	14.1	3.0
2017	43.6	27.6	13.0
2016	74.9	26.2	20.6

We currently record our estimates for pre-payment denials and for post-payment audit denials that will ultimately not be collected as a component of *Net operating revenues*. See Note 1, *Summary of Significant Accounting Policies*, “Net Operating Revenues,” to the accompanying consolidated financial statements. Given the continuing or increasing delays along with the increasing number of denials in the backlog, we may experience decreases in *Net operating revenues* and/or decreases in cash flow as a result of increasing accounts receivable, which may in turn lead to a change in the patients and conditions we treat. Any of these impacts could have an adverse effect on our financial position, results of operations, and liquidity. Although Congress has considered legislation to reform and improve the Medicare audit and appeals process, we cannot predict what, if any, legislation will be adopted or what, if any, effect that legislation might have on the audit and appeals process.

In May 2014, the American Hospital Association and others filed a lawsuit seeking to compel HHS to meet the statutory deadlines for adjudication of denied Medicare claims. In December 2016, the presiding federal district court judge in the lawsuit ordered HHS to eliminate the backlog of appeals by the end of 2020. HHS appealed the federal district court decision, and an appeals court remanded the order for further consideration of how HHS can eliminate the backlog. On November 1, 2018, the district court again ordered HHS to achieve the following reductions: 19% by the end of fiscal year 2019; 49% by the end of fiscal year 2020; 75% by the end of fiscal year 2021; and 100% by the end of fiscal year 2022.

The Medicare appeals adjudication process is administered by the Office of Medicare Hearings and Appeals ("OMHA"). Beginning in March 2020, OMHA increased the frequency of hearings and the number of claims set at each hearing, which we believe adds to the substantive and procedural deficiencies in the appeals process. We are exploring various remedies to counter those deficiencies. We believe it is too early to determine what impact, if any, these recent changes in the appeals process will have on our long-term success rate or *Net operating revenues*.We cannot predict what, if any, further action CMS will take to reduce the backlog or how long it will take to resolve our pending appeals of payment denials that are part of the backlog.

Efforts to reduce payments to healthcare providers undertaken by third-party payors, conveners, and referral sources could adversely affect our revenues and profitability.

Health insurers and managed care companies, including Medicare Advantage plans, may utilize certain third parties, known as conveners, to attempt to control costs. Conveners offer patient placement and care transition services to those payors as well as bundled payment participants, ACOs, and other healthcare providers with the intent of managing post-acute utilization and associated costs. Conveners may influence referral source decisions on which post-acute setting to recommend, as well as how long to remain in a particular setting. Given their focus on perceived financial savings, conveners customarily suggest that patients avoid higher acuity post-acute settings altogether or move as soon as practicable to lower acuity settings. Conveners are not healthcare providers and may suggest a post-acute setting or duration of care that may not be appropriate from a clinical perspective potentially resulting in a costly acute care hospital readmission.

We also depend on referrals from physicians, acute care hospitals, and other healthcare providers in the communities we serve. As a result of various alternative payment models, many referral sources are becoming increasingly focused on reducing post-acute costs by eliminating post-acute care referrals or referring patients to post-acute settings other than perceived high-cost rehabilitation hospitals, sometimes without understanding the potential impact on patient outcomes over an entire episode of care. Our ability to attract patients could be adversely affected if any of our hospitals or agencies fail to provide or maintain a reputation for providing high-quality care on a cost-effective basis as compared to other providers.

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

Many factors affect pricing of our services and, in turn, our revenues. For example, in the inpatient rehabilitation segment, these factors include the treating facility's urban or rural status, the length of stay, the payor and its applicable rate of reimbursement, and the patient's medical condition and impairment status (acuity). In recent years, our inpatient rehabilitation segment has experienced a shift in payor mix to a slightly larger percentage of Medicaid patients. We could also experience a shift to a lower average patient acuity. Both of these shifts adversely affect pricing growth. See the "Segment Results of Operations—Inpatient Rehabilitation—Net Operating Revenues" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations.* The expansion and growth of Medicaid resulting from provisions of the 2010 Healthcare Reform Laws have increased the number of those patients coming to us. Medicaid reimbursement rates are almost always the lowest among those of our payors, and frequently Medicaid patients come to us with other complicating conditions that make treatment more difficult and costly. We cannot predict the growth of, or changes to, Medicaid, but President Biden has stated that he favors extending public health insurance coverage to low income individuals currently ineligible for Medicaid. We cannot predict whether our payor mix will shift to lower reimbursement rate payors. In the future, we may experience shifts in our payor mix or the acuity of our patients that could adversely affect our pricing, *Net operating revenues,* and profitability.

Other Regulatory Risks

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 regulatory uncertainty around attempts to improve outcomes and reduce costs, including coordinated care and integrated delivery payment models. In an integrated delivery payment model, hospitals, physicians, and other care providers are reimbursed in a fashion meant to encourage coordinated healthcare on a more efficient, patient-centered basis. These providers are then paid based on the overall value and quality (as determined by outcomes) of the services they provide to a patient rather than the number of services they provide. While this is consistent with our goal and proven track record of being a high-quality, cost-effective provider, broad-based implementation of a new delivery payment model would represent a significant evolution or transformation of the healthcare industry, which may have a significant impact on our business and results of operations.

In recent years, HHS has been studying the feasibility of bundling, including conducting a voluntary, multi-year bundling pilot program to test and evaluate alternative payment methodologies. CMS' voluntary Bundled Payments for Care

Improvement Advanced ("BPCI Advanced") initiative began October 1, 2018, runs through December 31, 2023, and covers 29 types of inpatient and three types of outpatient clinical episodes, including stroke and hip fracture. Providers participating in BPCI Advanced are subject to a semi-annual reconciliation process where CMS compares the aggregate Medicare expenditures for all items and services included in a clinical episode against the target price for that type of episode to determine whether the participant is eligible to receive a portion of the savings, or is required to repay a portion of the payment above target. Accordingly, reimbursement may be increased or decreased, compared to what would otherwise be due, based on whether the total Medicare expenditures and patient outcomes meet, exceed or fall short of the targets.

Similarly, CMS has established per the 2010 Healthcare Reform Laws several separate ACO programs, the largest of which is the Medicare Shared Savings Program ("MSSP"), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Under the MSSP, there are two ACO tracks from which participants can choose. Each track offers a different degree to which participants share any savings realized or any obligation to repay losses suffered. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. Based on the CMS data below, the MSSP has not experienced meaningful growth in recent years.

	Number of ACOs	**Assigned Beneficiaries**
		(In Millions)
2021	477	10.7
2020	517	11.2
2019	487	10.4
2018	561	10.5

We continue to evaluate, on a case-by-case basis, appropriate BPCI Advanced and ACO participation opportunities for our hospitals and home health agencies. More than 35 of our inpatient rehabilitation hospitals have signed participation or preferred provider agreements with these alternative payment models. Those hospitals have treated only a limited number of patients under these alternative payment models to date. As of January 1, 2021, our home health and hospice segment is collaborating with approximately 140 alternative payment models, including Next Generation ACOs, MSSP ACOs, and Direct Contracting Models.

In December 2020, CMS announced another voluntary alternative payment model initiative, the Geographic Direct Contracting Model (the "GDCM"). Under the GDCM, Direct Contracting Entities ("DCEs"), which can include ACOs, health systems, health care provider groups, and health plans, will take responsibility for the total cost of care for all Medicare beneficiaries in a specific geographic region. DCEs may enter into agreements with preferred providers that provide for payment risk-sharing and offer Medicare beneficiaries benefits not otherwise available under traditional Medicare. The GDCM will be tested over a six-year period in four to ten regions. Many specifics of the GDCM remain unknown at this time, and it is not clear if, or how, the Biden administration will implement the GDCM.

On November 16, 2015, CMS published its final rule establishing the Comprehensive Care for Joint Replacement ("CJR") payment model, which holds acute care hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for lower extremity joint replacements (i.e., knees and hips) from surgery through recovery. The CJR originally was mandatory for the acute care hospitals in the 67 geographic areas covered. On November 30, 2017, CMS issued a final rule making the CJR voluntary in 33 of those areas. The CJR model's original five-year term ended in December 2020, but CMS has proposed to extend the model for three years for most providers in the 34 geographic areas with mandatory participation. Under CJR, healthcare providers in the mandatory participation areas are paid under existing Medicare payment systems. However, the acute-care hospital where a joint replacement takes place are held accountable for the quality and costs of care for the entire episode of care — from the time of the original admission through 90 days after discharge. Depending on the quality and cost performance during the entire episode, the acute-care hospital may receive an additional payment or be required to repay Medicare a portion of the episode costs. As a result, CMS believes acute care hospitals 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. As of December 31, 2020, we operated 26 inpatient rehabilitation hospitals in the 34 areas with mandatory participation, and we operated 9 other hospitals in markets where an acute care hospital voluntarily participated in CJR. CJR has not had a material impact on those hospitals.

HHS and CMS continue to explore ways to encourage and facilitate increased participation in alternative payment models and value-based purchasing initiatives. For example, the HHS-OIG and CMS finalized rules in 2020 modernizing the Anti-Kickback Statute and Stark law to, in part, promote a more coordinated, value-based system of care. 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 remain uncertain. The development of new delivery and payment systems will almost certainly take significant time and expense. Many of the alternative approaches, including those discussed above and the home health value-based purchasing model discussed below, being explored may not work or could change substantially prior to any nationwide implementations. While only a small percentage of our business currently is or is anticipated to be subject to the alternative payment models discussed above, we cannot be certain these models will not be expanded or made standard or new models will not be implemented broadly.

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

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

In addition to the legislative and regulatory actions that directly affect our reimbursement rates or further the evolution of the current healthcare delivery system, other legislative and regulatory changes, including as a result of ongoing healthcare reform, affect healthcare providers like us from time to time. For example, the 2010 Healthcare Reform Laws provide for the expansion of the federal Anti-Kickback Law and the False Claims Act (the "FCA") that, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the FCA, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the HHS-OIG or DOJ. Any such suspension would adversely affect our financial position, results of operations, and cash flows.

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

On September 30, 2019, CMS adopted a new rule as called for by the IMPACT Act that revises the discharge planning requirements applicable to our inpatient rehabilitation hospitals and home health agencies. Effective November 29, 2019, CMS now requires every hospital (including IRFs) to have a discharge planning process that focuses on patients' goals and preferences and on preparing them and, as appropriate, their caregivers, to be active partners in their post-discharge care. For our hospitals, this rule requires instituting standardized procedures to identify those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and to provide a discharge planning evaluation for such patients to ensure that appropriate arrangements for post-hospital care will be made before discharge. At the time of discharge, a hospital must transfer or refer the patient, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care. Patients must also be informed of all post-acute providers in the area and, for patients enrolled in managed care organizations, in network providers must be identified if the hospital has that information. Additional information must be provided to patients who are discharged home and referred for home health agency services or who are referred to other post-acute care services.

For home health agencies, the final rule includes several new requirements, including that home health agencies develop and implement an effective discharge planning process. Home health agencies must also send certain medical and other information to the post-discharge facility or health care practitioner, and comply with requests for additional information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner. The rule will likely require implementation of new processes and modification of existing discharge forms and reports, and patient visits may need to be extended in order to accommodate patient education. We expect to incur additional one-time and recurring expenses in both our segments to comply with the new requirements, but at this time we cannot predict what the final impact will be. In areas where we are not part of a managed care network with significant enrollment, this discharge planning rule may negatively affect the number of patients choosing us.

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

In June 2019, CMS commenced the Home Health Review Choice Demonstration ("RCD") in Illinois. RCD is intended to test whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud and whether the pre-claim review helps reduce expenditures while maintaining or improving quality of care. Under RCD, providers may choose pre-claim review or post-payment review of all Medicare claims submitted or elect not to participate, in which case they will incur a 25% payment reduction on all claims. If a home health agency elects to participate in the review and 90% or more of its claims are found to be valid during the six month pre-claim review period, that agency may then opt out of the RCD review, except for spot reviews of samples consisting of 5% of total claims. CMS implemented RCD in Ohio in September 2019. RCD was scheduled to expand to Texas in March 2020 and to North Carolina and Florida in May 2020. In late March 2020, however, CMS announced it was pausing the RCD for home health services in Illinois, Ohio, and Texas and that it would not start RCD in North Carolina and Florida until after the COVID-19 public health emergency ended. On August 21, 2020, CMS announced a new "phased-in approach" to the RCD due to the public health emergency and subsequently announced the delay of the phased-in participation of the RCD in Florida and North Carolina until March 31, 2021. As a result, North Carolina and Florida agencies may submit pre-claim review requests for billing periods beginning August 31, 2020. Cycle 1 of the RCD in Texas ended on September 30, 2020, and we achieved an affirmation rate greater than 90%.

We operate agencies (representing approximately 43% of our home health Medicare claims) in the five RCD states. We expect this demonstration project will require us to incur additional administrative and staffing costs and may impact the timeliness of claims payment given that Medicare administrative contractors in Illinois in a prior version of the project had difficulty processing pre-claim reviews on a timely basis. Accordingly, we may experience temporary decreases in *Net operating revenues* and in cash flow, or we may incur costs associated with patient care for which the Medicare claim is subsequently denied, which could have an adverse effect on our financial position, results of operations, and liquidity.

On December 14, 2020, CMS announced the proposal of a five-year review choice demonstration for inpatient rehabilitation services. CMS plans to implement the demonstration in Alabama, and then expand to Pennsylvania, Texas, and California in 2021. We operate 44 inpatient rehabilitation hospitals (representing approximately 33% of our IRF Medicare claims) in those four states. After the initial four states, CMS will expand the demonstration to include additional IRFs based on the Medicare Administrative Contractor to which those IRFs submit claims. Under the demonstration, participating IRFs would have an initial choice between pre-claim or post-payment review of 100% of claims submitted to demonstrate compliance with applicable Medicare coverage and clinical documentation requirements. Under the pre-claim review choice, services could begin prior to the submission of the review request and continue while the decision is being made. The pre-claim review request with required documentation must be submitted and reviewed before the final claim is submitted for payment. Under the post-payment review choice, IRFs would provide services, submit all claims for payment following their normal processes, and then submit required documentation for medical review. If 90% or more of its claims are found to be valid during the six-month review period, the IRF may then opt out of the RCD review, except for spot reviews of samples consisting of 5% of total claims. The IRF RCD would not create new documentation requirements. A number of key details on this proposal have yet to be released, and it is not clear if, or how, the Biden administration will implement this demonstration.

As discussed above, MedPAC makes healthcare policy recommendations to Congress and provides comments to CMS on Medicare payment related issues. Congress is not obligated to adopt MedPAC's recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt any given MedPAC recommendation. For example, in March and June 2020, MedPAC issued reports to Congress again recommending several possible changes, which MedPAC has advocated previously, to various post-acute payment systems. One possible change discussed was an increase to outlier payments to be funded by reductions to non-outlier payments rates under the IRF-PPS. This change would adversely impact us compared to other IRF providers because our hospitals have also historically averaged significantly less Medicare reimbursement for high cost outlier patients than other providers have averaged.

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

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

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

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

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements, as well as the way in which we deliver home health and hospice services. Those changes could also affect reimbursements as well as future compliance, training, and staffing costs. For example, the 2021 Budget Act creates a new Medicare survey program for hospice agencies which will require a survey at least once every three years. Hospices that are found to be out of compliance could be subjected to new civil monetary penalties that accrue according to days out of compliance, as well as other forms of corrective action.

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. Additionally, from time to time CMS has adopted changes in the medical conditions that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

Of note, the HHS-OIG periodically updates a work plan that identifies areas of compliance focus. In recent years, the 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. In January 2020, the HHS-OIG announced an active work plan to focus on incentives under the IRF-PPS to discharge patients prematurely to home health agencies and appropriate documentation to support claims by home health and hospice agencies, which is expected to be issued in 2021. In September 2020, the HHS-OIG announced an active work plan to focus on infection control at home health agencies during the COVID-19 pandemic, also expected to be issued in 2021. In January 2021, the HHS-OIG announced an audit to evaluate home health services provided by agencies during the COVID-19 public health emergency to determine which types of skilled services were furnished via telehealth, and whether those services were administered and billed in accordance with Medicare requirements. Another active work plan provides that the HHS-OIG will determine if hospice patients are receiving the required visits by registered nurses.

In September 2018, the HHS-OIG released a report purporting to identify a high error rate (approximately 80% of claims) among inpatient rehabilitation hospital admissions in a small sample of 220 claims. Based on its findings, the HHS-OIG extrapolated the error rate to the universe of inpatient rehabilitation claims and, among other things, recommended reevaluation of the IRF-PPS. However, that HHS-OIG report involved an extremely small sample size, was not a random sample of cases, included some citations to coverage requirements that did not match actual regulations, appeared to conflate technical documentation requirements with medical necessity determinations, and was at odds with actual MAC reviews of claims during that same timeframe which found substantially lower error rates. The HHS-OIG work plan, audit or similar future efforts could result in proposed changes to the payment systems for providers or increased denials of Medicare claims for patients notwithstanding the referring physicians' judgment that treatment is appropriate.

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

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. Those subpoenas requested documents, including copies of patient medical records, related to reimbursement claims submitted during periods ranging from January 2008 through December 2013. The associated investigation led by DOJ was based on whistleblower claims of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requested documents and materials relating to practices, procedures, protocols and policies of certain pre- and post-admissions activities at these hospitals including marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% Rule," 60% or more of the patients of an IRF must have at least one of a specified list of medical conditions in order to be reimbursed at the IRF-PPS payment rates, rather than at the lower acute care hospital payment rates. We settled the DOJ investigation, together with the related *qui tam* or whistleblower lawsuits, in 2019 for a total payment of $48 million. In return for the settlement payment, the plaintiffs dismissed with prejudice their pending *qui tam* claims, and DOJ provided Encompass Health and all its subsidiaries with a release from civil liability.

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

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

Settlements of alleged violations or imposed reductions in reimbursements, substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation and could cost us significant time and expense to defend.

The use of sub-regulatory guidance, statistical sampling, and extrapolation by CMS, Medicare contractors, HHS-OIG, and DOJ to deny claims, expand enforcement claims, and advocate for changes in reimbursement policy increases the risk that we could experience reduced revenue, suffer penalties, or be required to make significant changes to our operations.

Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Our ability to operate in a compliant manner impacts the claims denials, compliance enforcement, and regulatory processes discussed in other risks above. The federal government’s reliance on sub-regulatory guidance, such as handbooks, FAQs, internal memoranda, and press releases, presents a unique challenge to compliance efforts. Such sub-regulatory guidance purports to explain validly promulgated regulations but often expands or supplements existing regulations without constitutionally and statutorily required notice and comment and other procedural protections. Without procedural protections, sub-regulatory guidance poses a risk above and beyond reasonable efforts to follow validly promulgated regulations, particularly when the agency or MAC seeking to enforce such sub-regulatory guidance is not the agency or MAC issuing the guidance and therefore not as familiar with the substance and nature of the underlying regulations or even clinical issues involved.

On August 6, 2020, CMS issued a proposed rule invoking a rarely used retroactive-rulemaking authority to support CMS’s application of a Medicare payment methodology that the U.S. Supreme Court found to be procedurally improper in *Azar v. Allina Health Services* in 2019. CMS’ invocation of its retroactive-rulemaking authority in response to this Supreme Court decision is an unfavorable precedent for providers because it demonstrates a willingness by CMS to revive adverse reimbursement actions after those actions are deemed deficient on administrative procedural grounds.

Additionally, the federal government is increasingly turning to statistical sampling and extrapolation to expand claims denials and enforcement efforts and advocate for changes in reimbursement policy. Through sampling and extrapolation, the government takes a review of a small number of reimbursement claims and generalizes the results of that review to a much broader universe of claims, which can result in significant increases in the aggregate number and value of claims at issue. Increasing use of extrapolation can be found in payment review audits, such as those conducted by RACs and UPICs. In addition to payment reviews, government agencies may allege compliance violations, including submission of false claims, based on sampling and extrapolation and seek to change reimbursement policy. For example, the HHS-OIG issued a report in September 2018 purporting to identify a high error rate (approximately 80% of claims) among inpatient rehabilitation hospital admissions in a small sample of 220 claims. Based on its findings, the HHS-OIG extrapolated the error rate to the universe of inpatient rehabilitation claims and, among other things, recommended reevaluation of the IRF-PPS. However, the HHS-OIG report involves an extremely small sample size, is not a random sample of cases, includes incorrect references to coverage requirement regulations, appears to conflate technical documentation requirements with medical necessity determinations, and is at odds with actual MAC reviews of claims during that same timeframe which found substantially lower error rates. Notwithstanding the technical statistical flaws that can arise in sampling small groups of claims and the extremely problematic nature of extrapolation in the context of individualized decisions of medical judgment as some courts have noted, sampling and extrapolation pose a growing risk to healthcare providers in the form of more significant claims of overpayments and increased legal costs to defend against these problematic regulatory practices. In a recent federal court case, the fifth circuit court of appeals ruled in favor of CMS and affirmed the application of extrapolation errors identified in a sample of claims to support larger claims for overpayment. Any associated loss of revenue or increased legal costs could materially and adversely affect our financial position, results of operations, and cash flows.

The Hospital Pricing Transparency Rule could adversely affect our business and results of operations.

Effective on January 1, 2021, the hospital price transparency rule requires hospitals to publish on the internet in a consumer-friendly format their standard charges based on negotiated rates for all items and services and up to 300 common shoppable services. Shoppable services are those routinely provided in non-urgent situations and include those ancillary services that customarily accompany the primary service being provided. The charges for an individual item or service to be published include:

- gross charge (charge as reflected on a hospital's chargemaster, absent any discounts),
- payer-specific negotiated charge (charge negotiated with a third party payer for an item or service),
- de-identified minimum negotiated charge (lowest charge negotiated with all third-party payers),
- de-identified maximum negotiated charge (highest charge negotiated with all third-party payers), and
- discounted cash price (charge that applies to an individual who pays cash).

This rule imposes significant initial and ongoing burdens on hospitals to track and publish various billing information. In the event a hospital fails to comply with the new requirements and does not complete the prescribed corrective action, CMS may impose a civil monetary penalty of up to $300 per day.

Many states have also passed or are debating legislation establishing price transparency websites or mandating that health plans or hospitals make price information available to consumers. The associated reporting obligations vary from state to state. We cannot predict what the adverse effects, if any, of this new CMS rule or any state law or regulation, such as the effect on relations with managed care payors and referral sources, may be for us.

Efforts to comply with regulatory mandates to increase the use of electronic health data and health system interoperability may lead to enforcement and negative publicity which could adversely affect our business.

For many years, a primary focus of the healthcare industry has been to increase the use of electronic health records, or "EHR," and the sharing of the health data among providers, payors and other members of the industry. The federal government has been a significant driver of that initiative through rules and regulations. In 2009, as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the federal government set aside $27 billion of incentives for hospitals and providers to adopt EHR systems. In 2020, CMS and HHS's Office of the National Coordinator for Health IT ("ONC") finalized policy changes implementing interoperability, information blocking, and patient access provisions of the 21st Century Cures Act and supporting the MyHealthEData initiative, designed to allow patients to access their health claims information electronically through the application of their choosing. The companion rules will transform the way in which healthcare providers, health information technology developers, health information exchanges/health information networks ("HIEs/HINs"), and health plans share patient information. For example, the ONC rule prohibits healthcare providers, health IT developers, and HIEs/HINs from engaging in practices that are likely to interfere with, prevent, materially discourage, or otherwise inhibit the access, exchange or use of electronic health information, also known as "information blocking." The ONC rule also requires regulated actors to respond to requests for electronic health information in the content and manner requested, with some exceptions. Enforcement of ONC's and CMS' new health information access, exchange, and use standards promulgated in the 2020 rules will begin in 2021, and noncompliance can result in civil monetary penalties, exclusion from participation in federal health care programs and other appropriate "disincentives" that have not yet been identified by the agencies. The HHS-OCR patient right of access initiative, which began in late 2019 and has similar objectives to the new ONC initiative, such as promoting and enforcing patient access to health information, has led to 13 settlements of enforcement actions to date.

The goals of increased use of electronic health data and interoperability are improved quality of care and lower healthcare costs generally. However, increased use of electronic health data and interoperability inherently magnifies the risk of security breaches involving that data and information systems, which risk is discussed above. Additionally, the sharing of health information, that is interoperability, has received increasingly negative publicity. There is at least one well publicized instance where organizations received significant negative publicity for sharing health data despite having appeared to comply in all respects with privacy law. There can be no assurance that our efforts to improve the care we deliver and to comply with the law through increasing use of electronic data and system interoperability will not receive negative publicity that may materially and adversely affect our ability to get patient referrals or enter into joint ventures with other providers or may lead to greater regulatory scrutiny. Negative publicity may also lead to federal or state regulation that conflicts with current federal policy and interferes with the healthcare industry's efforts to improve care and reduce costs through use of electronic data and interoperability.

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

Each of our hospitals and home health and hospice agencies must comply with extensive enrollment requirements and conditions of participation for the Medicare program. If any fail to meet any of the Medicare enrollment requirements or conditions of participation, we may receive a notice of deficiency from the applicable survey agency or contractor, as applicable. If that hospital or agency then fails to institute an acceptable plan of correction and correct the deficiency within the applicable correction period, it could lose the ability to bill Medicare. A hospital or agency could be terminated from the Medicare program if it fails to address the deficiency within the applicable correction period. If CMS terminates one hospital or agency, it may increase its scrutiny of others under common control.

On September 5, 2019, CMS released a final rule that will implement over a period time additional provider enrollment provisions and create several new revocation and denial authorities in an attempt to bolster CMS' efforts to prevent waste, fraud and abuse. A few provisions of this new rule could significantly increase the complexity of filing enrollment applications for all of our provider entities, including increased burden related to tracking and identifying required reporting data from our joint venture partners. This rule requires Medicare and Medicaid providers and suppliers to disclose any current or previous (in the last five years), direct or indirect affiliation with a provider or supplier that has ever had a disclosable event. A disclosable event is any uncollected debt to Medicare or Medicaid, payment suspension under a federal health care program, denial, revocation or termination of enrollment (even if it is under appeal), or exclusion by the HHS-OIG from participation in a federal health care program. The rule also broadens the definition of an affiliation, including many indirect ownership or control situations such as ownership interests in a publicly traded company. If CMS determines an affiliation with a disclosable event poses an undue risk of fraud, waste or abuse, then the provider reporting that affiliation may be subject to exclusion from Medicare. Currently, information regarding uncollected debt, payment suspensions and enrollment actions are not generally available, so obtaining such information on affiliates could prove difficult or impossible in some situations. CMS intends to issue further guidance on the level of effort it expects providers to undertake to uncover information on their affiliates.

Under this new rule, CMS may revoke a provider's Medicare enrollment, including all of the provider's locations, if the provider bills for services performed at or items furnished from one location that it knew or should have known did not comply with Medicare enrollment requirements, including making the disclosures discussed above. CMS has the ability to prevent applicants from enrolling in the program for up to three years if a provider is found to have submitted false or misleading information in its initial enrollment application. Additionally, CMS can now block providers and suppliers who are revoked from re-entering the Medicare program for up to 10 years. CMS may also revoke a provider's enrollment if it fails to report on a timely basis any change in ownership or control, revocation or suspension of a federal or state license or certification, or any other change in its enrollment data.

Any termination of one or more of our hospitals or agencies from the Medicare program for failure to satisfy the enrollment requirements or conditions of participation could materially adversely affect our business, financial position, results of operations, and cash flows.

Other Operational and Financial Risks

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

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

We expend significant capital to protect against the threat of security breaches, including cyber attacks, email phishing schemes, malware and ransomware. Substantial additional expenditures may be required to respond to and remediate any problems caused by breaches, including the unauthorized access to or theft of patient data and protected health information stored in our information systems and the introduction of computer malware or ransomware to our systems. We also provide our employees annual training and regular reminders on important measures they can take to prevent breaches and other cyber threats, including phishing schemes. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. For example, it has been widely reported that many well-organized international interests, in certain cases with the backing of sovereign governments, are targeting the theft of patient information and the disruption of healthcare services through the use of advance persistent threats. Similarly, in recent years, several hospitals have reported being victims of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. In 2020, one large, national healthcare system reported a ransomware attack that forced its facilities to operate without access to information systems for some time. We are likely to face attempted attacks in the future. Accordingly, we may be vulnerable to losses associated with the improper functioning, breach or unavailability of our and our vendors' information systems, including systems used in acquired operations, and third-party systems we use.

In December 2020, it was reported that a sophisticated, well-funded state-sponsored threat actor implanted a backdoor security vulnerability in a widely used network monitoring software sold by SolarWinds, which software was then distributed to thousands of customers, including numerous government agencies and companies in the private sector, via an automatic update platform used to push out new software updates. Three of our servers downloaded the compromised software. The vulnerability was designed to enable hackers to install and execute additional malware that could be used to exfiltrate and facilitate remote access to data possessed by these government agencies and companies. The full scope of the security threat and extent of exploitation of the vulnerability is not yet known. Promptly after we learned of the compromised SolarWinds software update, we identified, isolated and remediated the malicious update then reviewed and ensured we were implementing the recommended security practices provided by industry and government experts. We also conducted a forensics investigation using all the indicators of compromise provided by leading security experts. Our forensic analysis to date has discovered no indicators of compromise. We continue to monitor this situation closely and work with our cyber security vendors, as well as industry and governmental cyber security partners combating this threat.

