Agenda Item #: 4D-1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date:	**December 20, 2022**	**[ ] Consent**	**[ ] Regular**
		[ ] Ordinance	**[X] Public Hearing**
Department:	**Housing and Economic Development**		

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends a motion to adopt: A Resolution of the Palm Beach County Board of County Commissioners (BCC), Florida, making certain findings and designating the real property located at 9645 and 9719 Lantana Road in unincorporated Palm Beach County, Florida 33467, further identified by Property Control Numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432 (the "Subject Property"), as a Brownfield Area pursuant to Section §376.80(2)(c), *Florida Statutes*, to be known as Encompass Health Green Reuse Area, for the purpose of rehabilitation, job creation and promoting economic development; providing for an effective date; and for other purposes.

Summary: On October 18, 2022, the BCC approved two (2) motions to allow for a Brownfield Area designation of the Subject Property: 1) A waiver of the statutory requirement that one of two public hearings be held after 5:00 p.m.; and, 2) The advertising of public hearings on Tuesday, November 15, 2022 at 9:30 a.m., and Tuesday, December 20, 2022 at 9:30 a.m. On November 15, 2022, the BCC approved a motion to approve on first reading and to advertise for adoption on December 20, 2022.

On September 14, 2022, the owner of the property, Encompass Health Rehabilitation of Lake Worth, LLC, submitted an application to the Department of Housing and Economic Development to designate the Subject Property as a Brownfield Area. The western portion of the Subject Property was formerly operated as a mulching business and is impacted by discharges of arsenic. The eastern portion of the property is a single-family home and is impacted by concentrations of the benzo(a)pyrene congeners. The applicant plans to develop the Subject Property as an institutional development (Hospital). The rezoning of the 8.21 acre site was approved by the BCC at the June 23, 2022 Zoning Hearing via Resolution 2022-0630, concurrent with a future land use amendment, to allow for the development of 76,049 square feet of hospital use. The approved Preliminary Site Plan indicates a two phased development with 54,642 square feet and 50 beds within Phase 1, and 21,407 square feet and 30 beds in Phase 2, with 147 parking spaces. Prior to redevelopment, the applicant is seeking a "Brownfield Area" designation under Florida's Brownfields Redevelopment Act. The applicant indicates that the proposed development will create no fewer than 88 permanent, full-time equivalent jobs in its first year of operation which exceeds the minimum job creation threshold of 5 jobs. **No County funds for implementation are required.** District 6 (HJF)

Background and Policy Issues: The Florida Brownfields Redevelopment Act (the "Act"), Sections §376.77-376.86, *Florida Statutes*, were adopted by the Florida Legislature in 1997 to provide incentives for local governments and individuals to voluntarily clean up and redevelop Brownfield Areas. Participation in the program results in environmental cleanup, protection of public health, reuse of infrastructure and job creation. Local governments play a key role in the Brownfields redevelopment program. **Continued on Page 3.**

Attachment(s):
1. Staff Report and Location Map
2. September 14, 2022 Encompass Health Brownfield Area Designation Application
3. November 7, 2022 Community Meeting Agenda
4. Resolution designating 9645 and 9719 Lantana Road a Brownfield Area

Recommended By: Jonathan Brown — **Department Director** — 11/28/2022 — **Date**

Approved By: Sara M. Mills — **Assistant County Administrator** — 12/14/2022 — **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2023	2024	2025	2026	2027
Grant Expenditures					
Operating Costs					
External Revenues					
Program Income					
In-Kind Match (County)					
NET FISCAL IMPACT					

# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included In Current Budget? **Yes ____** **No X**
Does this item include the use of Federal funds? **Yes ____** **No X**

Budget Account No.:

Fund _____ Dept. _____ Unit _____ Object _____ Program Code/Period _____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

No fiscal impact associated with designating the property as a Brownfield Area

C. Departmental Fiscal Review: _____
Shairette Major, Division Director II

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Development and Control Comments:

12/1
OFMB: 12/30 12/1

12/13 12/13/22
Contract Development and Control

B. Legal Sufficiency:

12/13/22
Assistant County Attorney

C. Other Department Review:

_____
Department Director

(THIS SUMMARY IS NOT TO BE USED AS A BASIS FOR PAYMENT)

Background and Policy Issues: Continued from Page 1

Financial and regulatory incentives become available when a local government designates a Brownfield Area by resolution. These financial and regulatory incentives enable local governments and state agencies to partner with the private sector to rehabilitate contaminated properties, create jobs and promote sustainable reuse of properties within designated Brownfield Areas. A "Brownfield Area" is defined by statute as *"…a contiguous area of one of more Brownfield sites, some of which may not be contaminated, and which has been designated by a local government by resolution."* A "Brownfield site" is defined by statute as *"…real property, the expansion, redevelopment or reuse of which may be complicated by actual or perceived environmental contamination."* Section §376.80(12), *Florida Statutes*, does not require a local government to use the term Brownfield within the name of the area being designated.

PALM BEACH COUNTY
DEPARTMENT OF HOUSING AND ECONOMIC DEVELOPMENT
SPECIAL PROJECTS

Application for Brownfields Designation – Staff Report

BCC Public Hearing – Adoption Hearing, December 20, 2022

I. General

Project Name:	**Encompass Health Green Reuse Area**
Request:	Brownfield Area Designation
Location:	North side of Lantana Road, approx. 0.25 miles east of State Road 7.
Address:	(unincorporated Palm Beach County)
Acres:	8.21
Applicant/Owner:	Encompass Health Rehabilitation Hospital of Lake Worth, LLC
Agent:	Brett Brumund , The Goldstein Environmental Law Firm, P.A.
Telephone No.	(305) 640-5300
Project Manager:	Alan Chin Lee, Manager Special Projects Scott Cirino, MPA, Senior Planner

Motion and Title: A Resolution of the Board of County Commissioners (BCC) of Palm Beach County, Florida, making certain findings and designating the real property located at 9645 and 9719 Lantana Road within unincorporated Palm Beach County, Florida 33467, further identified by Property Control Numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432 (the "Subject Property") as a Brownfield Area pursuant to Section §376.80(2)(c), *Florida Statutes*, to be known as Encompass Health Green Reuse Area, for the purpose of rehabilitation, job creation and promoting economic development; providing for an effective date; and, for other purposes.

Staff Recommendation: The Department of Housing and Economic Development (HED) recommends a motion to adopt.

Hearing History: On October 18, 2022, the BCC approved two (2) motions to allow for a Brownfield Area designation of the Subject Property: 1) A waiver of the statutory requirement that one of two public hearings be held after 5:00 p.m.; and, 2) The advertising of public hearings on Tuesday, November 15, 2022 at 9:30 a.m., and Tuesday, December 20, 2022 at 9:30 a.m. On November 15, 2022, the BCC approved a motion to approve on first reading and to advertise for adoption on December 20, 2022.

II. Background

The Florida Brownfields Redevelopment Act, Sections §376.77-376.86, *Florida Statutes*, were adopted by the Florida Legislature in 1997 to provide incentives for local governments and individuals to voluntarily clean up and redevelop Brownfield Areas. Participation in the Florida Brownfields Program (FBP) encourages environmental cleanup, protection of public health, reuse of infrastructure and job creation. Local governments play a key role in the Brownfields program. In accordance with §376.80(1)(b)2, *Florida Statutes*, adoption of a resolution designating a Brownfield Area at the request of any person other than a governmental entity requires two public hearings.

Approval of a Brownfield Area designation will not render the County liable for costs or site remediation, rehabilitation or removal of contamination. Financial and regulatory incentives become available when a local government designates a Brownfield Area by resolution. These incentives enable local governments and state agencies to partner with and/or encourage the private sector to rehabilitate contaminated properties to reduce public health and environmental hazards on sites that are abandoned or underused due to these hazards, create jobs and promote sustainable reuse of properties within designated Brownfield Areas. A "Brownfield Area" is defined by statute as *"...a contiguous area of one of more Brownfield sites, some of which may not be contaminated, and which has been designated by a local government by resolution."* A "Brownfield site" is defined by statute as *"...real property, the expansion, redevelopment or reuse of which may be complicated by actual or perceived environmental contamination."*

For additional information on the FBP, see the Florida Department of Environmental Protection (FDEP) Brownfields Program webpage at https://floridadep.gov/waste/waste-cleanup/content/brownfields-program.

On September 14, 2022, Encompass Health Rehabilitation Hospital of Lake Worth, LLC submitted an application to HED to designate the Subject Property as a Brownfield Area. The Subject Property was formerly operated as a mulching facility and a single-family residence, and is impacted by contaminants (Arsenic, Polycyclic Aromatic Hydrocarbons, and Total Range Petroleum Hydrocarbons) in the soil.

Encompass Health Rehabilitation Hospital plans to develop the Subject Property as an Institutional use (Hospital). The rezoning of the 8.21 acre site was approved at the June 23, 2022 BCC Zoning Hearing (Resolution R-2022-0630), concurrent with a future land use amendment (Ordinance 2022-014), to allow for the development of 76,049 square feet of hospital use.

The approved Preliminary Site Plan indicates a two phased development, with 54,642 square feet and 50 beds within Phase 1, and 21,407 square feet and 30 beds in Phase 2; and 147 parking spaces. Prior to redevelopment, Encompass Health Rehabilitation of Lake Worth, LLC is seeking a "Brownfield Area" designation under Florida's Brownfields Redevelopment Act

Additional Site Data

PCN(s)	00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432
Future Land Use:	Institutional (INT) with an underlying of Low Residential, two units per acres (LR-2) (INST/2)
Zoning:	Institutional and Public Facilities (IPF)
Control No./Name:	1997-00048 (Eastwood Mulch)
Planning Study Area:	N/A
Neighborhood Plan:	N/A
CCRT Area:	N/A
Comm. District	Commissioner Melissa McKinlay, District 6

Since 1997, the FBP has made a wide array of financial, regulatory, and technical incentives available to local governments, businesses, and communities to catalyze environmental cleanup and economic redevelopment of marginalized or otherwise underutilized properties. In doing so, the FBP has encouraged confidence in neighborhood revitalization and investment of private capital in land reuse and job creation in hundreds of communities throughout Florida. According to figures provided by FDEP, as of August 2021, 533 brownfield areas covering nearly 291,679 acres have been designated as brownfields, generating over $3.358 billion in private capital investment, and contributing to the creation of more than 86,360 confirmed and/or projected direct and indirect jobs. Brownfield areas have enjoyed a wide range of redevelopment uses,

including affordable housing, workforce housing, community health clinics, retail and commercial, renewable energy, transportation facilities, and conservation and recreation.

In accordance with §376.80(1)(c)1, *Florida Statutes*, within 30-days of adoption of a Brownfield Area resolution, HED is required to notify and provide a copy of the resolution to the FDEP, and the Palm Beach County Department of Environmental Resource Management, as the local pollution control program under §403.182, *Florida Statutes*.

If approved, Encompass Health Rehabilitation of Lake Worth, LLC will be required to enter into a Brownfield Site Rehabilitation Agreement (BSRA) with FDEP. A BSRA typically includes, but is not limited to:

- a rehabilitation schedule;
- commitment to conduct site rehabilitation under the observation of professional engineers and geologists, in accordance with FDEP quality assurance rules, and state, federal and local laws and the brownfield site contamination criteria, including any applicable requirements for risk based corrective action;
- timeframes for FDEP review of technical reports and plans;
- commitment to secure site access for FDEP and the local pollution control program; and,
- other requirements outlined under §376.80(5), *Florida Statutes.*

III. Staff Analysis

Per §376.80, *Florida Statutes*, prior to approval of a resolution for a Brownfield Area designation proposed by persons other than a government entity, the County must confirm that Encompass Health Hospital has established the following five (5) criteria:

1. Agreement to Redevelop the Brownfield Site. As the first requirement for designation, §376.80(2)(c)1, *Florida Statutes*, provides that *"A person who owns or controls a potential Brownfield Site is requesting the designation and has agreed to rehabilitate and redevelop the brownfield site."*

   The Applicant, Encompass Health Hospital, satisfies the first criterion in that it has made a showing that it controls the Subject Property and agrees to redevelop and rehabilitate it. The Encompass Health Hospital has documented ownership of the Subject Property with Special Warranty Deeds. Also, as previously noted, on June 23, 2022, the BCC approved the Applicant's, concurrent Planning and Zoning applications for institutional use development of the Subject Property. For the reasons discussed herein, Encompass Health Hospital meets the first criterion.

2. Economic Productivity. As the second requirement for designation, §376.80(2)(c)2, *Florida Statues*, provides that *"The rehabilitation and redevelopment of the proposed brownfield site will result in economic productivity of the area, along with the creation of at least 5 new permanent jobs at the brownfield site that are full-time equivalent positions not associated with the implementation of the rehabilitation agreement and are not associated with redevelopment project demolition or construction activities pursuant to the redevelopment of the proposed brownfield site or area...."*

   Encompass Health Hospital satisfies the second criterion because it has sufficiently demonstrated that the rehabilitation and redevelopment will result in economic productivity in the area, comprised of jobs within the health industry. The Applicant indicates that approximately eighty eight jobs will be created with the hospital development. Revenue to local government will include an increase in ad valorem taxes,

and the surrounding community will benefit from the economic impact associated with construction workers, future residents and jobs. The construction workers, future tenants and permanent employees will spend a percentage of their salaries with local merchants who, in turn, will reinvest locally in their respective businesses, as well as the businesses of other local merchants. Such job creation will result in the payment of significant payroll taxes and salaries, thereby benefitting the local economy and increasing the economic productivity in the area. Accordingly, Encompass Health Hospital meets this second criterion.

3. Consistency with Local Comprehensive Plan and Permittable Use Under Local Land Development Regulations. As the third requirement for designation, §376.80(2)(c)3,Florida Statutes provides that *"The redevelopment of the proposed brownfield site is consistent with the local comprehensive plan and is a permittable use under the applicable local land development regulations."*

   As previously noted, the Encompass Health Hospital satisfies this criterion with the recent June 23, 2022 BCC approval of concurrent future use atlas amendment and rezoning. The proposed institutional use development is permitted under the approved Institutional and Public Facilities (IPF) Zoning district (Resolution R-2022-0630), which is consistent with the Institutional with an underlying 2 units per acre (INST/2) on 8.21 acres (Ord. 2022-014) future land use designations. Planning Division comments included in the June 23, 2022 Zoning Staff report states *"Should the BCC approve the amendment request, then the proposed use or amendment is consistent with the Goals, Objectives and Policies of the Comprehensive Plan".* Accordingly, the Encompass Health Hospital meets this third criterion.

4. Public Notice and Comment. As the fourth requirement for designation, §376.80(2)(c)4, *Florida Statutes*, stipulates that *"Notice of the proposed rehabilitation of the brownfield area has been provided to neighbors and nearby residents of the proposed area to be designated, and the person proposing the area for designation has afforded to those receiving notice the opportunity for comments and suggestions about rehabilitation. Notice pursuant to this subsection must be posted in the affected area."*

   Encompass Health Hospital has demonstrated satisfaction of the fourth criterion by providing proof of posting notice at the Subject Property, and publishing notice in the Palm Beach Post, and posting legal ad on the local community bulletin at the Palm Beach County Greencare's Branch. The notices advised that Encompass Health Hospital, would conduct a public meeting, to afford an opportunity for members of the public to provide comments and suggestions regarding Brownfield Area designation, development, and rehabilitation of the Subject Property. The notices provided the Agent phone or mail contacts to obtain additional information regarding the community meeting or to provide comments or suggestions before or after the community meeting. It was also provided the County Brownfield Program Manager contact for additional inquiries regarding the designation process.

   HED Staff attended the November 7, 2022 public meeting coordinated by the Applicant. Brett Brumund, Esq., of The Goldstein Environmental Law Firm, P.A., who represents the Applicant, attended the public meeting to provide printed informational handouts and power point presentation discussing the environmental conditions and proposed site rehabilitation. However, no community members or other interest parties attended the public meeting, and as of this writing, no inquires have been made of HED Staff regarding the Brownfield designation process. For the reasons discussed herein, Encompass Health Hospital satisfies the fourth criterion.

5. Reasonable Financial Assurance. As the fifth requirement for designation, §376.80(2)(c)5, *Florida Statutes*, provides that *"The person proposing the area for designation has provided reasonable assurances that he or she has sufficient financial resources to implement and complete the rehabilitation agreement and redevelopment plan."*

   Encompass Health Hospital satisfies the fifth criterion in that it has provided the County with summary information. The total capital budget of $49.7 million for the project is to be fully funded through the financial resources of Encompass' principal, Encompass Health Corporation. Encompass Health is the largest owner and operator of rehabilitation hospitals in the United States with a national footprint of 152 hospitals. Accordingly, the success of previous projects, the magnitude of the capital previously raised, the quality of the development previously achieved, and the resources of its principal provide reasonable assurances that Encompass has sufficient financial resources to implement and complete the rehabilitation agreement in redevelopment plan. For the reasons discussed herein, Encompass Health Hospital satisfies the fifth criterion.

IV. Fiscal Impact Analysis

A Brownfield Area designation shall not render Palm Beach County liable for costs or site remediation, rehabilitation, and economic development or source removal, which terms are defined in Section 376.79(19) and (20), Florida Statutes, or for any other costs, above and beyond the costs attributed to the adoption of the Resolution. Accordingly, adoption of staff's recommendation to approve the designation request will not have any adverse impact on the County's operations.

V. Conclusions and Recommendations

Based on the foregoing, the Board of County Commissioners should designate the 8.21 acre area comprised of two parcels located at 9645 and 9719 Lantana Road (PCN's 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432) as a Brownfields Area (see Exhibits A and B), to be referred to as the **Encompass Health Green Reuse Area,"** in accordance with Florida's Brownfields Redevelopment Act.

VI. Exhibits

A. Site Map
B. Legal Description

Exhibit A

Location Map
Encompass Health Green Reuse Area

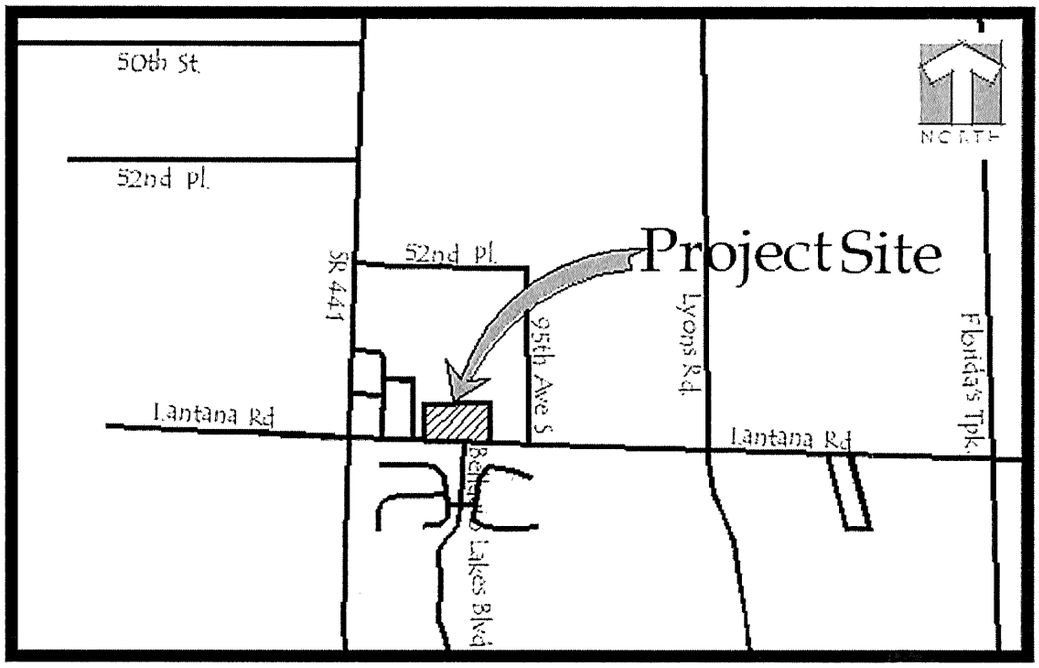


Exhibit B

Legal Description
Encompass Health Green Reuse Area

PARCEL 1
THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS THE SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

TOGETHER WITH

PARCEL 2
THAT PART OF THE WEST HALF OF TRACT 43, BLOCK 34, LYING NORTH OF THE RIGHT-OF-WAY FOR LANTANA ROAD, THE PALM BEACH FARMS CO., PLAT NO. 3, ACCORDING TO THE PLAT THEREOF, AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, LESS ADDITIONAL RIGHT-OFWAY FOR LANTANA ROAD CONVEYED TO PALM BEACH COUNTY IN OFFICIAL RECORDS BOOK 11213, PAGE 937, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

SAID LANDS SITUATE IN PALM BEACH COUNTY, FLORIDA AND CONTAINING 357,759 SQUARE FEET OR 8.213 ACRES, MORE OR LESS.