To date, we are not aware of having experienced a material compromise from a cyber breach or attack. However, given the increasing cyber security threats in the healthcare industry, there can be no assurance we will not experience business interruptions; data loss, ransom, misappropriation or corruption; theft or misuse of proprietary, patient or other personally identifiable information; or litigation, investigation, or regulatory action related to any of those, any of which could have a material adverse effect on our patient care, financial position, and results of operations and harm our business reputation.

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

ACE-IT is subject to a licensing, implementation, technology hosting, and support agreement with Cerner Corporation. Similarly, we have an agreement to license, host, and support a comprehensive home care management and clinical information system, Homecare Homebase[SM]. In addition, we have a number of partners and non-software vendors with whom we share data in order to provide patient care and otherwise operate our business. In fact, federal laws and regulations require interoperability among healthcare entities in many circumstances. Our inability, or the inability of our partners or vendors, to continue to maintain and upgrade information systems, software, and hardware could disrupt or reduce the efficiency of our operations, including affecting patient care. A security breach or other system failure involving Cerner, Homecare Homebase or another third-party with whom we share data or system connectivity could compromise our patient data or proprietary information or disrupt our ability to operate. In addition, costs, unexpected problems, and interruptions associated with the implementation or transition to new systems or technology or with adequate support of those systems or technology across numerous hospitals and agencies could have a material adverse effect on our business, financial position, results of operations, and cash flows.

We face intense competition for patients from other healthcare providers.

We operate in highly competitive, fragmented inpatient rehabilitation and home health and hospice industries. Although we are the nation’s largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated, 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 91% of our hospitals’ referrals come from acute care hospitals, that increase in competition could materially and adversely affect our admission referrals in the related markets. There are also large acute care systems that may have more resources available to compete than we have. Other providers of post-acute care services may attempt to become competitors in the future. For example, some nursing homes, including at least one public company operator, have been marketing themselves as offering certain rehabilitation services, even though nursing homes are not required to offer the same level of care, and are not licensed, as hospitals.

In the home health and hospice services industries, our primary competition comes from the home health business owned in part by a large insurance company, three other large public home health companies, locally owned private home health companies or acute care hospitals with adjunct home health services and typically varies from market to market. We also compete with a variety of other companies in providing home health and hospice services, some of which, including several large public companies, may have greater financial and other resources and may be more established in their respective communities. One public home health company has a strategy that emphasizes joint ventures with acute care hospitals, including a number of joint ventures with large systems, which frequently serve as the referral sources for home health patients in specific markets. Similarly, there is a large insurance company that offers Medicare Advantage coverage and owns an interest in a home health business that is the largest provider of Medicare-certified skilled home health services. Additionally, nursing homes compete for referrals in some instances when the patients may be suitable for home-based care.

Competing companies may offer newer or different services from those we offer or have better relationships with referring physicians and may thereby attract patients who are presently, or would be candidates for, receiving our inpatient rehabilitation, home health, or hospice services. The other public companies and the insurance companies have or may obtain significantly greater marketing and financial resources or other advantages of scale than we have or may obtain. Relatively few barriers to entry exist in most of our local markets. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing competing services, may expand their services to include inpatient rehabilitation, home health, hospice care, community care, or similar services.

There can be no assurance this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, from time to time, there are efforts in states with certificate of need (“CON”) laws to weaken those laws, which could potentially increase competition in those states. For example, in 2019, Florida enacted legislation to repeal CON regulations for several provider types, including IRFs, in two stages. Effective July 1, 2019, existing IRFs became eligible to expand without first obtaining a CON. Effective July 1, 2021, new IRFs can operate without first obtaining a CON. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations in those states. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, *Properties*.

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

Our success depends in large part on referrals from physicians, hospitals, case managers and other patient referral sources in the communities we serve. By law, referral sources cannot be contractually obligated to refer patients to any specific provider. However, there can be no assurance that individuals will not attempt to steer patients to competing post-acute providers or otherwise limit our access to potential referrals. The establishment of joint ventures or networks between referral sources, such as acute care hospitals, and other post-acute providers may hinder patient referrals to us. The growing emphasis on integrated care delivery across the healthcare continuum increases that risk.

Our growth and profitability depend on our ability to establish and maintain close working relationships with patient referral sources and to increase awareness and acceptance of the benefits of inpatient rehabilitation, home health, and hospice care by our referral sources and their patients. We cannot provide assurance that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to grow our business and operate profitably.

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. Our large home health competitors may have the ability to out bid us for acquisitions. In the inpatient rehabilitation industry, the costs of constructing new hospitals may be increasing faster than the general inflation rate. In many states, the need to obtain governmental approvals, such as a CON or an approval of a change in ownership, may represent a significant obstacle to completing transactions. Additionally, in states with CON laws, it is not unusual for third-party providers to challenge the initial awards of CONs, the increase in the number of approved beds in an existing CON, or the expansion of the area served, and the adjudication of those challenges and related appeals may take many years. These factors may delay, or increase the cost to us associated with, any acquisition or *de novo* development or prevent us from completing one or more acquisitions or *de novo* developments.

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

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

- limitations, including state CONs as well as anti-trust, Medicare, and other regulatory approval requirements, on our ability to complete such acquisitions, particularly those involving not-for-profit providers, on terms, timetables, and valuations reasonable to us;

- limitations in obtaining financing for acquisitions at a cost reasonable to us;

- difficulties integrating acquired operations, personnel, and information systems, and in realizing projected revenues, efficiencies and cost savings, or returns on invested capital;

- entry into markets, businesses or services in which we may have little or no experience;

- diversion of business resources or management's attention from ongoing business operations; and

- exposure to undisclosed or unforeseen liabilities of acquired operations, including liabilities for failure to comply with healthcare laws and anti-trust considerations in specific markets as well as risks and liabilities related to previously compromised information systems.

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

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

We may undertake strategic acquisitions from time to time. For example, we completed the acquisitions of the home health and hospice business of Camellia Heathcare and Alacare Home Health and Hospice in 2018 and 2019, respectively. Prior to consummation of any acquisition, the acquired business will have operated independently of us, with its own procedures, corporate culture, locations, employees and systems. We expect to integrate acquired businesses into our existing business utilizing certain common information systems, operating procedures, administrative functions, financial and internal controls and human resources practices to the extent practicable. There may be substantial difficulties, costs and delays involved in the integration of an acquired business with our business. Additionally, an acquisition could cause disruption to our business and operations and our relationships with customers, employees and other parties. In some cases, the acquired business has itself grown through acquisitions, and there may be legacy systems, operating policies and procedures, financial and administrative practices yet to be fully integrated. To the extent we are attempting to integrate multiple businesses at the same time, we may not be able to do so as efficiently or effectively as we initially anticipate. The failure to successfully integrate on a timely basis any acquired business with our existing business could have an adverse effect on our business, financial position, results of operations, and cash flows.

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We anticipate our acquisitions will result in benefits including, among other things, increased revenues. However, acquired businesses may not contribute to our revenues or earnings to the extent anticipated, and any synergies we expect may not be realized after the acquisitions have been completed. If the acquired businesses underperform and any underperformance is other than temporary, we may be required to take an impairment charge. Failure to achieve the anticipated benefits could result in the diversion of management’s time and energy and could have an adverse effect on our business, financial position, results of operations, and cash flows.

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

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This issue may be exacerbated if immigration is more limited in the future. As discussed above in the COVID-19 pandemic risk factor, the pandemic has affected the availability of clinical staff in many markets from time to time. A shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

If our labor costs increase, we may not experience reimbursement rate or pricing increases to offset these additional costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual market basket update from Medicare, as is expected to happen in 2021, or we experience a significant shift in our payor mix to lower rate payors such as Medicaid, our results of operations and cash flows will be adversely affected. Conversely, decreases in reimbursement revenues, such as with sequestration and the PDGM reimbursement rate reductions, may limit our ability to increase compensation or benefits to the extent necessary to retain key employees, in turn increasing our turnover and associated costs. Union activity is another factor that may contribute to increased labor costs. We currently have a minimal number of union employees, so an increase in labor union activity could have a significant impact on our labor costs. Our failure to recruit and retain qualified medical personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

We operate in a highly regulated industry in which healthcare providers are routinely subject to litigation. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are a defendant in a number of lawsuits, most of which are general and professional liability matters inherent in treating patients with medical conditions. Our more significant lawsuits and investigations, are discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Substantial damages, fines, or other remedies assessed against us or agreed to in settlements could have a material adverse effect on our business, financial position, results of operations, and cash flows, including indirectly as a result of the covenant defaults under our credit agreement or debt instruments or other claims such as those in securities actions. Additionally, the costs of defending litigation and investigations, even if frivolous or nonmeritorious, could be significant.

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

In 2019, we settled with DOJ to conclude an investigation that originated in 2013 based on the allegations made by relators. The seven-year investigation produced no evidence of falsity or fraudulent conduct. Eventually, the court overseeing the *qui tam* actions refused to give DOJ more time to decide whether to intervene and unsealed the cases. DOJ chose not to intervene and prosecute the matter. We settled the DOJ investigation, together with the related *qui tam* or "whistleblower" lawsuits, for a payment of $48 million, and we expressly denied any wrongdoing. Even when a matter is without merit, as we believe was the case with this investigation, we may still incur significant costs of defense or settlement costs or both.

It is possible that other *qui tam* lawsuits have been filed against us, which suits remain under seal, or that we are unaware of such filings or precluded by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the FCA.

The healthcare services we provide involve substantial risk of general and professional liability. Inpatient rehabilitative care involves three hours of daily intensive therapy for patients who are usually elderly and come to our hospitals with debilitating medical conditions, including COVID-19 and its associated conditions. Our clinicians must frequently assist patients who have difficulty with mobility. Home care services, by their very nature, are provided in an environment that is not in the substantial control of the healthcare provider. On any given day, we have thousands of care providers driving to and from the homes of patients. We cannot predict the impact any claims arising out of the travel, the home visits or the care being provided (regardless of their ultimate outcomes) could have on our business or reputation or on our ability to attract and retain patients and employees. We also cannot predict the adequacy of any reserves for such losses or recoveries from any insurance or re-insurance policies.

We self-insure a substantial portion of our professional, general, and workers' compensation liability risks, which may not include risks related to regulatory fines and penalties, through our captive insurance subsidiary, as discussed further in Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements. Changes in the number of these liability claims and the cost to resolve them impact the reserves for these risks. A variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the reserves for these liability risks, which could have an effect on our financial position and results of operations.

Additionally, we operate in states in which the litigation environment may pose a significant business risk to us. For instance, we have been involved in lawsuits, including putative class actions, brought under California's Private Attorneys General Act ("PAGA"). Under PAGA, individuals, including aggrieved employees, can bring individual or class-action claims alleging regulatory violations, including alleged violations of employment regulations. Additionally, judges and juries in California have demonstrated a willingness to grant large verdicts to plaintiffs in connection with employment and labor related cases. In 2017, the California Supreme Court held that plaintiffs bringing suit under PAGA are generally entitled to request and receive a significant amount of information from the employer early in the litigation, which creates pressure for employers to settle early to avoid substantial litigation costs and which has resulted in a significant increase PAGA claims in recent years.

We may incur additional indebtedness in the future, and that debt or the associated increased leverage may have negative consequences for our business. The restrictive covenants included in the terms of our indebtedness could affect our ability to execute aspects of our business plan successfully.

As of December 31, 2020, we have approximately $2.9 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $391.7 million in finance leases). See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. Subject to specified limitations, our credit agreement and the indentures governing our debt securities permit us and our subsidiaries to incur material additional debt. If new debt is added to our current debt levels, the risks described here could intensify.

Our indebtedness could have important consequences, including:

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

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

In addition, the terms of our credit agreement and the indentures governing our senior notes do, and our future debt instruments may, impose restrictions on us and our subsidiaries, including restrictions on our ability to, among other things, engage in one or more alternative separation transactions involving our home health and hospice segment (as discussed further above) or other transactions, pay dividends on or repurchase our capital stock, engage in transactions with affiliates, or incur or guarantee indebtedness. These covenants could also adversely affect our ability to finance our future operations or capital needs and pursue available business opportunities. For additional discussion of our material debt covenants, see the “Liquidity and Capital Resources” section of Item 7, *Management’s Discussion and Analysis of Financial Condition and Results of Operations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

In addition, our credit agreement requires us to maintain specified financial ratios and satisfy certain financial condition tests. See the “Liquidity and Capital Resources” section of Item 7, *Management’s Discussion and Analysis of Financial Condition and Results of Operations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. Although we remained in compliance with the financial ratios and financial condition tests as of December 31, 2020, 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, 2020, approximately 72% of our consolidated *Property and equipment, net* was held by our company and its guarantor subsidiaries under its credit agreement. See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements, the "Liquidity and Capital Resources" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Item 2, *Properties*.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We currently maintain our principal executive office at 9001 Liberty Parkway, Birmingham, Alabama, the lease for which expires in 2033 and has multiple renewal options for additional five-year terms.

In addition to our principal executive office and our home health and hospice corporate office, as of December 31, 2020, we leased or owned through various consolidated entities 137 hospitals and 323 agency offices. All but two of our hospital leases, which represent the largest portion of our rent expense, have at least five years remaining on their terms after taking into consideration one or more renewal options. Our consolidated entities associated with our leased hospitals are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses. Our home health and hospice business is based in Dallas, Texas where it leases office space for corporate and administrative functions. The remaining home health and hospice locations are in the localities served by that business and are subject to relatively small space leases, primarily 5,000 square feet or less. Those space leases are typically five years or less in term. We do not believe any one of our individual properties is material to our consolidated operations.

The following table sets forth information regarding our hospitals and our home health and hospice locations as of December 31, 2020:

		Number of Hospitals				
State	Licensed Beds	Building and Land Owned	Building Owned and Land Leased	Building and Land Leased	Total	Home Health and Hospice Locations
Alabama *+	427	2	3	2	7	57
Arizona	396	1	2	3	6	5
Arkansas +	368	3	1	1	5	5
California	234	3	—	1	4	—
Colorado	124	1	—	1	2	6
Connecticut *	—	—	—	—	—	1
Delaware *	40	—	1	—	1	—
Florida *	983	10	—	2	12	19
Georgia *+	170	2 (1)	1		3	25
Idaho	40	—	1	—	1	12
Illinois *	65	—	1	—	1	3
Indiana	98	1	—	—	1	1
Iowa	40	1	—	—	1	—
Kansas	242	1	—	2	3	6
Kentucky *+	323	2	1	—	3	3
Louisiana	47	1	—	—	1	3
Maine *	100	—	—	1	1	—
Maryland *+	64	1	—	—	1	3
Massachusetts *	529	2	—	2	4	5
Mississippi *+	43	—	—	1	1	20
Missouri *	191	—	2	—	2	2
Nevada *	219	2	—	1	3	4
New Hampshire	50	—	1	—	1	—
New Jersey *+	199	1	1	1	3	—
New Mexico	87	1	—	—	1	7
North Carolina *+	68	1	—	—	1	6
Ohio	260	2	1	1	4	1
Oklahoma	60	—	1	—	1	21
Oregon *	—	—	—	—	—	2
Pennsylvania	745	5	—	4	9	4
Puerto Rico *+	72	—	—	2	2	—
Rhode Island *+	—	—	—	—	—	1
South Carolina *+	456	2	4	1	7	4
South Dakota	40	1	—	—	1	—
Tennessee *+	493	5	4	—	9	8
Texas	1,593	12	3	9	24	63
Utah	84	1	—	—	1	12
Virginia *	297	2	1	3	6	12
West Virginia *+	258	1	3	—	4	—
Wyoming	—	—	—	—	—	2
	9,505	67	32	38	137	323 (2)

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* Hospital certificate of need state or U.S. territory. In Florida, existing IRFs became eligible to expand without first obtaining a CON effective July 1, 2019, and new IRFs may operate without first obtaining a CON effective July 1, 2021.

\+ Home health or hospice 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 241 locations where we provide home health services and 82 locations where we provide hospice services.

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

Item 3. Legal Proceedings

We provide services in the highly regulated healthcare industry. In the ordinary course of our business, we are a party to various legal actions, proceedings, and claims as well as regulatory and other governmental audits and investigations. These matters could potentially subject us to sanctions, damages, recoupments, fines, and other penalties. Some of these matters have been material to us in the past, and others in the future may, either individually or in the aggregate, be material and adverse to our business, financial position, results of operations, and liquidity. We do not believe any of our pending legal proceedings are material to us, but there can be no assurance our assessment will not change based on future developments.

Additionally, the False Claims Act (the "FCA") allows private citizens, called "relators," to institute civil proceedings on behalf of the United States alleging violations of the FCA. These lawsuits, also known as "*qui tam*" actions, are common in the healthcare industry and can involve significant monetary damages, fines, attorneys' fees and the award of bounties to the relators who successfully prosecute or bring these suits to the government. It is possible that *qui tam* lawsuits have been filed against us, which suits remain under seal, or that we are unaware of such filings or precluded by existing law or court order from discussing or disclosing the filing of such suits. Therefore, from time to time, we may be party to one or more undisclosed *qui tam* cases brought pursuant to the FCA.

Information relating to certain legal proceedings in which we are involved is included in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market Information

Shares of our common stock trade on the New York Stock Exchange under the ticker symbol "EHC."

Holders

As of February 12, 2021, there were 99,265,706 shares of Encompass Health common stock issued and outstanding, net of treasury shares, held by approximately 7,214 holders of record (participant positions at The Depository Trust Corporation plus record holders).

Dividends

On February 24, 2021, our board of directors declared a cash dividend of $0.28 per share, payable on April 15, 2021 to stockholders of record on April 1, 2021. We expect quarterly dividends to continue to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board each quarter after consideration of various factors, including our capital position and alternative uses of funds.

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

The following table sets forth, as of December 31, 2020, information concerning compensation plans under which our securities are authorized for issuance. The table does not reflect grants, awards, exercises, terminations, or expirations since that date. All share amounts and exercise prices have been adjusted to reflect stock splits that occurred after the date on which any particular underlying plan was adopted, to the extent applicable.

	Number of securities to be issued upon exercise of outstanding options	Weighted-average exercise price of outstanding options[1]	Number of securities available for future issuance
Plans approved by stockholders	2,532,030 [2]	$ 50.65	8,445,724 [3]
Plans not approved by stockholders	86,830 [4]		—
Total	2,618,860	$ 50.65	8,445,724

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

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

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

(4) This amount represents 86,830 restricted stock units issued under the 2004 Amended and Restated Director Incentive Plan, the material terms of which are described below.

2004 Amended and Restated Director Incentive Plan

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

Purchases of Equity Securities

The following table summarizes our repurchases of equity securities during the three months ended December 31, 2020:

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, 2020	1,102	$ 67.50	—	$199,253,887
November 1 through November 30, 2020	18,461	65.00	18,461	198,053,924
December 1 through December 31, 2020	—	—	—	198,053,924
Total	19,563	$ 65.14	18,461	

(1) Except as noted in the following sentence, the number of shares reported in this column represents shares tendered by an employee as payment of the tax liabilities incident to the vesting of previously awarded shares of restricted stock. In October, 729 shares were purchased pursuant to our Directors' Deferred Stock Investment Plan. This plan is a nonqualified deferral plan allowing non-employee directors to make advance elections to defer a fixed percentage of their director fees. The plan administrator acquires the shares in the open market which are then held in a rabbi trust. The plan also provides that dividends paid on the shares held for the accounts of the directors will be reinvested in shares of our common stock which will also be held in the trust. The directors' rights to all shares in the trust are nonforfeitable, but the shares are only released to the directors after departure from our board.

(2) On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock. On February 14, 2014, our board approved an increase in this common stock repurchase authorization from $200 million to $250 million. On July 24, 2018, our board approved resetting the aggregate common stock repurchase authorization to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended.

Company Stock Performance

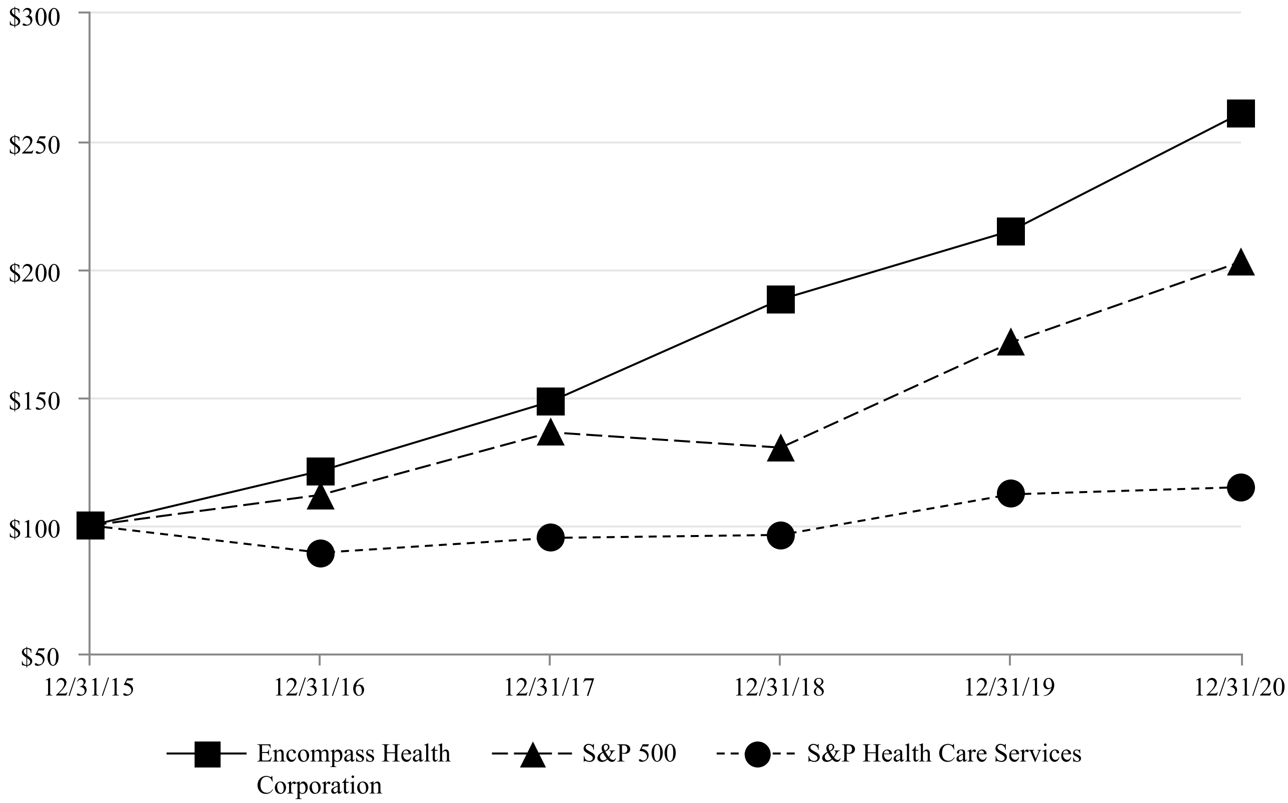
Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor's 500 Index ("S&P 500"), and the S&P Health Care Services Select Industry Index ("SPSIHP"), an equal-weighted index of at least 35 companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2015 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock. We have paid a quarterly cash dividend on our common stock since October 2013.

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

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

COMPARISON OF 5-YEAR CUMULATIVE TOTAL RETURN

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



	For the Year Ended December 31,					
	Base Period	Cumulative Total Return				
Company/Index Name	2015	2016	2017	2018	2019	2020
Encompass Health Corporation	100.00	121.32	148.43	188.32	215.12	261.08
Standard & Poor's 500 Index	100.00	111.96	136.40	130.42	171.49	203.04
S&P Health Care Services Select Industry Index	100.00	89.38	95.15	96.33	112.16	114.97

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Item 6. Selected Financial Data

We derived the selected consolidated financial data presented below as of December 31, 2020 and 2019 and for the years ended December 31, 2020, 2019, and 2018 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below as of December 31, 2018 and as of and for the years ended December 31, 2017 and 2016 from our consolidated financial statements and related notes not included herein. Refer to Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* and the notes to the accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations.

	For the Year Ended December 31,				
	2020	**2019**	**2018**	**2017**	**2016**
	(In Millions, Except per Share Data)				
Statements of Comprehensive Income Data:					
Net operating revenues	$ 4,644.4	$ 4,605.0	$ 4,277.3	$ 3,913.9	$ 3,642.6
Operating earnings [1]	563.9	612.1	555.2	578.3	588.1
Provision for income tax expense	103.8	115.9	118.9	145.8	163.9
Income from continuing operations	368.8	446.4	374.3	350.6	318.1
(Loss) income from discontinued operations, net of tax	—	(0.6)	1.1	(0.4)	—
Net income	368.8	445.8	375.4	350.2	318.1
Less: Net income attributable to noncontrolling interests	(84.6)	(87.1)	(83.1)	(79.1)	(70.5)
Net income attributable to Encompass Health common shareholders	$ 284.2	$ 358.7	$ 292.3	$ 271.1	$ 247.6
Weighted average common shares outstanding: [2]					
Basic	98.6	98.0	97.9	93.7	89.1
Diluted	99.8	99.4	99.8	99.3	99.5
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders:					
Continuing operations	$ 2.87	$ 3.66	$ 2.97	$ 2.88	$ 2.77
Discontinued operations	—	(0.01)	0.01	—	—
Net income	$ 2.87	$ 3.65	$ 2.98	$ 2.88	$ 2.77
Diluted earnings per share attributable to Encompass Health common shareholders:					
Continuing operations	$ 2.85	$ 3.62	$ 2.92	$ 2.84	$ 2.59
Discontinued operations	—	(0.01)	0.01	—	—
Net income	$ 2.85	$ 3.61	$ 2.93	$ 2.84	$ 2.59
Cash dividends per common share	$ 1.12	$ 1.10	$ 1.04	$ 0.98	$ 0.94

	As of December 31,				
	2020	2019	2018	2017	2016
			(In Millions)		
Balance Sheet Data:					
Total assets (3)	$ 6,445.9	$ 6,080.7	$ 5,175.0	$ 4,864.5	$ 4,663.8
Long-term debt, including current portion (2) (3)	3,288.9	3,062.6	2,514.4	2,577.7	3,016.4
Encompass Health shareholders' equity (2)	1,588.0	1,352.2	1,276.7	1,152.5	717.8

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

(2) During the fourth quarter of 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 ("Convertible Notes") for 257,110 shares of our then outstanding 6.50% Series A Convertible Perpetual Preferred Stock. On April 23, 2015, we exercised our rights to force conversion of all remaining outstanding shares of our convertible perpetual preferred stock into common stock. During the second quarter of 2017, we exercised the early redemption option and subsequently retired all $320 million of the Convertible Notes reducing our long-term debt balance by approximately $278 million. Substantially all of the holders elected to convert their Convertible Notes to shares of our common stock, which resulted in the issuance of 8.9 million shares from treasury stock.

(3) In May 2018, we acquired Camellia Healthcare and affiliated entities using cash on hand and borrowings under our revolving credit facility. In July 2019, we acquired privately owned Alacare Home Health & Hospice using cash on hand and borrowings under our revolving credit facility. See Note 2, *Business Combinations*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

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

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

In addition, management's discussion and analysis of our results of operations and cash flows for the year ended December 31, 2019 compared to the year ended December 31, 2018 may be found in, Part II, Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations* of our Annual Report on Form 10-K for the year ended December 31, 2019, filed with the Securities and Exchange Commission on February 27, 2020.

Executive Overview

Our Business

We are a leading provider of post-acute healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2020, our national footprint spans 39 states and Puerto Rico. As discussed in this Item, "Segment Results of Operations," we manage our operations in two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. For additional information about our business and reportable segments, see Item 1, *Business* and Item 1A, *Risk Factors*, of this report, Note 19, *Segment Reporting*, to the accompanying consolidated financial statements, and the "Segment Results of Operations" section of this Item.

On December 9, 2020, we announced a formal process to explore strategic alternatives for our home health and hospice business. A range of options are under consideration, including the full or partial separation of the home health and hospice business from Encompass Health through an initial public offering, spin-off, merger, sale or other transaction. No timetable has been established for the completion of the strategic review.

Inpatient Rehabilitation

We are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated, revenues, and number of hospitals. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. We operate hospitals in 35 states and Puerto Rico, with concentrations in the eastern half of the United States and Texas. As of December 31, 2020, we operate 137 inpatient rehabilitation hospitals and manage four inpatient rehabilitation units through management contracts. Our inpatient rehabilitation segment represented approximately 77% of our *Net operating revenues* for the year ended December 31, 2020.

Home Health and Hospice

Our home health business is the nation's fourth largest provider of Medicare-certified skilled home health services in terms of revenues. Our home health services include a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. Our hospice business is the nation's eighth largest provider of Medicare-certified hospice services in terms of revenues. We provide hospice services to terminally ill patients and their families that address patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support. As of December 31, 2020, we provide home health services in 241 locations and hospice services in 82 locations across 31 states, with a concentration in the southern half of the United States. In addition, one of these home health agencies operates as a joint venture that we account for using the equity method of accounting. Our home health and hospice segment represented approximately 23% of our *Net operating revenues* for the year ended December 31, 2020.

2020 Overview

The rapid onset of the COVID-19 Pandemic (the "pandemic") in the United States has resulted in significant changes to our operating environment. For discussion of the financial and operational impacts we have experienced as a result of the pandemic, see Item 1, *Business*, Item 1A, *Risk Factors,* and the "Results of Operations" and "Segment Results of Operations" sections of this Item.

We continued our development and expansion efforts during 2020. In our inpatient rehabilitation segment, we:

- began operating our new 50-bed inpatient rehabilitation hospital in Murrieta, California in February 2020;
- began operating a 40-bed inpatient rehabilitation hospital in Coralville, Iowa with our joint venture partner, University of Iowa Health Care, in June 2020;
- began operating our new 40-bed inpatient rehabilitation hospital in Sioux Falls, South Dakota in June 2020;
- began operating our new 40-bed inpatient rehabilitation hospital in Toledo, Ohio in November 2020;
- continued our capacity expansions by adding 117 new beds to existing hospitals; and

- announced or continued development of the following hospitals:

	Number of New Beds	
	2021[(1)]	2022[(1)]
De novos:		
Cumming, Georgia	50	—
North Tampa, Florida	50	—
Stockbridge, Georgia	50	—
Greenville, South Carolina	40	—
Pensacola, Florida	40	—
Shreveport, Louisiana	40	—
Waco, Texas	40	—
Libertyville, Illinois	—	60
St. Augustine, Florida	—	40
Lakeland, Florida	—	50
Clermont, Florida	—	50
Naples, Florida	—	50
Cape Coral, Florida	—	40
Jacksonville, Florida	—	50
Joint ventures:		
San Angelo, Texas	40	—
Knoxville, Tennessee	—	73
Shiloh, Illinois	—	40
Moline, Illinois	—	40
Owasso, Oklahoma	—	40

(1) Certain development projects may be delayed due to the pandemic.

In our home health and hospice segment, we acquired one home health location in Lynchburg, Virginia and began accepting patients at our home health location in Sebring, Florida and our new hospice location in Allen, Texas.

During 2020, *Net operating revenues* increased 0.9% over 2019 due primarily to pricing growth in our inpatient rehabilitation segment partially offset by decreased volumes in both segments and a pricing decrease in the home health and hospice segment. See the "Results of Operations" and "Segment Results of Operations" section of this Item for additional financial information.

We also continued taking steps to further increase the strength and flexibility of our balance sheet as well as augment returns from investments in operations with shareholder distributions via common stock dividends and repurchases of our common stock. For additional information, see the "Liquidity and Capital Resources" section of this Item.

Business Outlook

Notwithstanding the current impacts from the pandemic, we remain optimistic regarding the intermediate and long-term prospects for both of our business segments. Demographic trends, such as population aging, should continue to increase long-term demand for the services we provide. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. Even more specifically, the average age of our patients is approximately 76, and the population group ranging in ages from 75 to 79 is expected to grow at approximately 5% per year through 2026. We believe the demand for the services we provide will continue to increase as the U.S. population ages. We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute care services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring or opening home health and hospice agencies in those fragmented industries.

We are a leading provider of post-acute healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. We are committed to delivering high-quality, cost-effective, integrated patient care. As the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated, revenues, and number of hospitals, we believe we differentiate ourselves from our competitors based on the quality of our clinical outcomes, our cost-effectiveness, our financial strength, and our extensive application of technology. As the fourth largest provider of Medicare-certified skilled home health services in terms of revenues, we believe we differentiate ourselves from our competitors by the application of a highly integrated technology platform, our ability to manage a variety of care pathways, and a proven track record of consummating and integrating acquisitions.

Although the healthcare industry is currently engaged in addressing the healthcare crisis caused by the pandemic, the industry also faces the prospect of ongoing efforts to transform the healthcare system to coordinated care delivery and payment models. The nature, timing and extent of that transformation remains uncertain, as the development and implementation of new care delivery and payment systems will require significant time and resources. Our short-term goal is to serve our communities and provide the best care possible during the pandemic. Our long-term goal is to position the Company in a prudent manner to be responsive to industry shifts. We have invested in our core business and created an infrastructure that enables us to provide high-quality care on a cost-effective basis. We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2023. We continue to have a strong, well-capitalized balance sheet, including a substantial portfolio of owned real estate and significant availability under our revolving credit facility. For these and other reasons, we believe we will be able to adapt to changes in reimbursement, sustain our business model, and grow through acquisition and consolidation opportunities as they arise. See also Item 1, *Business*, "Competitive Strengths" and "Strategy and 2021 Strategic Priorities."

Key Challenges

Healthcare is a highly-regulated industry facing many well-publicized regulatory and reimbursement challenges. The Medicare reimbursement systems for both inpatient rehabilitation and home health have recently undergone significant changes. The future of many aspects of healthcare regulation remains uncertain. Successful healthcare providers are those able to adapt to changes in the regulatory and operating environments, build strategic relationships across the healthcare continuum, and consistently provide high-quality, cost-effective care. We believe we have the necessary capabilities — change agility, strategic relationships, quality of patient outcomes, cost effectiveness, and ability to capitalize on growth opportunities — to adapt to and succeed in a dynamic, highly regulated industry, and we have a proven track record of doing so.

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

- Operating in a Highly Regulated Industry. We are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. More specifically, because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. 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. See Item 1, *Business*, "Regulation," and Item 1A, *Risk Factors*, for detailed discussions of the most important regulations we face and our programs intended to ensure we comply with those regulations.

  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, Centers for Medicare & Medicaid Services ("CMS"), and state Medicaid programs. These audits as well as the ordinary course claim reviews of our billings result in payment denials, including recoupment of previously paid claims from current accounts receivable. Healthcare providers can challenge any denials through an administrative appeals process that can be extremely lengthy, taking several years. For additional details of these claim reviews, See Item 1, *Business*, "Sources of Revenues," Item 1A, *Risk Factors,* and Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues" and "Accounts Receivable," to the accompanying consolidated financial statements.

  See also Item 1, *Business*, "Regulation," and Item 1A, *Risk Factors*, to this report.

- Changes to Our Operating Environment Resulting from the COVID-19 pandemic. In response to the public health emergency associated with the pandemic, Congress and CMS adopted several statutory and regulatory measures intended to provide relief to healthcare providers in order to ensure patients would continue to have adequate access to care. On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the “CARES Act”), which temporarily suspended sequestration for the period of May 1 through December 31, 2020. The impact of the suspension of sequestration on our inpatient rehabilitation and home health and hospice revenues in 2020 was $35.3 million and $14.0 million, respectively. The CARES Act also authorized the cash distribution of relief funds from the United States Department of Health and Human Services (“HHS”) to healthcare providers. We did not request any relief funds. However, on April 10, 2020, HHS began distributing CARES Act relief funds to various of our bank accounts. We refused the CARES Act relief funds, and our banks returned all the funds to HHS. The Consolidated Appropriations Act, 2021 (the “2021 Budget Act”), signed into law on December 27, 2020, extends the sequestration suspension through March 31, 2021 and provides for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the CARES Act or the 2021 Budget Act. The CARES Act, the 2021 Budget Act, and CMS regulatory actions include a number of other provisions affecting our reimbursement and operations in both segments. The provisions are discussed in Item 1, *Business*, “Sources of Revenue,” Item 1A, *Risk Factors,* and the “Results of Operations” section of this Item.

- Changes to Our Operating Environment Resulting from Healthcare Reform. Concerns held by federal policymakers about the federal deficit and national debt levels, as well as other healthcare policy priorities, could result in enactment of legislation affecting portions of the Medicare program, including post-acute care services we provide. It is not clear what, if any, Medicare-related changes may ultimately be enacted and signed into law or otherwise implemented, but it is possible that any reductions in Medicare spending will have a material impact on reimbursements for healthcare providers generally and post-acute providers specifically. We cannot predict what, if any, changes in Medicare spending or modifications to the healthcare laws and regulations will result from future budget or other legislative or regulatory initiatives.

  Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notable for us are Medicare reimbursement reductions, such as reductions to annual market basket updates to providers and reimbursement rate rebasing adjustments, and promotion of alternative payment models, such as accountable care organizations (“ACOs”) and bundled payment initiatives including the Bundled Payments for Care Improvement Initiative Advanced (“BPCI Advanced”) and the Comprehensive Care for Joint Replacement (“CJR”) program. The Center for Medicare and Medicaid Innovation (“CMMI”) plays a key role in the development of many of these new payment and service delivery models. Our challenges related to healthcare reform are discussed in Item 1, *Business*, “Sources of Revenues,” and Item 1A, *Risk Factors*.

  As discussed in Item 1, *Business*, the future of the 2010 Healthcare Reform Laws as well as the nature and substance of any other healthcare legislation remain uncertain. Healthcare will almost certainly be the subject of significant regulatory and legislative changes under the Biden administration and a Democratic-controlled Congress. We will continue to evaluate these laws and regulations and position the Company for this industry shift. Based on our track record, we believe we can adapt to these regulatory and industry changes. Further, we have engaged, and will continue to engage, actively in discussions with key legislators and regulators to attempt to ensure any healthcare laws or regulations adopted or amended promote our goal of high-quality, cost-effective care.

  Each year, CMS adopts rules that update pricing and otherwise amend the respective payment systems. On August 4, 2020, CMS released its notice of final rulemaking for fiscal year 2021 under the inpatient rehabilitation facility prospective payment system (the “2021 IRF Rule”). Based on our analysis that utilizes, among other things, the acuity of our patients over the twelve-month period ended September 30, 2020, our experience with outlier payments over this same time frame, and other factors, we believe the 2021 IRF Rule will result in a net increase to our Medicare payment rates of approximately 2.3% effective October 1, 2020. On October 29, 2020, CMS released its notice of final rulemaking for calendar year 2021 for home health agencies under the home health prospective payment system (the “2021 HH Rule”). Based on our analysis of 30-day payment periods that both started and ended in 2020 and have been billed, we believe this rule will result in an increase to our Medicare home health payment rates of approximately 1.9% effective for 30-day payment periods ending on or after January 1, 2021. For additional details of the 2021 IRF Rule, 2021 HH Rule, and other proposed and adopted legislative and regulatory actions that may be material to our business, see Item 1, *Business,* and Item 1A, *Risk Factors*.

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

  In addition to the factors described above, beginning in March, we experienced significant volume decreases in both segments which we believe resulted from a number of conditions related to the pandemic as discussed in the "Results of Operations" section of this Item. While inpatient rehabilitation patient census and home health starts of episodes have substantially recovered, a current or future resurgence of COVID-19 infections could continue to cause disruptions to our volume growth.

- Recruiting and Retaining High-Quality Personnel. See Item 1A, Risk Factors, for a discussion of competition for staffing, shortages of qualified personnel, and other factors that may increase our labor costs. Recruiting and retaining qualified personnel, including management, for our inpatient hospitals and home health and hospice agencies remain a high priority for us. We attempt to maintain a comprehensive compensation and benefits package that allows us to remain competitive in this challenging staffing environment while remaining consistent with our goal of being a high-quality, cost-effective provider of post-acute services. Additionally, our operations have been affected and may in the future be affected by staffing shortages where employees must self-quarantine due to exposure to COVID-19 or where employees are unavailable due to a lack of childcare or care for elderly family.

We remain confident in the prospects of both of our business segments based on the increasing demands for the services we provide to an aging population. This confidence is further supported by our strong financial foundation and the substantial investments we have made in our businesses. We have a proven track record of working through difficult situations, and we believe in our ability to overcome current and future challenges.

Results of Operations

Payor Mix

During 2020, 2019, and 2018, we derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Medicare	70.5 %	75.1 %	75.9 %
Medicare Advantage	14.2 %	10.6 %	9.2 %
Managed care	9.0 %	8.3 %	8.8 %
Medicaid	3.4 %	2.8 %	2.6 %
Other third-party payors	0.9 %	0.9 %	1.1 %
Workers' compensation	0.5 %	0.7 %	0.7 %
Patients	0.4 %	0.5 %	0.5 %
Other income	1.1 %	1.1 %	1.2 %
Total	100.0 %	100.0 %	100.0 %

Our payor mix is weighted heavily towards Medicare. We receive Medicare reimbursements under the the inpatient rehabilitation facility prospective payment system, the home health prospective payment system, and the hospice payment system. For additional information regarding Medicare reimbursement, see the "Sources of Revenues" section of Item 1, *Business*.

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

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

Medicare as a percentage of revenue decreased during 2020 compared to 2019 primarily due to the pandemic, as discussed below. Within the inpatient rehabilitation segment, Medicare Advantage as a percentage of revenue increased during 2020 compared to 2019 due in part from suspension of prior authorization requirements. For additional discussion by segment, see the "Segment Results of Operations" section of this Item.

Our Results

From 2018 through 2020, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2020	2019	2018	2020 vs. 2019	2019 vs. 2018
	(In Millions)				
Net operating revenues	$ 4,644.4	$ 4,605.0	$ 4,277.3	0.9 %	7.7 %
Operating expenses:					
Salaries and benefits	2,682.0	2,573.0	2,354.0	4.2 %	9.3 %
Other operating expenses	634.4	623.6	585.1	1.7 %	6.6 %
Occupancy costs	81.2	82.3	78.0	(1.3)%	5.5 %
Supplies	200.5	167.9	158.7	19.4 %	5.8 %
General and administrative expenses	155.5	247.0	220.2	(37.0)%	12.2 %
Depreciation and amortization	243.0	218.7	199.7	11.1 %	9.5 %
Government, class action, and related settlements	2.8	—	52.0	N/A	(100.0)%
Total operating expenses	3,999.4	3,912.5	3,647.7	2.2 %	7.3 %
Loss on early extinguishment of debt	2.3	7.7	—	(70.1)%	N/A
Interest expense and amortization of debt discounts and fees	184.2	159.7	147.3	15.3 %	8.4 %
Other income	(10.6)	(30.5)	(2.2)	(65.2)%	1,286.4 %
Equity in net income of nonconsolidated affiliates	(3.5)	(6.7)	(8.7)	(47.8)%	(23.0)%
Income from continuing operations before income tax expense	472.6	562.3	493.2	(16.0)%	14.0 %
Provision for income tax expense	103.8	115.9	118.9	(10.4)%	(2.5)%
Income from continuing operations	368.8	446.4	374.3	(17.4)%	19.3 %
(Loss) income from discontinued operations, net of tax	—	(0.6)	1.1	(100.0)%	(154.5)%
Net income	368.8	445.8	375.4	(17.3)%	18.8 %
Less: Net income attributable to noncontrolling interests	(84.6)	(87.1)	(83.1)	(2.9)%	4.8 %
Net income attributable to Encompass Health	$ 284.2	$ 358.7	$ 292.3	(20.8)%	22.7 %

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2020	2019	2018
Operating expenses:			
Salaries and benefits	57.7 %	55.9 %	55.0 %
Other operating expenses	13.7 %	13.5 %	13.7 %
Occupancy costs	1.7 %	1.8 %	1.8 %
Supplies	4.3 %	3.6 %	3.7 %
General and administrative expenses	3.3 %	5.4 %	5.1 %
Depreciation and amortization	5.2 %	4.7 %	4.7 %
Government, class action, and related settlements	0.1 %	— %	1.2 %
Total operating expenses	86.1 %	85.0 %	85.3 %

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 and home health and hospice locations open throughout both the full current period and prior periods presented. These comparisons include the financial results of market consolidation transactions in existing markets, as it is difficult to determine, with precision, the incremental impact of these transactions on our results of operations.

2020 Compared to 2019

Net Operating Revenues

Our consolidated *Net operating revenues* increased in 2020 compared to 2019 primarily from pricing growth in our inpatient rehabilitation segment partially offset by decreased volumes in both segments and a pricing decrease in the home health and hospice segment. See additional discussion in the "Segment Results of Operations" section of this Item.

During January and February 2020, both segments were exhibiting strong year-over-year volume growth. Beginning in mid-March, we experienced decreased volumes in both segments which resulted from a number of conditions related to the COVID-19 pandemic including: lower acute-care hospital censuses due to the deferral of elective surgeries and shelter-in-place orders, restrictive visitation policies in place at acute-care hospitals that severely limit access to patients and caregivers by our clinical rehabilitation liaisons and care transition coordinators, lock down of assisted living facilities, and heightened anxiety among patients and their family members regarding the risk of exposure to COVID-19 during acute-care and post-acute care treatment.

Inpatient rehabilitation patient census and home health starts of episodes reached a low point the week ended April 12, 2020 (Easter weekend). While inpatient rehabilitation patient census and home health starts of episodes have substantially recovered, a current or future resurgence of COVID-19 infections could continue to cause disruptions to our volumes.

Salaries and Benefits

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

In April 2020, we initiated a program for eligible frontline employees to earn additional paid time off in recognition of their outstanding efforts responding to the pandemic. With more than 21,000 employees potentially benefiting from this additional paid time off, we accrued approximately $43 million in salary and benefits expense in the second quarter of 2020 in connection with this award (approximately $29 million in the inpatient rehabilitation segment; approximately $14 million in the home health and hospice segment).

Salaries and benefits in terms of dollars and as a percent of *Net operating revenues* increased in 2020 compared to 2019 primarily due to salary increases for our employees, the award of additional PTO to employees in response to the pandemic as discussed above, the ramp up of new stores, and declining employee productivity during the second quarter of 2020 due to the impact of the pandemic. See additional discussion in the "Segment Results of Operations" section of this Item.

Other Operating Expenses

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

As a percent of *Net operating revenues*, *Other operating expenses* increased during 2020 compared to 2019 primarily due to the pandemic related impact on patient volumes and increased lab costs, offset by lower travel and entertainment costs.

Supplies

Supplies expense includes all costs associated with supplies used while providing patient care. Specifically, these costs include personal protective equipment ("PPE"), pharmaceuticals, food, needles, bandages, and other similar items.

S*upplies* increased in terms of dollars and as a percent of *Net operating revenues* during 2020 compared to 2019 primarily due to increased utilization and cost of medical supplies, including PPE, due to the pandemic. We expect to continue to see increased utilization and cost of medical supplies in 2021 as a result of the pandemic.

General and Administrative Expenses

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

General and administrative expenses decreased in terms of dollars and as a percent of *Net operating revenues* during 2020 compared to 2019 primarily due to decreased expenses associated with stock appreciation rights. For additional information on stock appreciation rights, see Note 14, *Share-Based Payments*, to the accompanying consolidated financial statements.

Depreciation and Amortization

Depreciation and amortization increased during 2020 compared to 2019 due to our capital expenditures and development activities throughout 2019 and 2020. We expect *Depreciation and amortization* to increase going forward as a result of our recent and ongoing capital investments.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* in 2020 compared to 2019 primarily resulted from the issuances of our 2028 Notes and 2030 Notes in September 2019 and May 2020 partially offset by the November 2020 redemption of our 5.75% Senior Notes due 2024 (the "2024 Notes"). Cash paid for interest approximated $168 million and $156 million in 2020 and 2019, respectively. For additional information, see Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Other Income

Other income for 2019 included a $19.2 million gain as a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. See Note 9, *Investments in and Advances to Nonconsolidated Affiliates*, to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations in 2020 decreased compared to 2019 primarily due to the decrease in earnings, as discussed in the "Segment Results of Operations" section of this Item.

Provision for Income Tax Expense

Our *Provision for income tax expense* declined in 2020 compared to 2019 primarily due to lower *Income from continuing operations before income tax expense.* See also Note 16, *Income Taxes*, to the accompanying consolidated financial statements.

In addition to the CARES Act provisions previously discussed in the "Executive Overview" section of this Item, the CARES Act also includes provisions relating to net operating loss carryback periods, alternative minimum tax credit refunds,

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modifications to the net interest deduction limitations, technical corrections to tax depreciation methods for qualified improvement property and deferral of employer payroll taxes. The CARES Act did not materially impact our effective tax rate for the year ended December 31, 2020, although it will impact the timing of future cash payments for taxes.

Our cash payments for income taxes approximated $33 million and $104 million, net of refunds, in 2020 and 2019, respectively. These payments were based on estimates of taxable income for 2020. We estimate we will pay approximately $80 million to $110 million of cash income taxes, net of refunds, in 2021. These payments are expected to primarily result from federal and state income tax expenses based on estimates of taxable income for 2021. In 2020 and 2019, current income tax expense was $51.4 million and $75.9 million, respectively.

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

See Note 16, *Income Taxes*, to the accompanying consolidated financial statements and the “Critical Accounting Estimates” section of this Item.

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. In addition, we have experienced higher prices for our medical supplies, including PPE, as a result of the pandemic. Our supply chain efforts and our continual focus on monitoring and actively managing medical supplies and pharmaceutical costs has enabled us to accommodate increased pricing related to supplies and other operating expenses over the past few years. However, we cannot predict our ability to cover future cost increases including increase in the cost of PPE.

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 2020, 2019, or 2018, and therefore, are not presented as a separate discussion within this Item.

Segment Results of Operations

Our internal financial reporting and management structure is focused on the major types of services provided by Encompass Health. We manage our operations using two operating segments which are also our reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. For additional information regarding our business segments, including a detailed description of the services we provide, financial data for each segment, and a reconciliation of total segment Adjusted EBITDA to income from continuing operations before income tax expense, see Note 19, *Segment Reporting*, to the accompanying consolidated financial statements.

Inpatient Rehabilitation

During the years ended December 31, 2020, 2019 and 2018, our inpatient rehabilitation segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Medicare	66.7 %	72.2 %	73.2 %
Medicare Advantage	15.3 %	10.7 %	9.2 %
Managed care	10.4 %	9.8 %	10.3 %
Medicaid	3.9 %	3.1 %	3.0 %
Other third-party payors	1.2 %	1.2 %	1.5 %
Workers' compensation	0.6 %	0.8 %	0.8 %
Patients	0.5 %	0.7 %	0.6 %
Other income	1.4 %	1.5 %	1.4 %
Total	100.0 %	100.0 %	100.0 %

Medicare as a percentage of revenue decreased during 2020 compared to 2019 due to the pandemic. Medicare Advantage as a percentage of revenue increased during 2020 compared to 2019 due in part from suspension of prior authorization requirements.

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Additional information regarding our inpatient rehabilitation segment's operating results for the years ended December 31, 2020, 2019 and 2018, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2020	2019	2018	2020 vs. 2019	2019 vs. 2018
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Inpatient	$ 3,496.1	$ 3,423.5	$ 3,247.9	2.1 %	5.4 %
Outpatient and other	70.1	89.5	98.3	(21.7)%	(9.0)%
Inpatient rehabilitation segment revenues	3,566.2	3,513.0	3,346.2	1.5 %	5.0 %
Operating expenses:					
Salaries and benefits	1,903.8	1,813.1	1,701.5	5.0 %	6.6 %
Other operating expenses	534.7	521.9	502.3	2.5 %	3.9 %
Supplies	171.0	147.0	140.6	16.3 %	4.6 %
Occupancy costs	61.4	64.8	63.8	(5.2)%	1.6 %
Other income	(8.0)	(10.5)	(3.6)	(23.8)%	191.7 %
Equity in net income of nonconsolidated affiliates	(3.0)	(5.5)	(7.5)	(45.5)%	(26.7)%
Noncontrolling interests	83.3	82.6	77.2	0.8 %	7.0 %
Segment Adjusted EBITDA	$ 823.0	$ 899.6	$ 871.9	(8.5)%	3.2 %
	(Actual Amounts)				
Discharges	181,897	186,842	179,846	(2.6)%	3.9 %
Net patient revenue per discharge	$ 19,220	$ 18,323	$ 18,059	4.9 %	1.5 %
Outpatient visits	186,257	375,525	488,754	(50.4)%	(23.2)%
Average length of stay (days)	12.9	12.6	12.6	2.4 %	— %
Occupancy %	67.7%	69.5%	69.3%	(2.6)%	0.3 %
# of licensed beds	9,505	9,249	8,966	2.8 %	3.2 %
Full-time equivalents*	22,076	21,967	21,335	0.5 %	3.0 %
Employees per occupied bed	3.43	3.42	3.43	0.3 %	(0.3)%

* Full-time equivalents included in the above table represent our employees who participate in or support the operations of our hospitals and include an estimate of full-time equivalents related to contract labor.

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

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2020	2019	2018
Operating expenses:			
Salaries and benefits	53.4 %	51.6 %	50.8 %
Other operating expenses	15.0 %	14.9 %	15.0 %
Supplies	4.8 %	4.2 %	4.2 %
Occupancy costs	1.7 %	1.8 %	1.9 %

2020 Compared to 2019

Net Operating Revenues

Inpatient revenue increased during 2020 compared to 2019 primarily due to favorable pricing partially offset by decreased volumes. Discharge growth from new stores of 1.8% during 2020 resulted from our joint ventures in Lubbock, Texas (May 2019), Boise, Idaho (July 2019) and Coralville, Iowa (June 2020) and wholly owned hospitals in Katy, Texas (September 2019), Murrieta, California (February 2020) and Sioux Falls, South Dakota (June 2020). Discharge growth from new stores during 2020 also resulted from our joint venture hospital in Yuma, Arizona changing from the equity method of accounting to a consolidated entity effective July 1, 2019. Same-store discharges declined 4.4% during 2020 compared to 2019 primarily due to the pandemic. Growth in net patient revenue per discharge during 2020 compared to 2019 primarily resulted from an increase in reimbursement rates, a higher acuity patient mix and the suspension of sequestration starting in May 2020. The decrease in outpatient and other revenue during 2020 compared to 2019 primarily resulted from the COVID-related suspension of hospital-based outpatient services in 2020 and the closure of certain hospital-based outpatient programs in 2019.

See Note 2, *Business Combinations*, to the accompanying consolidated financial statements for information regarding our joint ventures discussed above. See Note 9, *Investments in and Advances to Nonconsolidated Affiliates*, to the accompanying consolidated financial statements for information regarding the consolidation of our Yuma Rehabilitation Hospital.

Adjusted EBITDA

The decrease in Adjusted EBITDA during 2020 compared to 2019 primarily resulted from COVID-related impacts on patient volumes and medical supplies as well as the award of additional paid time off to employees in response to the pandemic, as discussed above, plus the ramp up of new stores.

Home Health and Hospice

During the years ended December 31, 2020, 2019 and 2018, our home health and hospice segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2020	2019	2018
Medicare	83.1 %	84.2 %	85.3 %
Medicare Advantage	10.8 %	10.2 %	9.5 %
Managed care	4.4 %	3.6 %	3.6 %
Medicaid	1.4 %	1.7 %	1.2 %
Workers' compensation	0.1 %	0.1 %	0.2 %
Patients	0.1 %	0.1 %	0.1 %
Other income	0.1 %	0.1 %	0.1 %
Total	100.0 %	100.0 %	100.0 %

Additional information regarding our home health and hospice segment's operating results for the years ended December 31, 2020, 2019 and 2018, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2020	2019	2018	2020 vs. 2019	2019 vs. 2018
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Home health	$ 877.6	$ 918.0	$ 814.6	(4.4)%	12.7 %
Hospice	200.6	174.0	116.5	15.3 %	49.4 %
Home health and hospice segment revenues	1,078.2	1,092.0	931.1	(1.3)%	17.3 %
Operating expenses:					
Cost of services sold (excluding depreciation and amortization)	511.3	506.2	438.4	1.0 %	15.5 %
Support and overhead costs	402.8	381.7	323.5	5.5 %	18.0 %
Other income	—	—	(0.5)	— %	100.0 %
Equity in net income of nonconsolidated affiliates	(0.5)	(1.2)	(1.2)	(58.3)%	— %
Noncontrolling interests	1.3	9.5	8.5	(86.3)%	11.8 %
Segment Adjusted EBITDA	$ 163.3	$ 195.8	$ 162.4	(16.6)%	20.6 %
	(Actual Amounts)				
Home health:					
Total admissions	194,249	194,498	166,448	(0.1)%	16.9 %
Episodic admissions	158,912	159,727	137,396	(0.5)%	16.3 %
Recertifications	114,775	116,084	111,581	(1.1)%	4.0 %
Episodes	268,508	275,578	243,698	(2.6)%	13.1 %
Revenue per episode	$ 2,905	$ 2,972	$ 2,968	(2.3)%	0.1 %
Episodic visits per episode	16.4	17.1	17.6	(4.1)%	(2.8)%
Total visits	5,139,472	5,431,621	4,959,645	(5.4)%	9.5 %
Cost per visit	$ 80	$ 77	$ 76	3.9 %	1.3 %
Hospice:					
Admissions	12,878	10,452	7,474	23.2 %	39.8 %
Patient days	1,367,060	1,197,927	790,984	14.1 %	51.4 %
Average daily census	3,735	3,282	2,167	13.8 %	51.5 %
Revenue per day	$ 147	$ 145	$ 147	1.4 %	(1.4)%

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2020	2019	2018
Operating expenses:			
Cost of services sold (excluding depreciation and amortization)	47.4 %	46.4 %	47.1 %
Support and overhead costs	37.4 %	35.0 %	34.7 %

2020 Compared to 2019

Net Operating Revenues

The decline in home health revenue during 2020 compared to 2019 was driven by decreased volumes and pricing. Same-store episodic admissions declined 6.1% during 2020 compared to 2019 primarily due to the pandemic. New-store episodic admissions growth of 5.6% for 2020 primarily resulted from the acquisition of Alacare on July 1, 2019. Revenue per episode during 2020 compared to 2019 was negatively impacted by the implementation of the Patient Driven Groupings Model (the "PDGM") on January 1, 2020, offset by the suspension of sequestration starting in May 2020. Hospice revenue increased during 2020 compared to 2019 primarily due to the acquisition of Alacare and same-store admissions growth of 8.1%.