SUBJECT TO EASEMENTS, RESTRICTIONS, RESERVATIONS, COVENANTS, AND RIGHTS-OF-WAY OF RECORD.

THE GOLDSTEIN ENVIRONMENTAL LAW FIRM, P.A.

Brownfields, Transactions, Due Diligence, Development, Permitting, Cleanups & Compliance

2100 Ponce de Leon Boulevard, Suite 710
Coral Gables, Florida 33134
Telephone: (305) 777-1680
www.goldsteinenvlaw.com

Brett C. Brumund, Esq.
Direct Dial: (305) 640-5300
Email: bbrumund@goldsteinenvlaw.com

Via Email Only

September 14, 2022

Mr. Jonathan Brown, Director
Housing and Economic Development
Palm Beach County
100 Australian Avenue, 5th Floor
West Palm Beach, FL 33406

Re: Application for Designation Property Located at 9719 and 9645 Lantana Road, Lake Worth, Palm Beach County, Florida 33467 as a Brownfield Area by Palm Beach County Pursuant to § 376.80(2)(c), Florida Statutes

Dear Mr. Brown:

On behalf of Encompass Health Rehabilitation Hospital of Lake Worth, LLC ("Encompass"), we are pleased to submit the enclosure Application for Brownfield Area Designation of the property located at 9719 and 9645 Lantana Road, Lake Worth, Palm Beach County, FL, 33467 Parcel Numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432 (the "Subject Property") pursuant to Chapter 376.80(2)(c), Florida Statutes, of Florida's Brownfields Redevelopment Act. When fully redeveloped, the Subject Property will consist of a 50-bed inpatient rehabilitation hospital. A legal description, aerial photograph, and property cards depicting the location of the Subject Property are enclosed at Exhibit A.

Encompass is applying for this designation due to the manner in which the Subject Property's current and historical uses have complicated redevelopment. Encompass identified both soil and groundwater contamination during due diligence activities which has resulted in significant engineering, financing, construction, and liability challenges that Encompass must overcome to proceed with redevelopment. Accordingly, the requested designation, if granted, will allow Encompass to access limited but important state-based economic incentives to help underwrite the costs associated with managing the environmental risk as well as, generally, to put the project on more certain financial ground. In this sense, the designation will not only play a critical role in the successful redevelopment of the Subject Property, but also in the larger revitalization efforts for this area of Palm Beach County.

In considering this request for designation, a local government must evaluate and apply the criteria set forth in Chapter 376.80(2)(c), Florida Statutes. As reflected in Palm Beach County's Application for Brownfields Designation, incorporated herein at Exhibit B, which is supplemented by the Statement of Eligibility incorporated herein at Exhibit C, Encompass meets such statutory criteria. Accordingly,

based on the foregoing, we respectfully request that staff favorably review this request and recommend it for approval to the Palm Beach County Board of County Commissioners. Of course, as you evaluate the application and supporting materials, please feel free to contact us should you have any questions or require further information. Thank you.

Very truly yours,

THE GOLDSTEIN ENVIRONMENTAL LAW FIRM, P.A.

Brett C. Brumund
/bcb

Enclosures

cc: Mr. Alan Chin Lee, Department of Housing and Economic Sustainability
Encompass Health Rehabilitation Hospital of Lake Worth, LLC

Exhibit A

Property Detail

Parcel Control Number:	00-42-44-27-05-004-041	Location Address:	9645 LANTANA RD
Owners:	AGUIRRE EVANGELINE C ,CROOKS STAN L		
Mailing Address:	9645 LANTANA RD,LAKE WORTH FL 46761144		
Last Sale:	NOV-2010	Book/Page#:	24208 / 1205
		Price:	$260,000
Property Use Code:	01000 - SINGLE FAMILY	Zoning:	AR - Agricultural Residential (00-UNINCORPORATED)
Legal Description:	PALM BEACH FARMS CO PL E 1/2 OF TR 44 (LESS S 543 FT LANTANA RD R/W) BLK 44	Total SF:	6960
		Acres	4.16

2022 Values (Preliminary)

Improvement Value	$ 21,855
Land Value	$296,608
Total Market Value	$618,463
Assessed Value	$487,655
Exemption Amount	$50,000
Taxable Value	$437,655

All values are as of January 1st each year.

2022 Taxes (Preliminary)

Ad Valorem	$7,532
Non Ad Valorem	$749
Total Tax	$8,281

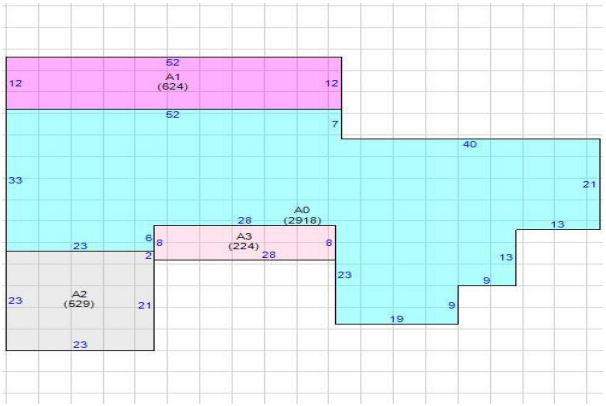
2022 Qualified Exemptions

Homestead
Additional Homestead

Applicants

AGUIRRE EVANGELINE C
CROOKS STAN L &

Building Footprint (Building 1)



Sub Area and Square Foot age (Building 1)

Description	Area Sq. Footage
FGR Finished Garage	529
FOP Finished Open Porch	624
FOP Finished Open Porch	224
BAS Base Area	2918
Total Square Footage :	4295
Total Area Under Air :	2918

Extra Features

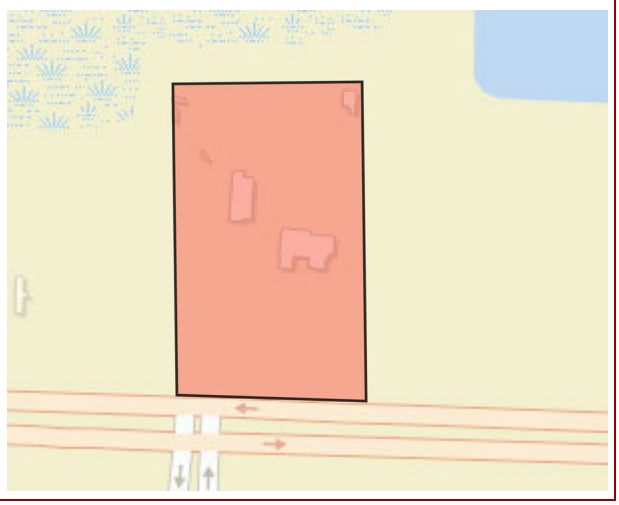
Description	Year Built	Unit
Pool - In-Ground	1987	1
Patio Roof	2014	400
Screen Enclosure	2014	400
Patio	2014	400

Unit may represent the perimeter, square footage, linear footage, total number or other measurement.

Structural Details (Building 1)

	Description	
1.	Exterior Wall 1	WSF: BRICK
2.	Year Built	1986
.	Air Condition Desc.	HTG & AC
4.	Heat Type	FORCED AIR DUCT
5.	Heat Fuel	ELECTRIC
6.	Bed Rooms	4
7.	Full Baths	
8.	Half Baths	0
9.	Exterior Wall 2	WSF: VINLY/STL/ALUM
10.	Roof Structure	GABLE/HIP
11.	Roof Cover	ASPHALT/COMPOSITION
12.	Interior Wall 1	DRYWALL
1 .	Interior Wall 2	N/A
14.	Floor Type 1	CARPETING
15.	Stories	1

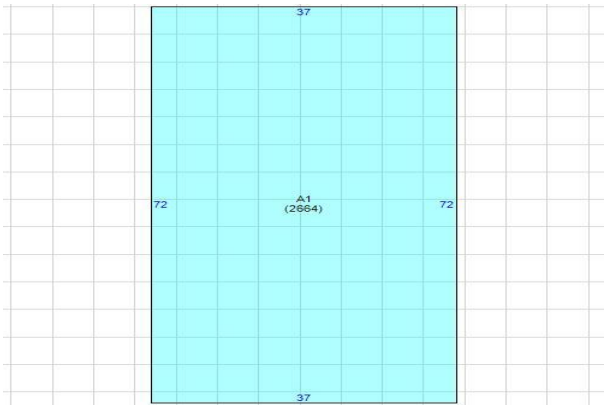
MAP



Building tprint (Building 2)

Owner Name: V AGUIRRE E ANGELINE C ,CROOKS STAN L & , V

PCN: V 00-42-43-27-05-034-0431 V



Structural Details (Building 2)

No	Description	
1.	Exterior Wall 1	WSF: INYL/STL/ALUM V
2.	Year Built V	1995 V
3.	Air Condition Desc. V	NO HTG/AC V
4. V	Heat Type	NONE
5.	Heat Fuel V	NONE V
6.	Bed Rooms V	
7.	FullVBaths	
8.	Half Baths V	
9.	Roof Structure V	STEEL FRAME OR TRUSS V
10.	Roof Cover	MOD. METAL
11.	Interior Wall 1 V	NONE
12.	Floor Type 1	CONCRETE FINISHED
13.	Stories	1

Subarea and Square tage (Building 2)

Description	Area	Sq. Footage V
BAS BASE AREA	1	1
UDG UNFINISHED DET. GARAGE V	2 V	2664 V
V		
Total Square Footage:	2665 V	2665 V
Total Area Under Air: V	1 V	1 V

Property Detail

Location Address	9719 LANTANA D
Municipality	UNINCORPORATED
Parcel Control Number	00-42-43-27-05-034-0432
Subdivision	PALM BEACH FA MS CO PL NO 3
Official Records Book	22933 Page 1743 R
Sale Date	OCT-2008
Legal Description	PALM BEACH FA MS CO PL 3 W 1/2 OF T 43 (LESS S 54 FT LANTANA D /W) BLK R 34

Owner Information

Owners	Mailing ddress
EASTWOOD LANTANA LLC R	PO BOX 1387 BOYNTON BEACH FL 33425 1387 R

S les Information

S les te	Price	OR Book/P ge R	S le Type R	Owner
OCT-2008	$431,900	22933 / 01743	WA ANTY DEED	EASTWOOD LANTANA LLC
OCT-2004	$640,000	17716 / 00779	WA R ANTY DEED	HODGES WILLIAM D
AP -2000	$650,000	11716 / 01060 R	WA ANTY DEED	ODUMS VEGETATION ECYCLING & NU SE Y R
JAN-1997	$200,000	09630 / 01181	WA ANTY DEED	ODUMS P W J R
MAY-1986	$100	04884 / 01076 R	QUIT CLAIM R	
MAY-1986	$145,000	04884 / 01075 R	WA ANTY DEED R	
JAN-1976	$100	02633 / 00829 R		

Exemption Information

No Exemption information available R

Property Inform tion

Number of Units	0
*Total Square Feet	0
Acres	4.05 R
Use Code	0000 - VACANT
Zoning	A - Agricultural esidential (00-UNINCORPORATED) R

Appr is ls R

T x Ye r	2022 P	2021 R	2020 R
Improvement Value	$16,447	$14,262	$14,616
Land Value	$259,889	$210,499	$200,475
Total Market Value	$276,336	$224,761 R	$215,091 R

P = Preliminary *All values are as of January 1st each year* R

Assessed nd T x ble V lues

T x Ye r	2022 P	2021	2020
Assessed Value	$247,237	$224,761	$215,091
Exemption Amount R	$0	$0	$0
Taxable Value	$247,237	$224,761	$215,091

T xes

T x Ye r	2022 P	2021	2020
Ad Valorem	$4,353	$3,904	$3,773
Non Ad Valorem	$288 R	$288 R	$288 R
Total tax R	$4,641	$4,192 R	$4,061 R


Lantana Rd
Lantana Rd
Lantana Rd

DESCRIPTION

PARCEL 1

THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS THE SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LSO KNOWN AS SURVEYED DESCRIPTION

A PORTION OF TRACT FORTY-THREE (43), BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF THE EAST ONE HALF OF SAID TRACT 43; THENCE NORTH 89°00'49" EAST ALONG THE NORTH LINE OF SAID TRACT 43, A DISTANCE OF 330.00 FEET TO THE NORTHEAST CORNER OF SAID TRACT 43; THENCE SOUTH 00°59'11" EAST ALONG THE EAST LINE OF SAID TRACT 43, A DISTANCE OF 557.01 FEET TO A POINT OF INTERSECTION WITH THE NORTH RIGHT-OF-WAY LINE OF LANTANA ROAD, AS RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474 OF SAID PUBLIC RECORDS; THENCE NORTH 88°23'30" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, A DISTANCE OF 330.34 FEET TO A POINT OF INTERSECTION WITH THE WEST LINE OF SAID EAST ONE HALF OF TRACT 43; THENCE NORTH 00°59'11" WEST ALONG SAID WEST LINE, A DISTANCE OF 542.06 FEET TO THE POINT OF BEGINNING.

CONTAINING 181,346 SQUARE FEET OR 4.1631 ACRES, MORE OR LESS.

TOGETHER WITH

PARCEL 2

THAT PART OF THE WEST HALF OF TRACT 43, BLOCK 34, LYING NORTH OF THE RIGHT-OF-WAY FOR LANTANA ROAD, THE PALM BEACH FARMS CO., PLAT NO. 3, ACCORDING TO THE PLAT THEREOF, AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, LESS ADDITIONAL RIGHT-OF-WAY FOR LANTANA ROAD CONVEYED TO PALM BEACH COUNTY IN OFFICIAL RECORDS BOOK 11213, PAGE 937, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

EASEMENT AS CREATED IN THAT CERTAIN ACCESS EASEMENT RECORDED IN OFFICIAL RECORDS BOOK 17416, PAGE 1813, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

ALSO KNOWN AS SURVEYED DESCRIPTION

A PORTION OF TRACT FORTY-THREE (43), BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF SAID TRACT 43; THENCE NORTH 89°00'49" EAST ALONG THE NORTH LINE OF SAID TRACT 43, A DISTANCE OF 330.00 FEET TO THE NORTHEAST CORNER OF THE WEST ONE HALF OF SAID TRACT 43; THENCE SOUTH 00°59'11" EAST ALONG THE EAST LINE OF SAID WEST ONE HALF OF TRACT 43, A DISTANCE OF 542.06 FEET TO A POINT OF INTERSECTION WITH THE NORTH RIGHT-OF-WAY LINE OF LANTANA ROAD, AS RECORDED IN OFFICIAL RECORD BOOK 11213, PAGE 937 OF SAID PUBLIC RECORDS; THENCE NORTH 88°23'30" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, A DISTANCE OF 330.34 FEET TO A POINT OF INTERSECTION WITH THE WEST LINE OF SAID TRACT 43; THENCE NORTH 00°59'11" WEST ALONG SAID WEST LINE, A DISTANCE OF 527.10 FEET TO THE POINT OF BEGINNING.

CONTAINING 176,413 SQUARE FEET OR 4.0499 ACRES, MORE OR LESS.

PARCEL 1 AND 2 ALSO KNOWN AS SURVEYED DESCRIPTION

A PORTION OF TRACT FORTY-THREE (43), BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHWEST CORNER OF SAID TRACT 43; THENCE NORTH 89°00'49" EAST ALONG THE NORTH LINE OF SAID TRACT 43, A DISTANCE OF 660.00 FEET TO THE NORTHEAST CORNER OF SAID TRACT 43; THENCE SOUTH 00°59'11" EAST ALONG THE EAST LINE OF SAID TRACT 43, A DISTANCE OF 557.01 FEET TO A POINT OF INTERSECTION WITH THE NORTH RIGHT-OF-WAY LINE OF LANTANA ROAD, AS RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474 OF SAID PUBLIC RECORDS; THENCE NORTH 88°23'30" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE AND ALONG THE NORTH RIGHT-OF-WAY LINE RECORDED IN OFFICIAL RECORD BOOK 11213, PAGE 937 OF SAID PUBLIC RECORDS, A DISTANCE OF 660.68 FEET TO A POINT OF INTERSECTION WITH THE WEST LINE OF SAID TRACT 43; THENCE NORTH 00°59'11" WEST ALONG SAID WEST LINE, A DISTANCE OF 527.10 FEET TO THE POINT OF BEGINNING.

SAID LANDS SITUATE IN PALM BEACH COUNTY, FLORIDA AND CONTAINING 357,759 SQUARE FEET OR 8.2130 ACRES, MORE OR LESS.

Exhibit B

PALM BEACH COUNTY APPLICATION FOR BROWNFIELDS DESIGNATION

Complete this form to request designation by Palm Beach County as a brownfields site or area. It is important to complete all applicable sections and attach all necessary information. It is required that a Brownfields Pre-Application Meeting be held before submitting this application. If you have any questions concerning completion of this application or wish to schedule a Pre-Application Meeting, please call (561) 233-3674 and ask to speak to the Brownfields Project Manager.

Property Information

Property Name: Encompass Health Green Reuse Area

Address: 9645 and 9719 Lantana Road

City: Lake Worth State: FL Zip Code: 33467

Property Size (acres/square feet): 8.2130 Acres

Parcel Number(s): 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432

Attach a location map and a current aerial with the property delineated.

Property Description

Briefly describe property (vacant land, unoccupied, etc.): 9645 Lantana Rd. - single family residence
9719 Lantana Rd. - vacant

Zoning: IPF Future Land Use Designation: INST

Attach Future Land Use map and Zoning map with the property delineated on each. Is property located within one or more of the following? (check all that apply)

_____Community Redevelopment Area

_____US EPA Assessment Grant Area

_____Existing Designated Brownfield Area

Is the property located within one-half mile of an existing major street? X Yes ____No

Does the property have public street access? X Yes ____No

Are there existing public water and sewer distribution lines? X Yes ____No

Is the property located outside a floodplain area? X Yes ____No

Describe all outstanding property taxes/liens due on the property: None.