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

Adjusted EBITDA

The decrease in Adjusted EBITDA during 2020 compared to 2019 resulted from COVID-related impacts on patient volumes as discussed above, a decrease in Medicare reimbursement rates primarily related to the implementation of PDGM, and an increase in *Cost of services* and *Support and overhead costs* as a percent of revenues. *Cost of services* as a percent of revenues increased primarily due to COVID-related impacts on patient volumes, staff productivity and medical supplies, as well as the award of additional paid-time-off to employees in response to the pandemic. *Support and overhead costs* as a percent of revenues increased primarily due to an increase in sales force full-time equivalents, increased administrative costs associated with the implementation of the PDGM and the Review Choice Demonstration programs, and a decline in the revenue base.

Liquidity and Capital Resources

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

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

To further enhance our liquidity and ensure availability under our credit agreement, in April 2020, we amended our credit agreement primarily to provide covenant relief due to business disruptions from the pandemic. The amendment included, among other things, the carve-out of the pandemic from the definition of material adverse effect for 364 days and modifications to the interest coverage and leverage ratios under the agreement. In May 2020, we issued an additional $300 million of our existing 4.50% Senior Notes due 2028 at a price of 99.0% of the principal amount and an additional $300 million of our existing 4.75% Senior Notes due 2030 at a price of 98.5% of the principal amount, which resulted in approximately $583 million in net proceeds. We used a portion of the net proceeds from this borrowing, together with cash on hand, to repay borrowings under our revolving credit facility.

In October 2020, we issued $400 million aggregate principal amount of 4.625% Senior Notes due 2031 at par. We used the net proceeds from this borrowing plus approximately $300 million of cash on hand to fully redeem approximately $700 million of the 2024 Notes at par in November 2020. As a result of this redemption, we recorded a $2.3 million *Loss on early extinguishment of debt* in the fourth quarter of 2020.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2023. We continue to have a strong, well-capitalized balance sheet, including a substantial portfolio of owned real estate, and we have significant availability under our revolving credit facility. We continue to generate strong cash flows from operations, and we have significant flexibility with how we choose to invest our cash and return capital to shareholders.

See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Current Liquidity

As of December 31, 2020, we had $224.0 million in *Cash and cash equivalents*. This amount excludes $86.9 million in restricted cash ($65.4 million included in *Restricted cash* and $21.5 million included in *Other long-term assets* in our consolidated balance sheet) and $72.6 million of restricted marketable securities (included in *Other long-term assets* in our consolidated balance sheet). Our restricted assets pertain primarily to obligations associated with our captive insurance company, as well as obligations we have under agreements with joint venture partners. See Note 4, *Cash and Marketable Securities*, to the accompanying consolidated financial statements.

In addition to *Cash and cash equivalents*, as of December 31, 2020, we had approximately $963 million available to us under our revolving credit facility. Our credit agreement governs the substantial majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $300 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. In calculating the leverage ratio under our credit agreement, we are permitted to use pro forma Adjusted EBITDA, the calculation of which includes historical income statement items and pro forma adjustments resulting from (1) the dispositions and repayments or incurrence of debt and (2) the investments, acquisitions, mergers, amalgamations, consolidations and operational changes from acquisitions to the extent such items or effects are not yet reflected in our trailing four-quarter financial statements. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2020, the maximum leverage ratio requirement per our credit agreement was 6.50x and the minimum interest coverage ratio requirement was 2.0x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2020 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2020, if we had drawn on the first day and maintained the maximum amount of outstanding draws under our revolving credit facility for the entire year, we would still be in compliance with the maximum leverage ratio and minimum interest coverage ratio requirements.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2024, and our bonds all mature in 2023 and beyond. See the “Contractual Obligations” section below for information related to our contractual obligations as of December 31, 2020.

We acquired a significant portion of our home health and hospice business when we purchased EHHI Holdings, Inc. (“EHHI”) on December 31, 2014. In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Encompass Health Home Health Holdings, Inc. (“Holdings”), a subsidiary of Encompass Health and an indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. Those sellers were members of EHHI management, and they contributed a portion of their shares of common stock of EHHI, valued at approximately $64 million on the acquisition date, in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. At any time after December 31, 2017, each management investor had the right (but not the obligation) to have his or her shares of Holdings stock repurchased by Encompass Health for a cash purchase price per share equal to the fair value. The fair value was determined using the product of the trailing twelve-month adjusted EBITDA measure for Holdings and a specified median market price multiple based on a basket of public home health companies and transactions, after adding cash and deducting indebtedness that included the outstanding principal balance under any intercompany notes. In February 2018, each management investor exercised the right to sell one-third of his or her shares of Holdings stock to Encompass Health, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. On February 21, 2018, Encompass Health settled the acquisition of those shares upon payment of approximately $65 million in cash. In July 2019, we received additional exercise notices, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. In September 2019, Encompass Health settled the acquisition of those shares upon payment of approximately $163 million in cash. As of December 31, 2019, the value of those outstanding shares of Holdings owned by management investors was approximately $208 million. In January 2020, we received additional exercise notices, representing approximately 4.3% of the outstanding shares of the common stock of Holdings. In February 2020, Encompass Health settled the acquisition of those shares upon payment of approximately $162 million in cash. Upon settlement of these exercises, approximately $46 million of the shares of Holdings held by two management investors remained outstanding.

On February 20, 2020, Encompass Health entered into exchange agreements (each, an “Exchange Agreement”) with these two management investors, pursuant to which they had the right to exchange all of the remaining shares of Holdings held by them for shares of common stock of Encompass Health (the “EHC Shares”). Each of the Exchange Agreements provided that the management investor must deliver a written exchange notice (an “Exchange Notice”) to Encompass Health in order to exchange his or her remaining shares of Holdings for EHC Shares. Each Exchange Agreement further provided that the number of EHC Shares to be delivered to the management investor was to be determined by dividing the fair value of the shares of Holdings held by the management investor on the date of the Exchange Agreement by the last reported sales price of Encompass Health’s common stock on the New York Stock Exchange (the “NYSE”) on the date of delivery of the Exchange Notice.

On February 20, 2020, Encompass Health received an Exchange Notice from each of the management investors. Based on the last sales price of Encompass Health’s common stock on the NYSE on February 20, 2020, Encompass Health delivered an aggregate 560,957 EHC Shares to the management investors. The total number of EHC Shares issued pursuant to the exchange agreements on March 6, 2020 represented less than 0.6% of the outstanding shares of Encompass Health common stock. Encompass Health issued the EHC Shares from its treasury shares. Encompass Health now owns 100% of Holdings and EHHI. See also Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

In conjunction with the EHHI acquisition, we granted stock appreciation rights ("SARs") based on Holdings common stock to certain members of EHHI management at closing. Half of the SARs vested on December 31, 2018 and the remainder vested on December 31, 2019. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings' common stock on the exercise date exceeds the per share fair value on the grant date. In February 2019, members of the management team exercised a portion of their vested SARs for approximately $13 million in cash. In July 2019, members of the management team exercised the remainder of the vested SARs, which resulted in cash distributions of approximately $55 million. As of December 31, 2019, the fair value of the remaining 115,545 SARs was approximately $101 million, all of which was included in *Other current liabilities* in the accompanying consolidated balance sheet. In January 2020, members of the management team exercised the remaining SARs and in February 2020, we settled those awards upon payment of approximately $101 million in cash. See also Note 14, *Share-Based Payments*, to the accompanying consolidated financial statements.

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

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

Sources and Uses of Cash

The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2020, 2019, and 2018 (in millions):

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Net cash provided by operating activities	$ 704.7	$ 635.3	$ 762.4
Net cash used in investing activities	(407.5)	(657.4)	(424.5)
Net cash (used in) provided by financing activities	(145.9)	48.2	(321.2)
Increase in cash, cash equivalents, and restricted cash	$ 151.3	$ 26.1	$ 16.7

2020 Compared to 2019

Operating activities. The increase in *Net cash provided by operating activities* during 2020 compared to 2019 primarily resulted from the timing of and increase in payroll accruals offset by a decrease in *Net income* due to the impact of the pandemic on our operations (see the "Results of Operations" section of this Item). The increase in payroll accruals was attributable to the award of additional paid time off to employees during the second quarter of 2020 in response to the pandemic and the deferral of payroll taxes resulting from government relief efforts during the pandemic.

Investing activities. The decrease in *Net cash used in investing activities* during 2020 compared to 2019 primarily resulted from the acquisition of Alacare during the third quarter of 2019, as described in Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

Financing activities. The increase in *Net cash used in financing activities* during 2020 compared to 2019 primarily resulted from the redemption of the Company's 2024 Notes in November 2020 partially offset by the issuance of senior notes in May and October 2020. See also Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2020 are as follows (in millions):

	Total	2021	2022-2023	2024-2025	2026 and thereafter
Long-term debt obligations:					
Long-term debt, excluding revolving credit facility and finance lease obligations [a]	$ 2,897.2	$ 14.5	$ 339.6	$ 581.8	$ 1,961.3
Interest on long-term debt [b]	944.0	136.4	258.0	225.4	324.2
Finance lease obligations [c]	633.6	53.9	100.5	97.4	381.8
Operating lease obligations [d]	338.3	58.5	90.2	62.1	127.5
Purchase obligations [e]	125.9	55.8	42.8	17.9	9.4
Other long-term liabilities [f][g]	3.2	0.4	0.4	0.4	2.0
Total	$ 4,942.2	$ 319.5	$ 831.5	$ 985.0	$ 2,806.2

(a) Included in long-term debt are amounts owed on our bonds payable and other notes payable. These borrowings are further explained in Note 10, *Long-term Debt,* to the accompanying consolidated financial statements.

(b) Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2020. Interest pertaining to our credit agreement and bonds is included to their respective ultimate maturity dates. Interest related to finance lease obligations is excluded from this line (see Note 7, *Leases*, and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements). Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of comprehensive income.

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

(d) Our inpatient rehabilitation segment leases approximately 12% of its hospitals as well as other property and equipment under operating leases in the normal course of business. Our home health and hospice segment leases relatively small office spaces in the localities it serves, space for its corporate office, and other equipment under operating leases in the normal course of business. Amounts include interest portion of future minimum operating lease payments. For more information, see Note 7, *Leases,* to the accompanying consolidated financial statements.

(e) Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on Encompass Health and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support and medical equipment. Purchase obligations are not recognized in our consolidated balance sheet.

(f) Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: general liability, professional liability, and workers' compensation risks, noncurrent amounts related to third-party billing audits, and deferred income taxes. For more information, see Note 11, *Self-Insured Risks,* Note 16, *Income Taxes,* and Note 18, *Contingencies and Other Commitments,* to the accompanying consolidated financial statements.

(g) The table above does not include *Redeemable noncontrolling interests* of $31.6 million because of the uncertainty surrounding the timing and amounts of any related cash outflows. See Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

Our capital expenditures include costs associated with our hospital refresh program, de novo projects, capacity expansions, technology initiatives, and building and equipment upgrades and purchases. During the year ended December 31, 2020, we made capital expenditures of approximately $408 million for property and equipment, intangible assets, and capitalized software. These expenditures in 2020 are exclusive of approximately $1 million in net cash related to our acquisition activity. During 2021, we expect to spend approximately $580 million to $665 million for capital expenditures. Approximately $165 million to $195 million of this budgeted amount is considered nondiscretionary expenditures, which we may refer to in other filings as “maintenance” expenditures. In addition, we expect to spend approximately $50 million to $100 million on home health and hospice acquisitions during 2021. 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 2019, February 2020, May 2020, July 2020, and October 2020, our board of directors declared cash dividends of $0.28 per share that were paid in January 2020, April 2020, July 2020, October 2020, and January 2021, respectively. We expect quarterly dividends to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board of directors after consideration of various factors, including our capital position and alternative uses of funds. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our revolving credit facility.

On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock, which amount was subsequently increased to $250 million. On July 24, 2018, our board approved resetting the aggregate common stock repurchase authorization to $250 million. As of December 31, 2020, approximately $198 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.

Supplemental Guarantor Financial Information

Our indebtedness under our credit agreement and the 5.125% Senior Notes due 2023, 5.75% Senior Notes due 2025, 4.50% Senior Notes due 2028, 4.75% Senior Notes due 2030, and 4.625% Senior Notes due 2031, (collectively, the “Senior Notes”) are guaranteed by certain consolidated subsidiaries. These guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. The Senior Notes are 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. The other subsidiaries of Encompass Health do not guarantee the Senior Notes (such subsidiaries are referred to as the “non-guarantor subsidiaries”).

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) either (a) our senior secured leverage ratio (as defined in our credit agreement) remains less than or equal to 2x and our leverage ratio (as defined in our credit agreement) remains less than or equal to 4.50x or (b) there is capacity under the Available Amount as defined in the credit agreement. The terms of our Senior Notes indenture allow us to declare and pay cash dividends on our common stock so long as (1) we are not in default, (2) the consolidated coverage ratio (as defined in the indenture) exceeds 2x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture’s restricted payments covenant to declare and pay dividends. See Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

As discussed in Note 12, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements, Holdings had 5.5% noncontrolling interest as of December 31, 2019, and accordingly, Holdings and its wholly-owned subsidiaries were not guarantors of our debt. In February 2020, we acquired for cash all but 1.2% of the remaining noncontrolling interest in Holdings following the most recent exercise of the put option by the management investors. On February 20, 2020, Encompass Health Corporation and each of the two remaining management investors agreed to exchange the remaining shares representing the noncontrolling interest for an equal value of shares of common stock of Encompass Health Corporation. We settled the exchanges on March 6, 2020 and now own 100% of Holdings. Pursuant to the terms of our credit agreement and our Senior Notes indentures, we executed joinders for Holdings and its wholly-owned subsidiaries on April 23, 2020 at which time they became guarantors of the indebtedness under the credit agreement and our Senior Notes indentures.

Summarized financial information is presented below for Encompass Health, the parent company, and the subsidiary guarantors on a combined basis after elimination of intercompany transactions and balances among Encompass Health and the subsidiary guarantors and does not include investments in and equity in the earnings of non-guarantor subsidiaries.

	For the Year Ended December 31, 2020
	(In Millions)
Net operating revenues	$ 3,402.0
Intercompany revenues generated from non-guarantor subsidiaries	19.9
Total net operating revenues	$ 3,421.9
Operating expenses	$ 2,988.8
Intercompany expenses incurred in transactions with non-guarantor subsidiaries	30.3
Total operating expenses	$ 3,019.1
Income from continuing operations	$ 167.8
Net income	$ 167.8
Net income attributable to Encompass Health	$ 167.3

	As of December 31, 2020
	(In Millions)
Total current assets	$ 718.5
Property and equipment, net	$ 1,597.5
Goodwill	1,973.6
Intercompany receivable due from non-guarantor subsidiaries	154.3
Other noncurrent assets	702.4
Total noncurrent assets	$ 4,427.8
Total current liabilities	$ 582.1
Long-term debt, net of current portion	$ 3,213.1
Other noncurrent liabilities	307.5
Total noncurrent liabilities	$ 3,520.6

Adjusted EBITDA

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

We use Adjusted EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our credit agreement, which is discussed in more detail in Note 10, *Long-term Debt*, to the accompanying consolidated financial statements. These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under our credit agreement—our interest coverage ratio and our leverage ratio—could result in our lenders requiring us to immediately repay all amounts borrowed. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might be on terms less favorable to us than those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, therein referred to as "Adjusted Consolidated EBITDA," allows us to add back to consolidated *Net income* interest expense, income taxes, and depreciation and amortization and then add back to consolidated *Net income* (1) all unusual or nonrecurring items reducing consolidated *Net income* (of which only up to $10 million in a year may be cash expenditures), (2) any losses from discontinued operations, (3) non-ordinary course fees, costs and expenses incurred with respect to any litigation or settlement, (4) share-based compensation expense, (5) costs and expenses associated with changes in the fair value of marketable securities, (6) costs and expenses associated with the issuance or prepayment debt and acquisitions, and (7) any restructuring charges not in excess of 20% of Adjusted Consolidated EBITDA. We also subtract from consolidated *Net income* all unusual or nonrecurring items to the extent they increase consolidated *Net income*.

Under the credit agreement, the Adjusted EBITDA calculation does not require us to deduct net income attributable to noncontrolling interests or gains on fair value adjustments of hedging and equity instruments, disposal of assets, and development activities. It also does not allow us to add back losses on fair value adjustments of hedging instruments or unusual or nonrecurring cash expenditures in excess of $10 million. These items and amounts, in addition to the items falling within the credit agreement's "unusual or nonrecurring" classification, may occur in future periods, but can vary significantly from period to period and may not directly relate to, or be indicative of, our ongoing liquidity or operating performance. Accordingly, the Adjusted EBITDA calculation presented here includes adjustments for them.

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

Our Adjusted EBITDA for the years ended December 31, 2020, 2019, and 2018 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Net income	$ 368.8	$ 445.8	$ 375.4
Loss (income) from discontinued operations, net of tax, attributable to Encompass Health	—	0.6	(1.1)
Provision for income tax expense	103.8	115.9	118.9
Interest expense and amortization of debt discounts and fees	184.2	159.7	147.3
Loss on early extinguishment of debt	2.3	7.7	—
Government, class action, and related settlements	2.8	—	52.0
Loss on disposal or impairment of assets	11.6	11.1	5.7
Depreciation and amortization	243.0	218.7	199.7
Stock-based compensation expense	29.5	114.4	85.9
Net income attributable to noncontrolling interests	(84.6)	(87.1)	(83.1)
Transaction costs	—	2.1	1.0
Gain on consolidation of joint venture formerly accounted for under the equity method of accounting	(2.2)	(19.2)	—
SARs mark-to-market impact on noncontrolling interests	—	(5.0)	(2.6)
Change in fair market value of equity securities	(0.4)	(0.8)	1.9
Payroll taxes on SARs exercise	1.5	1.0	—
Adjusted EBITDA	$ 860.3	$ 964.9	$ 901.0

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,		
	2020	2019	2018
Net cash provided by operating activities	$ 704.7	$ 635.3	$ 762.4
Interest expense and amortization of debt discounts and fees	184.2	159.7	147.3
Equity in net income of nonconsolidated affiliates	3.5	6.7	8.7
Net income attributable to noncontrolling interests in continuing operations	(84.6)	(87.1)	(83.1)
Amortization of debt-related items	(7.2)	(4.5)	(4.0)
Distributions from nonconsolidated affiliates	(3.8)	(6.6)	(8.3)
Current portion of income tax expense	51.4	75.9	128.0
Change in assets and liabilities	7.3	180.1	(46.0)
Cash used in (provided by) operating activities of discontinued operations	0.2	4.4	(0.8)
Transaction costs	—	2.1	1.0
SARs mark-to-market impact on noncontrolling interests	—	(5.0)	(2.6)
Change in fair market value of equity securities	(0.4)	(0.8)	1.9
Payroll taxes on SARs exercise	1.5	1.0	—
Other	3.5	3.7	(3.5)
Adjusted EBITDA	$ 860.3	$ 964.9	$ 901.0

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, 2020, 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, 2020, we are not involved in any unconsolidated SPE transactions.

Critical Accounting Estimates

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

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

Revenue Recognition

We recognize net operating revenue in the reporting period in which we perform the service based on our best estimate of the transaction price for the type of service provided to the patient. Our estimate of the transaction price includes estimates of price concessions for such items as contractual allowances (principally for patients covered by Medicare, Medicare Advantage, Medicaid, and other third-party payors), potential adjustments that may arise from payment and other reviews, and uncollectible amounts. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," to the accompanying consolidated financial statements of this report for a complete discussion of our revenue recognition policies.

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

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

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

The collection of outstanding receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to patient responsibility amounts and claims reviews conducted by MACs or other contractors.

The table below shows a summary of our net accounts receivable balances as of December 31, 2020 and 2019. Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, *Summary of Significant Accounting Policies*, "Accounts Receivable," to the accompanying consolidated financial statements.

	As of December 31,	
	2020	**2019**
	(In Millions)	
Current:		
0 - 30 Days	$ 409.4	$ 385.6
31 - 60 Days	54.3	45.2
61 - 90 Days	30.6	25.4
91 - 120 Days	16.9	12.7
120 + Days	51.8	29.8
Patient accounts receivable	563.0	498.7
Other accounts receivable	9.8	7.4
	572.8	506.1
Noncurrent patient accounts receivable	123.8	152.1
Accounts receivable	$ 696.6	$ 658.2

Changes in general economic conditions (such as increased unemployment rates or periods of recession), business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable. Our collection risks include patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding, pre-payment claim reviews by our respective MACs, and reimbursement claims audits by governmental or other payors and their agents. As of December 31, 2020 and 2019, $117.8 million and $144.5 million of our patient accounts receivable represented denials that were under review or audit in our inpatient rehabilitation segment. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. See Note 1, *Summary of Significant Accounting Policies*, “Net Operating Revenues” and “Accounts Receivable,” to the accompanying consolidated financial statements of this report.

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers’ compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers’ compensation risks are insured through a wholly owned insurance subsidiary. See Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

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

Periodically, we review our assumptions and the valuations provided by third-party actuaries to determine the adequacy of our self-insurance reserves. The following are certain of the key assumptions and other factors that significantly influence our estimate of self-insurance reserves: historical claims experience; trending of loss development factors; trends in the frequency and severity of claims; coverage limits of third-party insurance; demographic information; statistical confidence levels; medical cost inflation; payroll dollars; and hospital patient census.

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

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

Net self-insurance reserves as of December 31, 2020:	
As reported, with 50% statistical confidence level	136.9
With 70% statistical confidence level	146.3

We believe our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. See Note 11, *Self-Insured Risks*, to the accompanying consolidated financial statements for additional information.

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

Goodwill

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

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

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

See Note 1, *Summary of Significant Accounting Policies*, "Goodwill and Other Intangibles," and Note 8, *Goodwill and Other Intangible Assets*, to the accompanying consolidated financial statements for additional information.

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

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

In the fourth quarter of 2020, we performed our annual evaluation of goodwill and determined no adjustment to impair goodwill was necessary. If actual results are not consistent with our assumptions and estimates, we may be exposed to goodwill impairment charges. However, at this time, we continue to believe our inpatient rehabilitation and home health and hospice reporting units are not at risk for any impairment charges.

Income Taxes

We provide for income taxes using the asset and liability method. We also evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," and Note 16, *Income Taxes*, to the accompanying consolidated financial statements for a more complete discussion of income taxes and our policies related to income taxes.

The application of income tax law is inherently complex. Laws and regulations in this area are voluminous and are often ambiguous. We are required to make many subjective assumptions and judgments regarding our income tax exposures.

Interpretations of and guidance surrounding income tax laws and regulations change over time. As such, changes in our subjective assumptions and judgments can materially affect amounts recognized in our consolidated financial statements.

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

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

During the year ended December 31, 2020, we increased our valuation allowance by $7.8 million. As of December 31, 2020, we had a remaining valuation allowance of $46.2 million which primarily related to state net operating losses. 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 net operating losses 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, 2020 will be realized, no such assurances can be provided. If management's expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to increase our valuation allowance, or reverse amounts recorded currently in the valuation allowance, for all or a portion of our deferred tax assets. Similarly, future adjustments to our valuation allowance may be necessary if the timing of future tax deductions is different than currently expected. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. See Note 1, *Summary of Significant Accounting Policies*, "Litigation Reserves," and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements for additional information.

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

Business Combinations

We account for acquisitions of entities that qualify as business combinations under the acquisition method of accounting. Under the acquisition method of accounting, the total consideration is allocated to the tangible and identifiable intangible assets acquired and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the purchase price over the fair values of these identifiable assets and liabilities is recorded as goodwill. During the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill.

In determining the fair value of assets acquired and liabilities assumed in a business combination, we primarily use the income and multi-period excess earnings approaches to estimate the value of our most significant acquired intangible assets.

Both income approaches utilize projected operating results and cash flows and include significant assumptions such as base revenue, revenue growth rate, projected EBITDA margin, discount rates, rates of increase in operating expenses, and the future effective income tax rates. The valuations of our significant acquired businesses have been performed by a third-party valuation specialist under our management's supervision. We believe that the estimated fair value assigned to the assets acquired and liabilities assumed is based on reasonable assumptions and estimates that marketplace participants would use. However, such assumptions are inherently uncertain and actual results could differ from those estimates. Future changes in our assumptions or the interrelationship of those assumptions may result in purchase price allocations that are different than those recorded in recent years.

Acquisition related costs are not considered part of the consideration paid and are expensed as operating expenses as incurred. Contingent consideration, if any, is measured at fair value initially on the acquisition date as well as subsequently at the end of each reporting period until the contingency is resolved and settlement occurs. Subsequent adjustments to contingent considerations are recorded in our consolidated statements of comprehensive income. We include the results of operations of the businesses acquired as of the beginning of the acquisition dates.

Recent Accounting Pronouncements

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

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use a sensitivity analysis model to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2020, our primary variable rate debt outstanding related to $251.6 million outstanding under our term loan facilities. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $2.1 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $0.4 million over the next 12 months.

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

	December 31, 2020		December 31, 2019	
Financial Instrument:	**Book Value**	**Market Value**	**Book Value**	**Market Value**
5.125% Senior Notes due 2023				
Carrying Value	$ 298.1	$ —	$ 297.3	$ —
Unamortized debt discount and fees	1.9	—	2.7	—
Principal amount	300.0	302.6	300.0	306.6
5.75% Senior Notes due 2024				
Carrying Value	—	—	697.3	—
Unamortized debt discount and fees	—	—	2.7	—
Principal amount	—	—	700.0	708.8
5.75% Senior Notes due 2025				
Carrying Value	346.3	—	345.6	—
Unamortized debt discount and fees	3.7	—	4.4	—
Principal amount	350.0	361.4	350.0	369.7
4.50% Senior Notes due 2028				
Carrying Value	785.0	—	491.7	—
Unamortized debt discount and fees	15.0	—	8.3	—
Principal amount	800.0	840.0	500.0	519.4
4.75% Senior Notes due 2030				
Carrying Value	783.2	—	491.7	—
Unamortized debt discount and fees	16.8	—	8.3	—
Principal amount	800.0	856.0	500.0	520.0
4.625% Senior Notes due 2031				
Carrying Value	393.2	—	—	—
Unamortized debt discount and fees	6.8	—	—	—
Principal amount	400.0	424.9	—	—

Foreign operations, and the related market risks associated with foreign currencies, are currently, and have been, insignificant to our financial position, results of operations, and cash flows. See also Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Item 8. Financial Statements and Supplementary Data

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

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

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

Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2020, 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, 2020. 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, 2020, our internal control over financial reporting was effective.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2020 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, 2020 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 2021 Annual Meeting of Stockholders (the "2021 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 2021 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 2021 Proxy Statement under the captions "Items of Business Requiring Your Vote—Proposal 1—Election of Directors," "Corporate Governance and Board Structure—Corporate Governance—Code of Ethics," "—Board Structure and Committees—Audit Committee," "—Board Composition and Director Nomination Process—Director Nominees Proposed by Stockholders," and "Executive Officers."

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2021 Proxy Statement under the captions "Corporate Governance and Board Structure—Compensation of Directors," "Compensation and Human Capital Committee Matters," and "Executive Compensation."

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

The information required by Item 12 is hereby incorporated by reference from our 2021 Proxy Statement under the captions "Executive Compensation—Equity Compensation Plans" and "Security Ownership of Certain Beneficial Owners and Management."

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by Item 13 is hereby incorporated by reference from our 2021 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 2021 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-65 of this report.

Item 16. Form 10-K Summary

Not applicable.

SIGNATURES

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

ENCOMPASS HEALTH CORPORATION

By: /s/ MARK J. TARR

Mark J. Tarr
President and Chief Executive Officer

Date: February 26, 2021

[Signatures continue on the following page]

POWER OF ATTORNEY

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

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

Signature	Capacity	Date
/s/ MARK J. TARR **Mark J. Tarr**	President and Chief Executive Officer and Director	February 26, 2021
/s/ DOUGLAS E. COLTHARP **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 26, 2021
/s/ ANDREW L. PRICE **Andrew L. Price**	Chief Accounting Officer	February 26, 2021
/s/ LEO I. HIGDON, JR. **Leo I. Higdon, Jr.**	Chairman of the Board of Directors	February 24, 2021
/s/ Greg D. Carmichael **Greg D. Carmichael**	Director	February 25, 2021
/s/ JOHN W. CHIDSEY **John W. Chidsey**	Director	February 25, 2021
/s/ DONALD L. CORRELL **Donald L. Correll**	Director	February 24, 2021
/s/ YVONNE M. CURL **Yvonne M. Curl**	Director	February 24, 2021
/s/ CHARLES M. ELSON **Charles M. Elson**	Director	February 24, 2021
/s/ JOAN E. HERMAN **Joan E. Herman**	Director	February 26, 2021
/s/ LESLYE G. KATZ **Leslye G. Katz**	Director	February 24, 2021
/s/ Patricia A. Maryland **Patricia A. Maryland**	Director	February 25, 2021
/s/ JOHN E. MAUPIN, JR. **John E. Maupin, Jr.**	Director	February 25, 2021
/s/ Nancy M. Schlichting **Nancy M. Schlichting**	Director	February 25, 2021
/s/ L. EDWARD SHAW, JR. **L. Edward Shaw, Jr.**	Director	February 24, 2021
/s/ Terrance Williams **Terrance Williams**	Director	February 24, 2021

Item 15. Financial Statements

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Encompass Health Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Encompass Health Corporation and its subsidiaries (the "Company") as of December 31, 2020 and 2019, and the related consolidated statements of comprehensive income, of shareholders' equity and of cash flows for each of the three years in the period ended December 31, 2020, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020 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, 2020, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, the Company changed the manner in which it accounts for leases in 2019.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

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

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

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Inpatient Rehabilitation Segment Patient Accounts Receivable - Contractual Allowances and Uncollectible Amounts

As described in Notes 1 and 5 to the consolidated financial statements, revenues for inpatient rehabilitation services are recognized (or measured) using the input method as therapy, nursing, and auxiliary services are provided based on management's estimate of the respective transaction price. Management's estimate of the transaction price includes estimates of price concessions for such items as contractual allowances, potential adjustments that may arise from payment and other reviews, and uncollectible amounts. Revenues recognized by the inpatient rehabilitation segment are subject to a number of elements which impact both the overall amount of revenue realized as well as the timing of the collection of the related patient accounts receivable. Factors considered by management in determining the estimated transaction price include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Management assumes these factors will remain consistent with the experience for patients discharged in similar time periods for the same payor classes. The Company's consolidated accounts receivable balance is $696.6 million as of December 31, 2020. Management estimates the allowance for uncollectible amounts based on the aging of accounts receivable, historical collection experience for each type of payor, and other relevant factors. As disclosed by management, changes in general economic conditions (such as increased unemployment rates or periods of recession) are also considered.