Applicant Information

Name: Encompass Health Rehabilitation Hospital of Lake Worth, LLC

Address: 9001 Liberty Parkway

City: Birmingham State: AL Zip Code: 35242

Phone: (305) 640-5300 Fax: N/A E-Mail: bbrumund@goldsteinenvlaw.com

Interest in Property: Owner

Current Property Owner Information (if different from Applicant Information)

Name: N/A

Address:

City: State: Zip Code:

Phone: Fax: E-Mail:

Legal Status of the Current Property Owner(s):

_____Individual/Sole Proprietorship ___General Partnership _____State

_X__Limited Liability Co. _____Limited Partnership _____State

_____Florida Corporation

Environmental Status

Provide a brief description of the nature and geographical extent of contamination by hazardous substances and/or pollutants if known:
Soil is impacted by benzo(a)pyrene, total recoverable petroleum hydrocarbons ("TRPH"), and arsenic above Soil Cleanup Target Levels for residential use. Groundwater is impacted by arsenic, dieldrin, and beta-BHC above Groundwater Cleanup Target Levels. Please see Exhibit C for additional information.

Provide a brief description of any previous or current remedial action: Soil and groundwater assessment is ongoing. No remedial actions have been taken to date.

If remediation is needed will you agree to enter into a Brownfields Site Rehabilitation Agreement with the Florida Department of Environmental Protection (or authorized designee)? X Yes ____ No

Attach Phase I or Phase II Environmental Reports, if available.

Development Plan

General Description of Redevelopment Plans: The Applicant will be redeveloping the property for use as a 50-bed inpatient physical rehabilitation hospital.

Attach further illustrative or graphic information, as appropriate.

How many new permanent full-time or part-time jobs will the project create after remediation and redevelopment? 88

Financial Resources

Reasonable assurances must be provided by the applicant that sufficient financial resources are available to the applicant to implement and complete a rehabilitation agreement and redevelopment plan. Attach a statement, as well as any other appropriate information, outlining the financial resources available to the applicant for rehabilitation and redevelopment. This statement can include financial resources the applicant anticipates to obtain (private loans, equity and assistance) through designation as a brownfields site. In short, describe your general financial plan for your project.

The project will be developed using the financial resources of the Applicant and its principal, Encompass Health Corporation. Please see Exhibit C for additional information, including the proposed project budget and Encompass Health Corporation's most recent SEC Form 10-K.

Services to be Provided

Applicants are required to have a Pre-Application meeting either in person or via telephone conference call. Have you had a Brownfields Pre-Application Meeting? Yes X No

- If "No", please call (561) 233-3674 to schedule a Pre-Application meeting.

In order to better assist you, please check the type of designation you are requesting and the type of assistance/incentives you are seeking through this designation (check all that apply):

Type of Designation: X Area (several parcels) _____ Site (single parcel)

Type of Assistance/Incentives:

_____ Technical Assistance (aide in obtaining grants, loans, etc.)

_____ Loans (remediation loan funds via the County's EPA Revolving Loan Fund)

X Tax Credits/Exemptions due to Brownfield Site Designation

_____ Job Creation Credits due to Brownfield Site Designation

_____ Job Training Grants due to Brownfield Site Designation

_____ Other (explain) _____

What are your goals with respect to the property (i.e., sale, redevelopment, business expansion, etc.)? _____
Redevelopment.

Attachments Checklist

X Location map and current aerial with the property delineated
X Phase I and/or Phase II Environmental Report(s), if available
X Further Development Plan-related illustrative or graphic information
X Statement and any other appropriate information outlining the financial resources available to the applicant for rehabilitation and redevelopment.
_____ Zoning Verification Letter from the Palm Beach County Zoning Division stating that the proposed brownfields site is consistent with the County' Comprehensive Plan
_____ PBC Planning Division letter stating that the proposed brownfields site is consistent with the County's Comprehensive Plan

All applicants for Brownfields designation shall pay a non-refundable filing fee(s).

SIGNATURE PAGE

The contents of this application shall be considered public records of the County. The undersigned affirms that the information contained in this application is true and accurate.

Applicant:

Signature Date 9/12/2022

Robert W. McCallum, III
Print/Type Name

Vice President
Title

FOR OFFICE USE ONLY

Application Received By: _____ Date: _____

Application Completeness Review By: _____

_____ Application Complete

_____ Application Incomplete (Specify reason(s)): _____
_____
_____
_____
_____

Applicant Contacted on: _____

Date Information Received to Complete Application (If Applicable): _____

Signature of Reviewer: _____ Date: _____

BCC Public Hearing Date for Designation of Brownfields Site: _____

Exhibit C

Green Reuse Area Designation Eligibility Statement

Encompass Health Green Reuse Area
9719 and 9645 Lantana Road, Lake Worth, Palm Beach County, Florida 33467
Parcel Numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432

Encompass Health Rehabilitation Hospital of Lake Worth, LLC ("Encompass") proposes to redevelop and rehabilitate two parcels of land located at 9719 and 9645 Lantana Road, Lake Worth, Palm Beach County, FL, 33467 Parcel Numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432 (the "Subject Property"). When fully redeveloped, the Subject Property will consist of a 50-bed inpatient physical rehabilitation hospital (the "Project").[1] As demonstrated herein, the Project meets all five of the applicable brownfield area designation criteria set forth at Section 376.80(2)(c), Florida Statutes.[2] In addition, the Subject Property meets the definition of a "brownfield site" pursuant to Section 376.79(4), Florida Statutes.

I. Subject Property Satisfies the Statutory Criteria for Designation

1. Agreement to Redevelop the Brownfield Site. As the first requirement for designation, Florida Statutes § 376.80(2)(c)(1) provides that "[a] person who owns or controls a potential brownfield site is requesting the designation and has agreed to rehabilitate and redevelop the brownfield site."

Encompass satisfies this criterion in that it currently owns and has agreed to redevelop and rehabilitate the Subject Property.[3] Accordingly, Encompass meets this first criterion.

2. Economic Productivity. As the second requirement for designation, Florida Statutes § 376.80(2)(c)(2) provides that "[t]he rehabilitation and redevelopment of the proposed brownfield site will result in economic productivity of the area, along with the creation of at least 5 new permanent jobs at the brownfield site that are full-time equivalent positions not associated with the implementation of the rehabilitation agreement or an agreement and that are not associated with redevelopment project demolition or construction activities pursuant to the redevelopment of the proposed brownfield site or area. However, the job creation requirement shall not apply to the rehabilitation and redevelopment of a brownfield site that will provide affordable housing as defined in s. 420.0004 or the creation of recreational areas, conservation areas, or parks."

Encompass satisfies this criterion in that, when full developed, the Project will create no less than 88 permanent, full time equivalent ("FTE") jobs in its first year of operation, which greatly exceeds the minimum job creation threshold.[4]

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[1] See Attachment A for the proposed site plan.

[2] See Attachment B for a copy of § 376.80, Florida Statutes.

[3] Encompass purchased the Subject Property on August 31, 2022; however, Palm Beach County's property records are not current and do not show Encompass as the current owner. See Attachment C for the evidence of site control including executed Purchase and Sale Agreements with the Subject Property sellers and email correspondence from Encompass Health Corporation's Chief Real Estate Officer confirming Encompass' purchase of the Subject Property closed.

[4] See Attachment D for a summary of expected FTE job creation and proposed project budget.

Additionally, the Project will result in significant economic productivity of the area. The budget for rehabilitation and redevelopment is approximately $49.7 million, which will be spent in part on local labor, contractors, consultants, construction materials, furnishings, infrastructure improvements, and impact fees.[5] *This work will also support numerous temporary construction workers and materials suppliers during the redevelopment period. The construction workers will spend a percentage of their salaries with local merchants who, in turn, will reinvest locally in their respective businesses, as well as the businesses of other local merchants. Accordingly, Encompass satisfies this second criterion.*

3. Consistency with Local Comprehensive Plan and Permittable Use under Local Land Development Regulations. As the third requirement for designation, Florida Statutes § 376.80(2)(c)(3) provides that "[t]he redevelopment of the proposed brownfield site is consistent with the local comprehensive plan and is a permittable use under the applicable local land development regulations."

Encompass satisfies this criterion in that the Subject Property is located in an Institutional and Public Facilities ("IPF") zoning district and has an Institutional and Public Facilities ("INST"), with an underlying two units per acre, land use designation.[6] *According to Palm Beach County's Unified Land Development Code ("ULDC"), the IPF District is intended to provide for a variety of regional and community uses that are either publicly or privately operated.*[7] *Similarly, the INST future land use designation provides for medical uses including medical treatment, healthcare, and rehabilitation.*[8] *Because the proposed redevelopment as designed is consistent with the local plan and is a permittable use under the local land development regulations, Encompass satisfies the third criterion.*

4. Public Notice and Comment. Florida Statutes § 376.80(2)(c)(4) stipulates that "[n]otice of the proposed rehabilitation of the brownfield area has been provided to neighbors and nearby residents of the proposed area to be designated, and the person proposing the area for designation has afforded to those receiving notice the opportunity for comments and suggestions about rehabilitation. Notice pursuant to this subsection must be posted in the affected area." Additional notice requirements pertaining to applicants other than a governmental entity can be found at Florida Statutes § 376.80(1)(c)(4)(b) and consist of publication in a newspaper of general circulation in the area, publication in ethnic newspapers or local community bulletins, and announcement at a scheduled meeting of the local governing body before the actual public hearing.

Encompass will satisfy all applicable notice and opportunity to comment requirements established by Florida Statutes §376.80(2)(c)(4) and § 376.80(1)(c)(4)(b) as follows:

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[5] Id.

[6] See Attachment E for Resolution No. R-2022-0630, which approved the Subject Property rezoning; and see Attachment F for Ordinance 2022-014, which amended the Comprehensive Plan and Future Land Use Atlas. Please note, zoning and planning consistency letters have been requested from the appropriate County offices and will be provided upon Encompass' receipt.

[7] See Palm Beach Cty. Unified Land Dev. Code art. 3, ch. C, § 1(G)(1).

[8] See Palm Beach Cty. Comprehensive Plan, Future Land Use Element, § 2.2.8-e.

(i) a community meeting for purposes of affording interested parties the opportunity to provide comments and suggestions about the potential designation will be held as close as practicable to the Subject Property.

(ii) notice of the request to designate the Subject Property a Green Reuse Area and of the community meeting will be posted at the Subject Property;

(iii) notice of the request to designate the Subject Property a Green Reuse Area and of the community meeting will be published in the Palm Beach Post; and

(iv) notice of the request to designate the Subject Property a Green Reuse Area and of the community meeting has been published in the Palm Beach County community bulletin section of Craig's List.

All notices will contain the substantially the following narrative:

> *Representatives for Encompass Health Rehabilitation Hospital of Lake Worth, LLC will hold a community meeting, date and location to be announced, from 5:30 p.m. to 7:00 p.m. for the purpose of affording interested parties the opportunity to provide comments and suggestions about the potential designation of two parcels of land located at 9719 and 9645 Lantana Road, Lake Worth, Palm Beach County, Florida 33467, as a Brownfield Area. The designation is being made pursuant to Section 376.80, Florida Statutes, of Florida's Brownfield Redevelopment Act, and will involve two public hearings before the Palm Beach County Board of County Commissioners. The community meeting will also address future development and rehabilitation activities planned for the site.*
>
> *The community meeting is free and open to all members of the public.*
>
> *For more information regarding the community meeting, including directions, the dates of the two public hearings, or to provide comments and suggestions regarding designation, development, or rehabilitation at any time before or after the meeting date, please contact Palm Beach County Brownfield Program Manager, Alan Chin Lee by email at AChinLee@pbcgov.org or the Applicant's representative, Brett C. Brumund, who can be reached by telephone at (305) 640-5300, U.S. Mail at The Goldstein Environmental Law Firm, P.A., 2100 Ponce de Leon Blvd., Suite 710, Coral Gables, FL 33134, and/or email at bbrumund@goldsteinenvlaw.com.*

Proof of publication or posting, as appropriate, will be provided to the County.

5. Reasonable Financial Assurance. As the fifth requirement for designation, Florida Statutes § 376.80(2)(c)(5) provides that "[t]he person proposing the area for designation has provided reasonable assurance that he or she has sufficient financial resources to implement and complete the rehabilitation agreement and redevelopment plan."

The total capital budget of $49.7 million for the Project is to be fully funded through the financial resources of Encompass' principal, Encompass Health Corporation ("Encompass Health").[9] *Encompass Health is the largest owner and operator of rehabilitation hospitals in the United States with a national footprint of 152 hospitals in 36 states and Puerto Rico. Accordingly, the success of previous projects, the magnitude of the capital previously raised, the quality of the development previously achieved, and the resources of its principal provide reasonable assurances that*

[9] See Attachment G for Encompass Health's most recent U.S. Securities and Exchange Commission Form 10-K.

Encompass has sufficient financial resources to implement and complete the rehabilitation agreement and redevelopment plan. It therefore satisfies the fifth criterion.

II. Subject Property Meets the Definition of Brownfield Site

Section 376.79(4), Florida Statutes, defines "brownfield site" to mean ". . . real property, the expansion, redevelopment, or reuse of which may be complicated by actual or perceived environmental contamination." The facts here clearly reflect that the Subject Property falls within the definition of the term "brownfield site" in that actual contamination is present in soils and groundwater on the Subject Property. Specifically, Encompass' due diligence activities identified several recognized environmental conditions ("RECs") and business environmental risks ("BERs") associated with the Subject Property's current and historical uses that could indicate the potential presence of contamination. These RECs and BERs include a fuel oil spill on an adjacent property, the presence of several aboveground storage tanks on the Subject Property, general maintenance debris on the Subject Property, and historical landfilling operations.[10] Upon subsequent evaluation of the RECs and BERs through soil and groundwater sampling activities, Encompass documented contaminants including benzo(a)pyrene, total recoverable petroleum hydrocarbons ("TRPH"), and arsenic in soils above the applicable Cleanup Target Levels ("CTLs") as well as arsenic, dieldrin, and beta-BHC in groundwater above the applicable CTLs.[11]

As a result, Encompass must now carefully address the existing contamination through continued site assessment activities and by undertaking measures that may include contaminated soil management, engineering control construction, as well as imposing restrictions on the future use and access to the Subject Property's underlying soil and groundwater. As such, Encompass faces significant additional redevelopment costs and must work within a strict regulatory framework that exists to ensure contamination is properly and safely managed. To accomplish this, Encompass will be required to carefully manage the contamination at all stages of the redevelopment, imposing great legal and financial risk, by incorporating design and construction changes on the project that would not be required but for the presence of actual contamination.

In sum, the presence of contamination imposes a material level of regulatory, construction, health, and legal liability risk, complicates redevelopment efforts, and requires significant time and money for environmental, engineering, and legal consultants to properly address. Accordingly, this designation, if granted, will allow Encompass to access limited but important state-based economic incentives to help underwrite the unanticipated and unbudgeted costs associated with managing the environmental risk as well as, generally, to put the project on a more certain financial ground. In this sense, the designation will not only play a critical role in the successful redevelopment of the Subject Property, but also in the larger revitalization efforts for this area of County.

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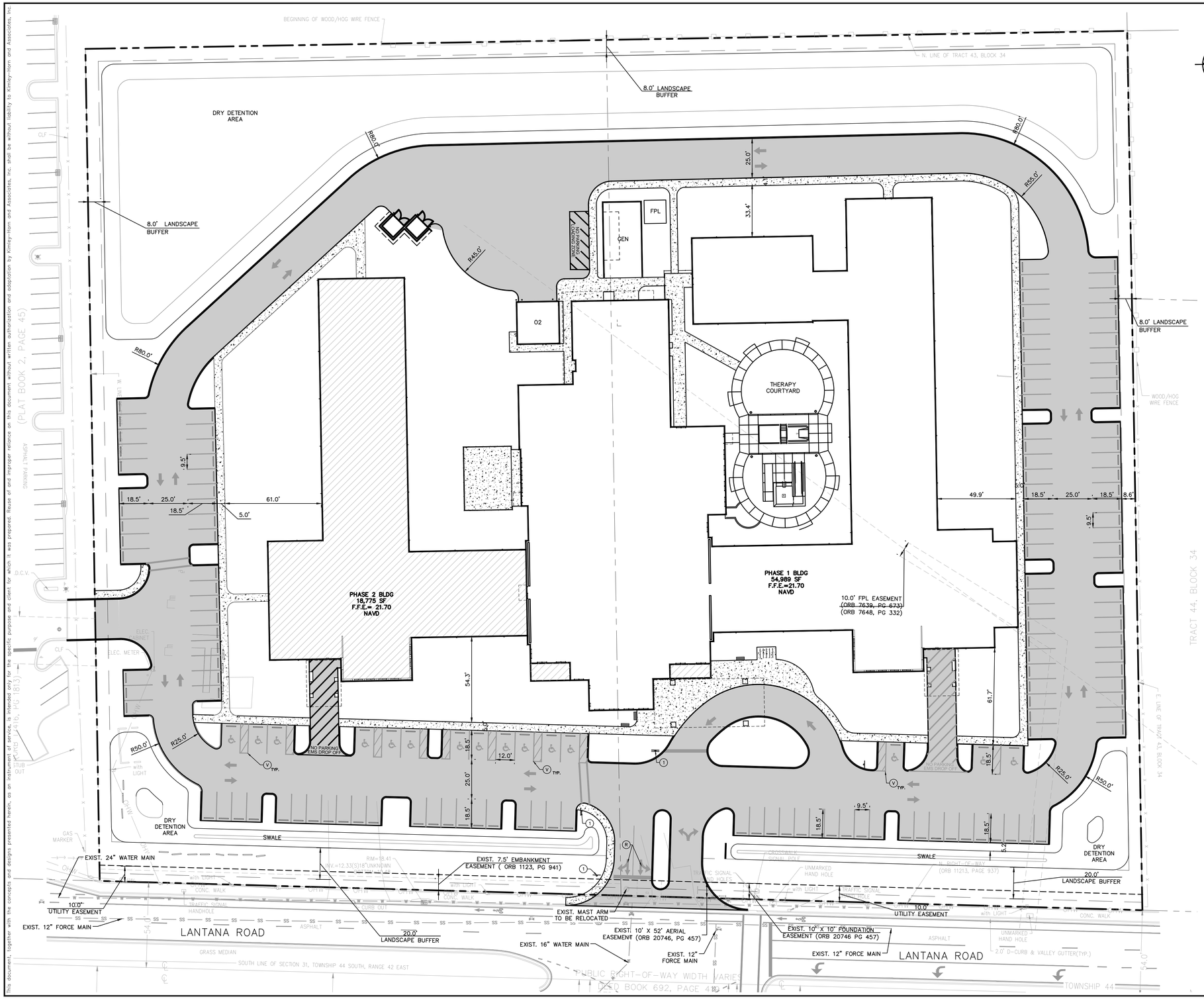
[10] See Attachment H for an excerpt from Encompass' Phase I Environmental Site Assessment ("ESA") Report. The complete report will be provided upon request.

[11] See Attachment I for an excerpt from Encompass' Supplemental Phase II ESA Report, which incorporates the findings of the initial Phase II ESA sampling events. The complete report will be provided upon request.

III. Conclusion

Encompass has demonstrated that the Subject Property meets the definition of a "brownfield site" and that it satisfies the five statutory criteria for designation. Accordingly, designation of the Subject Property as a Green Reuse Area pursuant to § 376.80(2)(c), Florida Statutes, of Florida's Brownfield Redevelopment Act is appropriate.