The principal considerations for our determination that performing procedures relating to the valuation of inpatient rehabilitation segment patient accounts receivable - contractual allowances and uncollectible amounts is a critical audit matter are the significant judgment by management to estimate patient accounts receivable and the amount that will ultimately be collected under the terms of the third-party payor contracts, which in turn led to significant auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of inpatient rehabilitation segment patient accounts receivable.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of inpatient rehabilitation patient accounts receivable related to contractual allowances and uncollectible amounts, which included controls over management's process, assumptions, and data used to estimate contractual allowances and uncollectible amounts and determine patient accounts receivable. These procedures also included, among others, i) evaluating management's process for developing the estimate for contractual allowances and uncollectible amounts, ii) testing the completeness and accuracy of underlying data used in the model, iii) evaluating the historical accuracy of management's process for developing the estimate of the amount which will ultimately be collected by comparing actual cash collections to the previously recorded patient accounts receivable, and iv) developing an independent expectation of the amount expected to be collected by management. Developing an independent expectation involved calculating the percentage of cash collections as compared to the recorded patient accounts receivable balance for prior years and comparing that percentage to management's collection expectation used to determine the current year estimate for contractual allowances and uncollectible amounts.

Valuation of Inpatient Rehabilitation Segment Patient Accounts Receivable - Denied Claims

As described in Note 1 to the consolidated financial statements, the Company's Medicare claims have been subject to review by Medicare Administrative Contractors ("MACs") under various programs such as "widespread probes" and the Targeted Probe and Educate initiative. The MACs reviews have resulted in denial of payment for claims billed under certain diagnosis codes. As of December 31, 2020, $117.8 million of the Company's patient accounts receivable represented denials that were under review or audit. While the Company generally appeals most of the denials of claims by the MACs, the resolution of these appeals may take several years, and the Company believes that is too early to determine what impact, if any, the resolution of outstanding appeals will have on their historical success rate. Adjustments related to payment reviews by third-party payors or their agents are based on historical experience and success rates in the claims adjudication process.

The principal considerations for our determination that performing procedures relating to the valuation of inpatient rehabilitation patient accounts receivable - denied claims is a critical audit matter are the significant judgment by management to estimate the ultimate expected amount of collectible accounts receivable related to denied claims. This in turn led to a high degree of auditor judgment and effort to evaluate the audit evidence obtained related to the valuation of such denied claims.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of inpatient rehabilitation patient accounts receivable related to denied claims, which included controls around the identification of denied claims at period-end, as well as controls to assess the reasonableness of the success rate estimates. These procedures also included, among others, i) evaluating management's process for developing the estimate for collectible amounts related to denied claims, as well as the relevance and use of the historical billing and collection data as an input to the valuation analysis, ii) evaluating the reasonableness of management's analysis and success rate estimate for denied claims by comparing it to the Company's adjudicated denied claim results, iii) performing testing over a sample of denied revenue transactions by inspecting evidence that the claim was denied, and iv) performing testing over a sample of cash collections from the historical collection data used in management's estimation of collectability.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 26, 2021

We have served as the Company's auditor since 2003.

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2020	**2019**	**2018**
	(In Millions, Except Per Share Data)		
Net operating revenues	**$ 4,644.4**	$ 4,605.0	$ 4,277.3
Operating expenses:			
Salaries and benefits	**2,682.0**	2,573.0	2,354.0
Other operating expenses	**634.4**	623.6	585.1
Occupancy costs	**81.2**	82.3	78.0
Supplies	**200.5**	167.9	158.7
General and administrative expenses	**155.5**	247.0	220.2
Depreciation and amortization	**243.0**	218.7	199.7
Government, class action, and related settlements	**2.8**	—	52.0
Total operating expenses	**3,999.4**	3,912.5	3,647.7
Loss on early extinguishment of debt	**2.3**	7.7	—
Interest expense and amortization of debt discounts and fees	**184.2**	159.7	147.3
Other income	**(10.6)**	(30.5)	(2.2)
Equity in net income of nonconsolidated affiliates	**(3.5)**	(6.7)	(8.7)
Income from continuing operations before income tax expense	**472.6**	562.3	493.2
Provision for income tax expense	**103.8**	115.9	118.9
Income from continuing operations	**368.8**	446.4	374.3
(Loss) income from discontinued operations, net of tax	**—**	(0.6)	1.1
Net and comprehensive income	**368.8**	445.8	375.4
Less: Net and comprehensive income attributable to noncontrolling interests	**(84.6)**	(87.1)	(83.1)
Net and comprehensive income attributable to Encompass Health	**$ 284.2**	$ 358.7	$ 292.3
Weighted average common shares outstanding:			
Basic	**98.6**	98.0	97.9
Diluted	**99.8**	99.4	99.8
Earnings per common share:			
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 2.87**	$ 3.66	$ 2.97
Discontinued operations	**—**	(0.01)	0.01
Net income	**$ 2.87**	$ 3.65	$ 2.98
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 2.85**	$ 3.62	$ 2.92
Discontinued operations	**—**	(0.01)	0.01
Net income	**$ 2.85**	$ 3.61	$ 2.93
Amounts attributable to Encompass Health:			
Income from continuing operations	**$ 284.2**	$ 359.3	$ 291.2
(Loss) income from discontinued operations, net of tax	**—**	(0.6)	1.1
Net income attributable to Encompass Health	**$ 284.2**	$ 358.7	$ 292.3

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

Encompass Health Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31, 2020	As of December 31, 2019
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 224.0**	$ 94.8
Restricted cash	**65.4**	57.4
Accounts receivable	**572.8**	506.1
Prepaid expenses and other current assets	**86.4**	97.5
Total current assets	**948.6**	755.8
Property and equipment, net	**2,206.6**	1,959.3
Operating lease right-of-use assets	**245.7**	276.5
Goodwill	**2,318.7**	2,305.2
Intangible assets, net	**431.3**	476.3
Deferred income tax assets	**—**	2.9
Other long-term assets	**295.0**	304.7
Total assets[1]	**$ 6,445.9**	$ 6,080.7
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	**$ 38.3**	$ 39.3
Current operating lease liabilities	**44.8**	40.4
Accounts payable	**115.0**	94.6
Accrued payroll	**253.8**	210.5
Accrued interest payable	**47.1**	32.4
Other current liabilities	**218.3**	303.8
Total current liabilities	**717.3**	721.0
Long-term debt, net of current portion	**3,250.6**	3,023.3
Long-term operating lease liabilities	**209.6**	243.8
Self-insured risks	**121.2**	117.2
Deferred income tax liabilities	**51.8**	—
Other long-term liabilities	**93.8**	42.7
	4,444.3	4,148.0
Commitments and contingencies		
Redeemable noncontrolling interests	**31.6**	239.6
Shareholders' equity:		
Encompass Health shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 113,835,708 in 2020; 113,230,774 in 2019	**1.1**	1.1
Capital in excess of par value	**2,326.6**	2,369.9
Accumulated deficit	**(242.3)**	(526.5)
Treasury stock, at cost (14,428,235 shares in 2020 and 14,637,858 shares in 2019)	**(497.4)**	(492.3)
Total Encompass Health shareholders' equity	**1,588.0**	1,352.2
Noncontrolling interests	**382.0**	340.9
Total shareholders' equity	**1,970.0**	1,693.1
Total liabilities[1] and shareholders' equity	**$ 6,445.9**	$ 6,080.7

(1) Our consolidated assets as of December 31, 2020 and December 31, 2019 include total assets of variable interest entities of $221.2 million and $215.0 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2020 and December 31, 2019 include total liabilities of the variable interest entities of $46.8 million and $41.1 million, respectively. See Note 3, *Variable Interest Entities.*

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	**Common Stock**	**Capital in Excess of Par Value**	**Accumulated Deficit**	**Accumulated Other Comprehensive Loss**	**Treasury Stock**	**Noncontrolling Interests**	**Total**
				(In Millions)				
December 31, 2017	98.3	$ 1.1	$ 2,747.4	$ (1,176.2)	$ (1.3)	$ (418.5)	$ 242.9	$ 1,395.4
Net income	—	—	—	292.3	—	—	69.2	361.5
Receipt of treasury stock	(0.2)	—	—	—	—	(8.3)	—	(8.3)
Dividends declared ($1.04 per share)	—	—	(103.7)	—	—	—	—	(103.7)
Stock-based compensation	—	—	28.9	—	—	—	—	28.9
Stock options exercised	0.1	—	3.2	—	—	—	—	3.2
Distributions declared	—	—	—	—	—	—	(71.1)	(71.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	38.8	38.8
Fair value adjustments to redeemable noncontrolling interests	—	—	(91.0)	—	—	—	—	(91.0)
Other	0.7	—	3.9	(1.3)	1.3	(1.1)	0.5	3.3
December 31, 2018	98.9	1.1	2,588.7	(885.2)	—	(427.9)	280.3	1,557.0
Net income	—	—	—	358.7	—	—	74.5	433.2
Receipt of treasury stock	(0.3)	—	—	—	—	(16.6)	—	(16.6)
Dividends declared ($1.10 per share)	—	—	(109.3)	—	—	—	—	(109.3)
Stock-based compensation	—	—	32.4	—	—	—	—	32.4
Stock options exercised	0.1	—	1.4	—	—	—	—	1.4
Distributions declared	—	—	—	—	—	—	(70.2)	(70.2)
Repurchases of common stock in open market	(0.8)	—	—	—	—	(45.9)	—	(45.9)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	20.0	20.0
Fair value adjustments to redeemable noncontrolling interests	—	—	(147.6)	—	—	—	—	(147.6)
Consolidation of Yuma Rehabilitation Hospital	—	—	—	—	—	—	25.0	25.0
Other	0.7	—	4.3	—	—	(1.9)	11.3	13.7
December 31, 2019	98.6	1.1	2,369.9	(526.5)	—	(492.3)	340.9	1,693.1
Net income	—	—	—	**284.2**	—	—	**77.2**	**361.4**
Receipt of treasury stock	**(0.2)**	—	—	—	—	**(15.7)**	—	**(15.7)**
Dividends declared ($1.12 per share)	—	—	**(111.6)**	—	—	—	—	**(111.6)**
Exchange of Holdings shares	**0.6**	—	**27.1**	—	—	**19.2**	—	**46.3**
Stock-based compensation	—	—	**29.5**	—	—	—	—	**29.5**
Stock options exercised	**0.1**	—	**1.1**	—	—	—	—	**1.1**
Distributions declared	—	—	—	—	—	—	**(72.1)**	**(72.1)**
Repurchases of common stock in open market	**(0.1)**	—	—	—	—	**(6.1)**	—	**(6.1)**
Capital contributions from consolidated affiliates	—	—	—	—	—	—	**42.8**	**42.8**
Fair value adjustments to redeemable noncontrolling interests	—	—	**1.4**	—	—	—	—	**1.4**
Other	**0.4**	—	**9.2**	—	—	**(2.5)**	**(6.8)**	**(0.1)**
December 31, 2020	**99.4**	**$ 1.1**	**$ 2,326.6**	**$ (242.3)**	**$ —**	**$ (497.4)**	**$ 382.0**	**$ 1,970.0**

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2020	**2019**	**2018**
		(In Millions)	
Cash flows from operating activities:			
Net income	**$ 368.8**	$ 445.8	$ 375.4
Loss (income) from discontinued operations, net of tax	**—**	0.6	(1.1)
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for government, class action, and related settlements	**2.8**	—	52.0
Depreciation and amortization	**243.0**	218.7	199.7
Amortization of debt-related items	**7.2**	4.5	4.0
Loss on early extinguishment of debt	**2.3**	7.7	—
Equity in net income of nonconsolidated affiliates	**(3.5)**	(6.7)	(8.7)
Distributions from nonconsolidated affiliates	**3.8**	6.6	8.3
Stock-based compensation	**29.5**	114.4	85.9
Deferred tax expense (benefit)	**52.4**	40.0	(9.1)
Gain on consolidation of Yuma Rehabilitation Hospital	**—**	(19.2)	—
Other, net	**5.9**	7.4	9.2
Changes in assets and liabilities, net of acquisitions —			
Accounts receivable	**(38.1)**	(22.9)	7.0
Prepaid expenses and other assets	**0.1**	(35.4)	11.5
Accounts payable	**13.6**	(6.1)	6.6
Accrued payroll	**92.0**	13.2	14.8
Other liabilities	**(74.9)**	(128.9)	6.1
Net cash (used in) provided by operating activities of discontinued operations	**(0.2)**	(4.4)	0.8
Total adjustments	**335.9**	188.9	388.1
Net cash provided by operating activities	**704.7**	635.3	762.4
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	**(1.1)**	(231.5)	(143.9)
Purchases of property and equipment	**(396.0)**	(372.4)	(254.5)
Additions to capitalized software costs	**(8.7)**	(13.0)	(16.0)
Purchases of intangible assets	**(3.5)**	(18.7)	(5.7)
Proceeds from sale of restricted investments	**12.6**	17.6	11.6
Purchases of restricted investments	**(8.7)**	(32.9)	(13.3)
Other, net	**(2.1)**	(6.5)	(2.7)
Net cash used in investing activities	**(407.5)**	**(657.4)**	**(424.5)**

(Continued)

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2020	**2019**	**2018**
		(In Millions)	
Cash flows from financing activities:			
Proceeds from bond issuance	**992.5**	1,000.0	—
Principal payments on debt, including pre-payments	**(718.3)**	(519.5)	(20.6)
Borrowings on revolving credit facility	**330.0**	635.0	325.0
Payments on revolving credit facility	**(375.0)**	(620.0)	(390.0)
Principal payments under finance lease obligations	**(22.5)**	(19.5)	(17.9)
Debt amendment and issuance costs	**(20.3)**	(21.5)	(0.1)
Repurchases of common stock, including fees and expenses	**(6.1)**	(45.9)	—
Dividends paid on common stock	**(111.9)**	(108.7)	(100.8)
Purchase of equity interests in consolidated affiliates	**(162.3)**	(162.9)	(65.1)
Distributions paid to noncontrolling interests of consolidated affiliates	**(72.2)**	(79.8)	(75.4)
Taxes paid on behalf of employees for shares withheld	**(15.7)**	(16.6)	(8.3)
Contributions from consolidated affiliates	**34.9**	15.9	12.6
Other, net	**1.0**	(8.3)	19.4
Net cash (used in) provided by financing activities	**(145.9)**	48.2	(321.2)
Increase in cash, cash equivalents, and restricted cash	**151.3**	26.1	16.7
Cash, cash equivalents. and restricted cash at beginning of year	**159.6**	133.5	116.8
Cash, cash equivalents, and restricted cash at end of year	**$ 310.9**	$ 159.6	$ 133.5
Reconciliation of Cash, Cash Equivalents, and Restricted Cash			
Cash and cash equivalents at beginning of period	$ 94.8	$ 69.2	$ 54.4
Restricted cash at beginning of period	57.4	59.0	62.4
Restricted cash included in other long-term assets at beginning of period	7.4	5.3	—
Cash, cash equivalents, and restricted cash at beginning of period	$ 159.6	$ 133.5	$ 116.8
Cash and cash equivalents at end of period	$ 224.0	$ 94.8	$ 69.2
Restricted cash at end of period	65.4	57.4	59.0
Restricted cash included in other long-term assets at end of period	21.5	7.4	5.3
Cash, cash equivalents, and restricted cash at end of period	$ 310.9	$ 159.6	$ 133.5
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	**$ (168.4)**	$ (155.7)	$ (149.6)
Income tax refunds	**1.4**	0.1	0.6
Income tax payments	**(34.3)**	(104.2)	(115.4)
Supplemental schedule of noncash financing activities:			
Adoption of ASC 842	**$ —**	$ 349.4	$ —

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

1. Summary of Significant Accounting Policies:

Organization and Description of Business—

Encompass Health Corporation, incorporated in Delaware in 1984, including its subsidiaries, is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 39 states and Puerto Rico through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. We manage our operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. See Note 19, *Segment Reporting*.

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of Encompass Health and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly-owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to Encompass Health* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

We use the measurement alternative 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 measurement alternative, these investments are recorded at the lower of cost or fair value, as appropriate.

We eliminate all significant intercompany accounts and transactions from our financial results.

Variable Interest Entities—

Any entity considered a variable interest entity ("VIE") is evaluated to determine which party is the primary beneficiary and thus should consolidate the VIE. This analysis is complex, involves uncertainties, and requires significant judgment on various matters. In order to determine if we are the primary beneficiary of a VIE, we must determine what activities most significantly impact the economic performance of the entity, whether we have the power to direct those activities, and if our obligation to absorb losses or receive benefits from the VIE could potentially be significant to the VIE.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) revenue reserves for contractual adjustments and uncollectible amounts; (2) fair value of acquired assets and assumed liabilities in business combinations; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) income tax valuation allowances; (8) uncertain tax positions; (9) fair value of stock options and restricted stock containing a market condition; (10) fair value of redeemable noncontrolling interests; (11) reserves for self-insured healthcare plans; (12) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (13) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties—

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

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

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

If we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements deemed after the fact to have not been appropriate. We could also be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals or agencies, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti-kickback and anti-fraud requirements, could materially and adversely affect us. Specifically, reductions in reimbursements, substantial damages, and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operation, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions. Because we receive a significant percentage of our revenues from Medicare, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows.

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

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

As discussed in Note 18, *Contingencies and Other Commitments*, we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

COVID-19 Pandemic

The rapid onset of the COVID-19 Pandemic (the "pandemic") has caused a disruption to our nation's healthcare system. Such disruption includes reductions in the availability of personal protective equipment ("PPE") to prevent spread of the disease during patient treatment and increases in the cost of PPE. Elective procedures were postponed by physicians and acute-care hospitals and limited by governmental order to preserve capacity for the expected volume of COVID-19 patients and reduce the risk of the spread of COVID-19. Initially, these postponements and limitations were widespread. Now, they are more market or state specific and driven by the extent of the pandemic in those areas. Beginning in March, we experienced decreased volumes in both segments which we believe resulted from a number of conditions related to the pandemic including: lower acute-care hospital censuses due to the deferral of elective surgeries and shelter-in-place orders, restrictive visitation policies in place at acute-care hospitals that severely limit access to patients and caregivers by our clinical rehabilitation liaisons and care transition coordinators, lock downs of assisted living facilities that prevent our home care and hospice clinicians and other care providers from visiting patients, and heightened anxiety among patients and their family members regarding the risk of exposure to COVID-19 during acute-care and post-acute care treatment. In the home health and hospice segment, we also experienced decreases in visits per episode and institutional referrals because of the pandemic, both of which negatively impacted pricing for home health.

In response to the public health emergency associated with the pandemic, Congress and Centers for Medicare and Medicaid Services ("CMS") adopted several statutory and regulatory measures intended to provide relief to healthcare providers in order to ensure patients would continue to have adequate access to care. On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the "CARES Act"), which temporarily suspended sequestration for the period of May 1 through December 31, 2020. The CARES Act also authorized the cash distribution of relief funds from the United States Department of Health and Human Services ("HHS") to healthcare providers. We did not request any relief funds. However, on April 10, 2020, HHS began distributing CARES Act relief funds to various of our bank accounts. We refused the CARES Act relief funds, and our banks returned all the funds to HHS. The Consolidated Appropriations Act, 2021 (the "2021 Budget Act"), signed into law on December 27, 2020, extends the sequestration suspension through March 31, 2021 and provides for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the CARES Act or the 2021 Budget Act. The CARES Act, the 2021 Budget Act, and CMS regulatory actions include a number of other provisions, which are discussed below, affecting our reimbursement and operations in both segments.

Additionally, the CARES Act, 2021 Budget Act, and a series of waivers and guidance issued by CMS suspend various Medicare patient coverage criteria and documentation and care requirements in an effort to provide regulatory relief until the public health emergency for the pandemic has ended. For inpatient rehabilitation, the regulatory relief includes the temporary suspension of the requirement that patients must be able to tolerate a minimum of three hours of therapy per day for five days per week, waiver of certain of the requirements that at least 60% of a facility's patients must have a diagnosis from at least 1 of 13 specified medical conditions, and waiver of the requirement for a physician to conduct and document a post-admission evaluation (as part of the Notice of Final Rulemaking for Fiscal Year 2021 for inpatient rehabilitation facilities under the inpatient rehabilitation facility prospective payment system, CMS removed the post-admission evaluation requirement from the inpatient rehabilitation coverage criteria effective October 1, 2020). In addition, the requirement of physician face-to-face visits at least three days a week may be fulfilled using telehealth. For home health, the relief includes the allowance of nurse practitioners and physician assistants under certain conditions to certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit and expands the use of telehealth. Additionally, CMS expanded the definition of "homebound" to include patients needing skilled services who are homebound due solely to their COVID-19 diagnosis or patients susceptible to contract COVID-19. For hospice, the relief includes the temporary waiver of the requirement to use volunteers and to conduct a nurse visit every two weeks to evaluate aides, as well as the expanded use of telehealth for routine services and patient recertification.

As discussed in Note 10, *Long-term Debt*, in April 2020, we amended our credit agreement primarily to provide covenant relief due to business disruptions from the pandemic. The amendment included, among other things, the carve-out of the pandemic from the definition of material adverse effect for 364 days and modifications to the interest coverage and leverage ratios under the agreement.

The foregoing and other disruptions to our business as a result of the pandemic have had and are likely to continue to have an adverse effect on our business and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Net Operating Revenues—

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

	Inpatient Rehabilitation			Home Health and Hospice			Consolidated		
	Year Ended December 31,			Year Ended December 31,			Year Ended December 31,		
	2020	2019	2018	2020	2019	2018	2020	2019	2018
Medicare	$2,375.5	$2,537.3	$2,451.7	$ 896.0	$ 920.0	$ 794.5	$3,271.5	$3,457.3	$3,246.2
Medicare Advantage	544.9	375.5	306.5	116.2	111.9	88.6	661.1	487.4	395.1
Managed care	371.4	342.7	343.3	47.8	39.1	33.2	419.2	381.8	376.5
Medicaid	140.1	110.3	101.3	15.6	18.4	11.6	155.7	128.7	112.9
Other third-party payors	43.0	43.4	49.0	—	—	—	43.0	43.4	49.0
Workers’ compensation	21.5	29.2	27.4	1.0	1.0	1.5	22.5	30.2	28.9
Patients	19.2	23.3	18.7	0.9	0.6	0.8	20.1	23.9	19.5
Other income	50.6	51.3	48.3	0.7	1.0	0.9	51.3	52.3	49.2
Total	$3,566.2	$3,513.0	$3,346.2	$1,078.2	$1,092.0	$ 931.1	$4,644.4	$4,605.0	$4,277.3

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

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

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

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

Medicare Administrative Contractors ("MACs"), under programs known as "widespread probes," have conducted pre-payment claim reviews of our Medicare billings and in some cases denied payment for certain diagnosis codes. We dispute, or "appeal," most of these denials. As discussed above, our historical experience and success in the adjudication of these appeals is a component of our estimate of transaction price. The Medicare appeals adjudication process is administered by the Office of Medicare Hearings and Appeals ("OMHA") and has been subject to significant delay resulting in a backlog of claims awaiting adjudication. Beginning in March 2020, OMHA increased the frequency of hearings and the number of claims set at each hearing, which we believe adds to the substantive and procedural deficiencies in the appeals process. If current OMHA practices continue, an increased number of unfavorable administrative law judge ("ALJ") decisions could have a negative effect on our long-term ALJ success rate. We are exploring various remedies to counter such negative effects. We believe it is too early to determine what impact, if any, these recent changes in the appeals process will have on our historical success rate or *Net operating revenues*.

In August 2017, CMS announced the Targeted Probe and Educate ("TPE") initiative. Under the TPE initiative, MACs use data analysis to identify healthcare providers with high claim error rates and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE initiative includes up to three rounds of claims review if necessary with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action, which may include extrapolation of error rates to a broader universe of claims or referral to a UPIC or RAC (defined below). We cannot predict the impact of the TPE initiative on our ability to collect claims on a timely basis.

In connection with CMS approved and announced Recovery Audit Contractors ("RACs") audits related to inpatient rehabilitation facilities ("IRFs"), we received requests from 2013 to 2020 to review certain patient files for discharges occurring from 2010 to 2020. These RAC audits are focused on identifying Medicare claims that may contain improper payments. RAC contractors must have CMS approval before conducting these focused reviews which cover issues ranging from billing documentation to medical necessity. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting.

CMS has also established Unified Program Integrity Contractors ("UPICs"), previously known as Zone Program Integrity Contractors. These contractors perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims. Like the RACs, the UPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, UPICs do not receive a specific financial incentive based on the amount of the error as a result of UPIC audits. We have, from time to time, received UPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all UPIC denials arising from these audits using the same process we follow for appealing other denials by contractors.

To date, the Medicare claims that are subject to these post-payment audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2020. Because we have confidence in the medical judgment of both the referring and admitting physicians who assess the treatment needs of their patients, we have appealed substantially all claim denials arising from these audits using the same process we follow for appealing denials by MACs. Due to the delays announced by CMS in the related adjudication process discussed above, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take several years. In addition, because we have limited experience with UPICs and RACs in the context of claims reviews of this nature, we cannot provide assurance as to the timing or outcomes of these disputes. As such, we make estimates for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for denials by MACs. During 2020, 2019, and 2018, our adjustment to *Net operating revenues* for claims that are part of this post-payment claims review process was not material.

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

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

Inpatient Rehabilitation Revenues

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

Home Health and Hospice Revenues

Home Health

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

We bill a portion of reimbursement from each Medicare episode near the start of each episode, and the resulting cash payment is typically received before all services are rendered. Effective January 1, 2021, this early payment process has been eliminated. As we provide home health services to our patients on a scheduled basis over the episode of care in a manner that approximates a pro rata pattern, revenue for the episode of care is recorded over an average length of treatment period using a calendar day prorating method. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the pro rata number of days in the episode which have been completed as of the period end date. As of December 31, 2020 and December 31, 2019, the difference between the cash received from Medicare for a request for anticipated payment on episodes in progress and the associated estimated revenue was not material and was recorded in *Other current liabilities* in our consolidated balance sheets.

We are subject to certain Medicare regulations affecting outlier revenue if our patient's care was unusually costly. Regulations require a cap on all outlier revenue at 10% of total Medicare revenue received by each provider during a cost reporting year. Management has reviewed the potential cap. Adjustments to the transaction price for the outlier cap were not material as of December 31, 2020 and December 31, 2019.

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

Hospice

Medicare revenues for hospice are recognized and recorded on an accrual basis using the input method based on the number of days a patient has been on service at amounts equal to an estimated daily or hourly payment rate. The performance obligation is the rendering of services to the patient during each day that they are on hospice care. The payment rate is dependent on whether a patient is receiving routine home care, general inpatient care, continuous home care or respite care. Adjustments to Medicare revenues are recorded based on an inability to obtain appropriate billing documentation or authorizations acceptable to the payor or other reasons unrelated to credit risk. Hospice companies are subject to two specific payment limit caps under the Medicare program. One limit relates to inpatient care days that exceed 20% of the total days of hospice care provided for the year. The second limit relates to an aggregate Medicare reimbursement cap calculated by the MAC. Adjustments to the transaction price for these caps were not material as of December 31, 2020 and December 31, 2019.

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

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

We record all equity securities with readily determinable fair values and for which we do not exercise significant influence at fair value and record the change in fair value for the reporting period in our consolidated statements of comprehensive income.