Attachment A



NORTH

GRAPHIC SCALE IN FEET
0 15 30 60

LEGEND:

- PROPERTY LINE
- PROPOSED STANDARD DUTY CONCRETE
- PHASE 2
- PROPOSED STANDARD DUTY ASPHALT

HORZONTAL CONTROL PLAN NOTES:

1. TYPE "D" CURB AND TYPE "F" CURB AND GUTTER SHALL BE CONSTRUCTED PER FDOT INDEX 520-001. ALL TYPE "D" CURB SHALL HAVE A 3' STRAIGHT TRANSITION AT THE BEGINNING AND ENDING POINTS WHEN NOT CONNECTING TO TYPE "F" CURB AND GUTTER.
2. ALL DIMENSIONS SHOWN ARE TO FACE OF CURB FOR TYPE "D" CURB OR EDGE OF PAVEMENT FOR TYPE "F" CURB, TYPE "E" CURB, HEADER CURB, OR NO CURB, UNLESS OTHERWISE NOTED.
3. ALL CURB RAMPS AND SIDEWALKS ENTERING PARKING OR TRAVEL WAYS SHALL HAVE DETECTABLE WARNING SURFACES 2' DEEP AND THE WIDTH OF THE SIDEWALK. REFER TO FDOT DESIGN STANDARDS INDEX 522-002.
4. ALL STOP BARS AND CROSSWALKS SHALL BE THERMOPLASTIC. ALL OTHER PAVEMENT MARKINGS SHALL BE DOUBLE-COATED PAINT, UNLESS OTHERWISE NOTED.
5. REFER TO LANDSCAPE PLANS FOR PLANTING AND DETAILS.

STRIPING KEY:

A = 6" SOLID WHITE
B = 8" SOLID WHITE
C = 12" SOLID WHITE
D = 18" SOLID WHITE
E = 24" SOLID WHITE
F = 6" SKIP WHITE TYP (10'-30')
G = 6" SKIP WHITE TYP (6'-10')
H = 6" SKIP WHITE TYP (2'-4')
I = 6" SOLID YELLOW
J = 18" SOLID YELLOW
K = 6" DOUBLE YELLOW
L = 6" SKIP YELLOW TYP (10'-30')
M = 6" SKIP YELLOW TYP (6'-10')
N = 6" SKIP YELLOW TYP (2'-4')
O = 24" SOLID WHITE LINE (CROSSWALK)
P = RPM BI-DIRECTIONAL AMBER/AMBER
R = WHITE ARROW (PAINT)
T = RPM BI-DIRECTIONAL WHITE/RED
U = RPM BI-DIRECTIONAL RED/YELLOW
V = ADA SIGNAGE AND STRIPING
W = WHEEL STOP (SEE SHEET C3.10)

** PAVEMENT MARKINGS SHALL BE SLIP RESISTANT PAINT WITH THE EXCEPTION OF STOP BARS AND CROSSWALKS, WHICH SHALL BE THERMOPLASTIC.

PARKING BY DISABLED PERMIT ONLY
$ 250 FINE F.S. 318.18
(2)

SIGN LEGEND:
STOP R1-1 (1)

VERTICAL DATUM
ELEVATIONS SHOWN HEREON ARE BASED ON THE NATIONAL GEODETIC VERTICAL DATUM OF 1929. NAVD '88 ELEV = 1.463' = NGVD '29 ELEVATION

THE PRESENCE OF GROUNDWATER SHOULD BE ANTICIPATED. CONTRACTOR'S BID SHALL INCLUDE CONSIDERATION FOR ADDRESSING THIS ISSUE AND OBTAINING ALL NECESSARY PERMITS.

CALL 2 WORKING DAYS BEFORE YOU DIG
IT'S THE LAW! DIAL 811
811 Know what's below. Call before you dig.
SUNSHINE STATE ONE CALL OF FLORIDA, INC.

No.	REVISIONS	DATE	BY

Kimley»Horn
1920 MERIVA WAY SUITE 200, WEST PALM BEACH, FL 33411
PHONE: 561-845-0665 FAX: 561-863-8175
WWW.KIMLEY-HORN.COM REGISTRY NO. 696

LICENSED PROFESSIONAL

KHA PROJECT 140900000
DATE APRIL 2022
SCALE AS SHOWN
DESIGNED BY LC
DRAWN BY ----
CHECKED BY MFS
DATE:

HORIZONTAL CONTROL PLAN

ENCOMPASS LAKE WORTH
PREPARED FOR
ENCOMPASS HEALTH CORPORATION
UNINCORPORATED PALM BEACH COUNTY FL

SHEET NUMBER
C2.00

Attachment B

Select Year: 2021 Go

The 2021 Florida Statutes

Title XXVIII
NATURAL RESOURCES; CONSERVATION, RECLAMATION, AND USE

Chapter 376
POLLUTANT DISCHARGE PREVENTION AND REMOVAL

View Entire Chapter

376.80 Brownfield program administration process.—

(1) The following general procedures apply to brownfield designations:

(a) The local government with jurisdiction over a proposed brownfield area shall designate such area pursuant to this section.

(b) For a brownfield area designation proposed by:

1. The jurisdictional local government, the designation criteria under paragraph (2)(a) apply, except if the local government proposes to designate as a brownfield area a specified redevelopment area as provided in paragraph (2)(b).

2. Any person, other than a governmental entity, including, but not limited to, individuals, corporations, partnerships, limited liability companies, community-based organizations, or not-for-profit corporations, the designation criteria under paragraph (2)(c) apply.

(c) Except as otherwise provided, the following provisions apply to all proposed brownfield area designations:

1. Notification to department following adoption.—A local government with jurisdiction over the brownfield area must notify the department, and, if applicable, the local pollution control program under s. 403.182, of its decision to designate a brownfield area for rehabilitation for the purposes of ss. 376.77-376.86. The notification must include a resolution adopted by the local government body. The local government shall notify the department, and, if applicable, the local pollution control program under s. 403.182, of the designation within 30 days after adoption of the resolution.

2. Resolution adoption.—The brownfield area designation must be carried out by a resolution adopted by the jurisdictional local government, which includes a map adequate to clearly delineate exactly which parcels are to be included in the brownfield area or alternatively a less-detailed map accompanied by a detailed legal description of the brownfield area. For municipalities, the governing body shall adopt the resolution in accordance with the procedures outlined in s. 166.041, except that the procedures for the public hearings on the proposed resolution must be in the form established in s. 166.041(3)(c)2. For counties, the governing body shall adopt the resolution in accordance with the procedures outlined in s. 125.66, except that the procedures for the public hearings on the proposed resolution shall be in the form established in s. 125.66(4)(b).

3. Right to be removed from proposed brownfield area.—If a property owner within the area proposed for designation by the local government requests in writing to have his or her property removed from the proposed designation, the local government shall grant the request.

4. Notice and public hearing requirements for designation of a proposed brownfield area outside a redevelopment area or by a nongovernmental entity. Compliance with the following provisions is required before designation of a proposed brownfield area under paragraph (2)(a) or paragraph (2)(c):

a. At least one of the required public hearings shall be conducted as closely as is reasonably practicable to the area to be designated to provide an opportunity for public input on the size of the area, the objectives for rehabilitation, job opportunities and economic developments anticipated, neighborhood residents' considerations, and other relevant local concerns.

b. Notice of a public hearing must be made in a newspaper of general circulation in the area, must be made in ethnic newspapers or local community bulletins, must be posted in the affected area, and must be announced at a scheduled meeting of the local governing body before the actual public hearing.

(2)(a) *Local government-proposed brownfield area designation outside specified redevelopment areas.*—If a local government proposes to designate a brownfield area that is outside a community redevelopment area, enterprise zone, empowerment zone, closed military base, or designated brownfield pilot project area, the local government shall provide notice, adopt the resolution, and conduct public hearings pursuant to paragraph (1)(c). At a public hearing to designate the proposed brownfield area, the local government must consider:

1. Whether the brownfield area warrants economic development and has a reasonable potential for such activities;

2. Whether the proposed area to be designated represents a reasonably focused approach and is not overly large in geographic coverage;

3. Whether the area has potential to interest the private sector in participating in rehabilitation; and

4. Whether the area contains sites or parts of sites suitable for limited recreational open space, cultural, or historical preservation purposes.

(b) *Local government-proposed brownfield area designation within specified redevelopment areas.*—Paragraph (a) does not apply to a proposed brownfield area if the local government proposes to designate the brownfield area inside a community redevelopment area, enterprise zone, empowerment zone, closed military base, or designated brownfield pilot project area and the local government complies with paragraph (1)(c).

(c) *Brownfield area designation proposed by persons other than a governmental entity.*—For designation of a brownfield area that is proposed by a person other than the local government, the local government with jurisdiction over the proposed brownfield area shall provide notice and adopt a resolution to designate the brownfield area pursuant to paragraph (1)(c) if, at the public hearing to adopt the resolution, the person establishes all of the following:

1. A person who owns or controls a potential brownfield site is requesting the designation and has agreed to rehabilitate and redevelop the brownfield site.

2. The rehabilitation and redevelopment of the proposed brownfield site will result in economic productivity of the area, along with the creation of at least 5 new permanent jobs at the brownfield site that are full-time equivalent positions not associated with the implementation of the brownfield site rehabilitation agreement and that are not associated with redevelopment project demolition or construction activities pursuant to the redevelopment of the proposed brownfield site or area. However, the job creation requirement does not apply to the rehabilitation and redevelopment of a brownfield site that will provide affordable housing as defined in s. 420.0004 or the creation of recreational areas, conservation areas, or parks.

3. The redevelopment of the proposed brownfield site is consistent with the local comprehensive plan and is a permittable use under the applicable local land development regulations.

4. Notice of the proposed rehabilitation of the brownfield area has been provided to neighbors and nearby residents of the proposed area to be designated pursuant to paragraph (1)(c), and the person proposing the area for designation has afforded to those receiving notice the opportunity for comments and suggestions about rehabilitation. Notice pursuant to this subparagraph must be posted in the affected area.

5. The person proposing the area for designation has provided reasonable assurance that he or she has sufficient financial resources to implement and complete the rehabilitation agreement and redevelopment of the brownfield site.

(d) *Negotiation of brownfield site rehabilitation agreement.*—The designation of a brownfield area and the identification of a person responsible for brownfield site rehabilitation simply entitles the identified person to negotiate a brownfield site rehabilitation agreement with the department or approved local pollution control program.

(3) When there is a person responsible for brownfield site rehabilitation, the local government must notify the department of the identity of that person. If the agency or person who will be responsible for the coordination

changes during the approval process specified in subsections (4), (5), and (6), the department or the affected approved local pollution control program must notify the affected local government when the change occurs.

(4) Local governments or persons responsible for rehabilitation and redevelopment of brownfield areas must establish an advisory committee or use an existing advisory committee that has formally expressed its intent to address redevelopment of the specific brownfield area for the purpose of improving public participation and receiving public comments on rehabilitation and redevelopment of the brownfield area, future land use, local employment opportunities, community safety, and environmental justice. Such advisory committee should include residents within or adjacent to the brownfield area, businesses operating within the brownfield area, and others deemed appropriate. The person responsible for brownfield site rehabilitation must notify the advisory committee of the intent to rehabilitate and redevelop the site before executing the brownfield site rehabilitation agreement, and provide the committee with a copy of the draft plan for site rehabilitation which addresses elements required by subsection (5). This includes disclosing potential reuse of the property as well as site rehabilitation activities, if any, to be performed. The advisory committee shall review any proposed redevelopment agreements prepared pursuant to paragraph (5)(i) and provide comments, if appropriate, to the board of the local government with jurisdiction over the brownfield area. The advisory committee must receive a copy of the executed brownfield site rehabilitation agreement. When the person responsible for brownfield site rehabilitation submits a site assessment report or the technical document containing the proposed course of action following site assessment to the department or the local pollution control program for review, the person responsible for brownfield site rehabilitation must hold a meeting or attend a regularly scheduled meeting to inform the advisory committee of the findings and recommendations in the site assessment report or the technical document containing the proposed course of action following site assessment.

(5) The person responsible for brownfield site rehabilitation must enter into a brownfield site rehabilitation agreement with the department or an approved local pollution control program if actual contamination exists at the brownfield site. The brownfield site rehabilitation agreement must include:

(a) A brownfield site rehabilitation schedule, including milestones for completion of site rehabilitation tasks and submittal of technical reports and rehabilitation plans as agreed upon by the parties to the agreement.

(b) A commitment to conduct site rehabilitation activities under the observation of professional engineers or geologists who are registered in accordance with the requirements of chapter 471 or chapter 492, respectively. Submittals provided by the person responsible for brownfield site rehabilitation must be signed and sealed by a professional engineer registered under chapter 471, or a professional geologist registered under chapter 492, certifying that the submittal and associated work comply with the law and rules of the department and those governing the profession. In addition, upon completion of the approved remedial action, the department shall require a professional engineer registered under chapter 471 or a professional geologist registered under chapter 492 to certify that the corrective action was, to the best of his or her knowledge, completed in substantial conformance with the plans and specifications approved by the department.

(c) A commitment to conduct site rehabilitation in accordance with department quality assurance rules.

(d) A commitment to conduct site rehabilitation consistent with state, federal, and local laws and consistent with the brownfield site contamination cleanup criteria in s. 376.81, including any applicable requirements for risk-based corrective action.

(e) Timeframes for the department's review of technical reports and plans submitted in accordance with the agreement. The department shall make every effort to adhere to established agency goals for reasonable timeframes for review of such documents.

(f) A commitment to secure site access for the department or approved local pollution control program to all brownfield sites within the eligible brownfield area for activities associated with site rehabilitation.

(g) Other provisions that the person responsible for brownfield site rehabilitation and the department agree upon, that are consistent with ss. 376.77-376.86, and that will improve or enhance the brownfield site rehabilitation process.

(h) A commitment to consider appropriate pollution prevention measures and to implement those that the person responsible for brownfield site rehabilitation determines are reasonable and cost-effective, taking into

account the ultimate use or uses of the brownfield site. Such measures may include improved inventory or production controls and procedures for preventing loss, spills, and leaks of hazardous waste and materials, and include goals for the reduction of releases of toxic materials.

(i) Certification that the person responsible for brownfield site rehabilitation has consulted with the local government with jurisdiction over the brownfield area about the proposed redevelopment of the brownfield site, that the local government is in agreement with or approves the proposed redevelopment, and that the proposed redevelopment complies with applicable laws and requirements for such redevelopment. Certification shall be accomplished by referencing or providing a legally recorded or officially approved land use or site plan, a development order or approval, a building permit, or a similar official document issued by the local government that reflects the local government's approval of proposed redevelopment of the brownfield site; providing a copy of the local government resolution designating the brownfield area that contains the proposed redevelopment of the brownfield site; or providing a letter from the local government that describes the proposed redevelopment of the brownfield site and expresses the local government's agreement with or approval of the proposed redevelopment.

(6) Any contractor performing site rehabilitation program tasks must demonstrate to the department that the contractor:

(a) Meets all certification and license requirements imposed by law; and

(b) Will conduct sample collection and analyses pursuant to department rules.

(7) During the cleanup process, if the department or local program fails to complete review of a technical document within the timeframe specified in the brownfield site rehabilitation agreement, the person responsible for brownfield site rehabilitation may proceed to the next site rehabilitation task. However, the person responsible for brownfield site rehabilitation does so at its own risk and may be required by the department or local program to complete additional work on a previous task. Exceptions to this subsection include requests for "no further action," "monitoring only proposals," and feasibility studies, which must be approved prior to implementation.

(8) If the person responsible for brownfield site rehabilitation fails to comply with the brownfield site rehabilitation agreement, the department shall allow 90 days for the person responsible for brownfield site rehabilitation to return to compliance with the provision at issue or to negotiate a modification to the brownfield site rehabilitation agreement with the department for good cause shown. If an imminent hazard exists, the 90-day grace period shall not apply. If the project is not returned to compliance with the brownfield site rehabilitation agreement and a modification cannot be negotiated, the immunity provisions of s. 376.82 are revoked.

(9) The department is specifically authorized and encouraged to enter into delegation agreements with local pollution control programs approved under s. 403.182 to administer the brownfield program within their jurisdictions, thereby maximizing the integration of this process with the other local development processes needed to facilitate redevelopment of a brownfield area. When determining whether a delegation pursuant to this subsection of all or part of the brownfield program to a local pollution control program is appropriate, the department shall consider the following. The local pollution control program must:

(a) Have and maintain the administrative organization, staff, and financial and other resources to effectively and efficiently implement and enforce the statutory requirements of the delegated brownfield program; and

(b) Provide for the enforcement of the requirements of the delegated brownfield program, and for notice and a right to challenge governmental action, by appropriate administrative and judicial process, which shall be specified in the delegation.

The local pollution control program shall not be delegated authority to take action on or to make decisions regarding any brownfield site on land owned by the local government. Any delegation agreement entered into pursuant to this subsection shall contain such terms and conditions necessary to ensure the effective and efficient administration and enforcement of the statutory requirements of the brownfield program as established by the act and the relevant rules and other criteria of the department.

(10) Local governments are encouraged to use the full range of economic and tax incentives available to facilitate and promote the rehabilitation of brownfield areas, to help eliminate the public health and

environmental hazards, and to promote the creation of jobs and economic development in these previously run-down, blighted, and underutilized areas.

(11)(a) The Legislature finds and declares that:

1. Brownfield site rehabilitation and redevelopment can improve the overall health of a community and the quality of life for communities, including for individuals living in such communities.

2. The community health benefits of brownfield site rehabilitation and redevelopment should be better measured in order to achieve the legislative intent as expressed in s. 376.78.

3. There is a need in this state to define and better measure the community health benefits of brownfield site rehabilitation and redevelopment.

4. Funding sources should be established to support efforts by the state and local governments, in collaboration with local health departments, community health providers, and nonprofit organizations, to evaluate the community health benefits of brownfield site rehabilitation and redevelopment.

(b) Local governments may and are encouraged to evaluate the community health benefits and effects of brownfield site rehabilitation and redevelopment in connection with brownfield areas located within their jurisdictions. Factors that may be evaluated and monitored before and after brownfield site rehabilitation and redevelopment include, but are not limited to:

1. Health status, disease distribution, and quality of life measures regarding populations living in or around brownfield sites that have been rehabilitated and redeveloped.

2. Access to primary and other health care or health services for persons living in or around brownfield sites that have been rehabilitated and redeveloped.

3. Any new or increased access to open, green, park, or other recreational spaces that provide recreational opportunities for individuals living in or around brownfield sites that have been rehabilitated and redeveloped.

4. Other factors described in rules adopted by the Department of Environmental Protection or the Department of Health, as applicable.

(c) The Department of Health may and is encouraged to assist local governments, in collaboration with local health departments, community health providers, and nonprofit organizations, in evaluating the community health benefits of brownfield site rehabilitation and redevelopment.

(12) A local government that designates a brownfield area pursuant to this section is not required to use the term “brownfield area” within the name of the brownfield area designated by the local government.

History.—s. 4, ch. 97-277; s. 3, ch. 98-75; s. 11, ch. 2000-317; s. 2, ch. 2004-40; s. 44, ch. 2005-2; s. 7, ch. 2006-291; s. 5, ch. 2008-239; s. 2, ch. 2014-114.