We record debt securities with readily determinable fair values and for which we do not exercise significant influence as available-for-sale securities. We carry the available-for-sale securities at fair value and report unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive loss*, which is a separate component of shareholders' equity. We recognize realized gains and losses in our consolidated statements of comprehensive income using the specific identification method. Unrealized losses are charged against earnings when a decline in fair value was determined to be other than temporary. Management reviews several factors to determine whether a loss is other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than cost, the financial condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

Accounts Receivable—

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

	As of December 31,	
	2020	2019
Medicare	66.5 %	72.1 %
Managed care and other discount plans, including Medicare Advantage	25.0 %	20.1 %
Medicaid	3.7 %	3.1 %
Other third-party payors	2.7 %	2.6 %
Workers' compensation	1.2 %	1.2 %
Patients	0.9 %	0.9 %
Total	100.0 %	100.0 %

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

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

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

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

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

Property and Equipment—

We report land, buildings, improvements, vehicles, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the underlying leases. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Vehicles	5
Furniture, fixtures, and equipment	2 to 10

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of comprehensive income. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

Leases—

We adopted ASC 842 effective January 1, 2019. We determine if an arrangement is a lease or contains a lease at inception and perform an analysis to determine whether the lease is an operating lease or a finance lease. We measure right-of-use assets and lease liabilities at the lease commencement date based on the present value of the remaining lease payments. As most of our leases do not provide a readily determinable implicit rate, we estimate an incremental borrowing rate based on the credit quality of the Company and by comparing interest rates available in the market for similar borrowings, and adjusting this amount based on the impact of collateral over the term of each lease. We use this rate to discount the remaining lease payments in measuring the right-of-use asset and lease liability. We use the implicit rate when readily determinable. We recognize lease expense for operating leases on a straight-line basis over the lease term. For our finance leases, we recognize amortization expense from the amortization of the right-of-use asset and interest expense on the related lease liability. Certain of our lease agreements contain annual escalation clauses based on changes in the Consumer Price Index. The changes to the Consumer Price Index, as compared to our initial estimate at the lease commencement date, are treated as variable lease payments and recognized in the period in which the obligation for those payments was incurred. We do not account for lease and non-lease components separately for purposes of establishing right-of-use assets and lease liabilities.

Leases with an initial term of twelve months or less are not recorded on the consolidated balance sheet. We recognize lease expense for these leases on a straight-line basis over the lease term.

Goodwill and Other Intangible Assets—

We are required to test our goodwill and indefinite-lived intangible asset for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform this impairment testing as of October 1st of each year. We recognize an impairment charge for any amount by which the carrying amount of the asset exceeds its implied fair value. We present an impairment charge as a separate line item within income from continuing operations in the consolidated statements of comprehensive income, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our inpatient rehabilitation and home health and hospice reporting units to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe we must perform the quantitative goodwill impairment test, we would determine the fair value of our reporting units using generally accepted valuation techniques including the income approach and the market approach. The income approach includes the use of each reporting unit's discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting units to our market capitalization. When we dispose of a hospital or home health or hospice agency, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

We assess qualitative factors related to our indefinite-lived intangible asset to determine whether it is necessary to perform the quantitative impairment test. If, based on this qualitative assessment, we were to believe we must perform the quantitative goodwill impairment test, we would determine the fair value of our indefinite-lived intangible asset using generally accepted valuation techniques including the relief-from-royalty method. This method is a form of the income approach in which value is equated to a series of cash flows and discounted at a risk-adjusted rate. It is based on a hypothetical royalty, calculated as a percentage of forecasted revenue, that we would otherwise be willing to pay to use the asset, assuming it were not already owned. This approach includes assumptions related to pricing and volume, as well as a royalty rate a hypothetical third party would be willing to pay for use of the asset. When making our royalty rate assumption, we consider rates paid in arms-length licensing transactions for assets comparable to our asset.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2020, 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 measurement alternative 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 measurement alternative, 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 measurement alternative investments and equity method goodwill for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate, and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds, and external appraisals, as appropriate. If an investment or equity method goodwill is considered to be impaired and the decline in value is other than temporary, we record an appropriate write-down.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. Excluding financing costs related to our revolving line of credit (which are included in *Other long-term assets*), financing costs are presented as a direct deduction from the face amount of the financings. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of comprehensive income.

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 comprehensive income.

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 report our restricted marketable securities at fair value. The fair values of our restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.

In addition, there are assets and liabilities that are not required to be reported at fair value on a recurring basis. However, these assets may be recorded at fair value as a result of impairment charges or other adjustments made to the carrying value of the applicable assets. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using quoted prices in private markets, discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the "Redeemable Noncontrolling Interests" section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders' balance.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Likewise, certain members of the home health and hospice management team held similar put rights regarding their interests in our home health and hospice business, as discussed in Note 12, *Redeemable Noncontrolling Interests*. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value*.

The fair value of the *Redeemable noncontrolling interests* related to our home health segment was determined using the product of a 12-month specified performance measure and a specified median market price multiple based on a basket of public health companies and publicly disclosed home health acquisitions with a value of $400 million or more. The fair value of our *Redeemable noncontrolling interests* in our joint venture hospitals is determined primarily using the income approach. The income approach includes the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable hospitals, or *Level 3* inputs. The projected operating results use management's best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures.

Share-Based Payments—

Encompass Health has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees, excluding stock appreciation rights ("SARs"), are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period. Share-based payments to employees in the form of SARs are recognized in the financial statements based on their current fair value and expensed ratably over the applicable service period.

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than $5.0 million, we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length to complete, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of comprehensive income, were $4.6 million, $6.1 million, and $6.7 million in each of the years ended December 31, 2020, 2019, and 2018, respectively.

Income Taxes—

We provide for income taxes using the asset and liability method. This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly. We have used the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation.

Encompass Health and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

Effective January 1, 2015, in connection with a new standard issued by the FASB, we changed our criteria for determining which disposals are presented as discontinued operations. Historically, any component that had been disposed of or was classified as held for sale qualified for discontinued operations reporting unless there was significant continuing involvement with the disposed component or continuing cash flows. In contrast, we now report the disposal of the component, or group of components, as discontinued operations only when it represents a strategic shift that has, or will have, a major effect on our operations and financial results. As a result, the sale or disposal of a single Encompass Health facility or location no longer qualifies as a discontinued operation. This accounting change was made prospectively. No new components were recognized as discontinued operations since this guidance became effective.

In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *(Loss) income from discontinued operations, net of tax*. In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Prepaid expenses and other current assets*, *Other long-term assets*, *Other current liabilities*, and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares, including warrants, that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

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*.

FORM 10-K

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recent Adopted Accounting Pronouncements—

In 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 was effective for us beginning January 1, 2020. The adoption of this guidance resulted in an immaterial change to our consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, "Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract." The update helps entities evaluate the accounting for fees paid by a customer in a cloud computing arrangement (hosting arrangement), by providing guidance in determining when the arrangement includes a software license. It requires entities to account for such costs consistent with the guidance on capitalizing costs associated with developing or obtaining internal-use software. The new guidance was effective for us beginning January 1, 2020. The adoption of this guidance did not have a material impact to our consolidated financial statements.

In March 2020, the Securities and Exchange Commission adopted final rules that amend the financial disclosure requirements in Rule 3-10 of Regulation S-X for guarantors of registered debt securities and subsidiary issuers. The new rules are effective January 4, 2021, but early adoption is permitted. The new rules permit alternative disclosures of summarized financial information, rather than our previous footnote presentation of consolidating financial statements. The new rules also permit the summarized financial information and related disclosures to be presented outside of the consolidated financial statements and accompanying notes. We elected to early adopt the new rules effective July 1, 2020. The summarized financial information and related disclosures are presented in Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* of this report.

Recent Accounting Pronouncements Not Yet Adopted—

In December 2019, the FASB issued ASU 2019-12, "Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes." The standard removes certain exceptions to the general principles of ASC 740 and simplifies other areas such as accounting for outside basis differences of equity method investments. Either prospective or retrospective transition of this standard is dependent upon the specific amendments. The new guidance is effective for us beginning January 1, 2021, including interim periods within that reporting period. We do not expect the adoption of this guidance to have a material impact to 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:

2020 Acquisitions

Inpatient Rehabilitation

During 2020, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In January 2020, we acquired 68% of the operations of a 13-bed inpatient rehabilitation unit in Denver, Colorado through a joint venture with Portercare Adventist Health System. The acquisition was funded through a contribution of our existing 40-bed inpatient rehabilitation hospital in Littleton, Colorado and through contributions of funds which were utilized by the consolidated joint venture to build a 20-bed expansion to the Littleton hospital.

- In May 2020, we acquired 51% of the operations of a 45-bed inpatient rehabilitation unit in Dayton, Ohio through a joint venture with Premier Health Partners. The acquisition was funded through contributions of funds which were utilized by the consolidated joint venture to build a 60-bed de novo inpatient rehabilitation hospital.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from its respective date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including an income approach using primarily discounted cash flow techniques for the noncompete intangible assets and an income approach utilizing the relief from royalty method for the trade name intangible asset. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result from these transactions are deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Property and equipment	$ 0.1
Identifiable intangible assets:	
Noncompete agreements (useful lives of 2 to 3 years)	0.7
Trade name (useful life of 20 years)	0.9
Goodwill	9.2
Total assets acquired	$ 10.9

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2020 is as follows (in millions):

Fair value of assets acquired	$ 1.7
Goodwill	9.2
Fair value of noncontrolling interest owned by joint venture partner	(10.9)
Net cash paid for acquisitions	$ —

Home Health and Hospice

In March 2020, we acquired the assets of Generation Solutions of Lynchburg, LLC in Lynchburg, Virginia. This acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in Central Virginia. The acquisition was funded using cash on hand and was immaterial to our financial position, results of operations, and cash flows.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of the acquired location from the date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired location's mobile workforce and established relationships within the community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. All of the goodwill recorded as a result of this transaction is deductible for federal income tax purposes.

The fair value of the assets acquired at the acquisition date were as follows (in millions):

Identifiable intangible assets:		
Licenses (useful lives of 10 years)	$	0.1
Goodwill		1.0
Total assets acquired	$	1.1

Information regarding the net cash paid for the home health and hospice acquisitions during 2020 is as follows (in millions):

Fair value of assets acquired	$	0.1
Goodwill		1.0
Net cash paid for acquisitions	$	1.1

2020 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2019 (in millions):

	Net Operating Revenues	Net Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2020		
Inpatient Rehabilitation	$ —	$ —
Home Health and Hospice	1.5	—
Combined entity: Supplemental pro forma from 01/01/2020-12/31/2020 (unaudited)	4,650.3	284.8
Combined entity: Supplemental pro forma from 01/01/2019-12/31/2019 (unaudited)	4,626.0	360.8

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2019 period.

2019 Acquisitions

Inpatient Rehabilitation

During 2019, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In July 2019, we acquired approximately 51% of the operations of a 30-bed inpatient rehabilitation unit in Boise, Idaho when Saint Alphonsus Regional Medical Center contributed those operations to a joint venture with us. We funded our ownership interest in that consolidated joint venture through contributions of cash which the joint venture entity used to fund the construction of a 40-bed de novo inpatient rehabilitation hospital.

- In September 2019, we acquired 75% of the operations of Heritage Valley Sewickley Hospital's 11-bed inpatient rehabilitation unit in Sewickley, Pennsylvania, when Heritage Valley Health System, Inc. contributed those operations to our existing joint venture entity in connection with the opening of a new hospital.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from its respective date of acquisition. Assets acquired were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including an income approach using primarily discounted cash flow techniques for the noncompete intangible assets and an income approach utilizing the relief from royalty method for the trade name intangible asset. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result from these transactions 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 assets:		
Noncompete agreement (useful life of 2 years)	$	0.1
Trade name (useful life of 20 years)		0.4
Goodwill		4.8
Total assets acquired		5.3
Total liabilities assumed		0.2
Net assets acquired	$	5.1

Information regarding the net cash paid for the inpatient rehabilitation acquisitions during 2019 is as follows (in millions):

Fair value of assets acquired	$	0.5
Goodwill		4.8
Fair value of liabilities assumed		(0.2)
Fair value of noncontrolling interest owned by joint venture partner		(5.1)
Net cash paid for acquisitions	$	—

Home Health and Hospice

Alacare Acquisition

In July 2019, we completed the acquisition of privately owned Alacare Home Health & Hospice ("Alacare") for a cash purchase price of $217.8 million. The Alacare portfolio consisted of 23 home health locations and 23 hospice locations in Alabama. The acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients across Alabama. We funded the transaction with cash on hand and borrowings under our revolving credit facility.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Alacare from its date of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and certain license intangible assets; an income approach utilizing the relief-from-royalty method for the trade name intangible asset; an income approach utilizing the excess earnings method for the certificates of need; and present value of the remaining lease payments for leases. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. All goodwill recorded as a result from this transaction is deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

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

Accounts receivable	$	10.2
Prepaid expenses and other current assets		1.7
Property and equipment, net		0.7
Identifiable intangible assets:		
Noncompete agreements (useful lives of 5 years)		1.0
Trade name (useful life of 6 months)		1.0
Certificates of need (useful lives of 10 years)		34.3
Licenses (useful lives of 10 years)		14.6
Internal-use software (useful lives of 3 years)		0.1
Goodwill		163.9
Other long-term assets		5.0
Total assets acquired		232.5
Liabilities assumed:		
Current portion of long-term debt		0.3
Accounts payable		1.2
Accrued payroll		8.1
Other current liabilities		2.0
Long-term operating lease liabilities		3.1
Total liabilities assumed		14.7
Net assets acquired	$	217.8

Information regarding the net cash paid for Alacare is as follows (in millions):

Fair value of assets acquired	$	68.6
Goodwill		163.9
Fair value of liabilities assumed		(14.7)
Net cash paid for acquisition	$	217.8

Other Home Health and Hospice Acquisitions

During 2019, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In February 2019, we acquired the assets of Tidewater Home Health, PA in Columbia, South Carolina.
- In March 2019, we acquired the assets and assumed the liabilities of two home health locations from Care Resource Group in East Providence, Rhode Island and Westport, Massachusetts.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management’s estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations’ mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

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

Operating lease right-of-use assets	$ 0.2
Identifiable intangible asset:	
Noncompete agreements (useful lives of 5 years)	0.2
Certificates of need (useful lives of 10 years)	2.0
License (useful life of 10 years)	0.8
Goodwill	10.8
Total assets acquired	14.0
Liabilities assumed:	
Current operating lease liabilities	0.1
Accrued payroll	0.1
Long-term lease liabilities	0.1
Total liabilities assumed	0.3
Net assets acquired	$ 13.7

Information regarding the net cash paid for the home health acquisitions during 2019 is as follows (in millions):

Fair value of assets acquired	$ 3.2
Goodwill	10.8
Fair value of liabilities assumed	(0.3)
Net cash paid for acquisitions	$ 13.7

2019 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2018 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2019		
Inpatient Rehabilitation	$ 4.4	$ (1.3)
Alacare	58.5	1.6
All Other Home Health and Hospice	6.5	(1.5)
Combined entity: Supplemental pro forma from 01/01/2019-12/31/2019 (unaudited)	4,674.6	364.3
Combined entity: Supplemental pro forma from 01/01/2018-12/31/2018 (unaudited)	4,415.9	301.8

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2018 reporting period.

2018 Acquisitions

Inpatient Rehabilitation

During 2018, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In September 2018, we acquired approximately 62% of a 29-bed inpatient rehabilitation unit, including a 60-bed certificate of need, in Murrells Inlet, South Carolina through a joint venture with Tidelands Health. The acquisition was funded through contributions of funds to be utilized by the consolidated joint venture to build a 46-bed de novo inpatient rehabilitation satellite location.
- In October 2018, we acquired approximately 50% of a 68-bed inpatient rehabilitation unit in Winston-Salem, North Carolina through a joint venture with Novant Health Inc. This acquisition was funded through a contribution of a 68-bed de novo inpatient rehabilitation hospital to the consolidated joint venture.
- In November 2018, we acquired approximately 68% of a 17-bed inpatient rehabilitation unit in Littleton, Colorado through a joint venture with Portercare Adventist Health System. The acquisition was funded through the contribution of our existing inpatient rehabilitation hospital in Littleton, Colorado to the consolidated joint venture.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. Estimated fair values were based on various valuation methodologies including: an income approach using primarily discounted cash flow techniques for the noncompete intangible assets; an income approach utilizing the relief from royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need intangible asset. The aforementioned income methods utilize management’s estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital’s historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. None of the goodwill recorded as a result 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):

Property and equipment	$	0.1
Identifiable intangible assets:		
Noncompete agreements (useful lives of 2 to 3 years)		1.4
Trade names (useful lives of 20 years)		2.3
Certificates of need (useful lives of 20 years)		12.5
Goodwill		23.2
Total assets acquired		39.5
Total liabilities assumed		0.2
Net assets acquired	$	39.3

Information regarding the net cash paid for all inpatient rehabilitation acquisitions during 2018 is as follows (in millions):

Fair value of assets acquired	$	16.3
Goodwill		23.2
Fair value of liabilities assumed		(0.2)
Fair value of noncontrolling interest owned by joint venture partner		(39.3)
Net cash paid for acquisitions	$	—

Home Health and Hospice

Camellia Acquisition

On May 1, 2018, we completed the previously announced acquisition of privately owned Camellia Healthcare and affiliated entities ("Camellia"). The Camellia portfolio consists of hospice, home health and private duty locations in Mississippi, Alabama, Louisiana and Tennessee. The acquisition leverages our home health and hospice operating platform across key certificate of need states and strengthens our geographic presence in the Southeastern United States. We funded the cash purchase price of the acquisition with cash on hand and borrowings under our revolving credit facility.

We accounted for this transaction under the acquisition method of accounting and reported the results of operations of Camellia from its date of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and certain license intangible assets; an income approach utilizing the relief-from-royalty method for the trade name intangible asset; and an income approach utilizing the excess earnings method for the certificate of need and certain license intangible assets. The aforementioned income methods utilize management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. All goodwill recorded as a result from this transaction is deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

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

Cash and cash equivalents	$ 1.3
Prepaid expenses and other current assets	0.3
Property and equipment, net	0.6
Identifiable intangible assets:	
Noncompete agreements (useful lives of 5 years)	0.5
Trade name (useful life of 1 year)	1.4
Certificates of need (useful lives of 10 years)	16.6
Licenses (useful lives of 10 years)	21.6
Goodwill	96.1
Total assets acquired	138.4
Liabilities assumed:	
Accounts payable	1.7
Accrued payroll	4.0
Total liabilities assumed	5.7
Net assets acquired	$ 132.7

Information regarding the net cash paid for Camellia is as follows (in millions):

Fair value of assets acquired, net of $1.3 million of cash acquired	$ 41.0
Goodwill	96.1
Fair value of liabilities assumed	(5.7)
Net cash paid for acquisition	$ 131.4

Other Home Health and Hospice Acquisitions

During 2018, we completed the following home health acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide post-acute healthcare services to patients in the applicable geographic areas. Each acquisition was funded using cash on hand.

- In January 2018, we acquired the assets of one hospice location from Golden Age Hospice, Inc. in Oklahoma City, Oklahoma.
- In June 2018, we acquired the assets of one hospice location from Medical Services of America in Las Vegas, Nevada.
- In November 2018, we acquired the assets of one home health and one hospice location from Tenet Hospital Limited in Birmingham, Alabama and El Paso, Texas. We also acquired 75% of the assets of a home health location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.
- In December 2018, we acquired 75% of the assets of a hospice location in Talladega, Alabama through a joint venture with Tenet Hospital Limited.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired locations from their respective dates of acquisition. Assets acquired were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using an income approach. The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to utilize the acquired locations' mobile workforce and established relationships within each community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets. All of the goodwill recorded as a result of these transactions is deductible for federal income tax purposes.

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

Total current assets	$ 0.1
Identifiable intangible asset:	
Noncompete agreements (useful lives of 5 years)	0.2
Certificates of need (useful lives of 10 years)	2.5
Licenses (useful lives of 10 years)	1.5
Goodwill	8.9
Total assets acquired	13.2
Total liabilities assumed	0.1
Net assets acquired	$ 13.1

Information regarding the net cash paid for home health and hospice acquisitions during 2018 is as follows (in millions):

Fair value of assets acquired	$ 4.3
Goodwill	8.9
Fair value of liabilities assumed	(0.1)
Fair value of noncontrolling interest owned by joint venture partner	(0.6)
Net cash paid for acquisitions	$ 12.5

2018 Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned acquisitions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2017 (in millions):

	Net Operating Revenues	Net (Loss) Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2018		
Inpatient Rehabilitation	$ 9.1	$ (1.6)
Camellia	50.0	(0.9)
All Other Home Health and Hospice	3.5	(0.3)
Combined entity: Supplemental pro forma from 01/01/2018-12/31/2018 (unaudited)	4,337.4	300.0
Combined entity: Supplemental pro forma from 01/01/2017-12/31/2017 (unaudited)	4,039.9	289.0

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2017 reporting period.

3. Variable Interest Entities:

As of December 31, 2020 and December 31, 2019, we consolidated nine and eight, respectively, limited partnership-like entities that are VIEs and of which we are the primary beneficiary. Our ownership percentages in these entities range from 50.0% to 75.0% as of December 31, 2020. 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, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 0.1	$ 0.2
Accounts receivable	33.1	29.3
Other current assets	8.6	6.4
Total current assets	41.8	35.9
Property and equipment, net	121.1	122.6
Operating lease right-of-use assets	4.7	6.0
Goodwill	19.2	15.9
Intangible assets, net	3.3	3.3
Deferred income tax assets	0.5	0.7
Other long-term assets	30.6	30.6
Total assets	$ 221.2	$ 215.0
Liabilities		
Current liabilities:		
Current portion of long-term debt	$ 0.9	$ 0.8
Current operating lease liabilities	1.5	1.4
Accounts payable	6.1	6.7
Accrued payroll	11.3	7.7
Other current liabilities	11.7	9.3
Total current liabilities	31.5	25.9
Long-term debt, net of current portion	9.6	10.5
Long-term operating lease liabilities	3.3	4.7
Other long-term liabilities	2.4	—
Total liabilities	$ 46.8	$ 41.1

4. Cash and Marketable Securities:

The components of our investments as of December 31, 2020 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 224.0	$ 86.9	$ —	$ 310.9
Equity securities	—	—	72.6	72.6
Total	$ 224.0	$ 86.9	$ 72.6	$ 383.5

The components of our investments as of December 31, 2019 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 94.8	$ 64.8	$ —	$ 159.6
Equity securities	—	—	63.5	63.5
Debt securities	—	—	12.6	12.6
Total	$ 94.8	$ 64.8	$ 76.1	$ 235.7

Restricted Cash—

As of December 31, 2020 and 2019, *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2020	2019
Current:		
Affiliate cash	$ 17.5	$ 16.0
Self-insured captive funds	47.9	41.4
	65.4	57.4
Noncurrent:		
Self-insured captive funds	21.5	7.4
Total restricted cash	$ 86.9	$ 64.8

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 11, *Self-Insured Risks*. These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures a substantial portion of Encompass Health's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2020 and 2019, $72.6

million and $76.1 million, respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets. During the years ended December 31, 2020, 2019, and 2018, $0.4 million, $1.2 million, and $(1.7) million, respectively, of unrealized net gains (losses) were recognized in our consolidated statements of comprehensive income on marketable securities still held at the reporting date.

A summary of our available-for-sale marketable securities as of December 31, 2019 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities	$ 12.6	$ —	$ —	$ 12.6

Cost in the above tables includes adjustments made to the cost basis of our debt securities for other-than-temporary impairments. During the years ended December 31, 2020, 2019, and 2018, we did not record any impairment charges related to our restricted marketable securities.

Investing information related to our available-for-sale marketable securities is as follows (in millions):

	For the Year Ended December 31,		
	2020	2019	2018
Proceeds from sales and maturities of available-for-sale marketable securities	$ 12.6	$ 6.4	$ —

Our portfolio of marketable securities is comprised of investments in mutual funds that hold investments in a variety of industries and geographies. As discussed in Note 1, *Summary of Significant Accounting Policies*, “Marketable Securities,” when our portfolio included marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examined the severity and duration of the impairments in relation to the cost of the individual investments. We also considered the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

5. Accounts Receivable:

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2020	2019
Current:		
Patient accounts receivable	$ 563.0	$ 498.7
Other accounts receivable	9.8	7.4
	572.8	506.1
Noncurrent patient accounts receivable	123.8	152.1
Accounts receivable	$ 696.6	$ 658.2

Because the resolution of claims that are part of Medicare audit programs can take several years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheet. See Note 1, *Summary of Significant Accounting Policies*, “Net Operating Revenues,” for additional information.

6. Property and Equipment:

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

	As of December 31, 2020	As of December 31, 2019
Land	$ 217.2	$ 169.6
Buildings	2,357.0	2,084.8
Leasehold improvements	232.5	192.6
Vehicles	33.9	31.2
Furniture, fixtures, and equipment	537.9	505.1
	3,378.5	2,983.3
Less: Accumulated depreciation and amortization	(1,374.4)	(1,211.8)
	2,004.1	1,771.5
Construction in progress	202.5	187.8
Property and equipment, net	$ 2,206.6	$ 1,959.3

As of December 31, 2020, approximately 72% of our consolidated *Property and equipment, net* held by Encompass Health Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 10, *Long-term Debt*, and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Liquidity and Capital Resources."

The amount of depreciation expense and interest capitalized is as follows (in millions):

	For the Year Ended December 31, 2020	2019	2018
Depreciation expense	$ 151.1	$ 130.0	$ 124.2
Interest capitalized	$ 6.0	$ 8.3	$ 6.0

FORM 10-K

7. Leases:

We lease real estate, vehicles, and equipment under operating and finance leases with non-cancelable terms generally expiring at various dates through 2037. Our operating and finance leases generally have 1- to 25-year terms, with one or more renewal options, primarily relating to our real estate leases, with terms to be determined at the time of renewal. The exercise of such lease renewal options is at our sole discretion, and to the extent we are reasonably certain we will exercise a renewal option, the years related to that option are included in our determination of the lease term for purposes of classifying and measuring a given lease. Certain leases also include options to purchase the leased property.

The components of lease costs are as follows (in millions):

	For the Year Ended December 31,	
	2020	2019
Operating lease cost	$ 68.5	$ 72.9
Finance lease cost:		
Amortization of right-of-use assets	32.1	30.3
Interest on lease liabilities	29.3	29.5
Total finance lease cost	61.4	59.8
Short-term and variable lease cost	3.7	1.5
Sublease income	(3.2)	(3.2)
Total lease cost	$ 130.4	$ 131.0

Supplemental consolidated balance sheet information related to leases is as follows (in millions):

		As of December 31,	
	Classification	2020	2019
Assets			
Operating lease	Operating lease right-of-use assets	$ 245.7	$ 276.5
Finance lease [(1)]	Property and equipment, net	322.8	327.0
Total leased assets		$ 568.5	$ 603.5
Liabilities			
Current liabilities:			
Operating lease	Current operating lease liabilities	$ 44.8	$ 40.4
Finance lease	Current portion of long-term debt	23.8	21.0
Noncurrent liabilities:			
Operating lease	Long-term operating lease liabilities	209.6	243.8
Finance lease	Long-term debt, net of current portion	367.9	363.1
Total leased liabilities		$ 646.1	$ 668.3

(1) Finance lease assets are recorded net of accumulated amortization of $129.6 million as of December 31, 2020.

	As of December 31,	
	2020	2019
Weighted Average Remaining Lease Term		
Operating lease	8.6 years	9.1 years
Finance lease	11.7 years	13.4 years
Weighted Average Discount Rate		
Operating lease	6.1 %	6.2 %
Finance lease	8.1 %	7.9 %

Maturities of lease liabilities as of December 31, 2020 are as follows (in millions):

Year Ending December 31,	Operating Leases	Finance Leases
2021	$ 58.5	$ 53.9
2022	47.7	50.9
2023	42.5	49.6
2024	35.6	48.4
2025	26.5	49.0
2026 and thereafter	127.5	381.8
Total lease payments	338.3	633.6
Less: Interest portion	(83.9)	(241.9)
Total lease liabilities	$ 254.4	$ 391.7

Supplemental cash flow information related to our leases is as follows (in millions):

	For the Year Ended December 31,	
	2020	2019
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 66.9	$ 70.4
Operating cash flows from finance leases	29.6	30.0
Financing cash flows from finance leases	22.5	19.5
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 39.0	$ 43.8
Finance leases	29.6	34.2

FORM 10-K

8. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2020, 2019, and 2018 (in millions):

	Inpatient Rehabilitation	Home Health and Hospice	Consolidated
Goodwill as of December 31, 2017	$ 1,166.0	$ 806.6	$ 1,972.6
Acquisitions	23.2	105.0	128.2
Goodwill as of December 31, 2018	1,189.2	911.6	2,100.8
Acquisitions	4.8	174.7	179.5
Consolidation of joint venture formerly accounted for under the equity method of accounting	24.9	—	24.9
Goodwill as of December 31, 2019	1,218.9	1,086.3	2,305.2
Acquisitions	9.2	1.0	10.2
Consolidation of joint venture formerly accounted for under the equity method of accounting	—	3.3	3.3
Goodwill as of December 31, 2020	$ 1,228.1	$ 1,090.6	$ 2,318.7

Goodwill increased in 2018 as a result of our acquisitions of Camellia and other inpatient and home health and hospice operations. *Goodwill* increased in 2019 as a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value and our acquisitions of Alacare and other inpatient and home health and hospice operations. *Goodwill* increased in 2020 as a result of our acquisitions of inpatient and home health operations as well as our consolidation of the Jupiter, Florida home health agency and the remeasurement of our previously held equity interest at fair value. See Note 2, *Business Combinations,* and Note 9, *Investments in and Advances to Nonconsolidated Affiliates.*

We performed impairment reviews as of October 1, 2020, 2019, and 2018 and concluded no *Goodwill* impairment existed. As of December 31, 2020, 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:			
2020	$ 197.3	$ (54.5)	$ 142.8
2019	197.2	(40.4)	156.8
Licenses:			
2020	$ 187.9	$ (107.4)	$ 80.5
2019	187.3	(94.1)	93.2
Noncompete agreements:			
2020	$ 75.2	$ (65.8)	$ 9.4
2019	74.2	(62.3)	11.9
Trade name - Encompass:			
2020	$ 135.2	$ —	$ 135.2
2019	135.2	—	135.2
Trade names - all other:			
2020	$ 44.3	$ (25.5)	$ 18.8
2019	41.6	(22.4)	19.2
Internal-use software:			
2020	$ 184.2	$ (141.4)	$ 42.8
2019	173.8	(116.0)	57.8
Market access assets:			
2020	$ 13.2	$ (11.4)	$ 1.8
2019	13.2	(11.0)	2.2
Total intangible assets:			
2020	$ 837.3	$ (406.0)	$ 431.3
2019	822.5	(346.2)	476.3

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

	For the Year Ended December 31,		
	2020	2019	2018
Amortization expense	$ 59.8	$ 58.4	$ 51.4

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
2021	$ 52.9
2022	42.9
2023	37.3
2024	32.1
2025	28.1

9. Investments in and Advances to Nonconsolidated Affiliates:

Investments in and advances to nonconsolidated affiliates as of December 31, 2020 represents our investment in four partially owned subsidiaries, of which three are general or limited partnerships, limited liability companies, or joint ventures in which Encompass Health or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 8% to 51%. We account for these investments using the equity method of accounting and measurement alternative. 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,	
	2020	**2019**
Equity method investments:		
Capital contributions	$ 0.9	$ 0.9
Cumulative share of income	68.7	68.1
Cumulative share of distributions	(66.1)	(63.6)
	3.5	5.4
Measurement alternative investments:		
Capital contributions, net of distributions and impairments	2.0	2.0
Total investments in and advances to nonconsolidated affiliates	$ 5.5	$ 7.4

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,	
	2020	**2019**
Assets—		
Current	$ 2.9	$ 4.2
Noncurrent	7.7	9.3
Total assets	$ 10.6	$ 13.5
Liabilities and equity—		
Current liabilities	$ 0.3	$ 0.5
Noncurrent liabilities	0.2	0.3
Partners' capital and shareholders' equity—		
Encompass Health	3.5	4.9
Outside partners	6.6	7.8
Total liabilities and equity	$ 10.6	$ 13.5

Condensed statements of comprehensive income (in millions):

	For the Year Ended December 31,		
	2020	**2019**	**2018**
Net operating revenues	$ 16.0	$ 32.6	$ 42.6
Operating expenses	(8.1)	(19.1)	(25.6)
Income from continuing operations, net of tax	7.9	13.4	17.1
Net income	7.9	13.4	17.1

As a result of an amendment to the joint venture agreement related to our Jupiter, Florida home health agency, the accounting for this agency changed from the equity method of accounting to a consolidated entity effective January 1, 2020. The amendment revised certain participatory rights held by our joint venture partner resulting in Encompass Health gaining control of this entity from an accounting perspective. We accounted for this change in control as a business combination and consolidated this entity using the acquisition method. The consolidation of the Jupiter, Florida agency did not have a material impact on our financial position, results of operations, or cash flows. As a result of our consolidation of this home health agency and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $3.3 million and we recorded a $2.2 million gain as part of *Other income* during the year ended December 31, 2020.

As a result of an amendment to the joint venture agreement related to Yuma Rehabilitation Hospital, the accounting for this hospital changed from the equity method of accounting to a consolidated entity effective July 1, 2019. The amendment revised certain participatory rights held by our joint venture partner resulting in Encompass Health gaining control of this entity from an accounting perspective. We accounted for this change in control as a business combination and consolidated this entity using the acquisition method. The consolidation of Yuma Rehabilitation Hospital did not have a material impact on our financial position, results of operations, or cash flows. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $24.9 million and we recorded a $19.2 million gain as part of *Other income* during the year ended December 31, 2019.

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10. Long-term Debt:

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

	As of December 31,	
	2020	**2019**
Credit Agreement—		
Advances under revolving credit facility	$ —	$ 45.0
Term loan facilities	251.6	265.2
Bonds payable—		
5.125% Senior Notes due 2023	298.1	297.3
5.75% Senior Notes due 2024	—	697.3
5.75% Senior Notes due 2025	346.3	345.6
4.50% Senior Notes due 2028	785.0	491.7
4.75% Senior Notes due 2030	783.2	491.7
4.625% Senior Notes due 2031	393.2	—
Other notes payable	39.8	44.7
Finance lease obligations	391.7	384.1
	3,288.9	3,062.6
Less: Current portion	(38.3)	(39.3)
Long-term debt, net of current portion	$ 3,250.6	$ 3,023.3

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
2021	$ 38.3	$ 38.3
2022	49.4	49.4
2023	337.3	335.4
2024	252.5	251.0
2025	384.0	380.2
Thereafter	2,273.2	2,234.6
Total	$ 3,334.7	$ 3,288.9

As a result of the 2020 and 2019 redemptions discussed below, we recorded a $2.3 million and $7.7 million *Loss on early extinguishment of debt* in 2020 and 2019, respectively. There were no redemptions resulting in a *Loss on early extinguishment of debt* during 2018.

Senior Secured Credit Agreement—

Credit Agreement

The credit agreement provided for a $270 million term loan commitment and a $1 billion revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in November 2024. Outstanding term loan borrowings are payable in equal consecutive quarterly installments, commencing on December 31, 2019, of 1.25% of the aggregate principal amount of the term loans outstanding as of December 31, 2019, with the remainder due at maturity. We have the right at any time to prepay, in whole or in part, any borrowing under the term loan facilities.

Amounts drawn on the term loan facilities and the revolving credit facility bear interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays Bank PLC's ("Barclays") prime rate and (b) the federal funds rate plus 0.5%, in each case, plus, in each case, an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.375% per annum on the daily amount of the unutilized commitments under the term loan facilities and revolving credit facility. The current interest rate on borrowings under the credit agreement is LIBOR plus 1.50%.

The credit agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, making certain investments, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the credit agreement and (2) our senior secured leverage ratio, as defined in the credit agreement, does not exceed 2x. In the event the senior secured leverage ratio exceeds 2x, these payments are subject to a limit of $200 million plus an amount equal to a portion of available excess cash flows each fiscal year. Our obligations under the credit agreement are secured by the current and future personal property of the Company and its subsidiary guarantors.

In April 2020, we amended our existing credit agreement and the amendments included the following material provisions:

1. Amendment of the financial covenants to update the applicable interest coverage ratio and leverage ratio included in that covenant. The revised applicable ratios are set forth below.

Fiscal Quarters Ending	Interest Coverage Ratio
December 31, 2019 and March 31, 2020	3.00 to 1.00
June 30, 2020, September 30, 2020, December 31, 2020, March 31, 2021, June 30, 2021, September 30, 2021 and December 31, 2021	2.00 to 1.00
March 31, 2022 and thereafter	3.00 to 1.00

Fiscal Quarters Ending	Leverage Ratio
December 31, 2019 and March 31, 2020	4.50 to 1.00
June 30, 2020	4.75 to 1.00
September 30, 2020	5.50 to 1.00
December 31, 2020	6.50 to 1.00
March 31, 2021	6.50 to 1.00
June 30, 2021	6.00 to 1.00
September 30, 2021	5.50 to 1.00
December 31, 2021	5.00 to 1.00
March 31, 2022 and thereafter	4.25 to 1.00

2. Amendment of the definition of “Material Adverse Effect” to carve out the direct and indirect impacts of pandemic and the related legislative, regulatory and executive actions on us from that definition for a period of 364 days; and

3. Amendment of the investment limitation covenant and the restricted payment limitation covenant, to add to each a leverage ratio condition (not in excess of 4.50x) to the provisions allowing unlimited investments and restricted payments in the event certain conditions are met including a senior secured leverage ratio (not in excess of 2:00x) and the existence of no events of default in addition to the new leverage ratio condition.

As of December 31, 2020, no amount was drawn under the revolving credit facility. As of December 31, 2019, $45 million was drawn under the revolving credit facility with an interest rate of 3.2%. As of December 31, 2020 and 2019, $36.7 million and $38.9 million, respectively, were being utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers’ compensation and other insurance coverages and for general corporate purposes. Currently, there are no undrawn term loan commitments under the credit agreement.

Bonds Payable—

Nonconvertible Notes

The Company’s 2023 Notes, 2024 Notes, 2025 Notes, 2028 Notes, 2030 Notes, and 2031 Notes (collectively, the “Senior Notes”) were issued pursuant to an indenture (the “Base Indenture”) dated as of December 1, 2009, as supplemented by each Senior Notes’ respective supplemental indenture (together with the Base Indenture, the “Indenture”). Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our Credit Agreement and other capital markets debt. The Senior Notes are senior, unsecured obligations of Encompass Health and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

2023 Notes

In March 2015, we issued $300 million of 5.125% Senior Notes due 2023 ("the 2023 Notes") at par, which resulted in approximately $295 million in net proceeds from the public offering. The 2023 Notes mature on March 15, 2023 and bear interest at a per annum rate of 5.125%. Inclusive of financing costs, the effective interest rate on the 2023 Notes is 5.4%. Interest on the 2023 Notes is payable semiannually in arrears on March 15 and September 15. We may redeem the 2023 Notes, in whole or in part, at any time on or after March 15, 2018 at the redemption prices set forth below:

Period	Redemption Price*
2019	102.563 %
2020	101.281 %
2021 and thereafter	100.000 %

* Expressed in percentage of principal amount

2024 Notes

In September 2012, we completed a public offering of $275 million aggregate principal amount of the 5.75% Senior Notes due 2024 ("the 2024 Notes") at par. In September 2014, we issued an additional $175 million of the 2024 Notes at a price of 103.625% of the principal amount, in January 2015, we issued an additional $400 million of the 2024 Notes at a price of 102% of the principal amount, and in August 2015, we issued an additional $350 million of our 2024 Notes at a price of 100.5% of the principal amount.

In June 2019, we redeemed $100 million of outstanding principal amount of our 2024 Notes using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 101.917%, which resulted in a total cash outlay of approximately $102 million. In November 2019, we redeemed $400 million of the outstanding principal amount of our 2024 Notes. Pursuant to the terms of the 2024 Notes, this optional redemption was made at a price of 100.958%, which resulted in a total cash outlay of approximately $404 million.

In November 2020, we redeemed the remaining $700 million of outstanding principal amount of the 2024 Notes. Pursuant to the terms of the 2024 Notes, this full redemption was made at a price of par. We used the net proceeds from the 2031 Notes offering, discussed and defined below, together with approximately $300 million of cash on hand to fund the redemption. The 2024 Notes would have matured on November 1, 2024. Inclusive of premiums and financing costs, the effective interest rate on the 2024 Notes was 5.8%. Interest was payable semiannually in arrears on May 1 and November 1 of each year.

2025 Notes

In September 2015, we issued $350 million of 5.75% Senior Notes due 2025 ("the 2025 Notes") at par. The 2025 Notes mature on September 15, 2025 and bear interest at a per annum rate of 5.75%. Inclusive of financing costs, the effective interest rate on the 2025 Notes is 6.0%. Interest on the 2025 Notes is payable semiannually in arrears on March 15 and September 15.

We may redeem the 2025 Notes, in whole or in part, at any time on or after September 15, 2020, at the redemption prices set forth below:

Period	Redemption Price*
2020	102.875 %
2021	101.917 %
2022	100.958 %
2023 and thereafter	100.000 %

* Expressed in percentage of principal amount

2028 and 2030 Notes

In September 2019, we issued $500 million of 4.50% Senior Notes due 2028 (the “2028 Notes”) at par and $500 million of 4.75% Senior Notes due 2030 (the “2030 Notes”) at par. The proceeds from this offering were used to fund the purchase of equity and vested stock appreciation rights from management investors of our home health and hospice segment, redeem a portion of our 2024 Notes as discussed above, and repay borrowings under our revolving credit facility.

In May 2020, we issued an additional $300 million of our 2028 Notes at a price of 99.0% of the principal amount and an additional $300 million of our 2030 Notes at a price of 98.5% of the principal amount, which resulted in approximately $583 million in net proceeds. We used a portion of the net proceeds from this borrowing, together with cash on hand, to repay borrowings under our revolving credit facility.

The 2028 Notes mature on February 1, 2028. Inclusive of financing costs, the effective interest rate on the 2028 Notes is 4.8%. Interest on the 2028 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2028 Notes, in whole or in part, at any time on or after February 1, 2023 at the redemption prices set forth below:

Period	Redemption Price*
2023	102.250 %
2024	101.125 %
2025 and thereafter	100.000 %

* Expressed in percentage of principal amount

The 2030 Notes mature on February 1, 2030. Inclusive of financing costs, the effective interest rate on the 2030 Notes is 5.2%. Interest on the 2030 Notes is payable semiannually in arrears on February 1 and August 1. We may redeem the 2030 Notes, in whole or in part, at any time on or after February 1, 2025 at the redemption prices set forth below:

Period	Redemption Price*
2025	102.375 %
2026	101.583 %
2027	100.792 %
2028 and thereafter	100.000 %

* Expressed in percentage of principal amount

2031 Notes

In October 2020, we issued $400 million aggregate principal amount of 4.625% Senior Notes due 2031 (the "2031 Notes") at par. The 2031 Notes mature on April 1, 2031 and bear interest at a per annum rate of 4.625%. Inclusive of financing costs, the effective interest rate on the 2031 Notes is 4.8%. Interest is payable semiannually in arrears on April 1 and October 1 of each year. We may redeem the 2031 Notes, in whole or in part, at any time on or after April 1, 2026 at the redemption prices set forth below:

Period	Redemption Price*
2026	102.313 %
2027	101.542 %
2028	100.771 %
2029 and thereafter	100.000 %

* Expressed in percentage of principal amount

Other Notes Payable—

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

	As of December 31,		
	2020	2019	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 28.0	$ 28.0	8.1% to 11.2%
Construction of a new hospital	11.8	12.9	5.0%
Other	—	3.8	4.3% to 6.8%
Other notes payable	$ 39.8	$ 44.7	

11. Self-Insured Risks:

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an insurance company licensed by the Cayman Island Monetary Authority. We use HCS to fund our first layer of insurance coverage up to approximately $36 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, 2020, 2019, and 2018 (in millions):

	2020	2019	2018
Balance at beginning of period, gross	$ 157.3	$ 160.9	$ 171.0
Less: Reinsurance receivables	(26.4)	(25.6)	(39.9)
Balance at beginning of period, net	130.9	135.3	131.1
Increase for the provision of current year claims	52.5	46.9	47.1
Decrease for the provision of prior year claims	(15.0)	(12.6)	(8.7)
Expenses related to discontinued operations	(0.2)	(0.1)	(0.2)
Payments related to current year claims	(8.4)	(7.5)	(7.0)
Payments related to prior year claims	(22.9)	(31.1)	(27.0)
Balance at end of period, net	136.9	130.9	135.3
Add: Reinsurance receivables	28.3	26.4	25.6
Balance at end of period, gross	$ 165.2	$ 157.3	$ 160.9

As of December 31, 2020 and 2019, $44.0 million and $40.1 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 1,600 and 1,000 individual claims at December 31, 2020 and 2019, 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.

12. Redeemable Noncontrolling Interests:

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2020	2019	2018
Balance at beginning of period	$ 239.6	$ 261.7	$ 220.9
Net income attributable to noncontrolling interests	7.4	12.6	13.9
Distributions declared	(8.5)	(9.2)	(8.6)
Contribution to joint ventures	3.1	1.0	9.6
Reclassification to noncontrolling interests	—	(11.2)	—
Purchase of redeemable noncontrolling interests	(162.3)	(162.9)	(65.1)
Exchange transaction	(46.3)	—	—
Change in fair value	(1.4)	147.6	91.0
Balance at end of period	$ 31.6	$ 239.6	$ 261.7

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The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests*, as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests*, as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented in the consolidated statements of comprehensive income (in millions):

	For the Year Ended December 31,		
	2020	2019	2018
Net income attributable to nonredeemable noncontrolling interests	$ 77.2	$ 74.5	$ 69.2
Net income attributable to redeemable noncontrolling interests	7.4	12.6	13.9
Net income attributable to noncontrolling interests	$ 84.6	$ 87.1	$ 83.1

On December 31, 2014, we acquired 83.3% of our home health and hospice business when we purchased EHHI Holdings, Inc. ("EHHI"). In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to Encompass Health Home Health Holdings, Inc. ("Holdings"), a subsidiary of Encompass Health and an indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. Those sellers were members of EHHI management, and they contributed a portion of their shares of common stock of EHHI, valued at approximately $64 million on the acquisition date, in exchange for approximately 16.7% of the outstanding shares of common stock of Holdings. At any time after December 31, 2017, each management investor had the right (but not the obligation) to have his or her shares of Holdings stock repurchased by Encompass Health for a cash purchase price per share equal to the fair value. In February 2018, each management investor exercised the right to sell one-third of his or her shares of Holdings stock to Encompass Health, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. On February 21, 2018, Encompass Health settled the acquisition of those shares upon payment of approximately $65 million in cash. In July 2019, we received additional exercise notices, representing approximately 5.6% of the outstanding shares of the common stock of Holdings. In September 2019, Encompass Health settled the acquisition of those shares upon payment of approximately $163 million in cash. As of December 31, 2019, the value of the outstanding shares of Holdings owned by management investors was approximately $208 million. In January 2020, we received additional exercise notices, representing approximately 4.3% of the outstanding shares of the common stock of Holdings. On February 18, 2020, Encompass Health settled the acquisition of those shares upon payment of approximately $162 million in cash. Upon settlement of these exercises, approximately $46 million of the shares of Holdings held by two management investors remained outstanding.

On February 20, 2020, Encompass Health entered into exchange agreements (each, an "Exchange Agreement") with these two management investors, pursuant to which they had the right to exchange all of the remaining shares of Holdings held by them for shares of common stock of Encompass Health (the "EHC Shares"). Each of the Exchange Agreements provided that the management investor must deliver a written exchange notice (an "Exchange Notice") to Encompass Health in order to exchange his or her remaining shares of Holdings for EHC Shares. Each Exchange Agreement further provided that the number of EHC Shares to be delivered to the management investor was to be determined by dividing the fair value of the shares of Holdings held by the management investor on the date of the Exchange Agreement by the last reported sales price of Encompass Health's common stock on the New York Stock Exchange (the "NYSE") on the date of delivery of the Exchange Notice.

On February 20, 2020, Encompass Health received an Exchange Notice from each of the management investors. Based on the last sales price of Encompass Health's common stock on the NYSE on February 20, 2020, Encompass Health delivered an aggregate 560,957 EHC Shares to the management investors. The total number of EHC Shares issued pursuant to the exchange agreements on March 6, 2020 represented less than 0.6% of the outstanding shares of Encompass Health common stock. Encompass Health issued the EHC Shares from its treasury shares. Encompass Health now owns 100% of Holdings and EHHI.

See also Note 13, *Fair Value Measurements.*

13. Fair Value Measurements:

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

		Fair Value Measurements at Reporting Date Using			
As of December 31, 2020	**Fair Value**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Valuation Technique [1]**
Other long-term assets:					
Equity securities	$ 72.6	$ —	$ 72.6	$ —	M
Debt securities	—	—	—	—	M
Redeemable noncontrolling interests	31.6	—	—	31.6	I
As of December 31, 2019					
Other long-term assets:					
Equity securities	$ 63.5	$ —	$ 63.5	$ —	M
Debt securities	12.6	12.6	—	—	M
Redeemable noncontrolling interests	239.6	—	—	239.6	I

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

The decrease in *Redeemable noncontrolling interests* from December 31, 2019 to December 31, 2020 primarily resulted from the final purchase of equity interests in Holdings from management investors discussed in Note 12, *Redeemable Noncontrolling Interests.*

In addition, there are assets and liabilities that are not required to be measured at fair value on a recurring basis. However, these assets may be recorded at fair value as a result of impairment charges or other adjustments made to the carrying value of the applicable assets.

As a result of our consolidation of the Jupiter, Florida home health agency and the remeasurement of our previously held equity interest at fair value, we recorded a $2.2 million gain as part of *Other income* during the year ended December 31, 2020. Also, as a result of our consolidation of Yuma Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value, we recorded a $19.2 million gain as part of *Other income* during the year ended December 31, 2019. We determined the fair value of our previously held equity interest using the income approach valuation technique. The income approach included the use of the hospital's or agency's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the hospital or agency. 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. See Note 9, *Investments in and Advances to Nonconsolidated Affiliates* for additional information. During the year ended December 31, 2018, we did not record any material gains or losses related to assets not required to be measured at fair value on a recurring basis.

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, 2020		As of December 31, 2019	
	Carrying Amount	**Estimated Fair Value**	**Carrying Amount**	**Estimated Fair Value**
Long-term debt:				
Advances under revolving credit facility	$ —	$ —	$ 45.0	$ 45.0
Term loan facilities	251.6	253.1	265.2	266.6
5.125% Senior Notes due 2023	298.1	302.6	297.3	306.6
5.75% Senior Notes due 2024	—	—	697.3	708.8
5.75% Senior Notes due 2025	346.3	361.4	345.6	369.7
4.50% Senior Notes due 2028	785.0	840.0	491.7	519.4
4.75% Senior Notes due 2030	783.2	856.0	491.7	520.0
4.625% Senior Notes due 2031	393.2	424.9	—	—
Other notes payable	39.8	39.8	44.7	44.7
Financial commitments:				
Letters of credit	—	36.7	—	38.9

Fair values for our long-term debt and financial commitments are determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy. See Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements" and "Redeemable Noncontrolling Interests."

14. Share-Based Payments:

The Company has awarded employee stock-based compensation in the form of stock options, SARs, and restricted stock awards ("RSAs") under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded during 2020, 2019, and 2018 was issued under the 2016 Omnibus Performance Incentive Plan, a stockholder-approved plan that reserves and provides for the grant of up to 14,000,000 shares of common stock. This plan allows for the grants of nonqualified stock options, incentive stock options, restricted stock, SARs, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of Encompass Health common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation and human capital committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which are generally three years.

The fair values of the options granted during the years ended December 31, 2020, 2019, and 2018 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,		
	2020	2019	2018
Expected volatility	24.8 %	25.3 %	29.2 %
Risk-free interest rate	1.0 %	2.7 %	2.7 %
Expected life (years)	7.1	7.1	7.1
Dividend yield	2.0 %	2.1 %	2.2 %

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, the Black-Scholes option-pricing model requires the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected term of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. We estimated our dividend yield based on our annual dividend rate and our stock price on the dividend payment dates. Under the Black-Scholes option-pricing model, the weighted-average grant date fair value per share of employee stock options granted during the years ended December 31, 2020, 2019, and 2018 was $15.48, $15.45, and $14.57, 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, 2019	565	$ 43.02		
Granted	113	76.54		
Exercised	(50)	22.53		
Outstanding, December 31, 2020	628	50.65	6.4	$ 20.1
Exercisable, December 31, 2020	413	41.10	5.3	17.2

We recognized approximately $1.5 million, $1.4 million, and $1.1 million of compensation expense related to our stock options for the years ended December 31, 2020, 2019, and 2018, respectively. As of December 31, 2020, there was $2.1 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 22 months. The total intrinsic value of options exercised during the years ended December 31, 2020, 2019, and 2018 was $2.3 million, $3.6 million, and $5.2 million, respectively.

Stock Appreciation Rights—

In conjunction with the EHHI acquisition, we granted SARs based on Holdings common stock to certain members of EHHI management at closing on December 31, 2014. Under a separate plan, we granted 122,976 SARs that vested based on continued employment and an additional maximum number of 129,124 SARs that vested based on continued employment and the extent of the attainment of a specified 2017 performance measure. The maximum number of performance SARs was achieved. Half of the SARs of each type vested on December 31, 2018 and the remainder vested on December 31, 2019. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings' common stock on the exercise date exceeded the per share fair value on the grant date. The fair value of Holdings' common stock was determined using the product of the trailing 12-month specified performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies and publicly disclosed home health acquisitions with a value of $400 million or more.

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

	As of December 31, 2019
Expected volatility	38.6 %
Risk-free interest rate	1.5 %
Expected life (years)	0.3
Dividend yield	— %

We did not include a dividend payment as part of our pricing model because Holdings currently does not pay dividends on its common stock. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of SARs granted in conjunction with the EHHI acquisition was $870.28 as of December 31, 2019. In February 2019, members of the management team exercised a portion of their vested SARs for approximately $13 million in cash. In July 2019, members of the management team exercised the remainder of the vested SARs for approximately $55 million in cash. As of December 31, 2019, the fair value of the remaining 115,545 SARs was approximately $101 million, all of which was included in O*ther current liabilities* in the consolidated balance sheet. In January 2020, members of the management team exercised the remaining SARs, and in February 2020, we settled those awards upon payment of approximately $101 million in cash.

We recognized approximately $0.1 million, $81.9 million, and $56.2 million of compensation expense related to our SARs for the years ended December 31, 2020, 2019, and 2018, respectively.

Restricted Stock—

The RSAs granted in 2020, 2019, and 2018 included service-based awards and performance-based awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For RSAs with a service and/or performance requirement, the fair value of the RSA is determined by the closing price of our common stock on the grant date.

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2019	818	$ 49.49
Granted	555	61.81
Vested	(609)	45.33
Forfeited	(33)	62.04
Nonvested shares at December 31, 2020	731	61.75

The weighted-average grant-date fair value of restricted stock granted during the years ended December 31, 2019 and 2018 was $49.84 and $37.61 per share, respectively. We recognized approximately $25.8 million, $29.5 million, and $27.1 million of compensation expense related to our restricted stock awards for the years ended December 31, 2020, 2019, and 2018, respectively. As of December 31, 2020, there was $35.2 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 20 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2020, 2019, and 2018 was $44.2 million, $45.2 million, and $22.1 million, respectively. We accrue dividends on outstanding RSAs, which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2020, 2019, and 2018, 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, 2020, 2019, and 2018, we issued 32,196, 23,270, and 24,771 RSUs, respectively, with a fair value of $65.39, $64.48, and $62.88, respectively, per unit. We recognized approximately $2.1 million, $1.5 million, and $1.6 million, respectively, of compensation expense upon their issuance in 2020, 2019, and 2018. There was no unrecognized compensation related to unvested shares as of December 31, 2020. During the years ended 2020, 2019, and 2018, we issued an additional 8,987, 8,876, and 8,045, respectively, of RSUs as dividend equivalents. As of December 31, 2020, 577,841 RSUs were outstanding.

15. Employee Benefit Plans:

Substantially all Encompass Health employees are eligible to enroll in Encompass Health-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2020, 2019, and 2018, costs associated with these plans, net of amounts paid by employees and stop-loss recoveries, approximated $189.2 million, $178.4 million, and $164.7 million, respectively.

Encompass Health offers two qualified 401(k) savings plans, the Encompass Health Retirement Investment Plan (the “RIP”) and the Encompass Home Health Savings Plan (the “HHSP”). The RIP allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. Inpatient rehabilitation employees who are at least 21 years of age are eligible to participate in the RIP and all contributions to the plan are in the form of cash. Encompass Health’s employer matching contribution under the RIP is 50% of the first 6% of each participant’s elective deferrals, which vest 100% after three years of service. Participants are always fully vested in their own contributions.

The HHSP allows eligible employees to contribute up to 60% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. All home health and hospice full-time and part-time employees are eligible to participate in the HHSP and all contributions to the plan are in the form of cash. Encompass Health’s employer matching contribution under the HHSP is 25% of the first 3% of each participant’s elective deferrals, which vest gradually over a six-year service period. Participants are always fully vested in their own contributions.

Employer contributions to the RIP and HHSP approximated $25.4 million, $23.4 million, and $21.5 million in 2020, 2019, and 2018, respectively. In 2020, 2019, and 2018, approximately $1.5 million, $1.4 million, and $2.5 million, respectively, from forfeited accounts were used to fund the matching contributions in accordance with the terms of the RIP and HHSP.

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals for all periods presented and individual goals for 2019 and 2018 only. 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 were weighted according to importance, were 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 2021, we expect to pay approximately $17.9 million under the program for the year ended December 31, 2020. In February 2020 and March 2019, we paid $18.4 million and $19.7 million, respectively, under the program for the years ended December 31, 2019 and 2018.

16. Income Taxes:

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,		
	2020	2019	2018
Current:			
Federal	$ 37.7	$ 58.1	$ 103.8
State and other	13.7	17.8	24.2
Total current expense	51.4	75.9	128.0
Deferred:			
Federal	39.5	32.0	(13.7)
State and other	12.9	8.0	4.6
Total deferred expense (benefit)	52.4	40.0	(9.1)
Total income tax expense related to continuing operations	$ 103.8	$ 115.9	$ 118.9

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,		
	2020	2019	2018
Tax expense at statutory rate	21.0 %	21.0 %	21.0 %
Increase (decrease) in tax rate resulting from:			
State and other income taxes, net of federal tax benefit	4.2 %	4.3 %	4.5 %
Increase (decrease) in valuation allowance	1.7 %	0.8 %	(0.4)%
Government, class action, and related settlements	— %	(1.2)%	2.7 %
Noncontrolling interests	(3.7)%	(3.0)%	(3.2)%
Share-based windfall tax benefits	(1.0)%	(1.0)%	(0.4)%
Other, net	(0.2)%	(0.3)%	(0.1)%
Income tax expense	22.0 %	20.6 %	24.1 %

The *Provision for income tax expense* in 2020 was greater than the federal statutory rate primarily due to: (1) state and other income tax expense and (2) the increase in valuation allowance offset by (3) the impact of noncontrolling interests and (4) share-based windfall tax benefits. The *Provision for income tax expense* in 2019 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests, (2) government, class action, and related settlements, and (3) share-based windfall tax benefits offset by (4) state and other income tax expense. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion. The *Provision for income tax expense* in 2018 was greater than the federal statutory rate primarily due to: (1) state and other income tax expense and (2) government, class action, and related settlements offset by (3) the impact of noncontrolling interests.