Attachment C

From: Ball, Edmund
To: [redacted]
Subject: Lake Worth (Unincorporated), Palm Beach County, FL - Land Purchase
Date: Wednesday, August 31, 2022 4:18:54 PM

All,

The land purchase relating to the Palm Beach County, FL (Unincorporated Lake Worth) Denovo project closed on 8/31/2022. Details are as follows:

Location:	A) 9719 Lantana Road, Lake Worth, Palm Beach County, FL 33467 B) 9645 Lantana Road, Lake Worth, Palm Beach County, FL 33467
Purchaser:	Encompass Health Rehabilitation Hospital of Lake Worth, LLC
Sellers:	A) Eastwood Lantana, LLC B) Exeter 1031 Exchange Services, LLC as Qualified Intermediary for Stan L. Crooks/Evangeline C. Aguirre (as to 75% of the sales proceeds) and Stan L. Crooks and Evangeline C. Aguirre (as to 25% of the sales proceeds)
Land Area:	A) ±4.05 Acres B) ±4.16 Acres
Purchase Price:	A) $4,102,223,44 ($4,000,000.00 land cost + $102,223.44* in closing costs) B) $4,177,370.96 ($4,000,000.00 land cost + $177,370.96* in closing costs) *includes brokerage fees which are usually paid for by Seller(s)
County:	Palm Beach County
Tax Parcel:	A) 00-42-43-27-05-034-0432 B) 00-42-43-27-05-034-0431
Taxes:	A) Property taxes were prorated at closing (a credit of $2,484.79 and a charge of $23.44 for non-ad valorem taxes) B) Property taxes were prorated at closing (a credit of $5,484.02)
NOTES:	Tax, RE & D&C are currently working together in applying for a Brownfield designation for both parcels.

Please let me know if you would like a copy of the closing statement, deed or other documents.

Thanks and have a great rest of the week.

Edmund H Ball
Chief Real Estate Officer
205-968-4490 (office)
205-641-9241 (mobile)
205-970-3493 (assistant)
Encompass Health Corporation
9001 Liberty Parkway
Real Estate – 4th Floor
Birmingham, AL 35242

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT (this "Agreement") is entered into on or as of this 1st day of June, 2021 (the "Effective Date"), by and between **Stan L. Crooks** and **Evangeline C. Aguirre**, both individual residents of the State of Florida, as tenants in common (collectively, "Seller"), and **Encompass Health Corporation**, a Delaware corporation ("Purchaser").

Recitals

A. Seller is the owner of that certain improved parcel of real property consisting of approximately 4.16 acres, more or less, located at 9645 Lantana Road, in Lake Worth, Palm Beach County, Florida (tax parcel control number 00-42-43-27-05-034-0431), which property is more particularly depicted on Exhibit A attached hereto and made a part hereof (the "Property").

B. Purchaser desires to purchase the Property, and Seller desires to sell the Property pursuant to the terms and conditions of this Agreement.

Agreement

NOW, THEREFORE, in consideration of the above Recitals and other good and valuable consideration, including the mutual covenants and promises herein contained, the receipt and sufficiency of which are hereby acknowledged, Seller and Purchaser hereby agree as follows:

1. Agreement to Sell; Personal Property. For the consideration set forth in Paragraph 2 below, Seller hereby agrees to grant, bargain, sell, assign and convey to Purchaser, the Property, together with all improvements, easements, licenses, privileges, appurtenances, water rights and other rights pertaining thereto, including without limitation all air or air space rights, all subsurface rights, all riparian rights, all title and interest of Seller in and to adjacent roads, rights of way, alleys, drainage facilities, utility facilities, impact fee credits, concurrency rights, development rights, sewer or water reservations or tap-in rights, and any and all similar development rights incident or related thereto. The final legal description for the Property shall be as set forth on the survey described in Paragraph 9(a). Purchaser agrees that Seller shall be permitted to remove from the Property prior to Closing (in Seller's discretion and at Seller's sole cost and expense) any personal property, and any part of the structures located on the Property. As Purchaser has no interest in or value assigned to the structures located at the Property, Seller may remove any part of the structures including attached fixtures or any other part of the structures, prior to Closing. Purchaser will not require Seller to meet any condition standards for the structures located on the Property. Purchaser acknowledges that Seller has a licensed plant nursery located on the Property, and Purchaser furthermore agrees that Seller may remove any of the plants or trees that are part of such nursery business prior to Closing.

2. Purchase Price. The total purchase price for the Property shall be $4,000,000 (the "Purchase Price"), to be paid as hereinafter provided. Notwithstanding the foregoing, in the event that the federal government increases the long term capital gains tax rate currently provided for Internal Revenue Code section 1(h) on or after the Effective Date and Seller recognizes gain on the sale of the Property that is subject to such increased capital gains tax rate with respect to the tax year in which Closing occurs, the total purchase price shall be increased by $25,000 for each 1% increase in the long term capital gains tax rate above the current 20% maximum rate (for example, if the long term capital gains tax rate that applies to the gain resulting from this tranasction at the time of Closing is 22%, then Purchaser will pay an additional $50,000 to Seller at Closing); provided, however, that Purchaser shall not be required to pay more than a total of an additional $500,000 for such potential increase.

3. Earnest Money. Purchaser will deliver, within three (3) business days following the Effective Date, a wire in the amount of Fifty Thousand and No/100 Dollars ($50,000) to First American Title Insurance Company (the "Escrow Agent") (the $50,000 deposit, together with any extension deposits made pursuant to Paragraph 4, and any interest thereon, is hereinafter referred to as the "Earnest Money"), to be held and disbursed by the Escrow Agent in accordance with the terms of this Agreement. Escrow Agent shall deposit the Earnest Money in its interest bearing trust account. Except as may be otherwise expressly provided in this Agreement, the Earnest Money shall not be refundable should Purchaser fail to purchase the Property and shall be forfeited to and retained by Seller as liquidated damages for taking the Property off the market prior to the Closing Date, and Seller shall have no further claim against Purchaser.

4. Right of Inspection. Commencing the next business day after the Effective Date, Purchaser, its employees, agents or designees, at Purchaser's sole expense, shall have ninety (90) days (as such period may be extended as provided for hereunder, the "Inspection Period") to examine and test the Property, and shall further have the right of ingress and egress over and through the Property during normal business hours for the purpose of inspecting, appraising, soil and environmental testing, testing for drainage, surveying, preparing engineering or architectural drawings, and any other activities reasonably necessary to assess the Property, including the review of the Title Commitment, as hereafter defined, and the satisfactory completion of the governmental permitting process (collectively, the "Inspections"). Purchaser shall indemnify and hold harmless Seller from and against any and all expenses, claims, or losses arising from any activities of Purchaser, its officers, agents, employees, or contractors on the Property prior to Closing, including without limitation, any attorney's fees or court costs occasioned by such claims. Within five (5) business days following the Effective Date as to subsection (i) hereof and ten (10) business days following the Effective Date as to subsections (ii), (iii) and (iv) hereof (as applicable, the "Seller's Documents Delivery Date"), Seller shall make available to Purchaser (i) Seller's owner's title insurance policy for the Property and any current title report or title commitment for the Property, (ii) Seller's existing survey and any plat of the Property, (iii) any environmental and property condition reports related to the Property and in Seller's possession or control, and (iv) copies of any unrecorded documents that potentially impact the use and/or development of the Property and are in Seller's possession or control (collectively, the "Existing Due

Diligence"). Seller acknowledges that the Existing Due Diligence is critical to Purchaser's Inspections, and as a result, the Inspection Period will be extended automatically one day for each day that the delivery of the Existing Due Diligence is delayed past the Seller's Documents Delivery Date.

Purchaser shall be permitted to extend the Inspection Period for two 180-day periods and then for three additional 90-day periods (collectively, the "Extension Period") for the purpose of pursuing and obtaining all final non-appealable zoning, lot combination and site plan approvals necessary for the hereafter defined Intended Use, by providing written notice of such extension to Seller prior to the end of the Inspection Period (as to the first extension) or the last day of the then applicable Extension Period (as to the remaining extensions) and by depositing with the Escrow Agent an additional Twelve Thousand Six Hundred Sixty-Seven and No/100 Dollars ($12,667) for each such extension, which additional deposits shall become part of the Earnest Money hereunder.

5. Application of Earnest Money or Refund. The Earnest Money shall be applied to the Purchase Price to be paid by Purchaser at Closing and shall be non-refundable to Purchaser, except as expressly provided otherwise in this Agreement.

6. Cooperation. Prior to the Closing Date, Seller shall cooperate, but will not be required to spend any monies other than any fees and expenses of Seller's counsel which Seller elects to incur, in whatever manner is reasonably required by Purchaser or any independent inspector, surveyor, or governmental authority in order for Purchaser to obtain any environmental site assessment reports, surveys or any other reports requested by Purchaser to assess the Property and to pursue the hereafter defined Plat and all approvals and entitlements required for the Intended Use, all at Purchaser's expense other than any fees and expenses of Seller's counsel which Seller elects to incur.

7. Possession. Seller shall deliver possession of the Property to Purchaser on the Closing Date.

8. Place and Date of Closing. The closing of the sale and purchase of the Property (the "Closing") shall take place within thirty (30) days following the completion of the Inspection Period (or, if exercised, the Extension Period), or such other date as may be agreed upon by the parties hereto in writing. The Closing shall take place at the offices of the Escrow Agent and shall be conducted pursuant to an escrow-style closing through the Escrow Agent (or such other party selected by Purchaser and Seller) so that it will not be necessary for any party to physically attend the Closing. The actual date of Closing is referred to herein as the "Closing Date."

9. Additional Inspections.

   a. Survey. Purchaser, at its expense, will cause a survey of the Property and improvements to be prepared by a surveyor acceptable to Purchaser. The survey shall be certified to Purchaser and First American Title Insurance Company (the "Title Company").

b. Environmental. Purchaser, at its expense, may obtain during the Inspection Period a written environmental site assessment report prepared by an environmental engineer acceptable to Purchaser.

c. Zoning. Purchaser intends to develop, improve and operate the Property and the Adjacent Property (as defined in Paragraph 36 below) as an inpatient rehabilitation hospital, together with on-site parking, signage, amenities and other support and accessory uses, all to be set forth on Purchaser's development plan (the "Intended Use"). Purchaser's obligation to close the purchase of the Property is subject to Purchaser's having received, prior to the expiration of the Inspection Period (or, if exercised, the Extension Period), adequate evidence (as determined by Purchaser in its sole and absolute discretion) that the Property is zoned in such a manner that the development and operation of the Property for the Intended Use will comply with any and all applicable laws and use restrictions affecting the Property. Seller agrees to cooperate with Purchaser in applying for any necessary rezoning of the Property such that the development and operation of the Property for the Intended Use will comply with any and all applicable laws and use restrictions affecting the Property.

d. Utilities. Purchaser, at its expense, will perform such investigations as are necessary in order for Purchaser to determine whether or not water, sanitary sewer, telephone, electricity, and all other necessary utility services are available at the boundary lines of the Property in such capacities as are reasonably determined by Purchaser and its engineers to be necessary for the Intended Use. To the extent such utilities are not so available, Seller will be responsible for causing all such utilities to be available at the boundary lines of the Property prior to Closing.

e. Lot Combination Plat. Purchaser, at its option and sole cost and expense, intends to cause the Property and the Adjacent Property, at or after Closing, to be combined so that they constitute a single platted, legal lot, and such platting/lot combination process shall be approved by Palm Beach County and/or the applicable governing authorities prior to Closing. Purchaser agrees to promptly respond in writing to any inquiry from Seller regarding the status of Purchaser's due diligence and entitlements efforts, including without limitation the platting, lot combination and zoning approval process. Purchaser agrees to provide to Seller upon request copies of all submittals related to the platting/lot combination process described herein and to promptly respond to any inquiries from Seller regarding the status of Purchaser's progress in finalizing the lot combination documents and having them approved by the applicable governmental authorities for recordation. Purchaser shall deliver to Seller a copy of the final recorded plat (the "Plat") promptly after its recordation. Purchaser agrees that Closing must take place prior to the Property and the Adjacent Property being officially combined.

The matters described in this Paragraph 9 (the "Additional Inspections") shall be deemed Inspections, and shall be subject to Purchaser's review and approval. If any Inspection or other matter related to the Property is deemed unacceptable by Purchaser for any reason in its sole discretion during the Inspection Period set forth in Paragraph 4, Purchaser shall

have the right to terminate this Agreement prior to the end of the Inspection Period, in which case all Earnest Money deposited shall be refunded to Purchaser and neither party shall have any further claim against the other. If Purchaser determines during any Extension Period that Purchaser will be unable to obtain all final entitlements and approvals (including, without limitation, zoning approvals, site plan approvals and the Plat) necessary for the Intended Use, Purchaser shall have the right to terminate this Agreement. If such termination by Purchaser occurs (i) prior to the end of the second Extension Period, all Earnest Money deposited shall be refunded to Purchaser and neither party shall have any further claim against the other or (ii) after the end of the second Extension Period and prior to the end of any applicable, properly exercised Extension Period, all Earnest Money deposited shall be released to Seller (unless the reason for termination is Purchaser's failure to obtain site plan approval for the Intended Use, in which case all Earnest Money deposited shall be refunded to Purchaser) and neither party shall have any further claim against the other.

10. Conveyance. At Closing, Seller (i) shall convey good and marketable fee simple title to the Property to Purchaser by special warranty deed subject only to such restrictions, easements and other matters of record reflected in the Title Commitment and accepted by Purchaser during the Inspection Period and (ii) shall execute an assignment of Seller's right, title and interest in and to all rights, credits, permits, approvals, authorizations and licenses relating to or affecting the Property, together with any and all entitlements, privileges, trips, square footage allocations, development approvals, land use approvals, impact fee credits, sewer rights, water rights and other development rights relating to or affecting the Property.

11. Costs and Fees. Purchaser shall be responsible for the title insurance premium for Purchaser's owner's title insurance policy (and the title search and abstract fees associated with said title insurance policy), the payment of all recording taxes, documentary stamps, transfer taxes and other charges for recording the deed, the cost of Purchaser's survey, the cost of the Plat, the cost of any other third party reports obtained by Purchaser, any closing or escrow fee charged by the Escrow Agent, and any other costs not described herein customarily borne by a purchaser in commercial real estate transactions in the county where the Property is located. Seller shall be responsible for any costs not described herein customarily borne by a seller in commercial real estate transactions in the county where the Property is located. Seller and Purchaser shall each pay its respective costs for its own attorneys' fees for services related to the negotiation and preparation of this Agreement and the sale and purchase of the Property.

12. Apportionments. Ad valorem taxes and assessments, if any, for the tax year in which the Closing occurs are to be apportioned (on the basis of a 365-day year) as of the Closing Date in accordance with the following procedures:

    a. Apportionment of ad valorem taxes and assessments, if any, shall be made on the basis of the tax year for which assessed. If the Closing Date shall occur before the tax rate for the current year shall be established, the tax rate for the preceding year shall be applied to the last assessed valuation. After the taxes and assessments, if any, are finally fixed, Seller and Purchaser shall make a recalculation of the apportionment of same, and Seller or Purchaser, as the case may be, shall make an

appropriate payment to the other based on such recalculation. All real property assessments levied against the Property prior to the Closing Date shall be apportioned as provided for herein. Seller's and Purchaser's obligations under this subparagraph (a) shall survive the Closing.

b. If any refund of real property taxes and assessments is made after the Closing Date in respect of a period any portion of which was prior to the Closing Date, the same shall be applied first to the costs incurred in obtaining the refund. The balance, if any, of such refund shall be paid to Seller (for the period prior to the Closing Date) and to Purchaser (for the period commencing with the Closing Date).

c. If there is a net balance due Seller on the foregoing apportionments, the same shall be paid by Purchaser at the Closing. If there be a net balance due Purchaser on the foregoing apportionments, the same shall be credited against the Purchase Price at the Closing.

d. In the event the tax parcel in which the Property is located contains any additional property as of the Closing Date, Seller and Purchaser agree to enter into a tax proration agreement at Closing, which shall provide, among other things, that (i) as soon as reasonably possible after Closing, the parties will diligently pursue until completion a tax parcel split that creates a separate tax parcel that includes the Property and no other property and (ii) in the event such tax parcel split is not effective prior to the delivery of any tax assessments following the Closing, each party will be responsible for its pro rata share of such assessment.

13. Representations and Warranties of Seller. To induce Purchaser to enter into this Agreement, Seller makes the following representations and warranties, all of which are true as of the date hereof (unless otherwise specified) and shall also be true as of the Closing Date:

a. Seller has full power and authority to enter into this Agreement and to perform all of its obligations hereunder. The execution and delivery of this Agreement and the performance by Seller of its obligations hereunder have been duly authorized by all requisite action and no further action or approval is required in order to constitute this Agreement as a binding and enforceable obligation of Seller.

b. No act or omission has occurred with respect to the Property and no materials or services have been furnished or delivered on or to the Property which would create or otherwise encumber the Property with any mechanics, materialman, laborer, or other similar type lien after the Closing Date.

c. Seller has no actual knowledge of and shall not initiate or participate in any changes in zoning proposed by any applicable zoning authority, except as may be requested by Purchaser.

d. The Property has full and free access to and from a dedicated public roadway, and there is no pending or, to the best of Seller's knowledge, any threatened

proceeding by any governmental authority or any other fact or condition which might limit or result in the termination of such access. Seller owns and will convey to Purchaser at Closing, good, indefeasible, fee simple title to the Property, free and clear of all conditions, exceptions or reservations, except the restrictions, easements, and other matters of record reflected in the Title Commitment and accepted by Purchaser during the Inspection Period.

e. There are no outstanding written or oral leases or agreements relating to the use or possession of the Property, and to the best of Seller's knowledge, there are no parties claiming any rights to possess any portion of the Property.

f. There are no special assessments of any kind presently pending against the Property and Seller has not received any notice of any special assessments being contemplated.

g. No default or breach exists under any of the covenants, conditions, restrictions, rights-of-way, or easements, if any, affecting all or any portion of the Property.

h. Seller has not received any notice of a violation of any law, ordinance, statute, code, rule, regulation, order or decree of any governmental authorities having jurisdiction over the Property.

i. There are no agreements to which Seller is a party or notices that Seller has received which in any way affect any portion of the Property or affect Seller's ability to sell or convey the Property.

j. No attachments, execution proceedings, assignments for the benefit of creditors, insolvency, bankruptcy, reorganization or other proceedings are pending or threatened against Seller, nor are any of such proceedings contemplated by Seller.

k. Seller has received no written notice and has no actual knowledge that there is any plan, study or effort of any governmental authority that would materially affect the current use of the Property, including, without limitation, any threatened condemnation or taking, or any intended public improvements that would result in any charge being levied against, or any lien assessed upon, the Property, including, without limitation, any resolution or ordinance intending to condemn any portion of the Property.

l. As of the Closing Date, no commissions, brokerage fees or similar payments with respect to the Property shall be due and owing for which Seller is bound and liable and there are no existing brokerage commission or similar agreements entered into by Seller to which Seller is bound or liable relating to the sale or leasing of all or any portion of the Property.

m. No other person or other entity has any right or option to acquire or lease any or all of the Property or any right of first refusal with regard to the purchase of the Property.

n. To the best knowledge of Seller, neither Seller nor any previous owner, tenant, occupant or user of the Property, nor any other person, has engaged in or permitted any operations or activities upon, or any use or occupancy of the Property, or any portion thereof, for the purpose of or in any way involving the handling, manufacture, treatment, storage, use, generation, release, discharge, refining, dumping or disposal of any Hazardous Materials (as hereinafter defined) in violation of any applicable laws or regulations on, under, in or about the Property, or transported any Hazardous Materials to, from or across the Property, nor are any Hazardous Materials presently constructed, deposited, stored, or otherwise located on, under, in or about the Property, nor have any Hazardous Materials migrated from the Property upon or beneath other properties, nor have any Hazardous Materials migrated or threatened to migrate from other properties upon, about or beneath the Property, nor are any underground improvements, including but not limited to storage tanks, dumps, or water, gas or oil wells now located or have ever been located on the Property. As used herein, the term "Hazardous Materials" means any substance:

i. the presence of which requires investigation or remediation under any federal, state or local statute, regulation, ordinance, order, action, policy or common law; or

ii. which is or becomes defined as a "hazardous waste," "hazardous substance," pollutant or contaminant under any federal, state or local statute, regulation, rule or ordinance or amendments thereto including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act (42 U.S.C. § 9601 et seq.) and/or the Resource Conservation and Recovery Act (42 U.S.C. § 6901 et seq.); or

iii. which is toxic, explosive, corrosive, flammable, infectious, radioactive, carcinogenic, mutagenic, or otherwise hazardous and is or becomes regulated by any governmental authority, agency, department, commission, board, agency or instrumentality of the United States, the State of Florida or any political subdivision thereof; or

iv. the presence of which on the Property causes or threatens to cause a nuisance upon the Property or to adjacent properties or poses or threatens to pose a hazard to the health or safety of persons on or about the Property; or

v. the presence of which on adjacent properties could constitute a trespass by Seller; or

vi. without limitation, which contains gasoline, diesel fuel or other petroleum hydrocarbons; or

vii. without limitation, which contains polychlorinated bipheynols (PCBs), asbestos or urea formaldehyde foam insulation; or

viii. without limitation, radon gas.