In addition to the CARES Act provisions previously discussed in Note 1, *Summary of Significant Accounting Policies*, "Risks and Uncertainties," the CARES Act also includes provisions relating to net operating loss carryback periods, alternative minimum tax credit refunds, modifications to the net interest deduction limitations, technical corrections to tax depreciation methods for qualified improvement property and deferral of employer payroll taxes. The CARES Act did not materially impact our effective tax rate for the year ended December 31, 2020, although it will impact the timing of future cash payments for taxes.

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of our deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2020	**2019**
Deferred income tax assets:		
Net operating loss	$ 57.6	$ 61.8
Property, net	6.6	33.9
Insurance reserve	17.8	17.0
Stock-based compensation	15.2	38.3
Operating lease liabilities	22.1	30.6
Other accruals	43.4	23.4
Tax credits	10.5	6.8
Other	0.1	0.2
Total deferred income tax assets	173.3	212.0
Less: Valuation allowance	(46.2)	(38.4)
Net deferred income tax assets	127.1	173.6
Deferred income tax liabilities:		
Revenue reserves	(5.7)	(11.6)
Intangibles	(99.7)	(94.6)
Operating lease right-of-use assets	(21.7)	(30.3)
Carrying value of partnerships	(51.4)	(34.0)
Other	(0.4)	(0.2)
Total deferred income tax liabilities	(178.9)	(170.7)
Net deferred income tax (liabilities) assets	$ (51.8)	$ 2.9

We have state NOLs of $57.6 million that expire in various amounts at varying times through 2031. For the years ended December 31, 2020 and 2019, the net increase in our valuation allowance was $7.8 million, and $4.7 million, respectively. The increase in our valuation allowance in 2020 and 2019 related primarily to our expected ability to use related net operating losses prior to their expiration.

As of December 31, 2020, we have a remaining valuation allowance of $46.2 million. This valuation allowance remains recorded due to uncertainties regarding our ability to utilize a portion of our state NOLs and other credits before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdictions, if the timing of future tax deductions differs from our expectations, or pursuant to changes in state tax laws and rates.

During the third quarter of 2016, we filed a non-automatic tax accounting method change related to billings denied under pre-payment claims reviews conducted by certain of our MACs. In March 2017, the IRS approved our request resulting in establishment of a deferred tax liability and additional cash tax benefits of approximately $51.3 million through December 31, 2017. This amount was reduced to $33.7 million after considering the federal tax rate reduction to 21% provided for in the 2017 Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act included revisions to Internal Revenue Code §451 that might have eliminated a portion of this deferral of revenue for tax purposes. Accordingly, we reversed $23.6 million of our revenue reserves and carrying value of partnerships deferred tax liabilities and recorded a current tax payable for the same amount in the first quarter of 2018. In September 2019, a Treasury Regulation was issued that supported the accounting method change we received calling for continued deferral of denied prepayment claims. As a result, we recorded additional deferred tax liabilities of $22.2 million and a corresponding benefit to our income tax receivable to fully defer taxable income related to pre-payment claim denials as of December 31, 2019. These changes did not have a material impact on our effective tax rate in any period of adjustment and all benefits are expected to reverse as pre-payment claims denials are settled or collected.

As of January 1, 2018, total remaining gross unrecognized tax benefits were $0.3 million, all of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2018, 2019 or 2020. Total remaining gross unrecognized tax benefits were $0.9 million, $0.4 million, and $0.2 million as of December 31, 2018, 2019, and 2020, respectively, all of which would have affected our effective tax rate if recognized.

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

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
January 1, 2018	$ 0.3	$ —
Gross amount of increases in unrecognized tax benefits related to prior periods	0.8	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.2)	—
December 31, 2018	0.9	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.5)	—
December 31, 2019	0.4	0.1
Gross amount of increases in unrecognized tax benefits related to current period	—	0.1
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.2)	(0.2)
December 31, 2020	$ 0.2	$ —

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 2020, 2019, and 2018 was not material. Accrued interest income related to income taxes as of December 31, 2020 and 2019 was not material.

In December 2016, we signed an agreement with the IRS to participate in their Compliance Assurance Process (“CAP”) for the 2017 tax year. CAP is a program in which we and the IRS endeavor to agree on the treatment of significant tax positions prior to the filing of our federal income tax returns. We renewed this agreement in January 2018 for the 2018 tax year, in December 2018 for the 2019 tax year, and in February 2020 for the 2020 tax year. As a result of these agreements, the IRS is currently examining the 2019 and 2020 tax years. In July 2020, the IRS issued a no-change letter effectively closing our 2018 tax year audit. The statute of limitations has expired or we have settled federal income tax examinations with the IRS for all tax years through 2018. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are not currently under audit by any states.

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

17. Earnings per Common Share:

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

	For the Year Ended December 31,		
	2020	2019	2018
Basic:			
Numerator:			
Income from continuing operations	$ 368.8	$ 446.4	$ 374.3
Less: Net income attributable to noncontrolling interests included in continuing operations	(84.6)	(87.1)	(83.1)
Less: Income allocated to participating securities	(1.0)	(1.3)	(0.9)
Income from continuing operations attributable to Encompass Health common shareholders	283.2	358.0	290.3
(Loss) income from discontinued operations, net of tax, attributable to Encompass Health common shareholders	—	(0.6)	1.1
Net income attributable to Encompass Health common shareholders	$ 283.2	$ 357.4	$ 291.4
Denominator:			
Basic weighted average common shares outstanding	98.6	98.0	97.9
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 2.87	$ 3.66	$ 2.97
Discontinued operations	—	(0.01)	0.01
Net income	$ 2.87	$ 3.65	$ 2.98
Diluted:			
Numerator:			
Income from continuing operations	$ 368.8	$ 446.4	$ 374.3
Less: Net income attributable to noncontrolling interests included in continuing operations	(84.6)	(87.1)	(83.1)
Income from continuing operations attributable to Encompass Health common shareholders	284.2	359.3	291.2
(Loss) income from discontinued operations, net of tax, attributable to Encompass Health common shareholders	—	(0.6)	1.1
Net income attributable to Encompass Health common shareholders	$ 284.2	$ 358.7	$ 292.3
Denominator:			
Diluted weighted average common shares outstanding	99.8	99.4	99.8
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 2.85	$ 3.62	$ 2.92
Discontinued operations	—	(0.01)	0.01
Net income	$ 2.85	$ 3.61	$ 2.93

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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,		
	2020	2019	2018
Basic weighted average common shares outstanding	98.6	98.0	97.9
Restricted stock awards, dilutive stock options, and restricted stock units	1.2	1.4	1.9
Diluted weighted average common shares outstanding	99.8	99.4	99.8

Options to purchase approximately 0.2 million and 0.1 million shares of common stock were outstanding as of December 31, 2020 and 2019, respectively, but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive. There were no antidilutive options to purchase shares of common stock outstanding as of December 31, 2018.

In February 2014, our board of directors approved an increase in our common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. On July 24, 2018, the Company's board approved resetting the aggregate common stock repurchase authorization to $250 million. During 2020 and 2019, we repurchased 0.1 million and 0.8 million shares of our common stock in the open market for $6.1 million and $45.9 million, respectively. There were no repurchases of our common stock during 2018.

In July 2017, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.25 per share. The cash dividend of $0.25 per common share was declared and paid in each quarter through July 2018. In July 2018, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.27 per share. The cash dividend of $0.27 per common share was declared and paid in each quarter through July 2019. In July 2019, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.28 per share. The cash dividend of $0.28 per common share was declared and paid in each quarter through January 2021. Future dividend payments are subject to declaration by our board of directors.

18. Contingencies and Other Commitments:

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

Nichols Litigation—

We were named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned *Nichols v. HealthSouth Corp*. In July 2019, we entered into settlement agreements with all but one plaintiff and paid those settling plaintiffs an aggregate amount of cash less than $0.1 million. The remaining plaintiff alleges that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiff is seeking compensatory and punitive damages.

This case was stayed in the circuit court on August 8, 2005. However, the complaint has been amended from time to time, including to request certification as a class action. Additionally, one of the former officers named as a defendant has repeatedly attempted to remove the case to federal district court. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. On December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lacked standing because their claims were derivative in nature, and the claims were time-barred by the statute of limitations. On May 26, 2016, the trial court granted our motion to dismiss. On appeal, the Supreme Court of Alabama reversed the trial court's dismissal on March 23, 2018. On April 6, 2018, we filed an application for rehearing with the Alabama Supreme Court. On March 22, 2019, the Alabama Supreme Court denied our application for rehearing and remanded the case to the trial court for further proceedings. The court has not yet set a date for the trial to begin.

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

Other Matters—

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

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

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are $55.8 million in 2021, $25.0 million in 2022, $17.8 million in 2023, $12.1 million in 2024, $5.8 million in 2025, and $9.4 million thereafter. These contracts primarily relate to software licensing and support.

19. Segment Reporting:

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

- *Inpatient Rehabilitation* - Our national network of inpatient rehabilitation hospitals stretches across 35 states and Puerto Rico, with a concentration of hospitals in the eastern half of the United States and Texas. As of December 31, 2020, we operate 137 inpatient rehabilitation hospitals. We are the sole owner of 87 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 50 jointly owned hospitals. In addition, we manage four inpatient rehabilitation units through management contracts. We provide specialized rehabilitative treatment on both an inpatient and outpatient basis. Our inpatient rehabilitation hospitals provide a higher level of rehabilitative care to patients who are recovering from conditions such as stroke and other neurological disorders, cardiac and pulmonary conditions, brain and spinal cord injuries, complex orthopedic conditions, and amputations.

- *Home Health and Hospice* - As of December 31, 2020, we provide home health services in 241 locations and hospice services in 82 locations across 31 states with a concentration in the southern half of the United States. In addition, one of these home health agencies operates as a joint venture which we account for using the equity method of accounting. We are the sole owner of 317 of these locations. We retain 50.0% to 81.0% ownership in the remaining six jointly owned locations. Our home health services include a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational, and speech therapy, medical social work, and home health aide services. Our hospice services include in-home services to terminally ill patients and their families to address patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support.

The accounting policies of our reportable segments are the same as those described in Note 1, *Summary of Significant Accounting Policies*. All revenues for our services are generated through external customers. See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," for the disaggregation of our revenues. No corporate overhead is allocated to either of our reportable segments. Our chief operating decision maker evaluates the performance of our segments and allocates resources to them based on adjusted earnings before interest, taxes, depreciation, and amortization ("Segment Adjusted EBITDA").

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

	Inpatient Rehabilitation			Home Health and Hospice		
	For the Year Ended December 31,			For the Year Ended December 31,		
	2020	2019	2018	2020	2019	2018
Net operating revenues	$ 3,566.2	$ 3,513.0	$ 3,346.2	$ 1,078.2	$ 1,092.0	$ 931.1
Operating expenses:						
Inpatient rehabilitation:						
Salaries and benefits	1,903.8	1,813.1	1,701.5	—	—	—
Other operating expenses	534.7	521.9	502.3	—	—	—
Supplies	171.0	147.0	140.6	—	—	—
Occupancy costs	61.4	64.8	63.8	—	—	—
Home health and hospice:						
Cost of services sold (excluding depreciation and amortization)	—	—	—	511.3	506.2	438.4
Support and overhead costs	—	—	—	402.8	381.7	323.5
	2,670.9	2,546.8	2,408.2	914.1	887.9	761.9
Other income	(8.0)	(10.5)	(3.6)	—	—	(0.5)
Equity in net income of nonconsolidated affiliates	(3.0)	(5.5)	(7.5)	(0.5)	(1.2)	(1.2)
Noncontrolling interests	83.3	82.6	77.2	1.3	9.5	8.5
Segment Adjusted EBITDA	$ 823.0	$ 899.6	$ 871.9	$ 163.3	$ 195.8	$ 162.4
Capital expenditures	$ 404.6	$ 391.4	$ 264.6	$ 3.6	$ 12.7	$ 11.6

	Inpatient Rehabilitation	Home Health and Hospice	Encompass Health Consolidated
As of December 31, 2020			
Total assets	$ 4,834.7	$ 1,611.2	$ 6,445.9
Investments in and advances to nonconsolidated affiliates	1.5	4.0	5.5
As of December 31, 2019			
Total assets	$ 4,501.4	$ 1,612.8	$ 6,080.7
Investments in and advances to nonconsolidated affiliates	2.0	5.4	7.4

Segment reconciliations (in millions):

	For the Year Ended December 31,		
	2020	2019	2018
Total Segment Adjusted EBITDA	$ 986.3	$ 1,095.4	$ 1,034.3
General and administrative expenses	(155.5)	(247.0)	(220.2)
Depreciation and amortization	(243.0)	(218.7)	(199.7)
Loss on disposal or impairment of assets	(11.6)	(11.1)	(5.7)
Government, class action, and related settlements	(2.8)	—	(52.0)
Loss on early extinguishment of debt	(2.3)	(7.7)	—
Interest expense and amortization of debt discounts and fees	(184.2)	(159.7)	(147.3)
Net income attributable to noncontrolling interests	84.6	87.1	83.1
SARs mark-to-market impact on noncontrolling interests	—	5.0	2.6
Change in fair market value of equity securities	0.4	0.8	(1.9)
Gain on consolidation of joint venture formerly accounted for under the equity method of accounting	2.2	19.2	—
Payroll taxes on SARs exercise	(1.5)	(1.0)	—
Income from continuing operations before income tax expense	$ 472.6	$ 562.3	$ 493.2

	As of December 31, 2020	As of December 31, 2019
Total assets for reportable segments	$ 6,445.9	$ 6,114.2
Reclassification of noncurrent deferred income tax liabilities to net noncurrent deferred income tax assets	—	(33.5)
Total consolidated assets	$ 6,445.9	$ 6,080.7

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

	For the Year Ended December 31,		
	2020	2019	2018
Inpatient rehabilitation:			
Inpatient	$ 3,496.1	$ 3,423.5	$ 3,247.9
Outpatient and other	70.1	89.5	98.3
Total inpatient rehabilitation	3,566.2	3,513.0	3,346.2
Home health and hospice:			
Home health	877.6	918.0	814.6
Hospice	200.6	174.0	116.5
Total home health and hospice	1,078.2	1,092.0	931.1
Total net operating revenues	$ 4,644.4	$ 4,605.0	$ 4,277.3

FORM 10-K

20. Quarterly Data (Unaudited):

	2020				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 1,182.0	$ 1,074.1	$ 1,173.9	$ 1,214.4	$ 4,644.4
Operating earnings [a]	159.3	85.2	151.1	168.3	563.9
Provision for income tax expense	27.1	11.8	26.9	38.0	103.8
Income from continuing operations	108.8	48.2	100.1	111.7	368.8
(Loss) income from discontinued operations, net of tax	(0.1)	0.1	—	—	—
Net income	108.7	48.3	100.1	111.7	368.8
Less: Net income attributable to noncontrolling interests	(21.7)	(14.8)	(22.4)	(25.7)	(84.6)
Net income attributable to Encompass Health	$ 87.0	$ 33.5	$ 77.7	$ 86.0	$ 284.2
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.88	$ 0.34	$ 0.78	$ 0.87	$ 2.87
Discontinued operations	—	—	—	—	—
Net income	$ 0.88	$ 0.34	$ 0.78	$ 0.87	$ 2.87
Diluted earnings per share attributable to Encompass Health common shareholders: [b]					
Continuing operations	$ 0.87	$ 0.34	$ 0.78	$ 0.86	$ 2.85
Discontinued operations	—	—	—	—	—
Net income	$ 0.87	$ 0.34	$ 0.78	$ 0.86	$ 2.85

(a) We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

	2019				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 1,124.0	$ 1,135.0	$ 1,161.6	$ 1,184.4	$ 4,605.0
Operating earnings [(a)]	167.1	152.6	151.2	141.2	612.1
Provision for income tax expense	30.8	23.5	34.3	27.3	115.9
Income from continuing operations	125.7	111.0	119.5	90.2	446.4
Loss from discontinued operations, net of tax	(0.5)	(0.1)	—	—	(0.6)
Net income	125.2	110.9	119.5	90.2	445.8
Less: Net income attributable to noncontrolling interests	(22.9)	(19.7)	(21.9)	(22.6)	(87.1)
Net income attributable to Encompass Health	$ 102.3	$ 91.2	$ 97.6	$ 67.6	$ 358.7
Earnings per common share:					
Basic earnings per share attributable to Encompass Health common shareholders: [(b)]					
Continuing operations	$ 1.05	$ 0.93	$ 0.99	$ 0.69	$ 3.66
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 1.04	$ 0.93	$ 0.99	$ 0.69	$ 3.65
Diluted earnings per share attributable to Encompass Health common shareholders: [(b)]					
Continuing operations	$ 1.04	$ 0.92	$ 0.98	$ 0.68	$ 3.62
Discontinued operations	(0.01)	—	—	—	(0.01)
Net income	$ 1.03	$ 0.92	$ 0.98	$ 0.68	$ 3.61

(a) We define operating earnings as income from continuing operations attributable to Encompass Health before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

EXHIBIT LIST

Effective as of January 1, 2018, we changed our name to Encompass Health Corporation. By operation of law, any reference to “HealthSouth” in these exhibits should be read as “Encompass Health” as set forth in the Exhibit List below.

No.	Description
3.1.1	Amended and Restated Certificate of Incorporation of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.1 to Encompass Health’s Current Report on Form 8-K filed on October 25, 2017).
3.1.2	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to Encompass Health’s Current Report on Form 8-K filed on March 9, 2006).
3.2	Amended and Restated Bylaws of Encompass Health Corporation, effective as of January 1, 2018 (incorporated by reference to Exhibit 3.2 to Encompass Health’s Current Report on Form 8-K filed on October 25, 2017).
4.1.1	Indenture, dated as of December 1, 2009, between Encompass Health Corporation and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health’s 5.125% Senior Notes due 2023, 5.75% Senior Notes due 2024, and 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.7.1 to Encompass Health’s Annual Report on Form 10-K filed on February 23, 2010).
4.1.2	First Supplemental Indenture, dated December 1, 2009, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.7.2 to Encompass Health’s Annual Report on Form 10-K filed on February 23, 2010).
4.1.3	Second Supplemental Indenture, dated as of October 7, 2010, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.2 to Encompass Health’s Current Report on Form 8-K filed on October 12, 2010).
4.1.4	Third Supplemental Indenture, dated October 7, 2010, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.3 to Encompass Health’s Current Report on Form 8-K filed on October 12, 2010).
4.1.5	Fourth Supplemental Indenture, dated September 11, 2012, among Encompass Health Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York (incorporated by reference to Exhibit 4.2 to Encompass Health’s Current Report on Form 8-K filed on September 11, 2012).
4.1.6	Fifth Supplemental Indenture, dated as of March 12, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to Encompass Health’s 5.125% Senior Notes due 2023 (incorporated by reference to Exhibit 4.2 to Encompass Health’s Current Report on Form 8-K filed on March 12, 2015).
4.1.7	Sixth Supplemental Indenture, dated as of August 7, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee (incorporated by reference to Exhibit 4.4 to Encompass Health’s Current Report on Form 8-K filed on August 12, 2015).
4.1.8	Seventh Supplemental Indenture, dated as of September 16, 2015, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to Encompass Health’s 5.75% Senior Notes due 2025 (incorporated by reference to Exhibit 4.2 to Encompass Health’s Current Report on Form 8-K filed on September 21, 2015).
4.1.9	Eighth Supplemental Indenture dated as of September 18, 2019, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.500% Notes due 2028 (incorporated by referenced to Exhibit 4.2 to the Encompass Health’s Current Report on Form 8-K filed on September 18, 2019).
4.1.10	Ninth Supplemental Indenture dated as of September 18, 2019, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.750% Notes due 2030 (incorporated by referenced to Exhibit 4.3 to the Encompass Health’s Current Report on Form 8-K filed on September 18, 2019).

4.1.11	Tenth Supplemental Indenture, dated as of October 5, 2020, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.625% Notes due 2031 (incorporated by reference to Exhibit 4.2 to the Encompass Health's Current Report on Form 8-K filed on October 5, 2020).
4.2	Description of Securities Registered under Section 12 of the Securities Exchange Act of 1934 (Common Stock)(incorporated by reference to Exhibit 4.2 to Encompass Health's Annual Report on Form 10-K filed on February 27, 2020).
10.1.1	Encompass Health Corporation Amended and Restated 2004 Director Incentive Plan (incorporated by reference to Exhibit 10.12.1 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+
10.1.2	Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan)(incorporated by reference to Exhibit 10.12.2 to Encompass Health's Annual Report on Form 10-K filed on March 29, 2006).+
10.2	Form of Indemnity Agreement entered into between Encompass Health Corporation and the directors of Encompass Health (incorporated by reference to Exhibit 10.31 to Encompass Health's Annual Report on Form 10-K filed on June 27, 2005).+
10.3	Encompass Health Corporation Fifth Amended and Restated Change in Control Benefits Plan (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on November 2, 2020).+
10.4	Description of the Encompass Health Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, "Other Matters," in Encompass Health's Quarterly Report on Form 10-Q filed on November 4, 2009).+
10.5	Description of the Encompass Health Corporation Senior Management Bonus and Long-Term Incentive Plans (incorporated by reference to the section captioned "Executive Compensation – Compensation Discussion and Analysis – Elements of Executive Compensation" in Encompass Health's Definitive Proxy Statement on Schedule 14A filed on March 27, 2020).+
10.6.6	Description of the annual compensation arrangement for non-employee directors of Encompass Health Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in Encompass Health's Definitive Proxy Statement on Schedule 14A, filed on March 27, 2020).+
10.7	Encompass Health Corporation Fifth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.2 to Encompass Health's Quarterly Report on Form 10-Q filed on October 31, 2018).+
10.8	Encompass Health Corporation Nonqualified 401(k) Plan (incorporated by reference to Exhibit 4.2 to Encompass Health's Annual Report on Form 10-K filed on February 27, 2020).+
10.9.1	Encompass Health Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to Encompass Health's Registration Statement on Form S-8 filed on August 2, 2011).+
10.9.2	Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.2 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.3	Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.10.3 to Encompass Health's Annual Report on Form 10-K filed on February 22, 2017).+
10.9.4	Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Encompass Health's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.10	Encompass Health Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to Exhibit 10.15 to Encompass Health's Annual Report on Form 10-K filed on February 19, 2013).+
10.11.1	Encompass Health Corporation 2016 Omnibus Performance Incentive Plan (incorporated by reference to Exhibit 10.1.1 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.2	Form of Non-Qualified Stock Option Agreement (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1 to Current Report on Form 8-K filed on December 12, 2016).+
10.11.3	Form of Restricted Stock Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.3 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.11.4	Form of Performance Share Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.4 to Quarterly Report on Form 10-Q filed on July 29, 2016).+

10.11.5	Form of Restricted Stock Unit Award (2016 Omnibus Performance Incentive Plan)(incorporated by reference to Exhibit 10.1.5 to Quarterly Report on Form 10-Q filed on July 29, 2016).+
10.12	Second Amended and Restated Collateral and Guarantee Agreement, dated November 25, 2019, by and among Encompass Health Corporation, certain of its subsidiaries, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.2 to Encompass Health's Current Report on Form 8-K filed on December 2, 2019).
10.13.1	Fifth Amended and Restated Credit Agreement, dated November 25, 2019, by and among Encompass Health Corporation, certain of its subsidiaries, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Bank USA, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to Encompass Health's Current Report on Form 8-K filed on December 2, 2019).
10.13.2	First Amendment to Fifth Amended and Restated Credit Agreement, dated April 24, 2020, by and among Encompass Health Corporation, certain of its subsidiaries, and Barclays Bank PLC, as administrative agent and collateral agent (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on April 27, 2020).
10.14	Homecare Homebase, L.L.C. Restated Client Service and License Agreement, dated December 31, 2014, by and between Homecare Homebase, L.L.C. and EHHI Holdings, Inc. (incorporated by reference to Exhibit 10.19 to Encompass Health's Annual Report on Form 10-K filed on March 2, 2015).*
10.15	Second Amended and Restated Senior Management Agreement, dated as of October 7, 2019, by and among EHHI Holdings, Inc., April Anthony, and Encompass Health Corporation (incorporated by reference to Exhibit 4.2 to Encompass Health's Annual Report on Form 10-K filed on February 27, 2020).+
21.1	Subsidiaries of Encompass Health Corporation
22.1	Subsidiary Guarantors and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.
24.1	Power of Attorney (included as part of signature page).
31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	Sections of the Encompass Health Corporation Annual Report on Form 10-K for the year ended December 31, 2020, formatted in XBRL (eXtensible Business Reporting Language), submitted in the following files:
	101.INS XBRL Instance Document
	101.SCH XBRL Taxonomy Extension Schema Document
	101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
	101.DEF XBRL Taxonomy Extension Definition Linkbase Document
	101.LAB XBRL Taxonomy Extension Label Linkbase Document
	101.PRE XBRL Taxonomy Extension Presentation Linkbase Document
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)

+ Management contract or compensatory plan or arrangement.

* Certain portions of this exhibit have been omitted pursuant to a request for confidential treatment. The nonpublic information has been filed separately with the Securities and Exchange Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

Board of Directors

LEO I. HIGDON, JR.
Chairman of the Board
Encompass Health Corporation
Director
Eaton Vance Corp.
Citizens Financial Group, Inc.

GREG D. CARMICHAEL
Chairman and Chief Executive Officer
Fifth Third Bancorp

JOHN W. CHIDSEY
Chief Executive Officer
Subway Restaurants

DONALD L. CORRELL
Chief Executive Officer and Co-founder
Water Capital Partners, LLC

YVONNE M. CURL
Director/Trustee
VALIC Companies I & II

CHARLES M. ELSON
Edgar S. Woolard, Jr.
Chair in Corporate Governance
Alfred Lerner College of Business
and Economics
University of Delaware

JOAN E. HERMAN
President and Chief Executive Officer
Herman & Associates, LLC

LESLYE G. KATZ
Former Senior Vice President and
Chief Financial Officer
IMS Health, Inc.

PATRICIA A. MARYLAND
Former President and
Chief Executive Officer
Ascension Healthcare

JOHN E. MAUPIN, JR.
Former President and
Chief Executive Officer
Morehouse School of Medicine

NANCY M. SCHLICHTING
Director
Walgreens Boots Alliance, Inc.
Hill-Rom Holdings, Inc.

L. EDWARD SHAW, JR.
Former General Counsel
Aetna, Inc.

MARK J. TARR
President and Chief Executive Officer
Encompass Health Corporation

TERRANCE WILLIAMS
Executive Vice President and
General Manager
Allstate Agency Distribution

Executive Officers

MARK J. TARR
President and Chief Executive Officer

DOUGLAS E. COLTHARP
Executive Vice President and
Chief Financial Officer

BARBARA A. JACOBSMEYER
Executive Vice President and
President, Inpatient Hospitals

PATRICK DARBY
Executive Vice President,
General Counsel and Secretary

ELISSA J. CHARBONNEAU, D.O.
Chief Medical Officer

ANDREW L. PRICE
Chief Accounting Officer

EDMUND M. FAY
Senior Vice President and Treasurer

APRIL ANTHONY
Chief Executive Officer,
Home Health and Hospice

Stockholder Information

PRINCIPLE CORPORATE OFFICES
Encompass Health Corporation
9001 Liberty Parkway
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205.967.7116

INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM
PricewaterhouseCoopers LLP
569 Brookwood Village, Suite 851
Birmingham, AL 35209

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Computershare
P.O. Box 505005
Louisville, KY 40233

By overnight delivery:
462 South 4th Street, Suite 1600
Louisville, KY 40202
1.877.456.7913 (U.S.)
1.781.575.4686 (non-U.S.)
web.queries@computershare.com

STOCK LISTING
Encompass Health Corporation common stock trades on the New York Stock Exchange under the symbol “EHC.”

STOCKHOLDER INFORMATION AND INQUIRIES
Stockholders and investors seeking information concerning stock ownership or Encompass Health generally are invited to contact Encompass Health’s Investor Relations by calling 205.968.6400 or sending an email to investorrelations@encompasshealth.com.

Information concerning Encompass Health can also be obtained through our website at www.encompasshealth.com.

ANNUAL MEETING OF STOCKHOLDERS
The annual meeting will be held on May 6, 2021 at 11:00 a.m., central time, in virtual format and will be accessible online at www.virtualshareholdermeeting.com/EHC2021.

CERTIFICATIONS
Our chief executive officer and chief financial officer have filed with the Securities and Exchange Commission the certifications required by Section 302 of the Sarbanes-Oxley Act of 2002 as Exhibits 31.1 and 31.2 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2020.