With respect to the representations and warranties contained in this Paragraph 13, Seller agrees to indemnify, defend, reimburse and hold harmless Purchaser, its affiliates, successors and assigns from any and all liabilities, costs, damages and expenses (including without limitation, attorneys' fees) arising from or related to the breach of any representation or warranty as to conditions existing on or prior to the Closing Date. The provisions of this Paragraph 13 shall survive Closing.

14. Title Commitment.

a. During the Inspection Period, Purchaser, at its expense, shall obtain a title commitment, together with legible copies of all exceptions (the "Title Commitment") issued by the Title Company for an owner's title insurance policy in the amount of the Purchase Price setting forth the status of title to the Property and any exceptions thereto. After the Effective Date, Seller shall in no way encumber or burden the Property without the prior written consent of Purchaser.

b. If a search of the title discloses judgments, bankruptcies or other liens against other persons having names the same as or similar to that of Seller, Seller, on request, shall deliver to Purchaser and the Title Company affidavits showing that such judgments, bankruptcies or other liens are not against Seller.

c. Purchaser may object to any matters shown on the Title Commitment or Purchaser's survey by notifying Seller in writing of any objections prior to the expiration of the Inspection Period. Seller shall have thirty (30) days after receipt of title and survey objections to either cure such objections or notify Purchaser of which objections Seller will and will not cure. Should Seller notify Purchaser that Seller will not cure any timely made title and survey objections or should Seller fail to timely cure any such objections, Purchaser shall have the right either (i) to terminate this Agreement prior to Closing, in which case the Earnest Money shall be refunded promptly to Purchaser, this Agreement shall terminate, and neither party shall have any further claim against the other, or (ii) to waive the necessity of such cure(s) and to proceed to Closing with no reduction in the Purchase Price.

d. If any update to the Title Commitment or Purchaser's survey prior to Closing reveals any new encumbrance, lien or question of title which was not created or caused to be created by Purchaser, then Purchaser shall have the right to object to the same in writing to Seller. Seller shall have five (5) business days after receipt of any such subsequent title and survey objections to either cure such objections or notify Purchaser of which objections Seller will and will not cure. Should Seller notify Purchaser that Seller will not cure any subsequent title and survey objections or should Seller fail to timely cure any such objections, Purchaser shall have the right either (i) to terminate this Agreement prior to Closing, in which case the Earnest Money shall be refunded promptly to Purchaser, this Agreement

shall terminate, and neither party shall have any further claim against the other, or (ii) to waive the necessity of such cure(s) and to proceed to Closing with no reduction in the Purchase Price.

e. At the Closing, Seller shall deliver to Purchaser, with a copy thereof to the Title Company, an affidavit with respect to (i) mechanic's liens, certifying that as of the Closing Date there are no known unpaid bills rendered or to be rendered for services performed or materials furnished to the Property and (ii) parties in possession, certifying that on the Closing Date, there are no parties other than Seller in possession of the Property.

15. Conditions Precedent to Closing. The obligations of Purchaser and Seller under this Agreement are subject to all covenants, agreements, actions, proceedings, instruments and documents required pursuant to this Agreement (including without limitation satisfaction of the Additional Inspections) having been performed, complied with or delivered (as the case may be) in accordance with this Agreement.

16. Documents for Closing.

a. Seller's attorney shall prepare the necessary instruments required in the Title Commitment in connection with transferring title to the Property to Purchaser. In addition to the special warranty deed, Seller shall (if applicable) prepare a resolution authorizing the sale of the Property to Purchaser and authorizing specific corporate officers, partners, or representatives as the case may be, to execute the necessary documents to transfer title to the Property to Purchaser. Seller, at Seller's sole cost and expense, shall also deliver or cause to be delivered to Purchaser the following documents:

i. a certificate of non-foreign status to ensure Seller's compliance with Foreign Investment in Real Property Tax Act ("FIRPTA") (Section 1445 of the Internal Revenue Code of 1986, as amended); and

ii. such additional documents and instruments as Purchaser or the Title Company may reasonably require to transfer Seller's interest in the Property pursuant to the terms of this Agreement, each of which shall be in form and substance satisfactory to Purchaser, the Title Company and Purchaser's counsel.

b. At the Closing, Purchaser shall deliver, or cause to be delivered, to Seller in accordance with the terms of this Agreement the Purchase Price less the Earnest Money and prorations.

17. Remedies. Notwithstanding anything to the contrary set forth in this Agreement or in any document delivered in connection with the transaction contemplated by this Agreement, the parties hereto agree that if Seller fails to comply with any of the provisions of this Agreement, Purchaser shall have the right to (a) terminate this Agreement and receive (i) a prompt refund of the Earnest Money and (ii) prompt reimbursement from Seller of the actual, documented out-of-pocket costs incurred by Purchaser in connection with this

Agreement, Purchaser's inspections of the Property and its pursuit of the approvals and entitlements for the Intended Use, as full liquidated damages, or (b) bring a suit for specific performance under this Agreement. Notwithstanding the foregoing, if specific performance is unavailable to Purchaser as a remedy due to the fraud or willful misconduct of Seller, Purchaser may sue Seller to recover the Earnest Money and monetary damages.

18. Condemnation and Destruction. If, on or prior to the Closing Date, all or any reasonably substantial portion of the Property is the subject of a pending or contemplated taking by eminent domain which has not been consummated or if the Property has been materially damaged or destroyed, Seller shall notify Purchaser of such fact and Purchaser shall have the option to terminate this Agreement and, in the event Purchaser shall elect to terminate this Agreement, Purchaser shall be entitled to a prompt refund of the Earnest Money. If this Agreement is terminated and the Earnest Money is returned, as aforesaid, neither party shall have any further rights or obligations hereunder. If, after receipt of Seller's notice, as aforesaid, Purchaser does not exercise its option to terminate this Agreement, the parties hereto shall remain bound hereunder and Seller shall assign and turn over, and Purchaser shall be entitled to receive and keep, all awards for the taking by eminent domain described in said notice or all insurance proceeds payable as a result of such destruction or damage.

19. Final Agreement. This Agreement represents the final agreement of the parties and no agreements or representations, unless incorporated in this Agreement shall be binding on any of the parties and no portion hereof shall be amended or modified unless such change shall be in writing and signed by both parties thereto.

20. Notice. All notices, requests, demands or other communications required or permitted under this Agreement shall be in writing and delivered either: (i) personally; (ii) by certified or registered mail, return receipt requested, postage prepaid; (iii) by a recognized overnight courier service (such as Fed Ex); or (iv) by email (provided that a notice delivered by email shall promptly thereafter be delivered by one of the other methods permitted in this Paragraph 20), addressed as follows:

If to Seller: Stan L. Crooks and Evangeline C. Aguirre
9645 Lantana Road
Lake Worth, FL 33467
Phone: 561-317-9438
Email:lettsville@gmail.com

If to Purchaser: Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242
Attn: Real Estate Department
Phone: 205-970-7316
Email: david.stephenson@encompasshealth.com

With a copy to: Bradley Arant Boult Cummings LLP
1819 Fifth Avenue North

Birmingham, AL 35203
Attn: Dawn Helms Sharff
Phone: 205-521-8200
Email: dsharff@bradley.com

If to Escrow Agent: First American Title Insurance Company
4211 W. Boy Scout Blvd., Suite 650
Tampa, FL 33607
Attn: Lauri Slater
Email: lslater@firstam.com

All notices given in accordance with the terms hereof shall be deemed received at such time as they are actually delivered (if personally delivered) or sent by email (if delivered by email), on the next business day if sent by overnight courier, or on the third business day following deposit with the United States Mail as a registered or certified matter with postage prepaid. Either party hereto may change the address for receiving notices, requests, demands or other communication by notice sent in accordance with the terms of this Paragraph 20.

21. Number and Gender. Whenever the singular number is used herein and when required by the context, the same shall include the plural, and the masculine gender shall include the feminine and neuter genders, and the word "person" shall include a corporation, firm, partnership, joint venture, trust or estate.

22. Counterparts; Electronic Execution and Retention. This Agreement may be executed in any number of counterparts, each of which, when so executed, shall be deemed to be an original, and such counterparts shall, together, constitute and be one and the same instrument. A signature on a counterpart may be made by facsimile or otherwise electronically transmitted, and such signature shall have the same force and effect as an original signature. Further, this Agreement may be retained in any electronic format, and all electronic copies thereof shall likewise be deemed to be an original and shall have the same force and effect as an original copy of this Agreement.

23. Governing Law. This Agreement shall be governed by, construed and enforced in accordance with the laws of the State in which the Property is located, without regard to its conflicts of law provisions.

24. Assignment; Successors and Assigns. This Agreement may be assigned by Purchaser without Seller's consent (so long as the assignee assumes all of Purchaser's obligations hereunder and Purchaser promptly furnishes to Seller a copy of the fully executed assignment and assumption agreement), and shall be binding upon and inure to the benefit of the parties hereto and their respective representatives, successors and assigns. In the event this Agreement is assigned by Purchaser to any person other than a special purpose entity affiliated with Purchaser and formed by Purchaser for the purpose of acquiring the Property, Purchaser will pay Seller a ten thousand dollar ($10,000)

assignment fee. Seller shall not assign this Agreement, in whole or in part, without the prior written consent of Purchaser.

25. Survival. The representations, warranties and indemnities contained herein shall be deemed to have been made again by the parties as of the Closing Date, and shall survive the expiration or termination of this Agreement, the discharge of all other obligations owed by the parties to each other, and any transfer of title to the Property, and shall not be affected by any investigation by or on behalf of Purchaser, or by any information which Purchaser may have or obtain with respect thereto.

26. Confidentiality. Except for those public disclosures required by applicable law, Seller and Purchaser hereby agree that prior to the Closing the matters contained herein shall remain confidential, and that neither party will reveal the contents of this Agreement to any third parties other than their respective agents, employees, attorneys, accountants, consultants and any prospective assignees of this Agreement. Seller further agrees that Purchaser may provide a copy of this Agreement to and/or discuss the terms herein with architects, engineers, title examiners and other third party service providers that Purchaser engages in relation to the Property, any prospective investors, and any governmental officials and utility and other non-governmental entities with whom Purchaser may deal prior to Closing in regard to the Property. Each party will have all remedies available at law or in equity in the event of a breach of this paragraph by the other party hereto or its affiliates.

27. Severability. In the event that any condition or covenant herein contained is held to be invalid or void by any court of competent jurisdiction, the same shall be deemed severable from the remainder of this Agreement and shall in no way affect any other covenant or conditions herein contained. If such condition, covenant or other provision shall be deemed invalid due to its scope or breadth, such provision shall be deemed valid to the extent of the scope or breadth permitted by law.

28. Waiver and Amendment. No breach of any provision hereof can be waived unless in writing. Waiver of any one breach shall not be deemed to be a waiver of any other breach of the same or any other provision hereof. This Agreement may be amended only by a written agreement executed by all of the parties hereto.

29. Captions and Interpretations. Paragraph titles or captions contained herein are inserted as a matter of convenience and for reference, and in no way define, limit, extend or describe the scope of this Agreement or any provision hereof. No provision in this Agreement is to be interpreted for or against either party because that party or his legal representative drafted such provision.

30. Public Announcements. Seller and Purchaser agree that public announcements, if any, concerning the subject matter of this Agreement shall be mutually approved in advance; provided, however, Purchaser shall be allowed to make a public announcement that it intends to build an inpatient rehabilitation hospital in the market in which the Property is located without any prior approval of Seller.

31. Broker Commission. Renaissance Realty Associates (the "Broker") represents Purchaser in connection with this transaction, and if a Closing occurs pursuant to this Agreement, Purchaser shall pay the Broker a commission upon Closing pursuant to a separate agreement between Purchaser and Broker. Seller and Purchaser each warrants that, except for the Broker (who represents Purchaser), it has not been represented by a broker in conjunction with negotiating this sale. Seller and Purchaser each hereby covenants and agrees to defend, indemnify, and hold harmless the other party against and from any and all loss, expense, liability, cost, claim, demand, damage, action, cause of action, and suit arising out of or in any manner relating to the alleged employment by such party of any real estate broker or agent in connection with this transaction. The provisions of this Paragraph 31 shall survive the Closing and any termination of this Agreement.

32. Signage. Purchaser shall be permitted to erect a sign at the Property prior to the Closing Date, which sign shall advertise the Property as a future inpatient rehabilitation hospital location of Purchaser.

33. Business Days. In the event any period of time provided for in this Agreement ends on a day other than a business day on which banks are generally open for a full day for business, such ending date shall automatically be extended to the next business day.

34. Representations and Warranties of Seller and Purchaser. Purchaser and Seller hereby represent that the terms and conditions set forth in this Agreement were negotiated at arm's length by the parties and that the Purchase Price represents a reasonable estimation of the fair market value of the Property not taking into account any former, current or future business relationships between Seller and Purchaser. The parties further represent and warrant that it is not a purpose of this Agreement or the transaction contemplated herein to induce the referral of patients. The parties acknowledge that there is no requirement nor payment under this Agreement or any agreement between the parties that either refers, recommends or arranges for any items or services paid for by Medicare or Medicaid. Either party may refer patients to any hospital providing services needed by a patient, and will make such referrals, if any, consistent with professional medical judgment and the wishes of the patient.

35. Seller's Covenants. While this Agreement is in effect, Seller will not actively market, sell or encumber the Property in any manner, will not accept, negotiate or entertain any other offers for the Property and will maintain the Property in its current condition and in compliance with applicable laws. Seller shall not take any other action which would cause any representation, warranty or covenant set out herein to be untrue as of Closing without Purchaser's prior written consent. Without the prior written consent of Purchaser, which may be granted or denied in Purchaser's sole and absolute discretion, Seller shall not enter into any oral or written service, maintenance, employment or other contracts, leases or agreements affecting the Property which would survive the Closing or otherwise affect the use, operation or enjoyment of the Property after the Closing, it being understood that Purchaser does not intend to take an assignment of any leases, service contracts or similar agreements at Closing.

36. Contingency Regarding Adjacent Property. On or around the date hereof, Purchaser intends to be under contract to purchase from Eastwood Lantana LLC certain property

adjacent to the Property and located at 9719 Lantana Road, as depicted on Exhibit A attached hereto and made a part hereof (the "Adjacent Property"), pursuant to the terms of a separate purchase and sale agreement. Notwithstanding anything in this Agreement to the contrary, at Purchaser's election, Purchaser's obligation to close on the purchase of the Property shall be contingent on Purchaser's closing on the Adjacent Property. Notwithstanding anything to the contrary implied in this Agreement, should Purchaser fail to close on the Adjacent Property for any reason other than a default of Purchaser prior to the Closing Date, Purchaser shall have a right to terminate this Agreement and receive a full refund of the Earnest Money upon written notice given to Seller and the Escrow Agent prior to Closing. Purchaser will provide to Seller, withing thirty days of the Effective Date, confirmation in writing that Purchaser has a signed purchase and sale agreement with Eastwood Lantana LLC for the Adjacent Property. Purchaser's failure to provide this confirmation to Seller within thirty days of the Effective Date will allow Seller, at Seller's election, to terminate this Agreement without penalty or cost to Seller (in which case Purchaser shall receive a full refund of the Earnest Money).

[remainder of page blank]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective duly authorized representatives as of the date set forth above.

PURCHASER:

ENCOMPASS HEALTH CORPORATION

By: _____
Name: EDMUND H BALL
Title: CHIEF REAL ESTATE OFFICER

SELLER:

_____
Stan L. Crooks

_____
Evangeline C. Aguirre

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective duly authorized representatives as of the date set forth above.

PURCHASER:

ENCOMPASS HEALTH CORPORATION

By:_____
Name:_____
Title:_____

SELLER:

_____
Stan L. Crooks

_____
Evangeline C. Aguirre

JOINDER

First American Title Insurance Company hereby acknowledges the receipt of the initial Earnest Money described in the Agreement to which this Joinder is attached and agrees to hold all Earnest Money in accordance with the terms hereof, and in accordance with the terms of its Conditions of Escrow, a copy of which is attached hereto as Exhibit B.

FIRST AMERICAN TITLE INSURANCE COMPANY

By: _____
Name: _____
Title: _____

Date: _____

Exhibit A

[Depiction of Property and Adjacent Property]

Exhibit B

FIRST AMERICAN TITLE INSURANCE COMPANY

CONDITIONS OF ESCROW

Except as specifically modified by the written escrow instruction(s) received and accepted by the Escrow Agent, the following Conditions of Escrow shall apply to this escrow or settlement.

1. ESCROW AGENT: First American Title Insurance Company is herein referred to as the Escrow Agent.

2. DEPOSIT OF FUNDS: All checks, money orders or drafts will be processed for collection in the normal course of business. Escrow Agent may commingle funds received by it in escrow with escrow funds of others, and may, without limitation, deposit such funds in its custodial or escrow accounts with any reputable trust company, bank, savings bank, savings association, or other financial services entity, including any affiliate of Escrow Agent. It is understood that Escrow Agent shall be under no obligation, except to the extent noted on Instruction For Investment of Escrow Funds form, to invest the funds deposited with it on behalf of any depositor, nor shall it be accountable for any earnings or incidental benefit attributable to the funds which may be received by Escrow Agent while it holds such funds. Deposits held by Escrow Agent shall be subject to the provisions of applicable state statutes governing unclaimed property.

3. LIMITATIONS OF LIABILITY: Escrow Agent shall not be liable for any loss or damage resulting from the following item(s):

(a) The effect of the transaction underlying this escrow including, without limitation, any defect in the title to the real estate, any failure or delay in the surrender of possession of the property, the rights or obligations of any party in possession of the property, the financial status or insolvency of any other party, and/or any misrepresentations of fact made by any other party;

(b) The legal sufficiency of the document(s) purporting to transfer or otherwise encumber title to the real estate; provided, however, that this limitation of liability shall not affect the liability of First American Title Insurance Company under any title insurance policy which it has issued or may issue.

(c) The default, error, act or failure to act by any other party to the escrow;

(d) Any loss, loss of value or impairment of funds which have been deposited in escrow while those funds are in the course of collection or while those funds are on deposit in a depository institution if such loss, loss of value or impairment results from the failure, insolvency or suspension of a depository institution;

(e) Any defects or conditions of title to any property that is the subject of this escrow provided, however, that this limitation of liability shall not affect the liability of First American Title Insurance Company under any title insurance policy which it has issued or may issue. NOTE: No title insurance liability is created by this agreement;

(f) The expiration of any time limit or other consequences of delay, absent receipt of a properly executed escrow instruction, accepted by Escrow Agent, instructing the Escrow Agent to comply with said time limit; and

(g) Escrow Agent's compliance with any legal process including, but not limited to, subpoena, writs, orders, judgments and decrees of any court whether issued with or without jurisdiction and whether or not subsequently vacated, modified, set aside or reversed.

(NOTE: This paragraph shall not be construed to limit Escrow Agent's liability for its own gross negligence or willful misconduct.)

4. DEFAULT AND/OR DISPUTES: In the event any party to the transaction underlying this escrow shall tender any performance after the time when such performance was due, Escrow Agent may proceed under this escrow, unless one of the parties to this escrow shall give to the Escrow Agent a written direction to stop the further performance of the Escrow Agent's functions hereunder. In the event of written notice of default or dispute is given to the Escrow Agent by any party, Escrow Agent will promptly notify all other parties of such notice. Thereafter, Escrow Agent will decline to disburse funds or to deliver any instrument or otherwise continue to perform its escrow functions, except upon receipt of a mutual written agreement of the parties or upon an appropriate order of court.

5. ACCOUNTING: Escrow Agent shall account to the parties for all funds received and disbursed hereunder at the time of final settlement and closing of this escrow. Escrow Agent shall not be liable for the accuracy of information furnished to it by other persons in the normal course of business, or the failure to adjust items not designated in writing. Adjustment items shall be prorated on the basis of a calendar year and a thirty day month. Escrow Agent shall account for adjustments, credits and charges of expense items according to the custom and usage of the community. Absent specific written instructions to the contrary, signed approval of settlement statements or other accounting of funds shall constitute the authority to Escrow Agent to disburse funds as shown thereon, and deliver instruments held in escrow as set forth in the escrow instruments. Upon completion of the disbursement of funds and delivery of instruments, Escrow Agent shall be released and discharged of its escrow obligations hereunder.

6. FEES, CHARGES AND/OR OTHER EXPENSES: Escrow Agent shall charge for its service hereunder in accordance with its current schedule of fees (which includes annual maintenance fees) unless otherwise provided. Unless otherwise directed, such fees shall be charged to the buyer and seller equally. All fees, charges and expenses are due and payable at settlement and such amounts may be deducted by Escrow Agent from any funds held in escrow due to the party from whom such amounts are due and owing. Additional amounts which may become due for any reason shall be promptly paid to Escrow Agent by the party owing such amounts. Escrow Agent shall not be required to advance its own funds for any purpose provided that any such advance, made at its option, shall be promptly reimbursed by the party for whom it is advanced, and such optional advance shall not be an admission of liability on the part of Escrow Agent.

7. APPLICABILITY: These conditions of escrow shall apply to and be for the benefit of agents, if any, of the Escrow Agent so employed by it for services in connection with this escrow.

8. ATTORNEYS' FEES: In the event that litigation is initiated relating to this escrow, the parties hereto agree that Escrow Agent shall be held harmless from any and all attorneys' fees, court costs and expenses relating to that litigation to the extent that litigation does not arise as a result of the Escrow Agent's gross negligence or willful misconduct. The parties hereto agree to indemnify Escrow Agent for all such attorneys' fees, court costs and expenses.

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT (this "Agreement") is entered into on or as of this 18th day of May, 2021 (the "Effective Date"), by and between EASTWOOD LANTANA, LLC, a Delaware limited liability company ("Seller"), and ENCOMPASS HEALTH CORPORATION, a Delaware corporation ("Purchaser").

Recitals

A. Seller is the owner of that certain improved parcel of real property consisting of approximately 4.05 acres, more or less, located at 9719 Lantana Road, in Lake Worth, Palm Beach County, Florida (tax parcel control number 00-42-43-27-05-034-0432), which property is more particularly depicted on Exhibit A attached hereto and made a part hereof and legally described on Exhibit B attached hereto (the "Property").

B. Purchaser desires to purchase the Property, and Seller desires to sell the Property pursuant to the terms and conditions of this Agreement.

Agreement

NOW, THEREFORE, in consideration of the above Recitals and other good and valuable consideration, including the mutual covenants and promises herein contained, the receipt and sufficiency of which are hereby acknowledged, Seller and Purchaser hereby agree as follows:

1. Agreement to Sell. For the consideration set forth in Paragraph 2 below, Seller hereby agrees to grant, bargain, sell, assign and convey to Purchaser, the Property, together with all improvements, easements, licenses, privileges, appurtenances, water rights and other rights pertaining thereto, including without limitation all air or air space rights, all subsurface rights, all riparian rights, all title and interest of Seller in and to adjacent roads, rights of way, alleys, drainage facilities, utility facilities, impact fee credits, concurrency rights, development rights, sewer or water reservations or tap-in rights, and any and all similar development rights incident or related thereto.

2. Purchase Price. The total purchase price for the Property shall be $4,000,000 (the "Purchase Price"), to be paid as hereinafter provided.

3. Earnest Money. Purchaser will deliver, within three (3) business days following the Effective Date, a wire in the amount of Twenty-Five Thousand and No/100 Dollars ($25,000) to First American Title Insurance Company (the "Title Company") (the $25,000 deposit, together with any additional deposits made pursuant to Paragraph 4, and any interest thereon, is hereinafter referred to as the "Earnest Money"), to be held and disbursed by the Title Company in accordance with the terms of this Agreement. Title Company shall deposit the Earnest Money in its interest bearing trust account. Except as may be otherwise expressly provided in this Agreement, the Earnest Money shall not be refundable should Purchaser fail to purchase the Property and shall be forfeited to and retained by Seller as liquidated damages for taking the Property off the market prior to the Closing Date, and Seller shall have no further claim against Purchaser.

4. Right of Inspection.

   (a) Commencing the next business day after the Effective Date, Purchaser, its employees, agents or designees, at Purchaser's sole expense, shall have ninety (90) days (as such period may be extended as provided for hereunder, the "Inspection Period") to examine and test the Property, and shall further have the right of ingress and egress over and through the Property during normal business hours for the purpose of inspecting,

appraising, soil and environmental testing, testing for drainage, surveying, preparing engineering or architectural drawings, and any other activities reasonably necessary to assess the Property, including the review of the Title Commitment, as hereafter defined, and the satisfactory completion of the governmental permitting process (collectively, the "Inspections"). However, no Phase II environmental testing or sampling or any other invasive or intrusive testing or sampling (other than a typical geotechnical study) may be performed without Seller's prior written consent, which consent Seller agrees not to unreasonably withhold or delay provided Seller has first received a detailed description of the contemplated scope of work. Purchaser will give Seller not less than forty-eight (48) hours advance notice of its (and any of its Consultants) entry onto the Property by prior telephonic conference of such intention with Zach Hodges, Phone: (561) 965-2198 or by written notice of such intention to (and as confirmed by) Zach Hodges by e-mail to: zhodges@atldiversified.com. All of Purchaser's and its officers, agents, employees, members, shareholders, consultants, design professionals, engineers, land planners, architects and contractors (collectively, "Consultants") Inspections of the Property shall be conducted in such a way as to reasonably minimize interference with the business operations on the Property. Purchaser acknowledges that Seller conducts dangerous operations on the Property and Purchaser assumes all risks in connection with the entry by Purchaser and its Consultants onto the Property and the Inspections. Purchaser shall assume all risks involved in entering upon the Property for the Inspections and shall indemnify, defend and hold harmless Seller and the Seller Indemnified Parties (as hereinafter defined) from and against any and all expenses, claims, or losses arising from any activities of Purchaser or its Consultants on the Property prior to Closing, including without limitation, any attorney's fees or court costs occasioned by such claims. By not later than the Effective Date (the "Seller's Documents Delivery Date"), Seller shall make available to Purchaser, the documents listed on Exhibit C attached hereto (collectively, the "Existing Due Diligence").

(b) Prior to entering upon the Property or performing (or causing to be performed) any testing of the Property, Purchaser shall provide Seller with a Certificate of Insurance reflecting evidence of (1) commercial general liability and property damage insurance with limits of at least One Million Dollars ($1,000,000.00) per occurrence for bodily or personal injury or death and at least Two Million Dollars ($2,000,000.00) in the aggregate, and (2) contractual liability insurance naming Seller as an additional insured as its interest may appear under this Agreement only, and which policy(ies) shall be kept in force until the Closing Date. Purchaser will also provide certificates of insurance from those Consultants who will be entering the Property in connection with the Inspections at the time Purchaser notifies Seller of said Consultants' proposed date of entry onto the Property pursuant to Paragraph 4(a) but in no event later than the date of the Consultants' actual entry onto the Property. Purchaser shall notify all Consultants of the requirements of this Paragraph 4(b). In the event Purchaser or its Consultants fail to comply with the terms of this Paragraph 4(b), Seller shall have the right to prevent all further Inspections until Purchaser or its Consultants are in compliance.

(c) Notwithstanding anything herein to the contrary, Purchaser shall not be entitled to possession of the Property prior to Closing except for the aforementioned investigation purpose and for such other purposes as are specifically provided herein. Notwithstanding Purchaser's right to seek and obtain the Approvals, Purchaser shall have no right or ability to bind either Seller or the Property until such time as fee simple title to the Property is conveyed to Purchaser by Seller.

5. Approval Period.

(a) If Purchaser does not terminate this Agreement prior to the end of the Inspection Period, Purchaser shall automatically have an additional two hundred seventy (270)-day period (the "Approval Period") for Purchaser to pursue the various zoning, lot combination, site plan and other approvals necessary for the hereafter defined Intended Use (collectively, the "Approvals"). Within two business days after the last day of the Inspection Period, Purchaser will deliver a wire in the amount of Two Hundred Thousand and No/100 Dollars ($200,000) to the Title Company, which additional deposit shall become part of the Earnest Money hereunder.

(b) Purchaser shall be permitted to extend the Approval Period for four 90-day periods (collectively, the "Extension Period") for the purpose of continuing to pursue and obtain the Approvals, by providing written notice of such extension to Seller prior to the end of the Approval Period (as to the first Extension Period) or the last day of the then applicable Extension Period (as to the remaining extensions) and by depositing with the Title Company an additional Seventy-Five Thousand Dollars ($75,000) for each such extension (the "Extension Deposits"), which Extension Deposits shall become part of the Earnest Money hereunder. All Extension Deposits shall be non-refundable to Purchaser (except as expressly provided otherwise in this Agreement) but shall be applicable to the Purchase Price at Closing.

(c) Purchaser covenants and agrees that the Approvals to be obtained by Purchaser shall not impede, obstruct or limit Seller's operation of the existing business operations on the Property and that Purchaser shall take no actions that would cause any such impact and/or disruption. A breach of this covenant by Purchaser shall constitute a default by Purchaser under this Agreement entitling Seller to the remedies set forth in Paragraph 18(b).

(d) Purchaser shall provide Seller with (i) copies of all documents submitted to governmental authorities in connection with obtaining the Approvals promptly after such submittal, and (ii) at least three (3) business days' prior written notice of all meetings or hearings scheduled by Purchaser or its applicable Consultants with any governmental authority, community, neighborhood or other interested persons, groups or stakeholders in connection with obtaining the Approvals. In addition, (i) promptly after any written request from Seller (but no more frequently than monthly), Purchaser shall provide Seller with an update of the status of Purchaser's efforts to obtain the Approvals, and (ii) Purchaser shall meet (physically or by telephone) as reasonably requested by Seller to discuss the process so as to provide Seller with sufficient information about the status of the Approvals.

(e) Purchaser hereby agrees to indemnify, hold harmless and defend Seller and its agents, members, directors, officers, employees, attorneys, successors, assigns and affiliates (collectively, the "Seller Indemnified Parties"), and each of them, from and against any and all losses, causes of action, liabilities, claims, demands, obligations, damages, costs and expenses, including reasonable attorneys' and accountants' fees and costs, to which any of the Seller Indemnified Parties may become subject to the extent the same is caused by (i) any act, omission, conduct or activity of Purchaser or any of its officers, directors, employees, agents, attorneys, Consultants, successors or assigns, at the Property and (ii) Purchaser's efforts to seek and obtain all Approvals. Notwithstanding anything to the contrary set forth herein, Purchaser shall not be required to indemnify Seller for Seller's attorneys' fees or other fees and expenses of Seller's professionals in connection with

their review of documents submitted to governmental authorities or their attendance at meetings or hearings.

6. Application of Earnest Money or Refund. The Earnest Money shall be applied to the Purchase Price to be paid by Purchaser at Closing and shall be non-refundable to Purchaser, except as expressly provided otherwise in this Agreement.

7. Cooperation. Prior to the Closing Date, Seller shall cooperate, at no cost to Seller (except for any fees and expenses of Seller's counsel which Seller elects to incur), in whatever manner is reasonably requested by Purchaser or any independent inspector, surveyor, or governmental authority in order for Purchaser to obtain any environmental site assessment reports, surveys or any other reports requested by Purchaser to assess the Property and to pursue all Approvals.

8. Possession. Seller shall deliver possession of the Property to Purchaser on the Closing Date subject to the Permitted Exceptions (as defined in Paragraph 15(c)).

9. Place and Date of Closing. The closing of the sale and purchase of the Property (the "Closing") shall take place within thirty (30) days following the earlier of (i) the date Site Plan Approval is obtained, or (ii) the expiration of the Approval Period (or, if exercised, the Extension Period), or such other date as may be agreed upon by the parties hereto in writing. The Closing shall take place at the offices of the Title Company and shall be conducted pursuant to an escrow-style closing through the Title Company (or such other party selected by Purchaser and Seller) so that it will not be necessary for any party to physically attend the Closing. The actual date of Closing is referred to herein as the "Closing Date."

10. Additional Inspections.

(a) Survey. Purchaser, at its expense, during the Inspection Period will cause a survey of the Property and improvements to be prepared by a surveyor acceptable to Purchaser. The survey shall be certified to Purchaser and the Title Company.

(b) Environmental. Subject to the terms of Paragraph 4, Purchaser, at its expense, may obtain during the Inspection Period a written environmental site assessment report prepared by an environmental engineer acceptable to Purchaser.

(c) Zoning. Purchaser intends to develop, improve and operate the Property and the Adjacent Property (as defined in Paragraph 37 below) as an inpatient rehabilitation hospital, together with on-site parking, signage, amenities and other support and accessory uses, all to be set forth on Purchaser's development plan (the "Intended Use"). Purchaser's obligation to close the purchase of the Property is subject to Purchaser's having received, prior to the expiration of the Approval Period (or, if exercised, the Extension Period), adequate evidence (as determined by Purchaser in its sole and absolute discretion) that final site plan approval for Purchaser's Intended Use on the Property and the Adjacent Property has been obtained and the applicable appeal period has expired without the filing of any appeal or lawsuit seeking to challenge the site plan approval ("Site Plan Approval"). Purchaser shall provide Seller with evidence of Site Plan Approval within two (2) business days after Purchaser's receipt of same. Seller agrees to cooperate, at no cost to Seller (except for any fees and expenses of Seller's counsel which Seller elects to incur), with Purchaser in applying for the Approvals. Notwithstanding the foregoing, Purchaser shall have no right or ability to bind either the Seller or the Property prior to Closing.

(d) Utilities. Purchaser, at its expense, will perform such investigations as are necessary in order for Purchaser to determine whether or not water, sanitary sewer, telephone, electricity, and all other necessary utility services are available at the boundary lines of the Property in such capacities as are reasonably determined by Purchaser and its engineers to be necessary for the Intended Use. To the extent such utilities are not so available and Purchaser nonetheless elects to proceed with the Closing hereunder, Purchaser will be solely responsible, at no cost to Seller, for causing all such utilities to be available at the boundary lines of the Property.

(e) Lot Combination Plat. Purchaser, at its option and sole cost and expense, intends to seek all necessary Approvals that will permit the Property and the Adjacent Property to be combined so that they constitute a single platted, legal lot (the "Plat Approval"); provided, however, Plat Approval shall not be a condition to Purchaser's obligation to close.

The matters described in this Paragraph 10 (the "Additional Inspections") shall be deemed Inspections, shall be subject to Purchaser's review and approval, and shall be subject to all of the terms and conditions of Paragraph 4. If any Inspection or other matter related to the Property is deemed unacceptable by Purchaser for any reason in its sole discretion during the Inspection Period set forth in Paragraph 4, Purchaser shall have the right to terminate this Agreement prior to the end of the Inspection Period, in which case all Earnest Money deposited shall be refunded to Purchaser and neither party shall have any further claim against the other, except with respect to those obligations that expressly survive termination of this Agreement prior to the execution of the Approval Period. If, during the Approval Period, Purchaser determines that Purchaser will be unable to obtain all Approvals, Purchaser shall have the right to terminate this Agreement. If such a termination by Purchaser occurs during the Approval Period, (i) the initial $225,000 Earnest Money deposit shall be refunded to Purchaser, and (ii) all Extension Deposits shall be released to Seller, and neither party shall have any further claim against the other, except with respect to those obligations that expressly survive termination of this Agreement.

11. Conveyance. At Closing, Seller (i) shall convey fee simple title to the Property to Purchaser by special warranty deed subject only to the Permitted Exceptions, (ii) shall execute a quitclaim deed for the Property, utilizing the legal description for the Property set forth on the survey obtained by Purchaser in connection with this Agreement but only if there is a discrepancy between the legal description on Exhibit A attached hereto and the legal description on the survey, and (iii) shall execute a quit-claim assignment of Seller's right, title and interest, if any, in and to all rights, credits, permits, approvals, authorizations and licenses relating to or affecting the Property, together with any and all entitlements, privileges, trips, square footage allocations, development approvals, land use approvals, impact fee credits, sewer rights, water rights and other development rights relating to or affecting the Property.

12. Costs and Fees. Seller shall be responsible for the payment of all recording taxes, documentary stamps, transfer taxes and other charges for recording the deed, one-half of any closing or escrow fee charged by the Title Company, and any other costs not described herein customarily borne by a seller in commercial real estate transactions in the county where the Property is located. Purchaser shall be responsible for the title insurance premium for Purchaser's owner's title insurance policy (and the title search and abstract fees associated with said title insurance policy including any endorsements requested by Purchaser). In addition, Purchaser shall be responsible for the cost of Purchaser's survey, all fees costs and expenses in connection with seeking to obtain Approvals, all costs in connection with the Inspections, the cost of any other third party reports obtained by Purchaser, one-half of any closing or escrow fee charged by the Title Company, and any other costs not described herein customarily borne by a purchaser in commercial real estate

transactions in the county where the Property is located. Seller and Purchaser shall each pay its respective costs for its own attorneys' fees for services related to the negotiation and preparation of this Agreement and the sale and purchase of the Property.

13. Apportionments. Ad valorem taxes and assessments, if any, for the tax year in which the Closing occurs are to be apportioned (on the basis of a 365-day year) as of the Closing Date in accordance with the following procedures:

(a) Apportionment of ad valorem taxes and assessments, if any, shall be made on the basis of the tax year for which assessed. Taxes shall be prorated based on the current year's tax with due allowance made for maximum allowable discounts. If the Closing Date shall occur before the tax rate for the current year shall be established, the tax rate for the preceding year shall be applied to the last assessed valuation. After the taxes and assessments, if any, are finally fixed, Seller and Purchaser shall make a recalculation of the apportionment of same, and Seller or Purchaser, as the case may be, shall make an appropriate payment to the other based on such recalculation. All real property assessments levied against the Property prior to the Closing Date shall be apportioned as provided for herein. Seller's and Purchaser's obligations under this subparagraph (a) shall survive the Closing.

(b) Notwithstanding the terms of subsection (a) above, in the event the taxes for the Property increase as a result of the Approvals, the cost of any such increase shall be borne solely by Purchaser.

(c) Certified, confirmed or ratified liens for governmental improvements as of the Closing Date, if any, shall be paid in full by Seller provided, however, if a certified, confirmed or ratified lien is payable in installments, Seller will pay all installments due and payable on or before the Closing Date, with any installment for any period due on or before, but extending beyond, the Closing Date to be prorated, and Purchaser will assume all installments that become due and payable after the Closing Date. Notwithstanding the foregoing, if such liens or assessments are part of the real estate tax bill, then such liens and assessments shall be prorated as part of such tax bill and this provision shall be of no effect. Pending or possible liens for governmental improvements (not yet certified or assessed) as of the day immediately preceding the Closing Date shall be assumed by Purchaser.

(d) If any refund of real property taxes and assessments is made after the Closing Date in respect of a period any portion of which was prior to the Closing Date, the same shall be applied first to the costs incurred in obtaining the refund. The balance, if any, of such refund shall be paid to Seller (for the period prior to the Closing Date) and to Purchaser (for the period commencing with the Closing Date).

(e) If there is a net balance due Seller on the foregoing apportionments, the same shall be paid by Purchaser at the Closing. If there be a net balance due Purchaser on the foregoing apportionments, the same shall be credited against the Purchase Price at the Closing.

(f) In the event the tax parcel in which the Property is located contains any additional property as of the Closing Date, Seller and Purchaser agree to enter into a tax proration agreement at Closing, which shall provide, among other things, that (i) as soon as reasonably possible after Closing, the parties will diligently pursue until completion a tax parcel split that creates a separate tax parcel that includes the Property and no other

property and (ii) in the event such tax parcel split is not effective prior to the delivery of any tax assessments following the Closing, each party will be responsible for its pro rata share of such assessment.

14. Representations and Warranties of Seller. To induce Purchaser to enter into this Agreement, Seller makes the following representations and warranties, all of which are true as of the Effective Date hereof (unless otherwise specified) and shall also be true as of the Closing Date:

(a) Seller has full power and authority to enter into this Agreement and to perform all of its obligations hereunder. The execution and delivery of this Agreement and the performance by Seller of its obligations hereunder have been duly authorized by all requisite action and no further action or approval is required in order to constitute this Agreement as a binding and enforceable obligation of Seller.

(b) No materials or services have been furnished or delivered on or to the Property which would create or otherwise encumber the Property with any mechanics, materialman, laborer, or other similar type lien after the Closing Date excluding, however, any of the foregoing created by the acts of Purchaser or its Consultants.

(c) Seller shall not initiate any changes in zoning, except as may be requested by Purchaser, provided, however, any such changes in zoning requested by Purchaser shall not be effective until the Closing occurs.

(d) Seller owns and will convey to Purchaser at Closing fee simple title to the Property, free and clear of all conditions, exceptions or reservations, except the Permitted Exceptions.

(e) There are no outstanding written or oral leases relating to the use or possession of the Property and, to Seller's knowledge, there are no parties claiming any rights to possess any portion of the Property except as otherwise disclosed in the Title Commitment.

(f) Except as disclosed in the Existing Due Diligence or in the Title Commitment, there are no special assessments of any kind presently pending against the Property and Seller has not received any written notice from any governmental authority of any special assessments being contemplated.

(g) Except as disclosed in the Existing Due Diligence or on Exhibit D attached hereto, Seller has not received any notice from any governmental authority of a violation of any law, ordinance, statute, code, rule, regulation, order or decree of any governmental authorities having jurisdiction over the Property which has not been remedied.

(h) Except as disclosed in the Existing Due Diligence or in the Title Commitment, there are no agreements to which Seller is a party which in any way affect any portion of the Property or affect Seller's ability to sell or convey the Property.

(i) No attachments, execution proceedings, assignments for the benefit of creditors, insolvency, bankruptcy, reorganization or other proceedings are pending or threatened against Seller, nor are any of such proceedings contemplated by Seller.

(j) Seller has received no written notice of, nor to Seller’s knowledge is there, any plan or study of any governmental authority that would materially affect the Purchaser’s Intended Use, including, without limitation, any threatened condemnation or taking, or any intended public improvements that would result in any charge being levied against,

or any lien assessed upon, the Property, including, without limitation, any resolution or ordinance intending to condemn any portion of the Property.

(k) As of the Closing Date, no commissions, brokerage fees or similar payments with respect to the Property shall be due and owing for which Seller is bound and liable and there are no existing brokerage commission or similar agreements entered into by Seller to which Seller is bound or liable relating to the sale or leasing of all or any portion of the Property.

(l) No other person or other entity has any right or option to acquire or lease any or all of the Property or any right of first refusal with regard to the purchase of the Property.

(m) Except as provided as part of the Existing Due Diligence, Seller has received no written notification from any governmental agency with respect to any Hazardous Materials on the Property in violation of any applicable laws or regulations.

(n) Except as disclosed in any environmental site assessment report of the Property or in any letter or other document addressing environmental matters, and delivered by Seller to Purchaser as part of the Existing Due Diligence, to Seller's knowledge, there presently does not exist on, above, or under the Property any Hazardous Materials in violation of any applicable laws or regulations. As used herein, the term "Hazardous Materials" means any substance:

(i) the presence of which requires investigation or remediation under any federal, state or local statute, regulation, ordinance, order, action, policy or common law; or

(ii) which is or becomes defined as a "hazardous waste," "hazardous substance," pollutant or contaminant under any federal, state or local statute, regulation, rule or ordinance or amendments thereto including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act (42 U.S.C. § 9601 et seq.) and/or the Resource Conservation and Recovery Act (42 U.S.C. § 6901 et seq.); or

(iii) which is toxic, explosive, corrosive, flammable, infectious, radioactive, carcinogenic, mutagenic, or otherwise hazardous and is or becomes regulated by any governmental authority, agency, department, commission, board, agency or instrumentality of the United States, the State of Florida or any political subdivision thereof; or

(iv) the presence of which on the Property causes or threatens to cause a nuisance upon the Property or to adjacent properties or poses or threatens to pose a hazard to the health or safety of persons on or about the Property; or

(v) the presence of which on adjacent properties could constitute a trespass by Seller; or

(vi) without limitation, which contains gasoline, diesel fuel or other petroleum hydrocarbons; or

(vii) without limitation, which contains polychlorinated bisphenols (PCBs), asbestos or urea formaldehyde foam insulation; or

(viii) without limitation, radon gas.

(o) For purposes of this Agreement whenever the phrase "to Seller's knowledge" or words of similar import are used, they shall be deemed to refer to facts within the actual, current conscious knowledge (not constructive or implied knowledge) of William D. Hodges in his capacity as Manager of Seller, without any investigation or inquiry. Seller hereby represents and warrants that William D. Hodges is the individual affiliated with Seller who is most knowledgeable of the matters described in this Paragraph 14.

(p) Subject to the remaining provisions of this Paragraph 14(p), at Closing, Seller shall recertify to Purchaser the continuing accuracy in all material respects of Seller's representations and warranties in this Paragraph 14, and such representations and warranties shall survive the Closing until that certain date that is six (6) months after the Closing Date (the "Survival Period"). Purchaser must provide written notice to Seller of any breach or failure of any of the representations or warranties in this Paragraph 14 on or before the last day of the Survival Period. After expiration of the Survival Period, Seller shall have no further liability with respect to the representations and warranties in this Paragraph 14 except for those, if any, with respect to which (i) written notice has been delivered by Purchaser to Seller on or before the expiration of the Survival Period setting forth in detail the nature of the inaccurate representation or warranty, and (ii) if the parties have been unable to resolve the dispute, suit has been filed in a court of competent jurisdiction and served upon Seller within sixty (60) days after the expiration of the Survival Period. In no event shall the aggregate of the damages recovered by Purchaser under this Paragraph 14(p) exceed $200,000.00. Notwithstanding anything in this Paragraph 14 to the contrary, if, between the Effective Date and the Closing Date, Seller learns of information such that any of Seller's representations and warranties in this Paragraph 14 are or have become materially inaccurate, Seller shall provide Purchaser with written notice thereof. Purchaser shall then have thirty (30) days after receipt of such notice in which to elect, as its sole remedy (unless such representation or warranty became materially inaccurate due to Seller's intentional actions or omissions, or was materially inaccurate or untrue when Seller made such representation or warranty on the Effective Date), to terminate this Agreement by giving written notice thereof to Seller, or to accept such changed representation or warranty and at Closing, Seller's representations and warranties in this Paragraph 14 shall be deemed modified accordingly. If Purchaser exercises its option to terminate this Agreement under this Paragraph 14(p), the Earnest Money (including all Extension Deposits) shall be returned to Purchaser and the parties shall be without further duties or obligations to one another under this Agreement except with respect to those obligations that survive termination of this Agreement. If Seller has not received any written notice of election from Purchaser within the aforesaid thirty (30) day period, Purchaser shall be deemed to have elected to accept such changed representations and/or warranties and at Closing, Seller's representations and warranties in this Paragraph 14 shall be deemed modified accordingly.

15. Title Commitment.

(a) During the Inspection Period, Purchaser, at its expense, shall obtain a title commitment, together with legible copies of all exceptions (the "Title Commitment") issued by the Title Company for an owner's title insurance policy in the amount of the Purchase Price setting forth the status of title to the Property and any exceptions thereto. After the Effective Date, Seller shall in no way encumber or burden the Property without the prior written consent of Purchaser.

(b) If a search of the title discloses judgments, bankruptcies or other liens against other persons having names the same as or similar to that of Seller, Seller, on request, shall deliver to Purchaser and the Title Company affidavits showing that such judgments, bankruptcies or other liens are not against Seller.

(c) Purchaser may object to any matters shown on the Title Commitment or Purchaser's survey (the "Survey") by notifying Seller in writing of any objections prior to the expiration of the Inspection Period. Any matter disclosed by the Title Commitment or the Survey which is not timely objected to by Purchaser shall be deemed a Permitted Exception. Seller shall have thirty (30) days after receipt of title and survey objections to either cure such objections or notify Purchaser of which objections Seller will and will not cure. If Seller's title response provides that Seller will attempt to cure any such objections, then Seller will proceed to use good faith efforts to cure such objections and will take such actions as are reasonably required; provided, however, Seller shall not be obligated to institute any litigation, including, without limitation, the payment of money with respect thereto, to cure such objections. Should Seller notify Purchaser that Seller will not cure any timely made title and survey objections or should Seller fail to timely cure any such objections, Purchaser shall have the option, exercised in writing not later than thirty (30) days after receipt of Seller's aforesaid written notice, to either (i) to terminate this Agreement in which case the Earnest Money (including all Extension Deposits) shall be refunded promptly to Purchaser, this Agreement shall terminate, and neither party shall have any further claim against the other except for those obligations which are specified herein to survive termination of this Agreement, or (ii) to waive the necessity of such cure(s) and to proceed to Closing with no reduction in the Purchase Price. For purposes of this Agreement, the term "Permitted Exceptions" shall mean, collectively, (i) the exceptions and any additional matters set forth in the Title Commitment and the Survey which Purchaser does not timely object to under this Agreement, or if timely objected to by Purchaser, but not cured by Seller, and subsequently waived by Purchaser as set forth in this Paragraph 15(c) and (ii) any matters resulting from the actions of Purchaser or caused by any of Purchaser's Consultants.

(d) If any update to the Title Commitment or Survey prior to Closing reveals any new encumbrance, lien or question of title which was not created or caused to be created by Purchaser or Purchaser's Consultants, then Purchaser shall have the right to object to the same in writing to Seller. Seller shall have five (5) business days after receipt of any such subsequent title and survey objections to either cure such objections or notify Purchaser of which objections Seller will and will not cure. Should Seller notify Purchaser that Seller will not cure any subsequent title and survey objections or should Seller fail to timely cure any such objections, Purchaser shall have the option, exercised in writing not later than thirty (30) days after receipt of Seller's aforesaid written notice, to either (i) to terminate this Agreement prior to Closing, in which case the Earnest Money (including all Extension Deposits) shall be refunded promptly to Purchaser, this Agreement shall terminate, and neither party shall have any further claim against the other except for those obligations which are specified herein to survive termination of this Agreement, or (ii) to waive the necessity of such cure(s) and to proceed to Closing with no reduction in the Purchase Price.

(e) At the Closing, Seller shall deliver to Purchaser, with a copy thereof to the Title Company, an affidavit with respect to (i) mechanic's liens, certifying that as of the Closing Date there are no known unpaid bills rendered or to be rendered for services performed or materials furnished to the Property on behalf of Seller, and (ii) parties in possession, certifying that on the Closing Date, there are no parties other than Seller in

possession of the Property. Purchaser acknowledges that the affidavit will take exception for any possible unpaid bills for services or materials furnished on behalf of Purchaser.

16. Conditions Precedent to Closing. The obligations of Purchaser under this Agreement are subject to (i) Site Plan Approval having been obtained, (ii) the representations and warranties of Seller being materially true and correct subject, however, to the terms of Paragraph 14(p) and (iii) Seller not being in default on the Closing Date of those terms and provisions of this Agreement applicable to Seller.

17. Documents for Closing.

(a) Seller's attorney shall prepare the necessary instruments required in the Title Commitment in connection with transferring title to the Property to Purchaser. In addition to the special warranty deed, Seller shall (if applicable) prepare a resolution authorizing the sale of the Property to Purchaser and authorizing specific corporate officers, partners, or representatives as the case may be, to execute the necessary documents to transfer title to the Property to Purchaser. Seller, at Seller's sole cost and expense, shall also deliver or cause to be delivered to Purchaser the following documents:

(i) a certificate of non-foreign status to ensure Seller's compliance with Foreign Investment in Real Property Tax Act ("FIRPTA") (Paragraph 1445 of the Internal Revenue Code of 1986, as amended); and

(ii) such additional documents and instruments as Purchaser or the Title Company may reasonably require to transfer Seller's interest in the Property pursuant to the terms of this Agreement, each of which shall be in form and substance satisfactory to Purchaser, the Title Company and Purchaser's counsel.

(b) At the Closing, Purchaser shall deliver, or cause to be delivered, to Seller in accordance with the terms of this Agreement the Purchase Price less the Earnest Money and prorations.

18. Remedies.

(a) Notwithstanding anything to the contrary set forth in this Agreement or in any document delivered in connection with the transaction contemplated by this Agreement, the parties hereto agree that if Seller fails to comply with any of the provisions of this Agreement, Purchaser shall have the right to (a) terminate this Agreement and receive (i) a prompt refund of the Earnest Money (including all Extension Deposits) and (ii) prompt reimbursement from Seller of the actual, documented out-of-pocket costs incurred by Purchaser in connection with this Agreement, Purchaser's Inspections and its pursuit of the Approvals (collectively, "Purchaser's Costs"), as full liquidated damages provided, however, in no event shall Purchaser's Costs exceed $500,000.00 in the aggregate (and the parties shall no further rights or obligations under this Agreement (except those that expressly survive termination hereunder), or (b) institute proceedings in any court of competent jurisdiction to specifically enforce the performance by Seller of the terms of this Agreement and recover all costs, expenses and fees (including reasonable attorneys' fees) related to the precedings provided such suit is filed and served upon Seller within ninety (90) days of the date of the alleged breach by Seller. In the event that, due to any act or omission of Seller, the remedy of specific performance referred to in immediately preceding sentence shall be rendered unavailable then Purchaser shall be entitled to recover from Seller compensatory and indirect damages (but not punitive damages) and

all costs, expenses and fees (including reasonable attorneys' fees) related to any enforcement action hereunder. All other remedies of Purchaser in the event of a breach of Seller's obligations herein are hereby waived by Purchaser. In the event Purchaser elects subsection (a) above, Purchaser's Costs shall be evidenced by paid invoices and/or paid receipts and other statements submitted to Seller and Seller's attorney and such other reasonable information requested by Seller and Seller's attorney.

(b) If Purchaser fails to comply with the terms of this Agreement, Seller's sole remedy (except for breaches related to Purchaser's indemnity and insurance obligations) shall be to terminate this Agreement and receive the Earnest Money (including all Extension Deposits), as provided in Paragraph 3 above, as AGREED LIQUIDATED DAMAGES for such breach, and upon payment in full to Seller of such deposit monies, the parties shall have no further rights, claims, liabilities or obligations under this Agreement, except those that expressly survive termination. Purchaser acknowledges that in the event of a breach of this Agreement by Purchaser, it would be difficult or impossible to calculate Seller's actual damages, that it is therefore appropriate to provide for payment of liquidated damages to Seller in that event, and that the amount of liquidated damages provided for in this Agreement bears a rational relationship to the probable amount of actual damages Seller will suffer, is reasonable, and is not so excessive as to constitute a penalty or forfeiture.

19. Condemnation. If, on or prior to the Closing Date, all or any reasonably substantial portion of the Property is the subject of a pending or contemplated taking by eminent domain which has not been consummated, Seller shall notify Purchaser of such fact and Purchaser shall have the option, to be exercised in writing not later than sixty (60) days after receipt of Seller's written notice, to terminate this Agreement and, in the event Purchaser shall elect to terminate this Agreement, Purchaser shall be entitled to a prompt refund of the Earnest Money (including all Extension Deposits). If this Agreement is terminated and the Earnest Money is returned, as aforesaid, neither party shall have any further rights or obligations hereunder except those that expressly survive termination. If, after receipt of Seller's notice, as aforesaid, Purchaser does not exercise its option to terminate this Agreement within said sixty (60) day period, the parties hereto shall remain bound hereunder and Seller shall assign and turn over, and Purchaser shall be entitled to receive and keep, all awards for the taking by eminent domain described in said notice.

20. Final Agreement. This Agreement represents the final agreement of the parties and no agreements or representations, unless incorporated in this Agreement shall be binding on any of the parties and no portion hereof shall be amended or modified unless such change shall be in writing and signed by both parties thereto.

21. Notice. All notices, requests, demands or other communications required or permitted under this Agreement shall be in writing and delivered either: (i) personally; (ii) by certified or registered mail, return receipt requested, postage prepaid; (iii) by a recognized overnight courier service (such as Fed Ex); or (iv) by email (provided that a notice delivered by email shall promptly thereafter be delivered by one of the other methods permitted in this Paragraph 21), addressed as follows:

If to Seller: Eastwood Lantana, LLC
c/o Arbor Tree & Land, Inc.
7089 Hemstreet Place
West Palm Beach, FL 33413
Attn: Zach Hodges
Attn: Frank Fernandez

Phone: (561) 965-2198 (Hodges)
Phone: (561) 965-2198 Fernandez)
Email: zhodges@atldiversified.com
Email: ffernandez@atldiversified.com

With a copy to: Gunster, Yoakley & Stewart, P.A.
777 South Flagler Drive, Suite 500 East
West Palm Beach, FL 33401
Attn: Paul K. Hines, Esq.
Phone: 561-650-0685
Email: phines@gunster.com

If to Purchaser: Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242
Attn: Real Estate Department
Phone: 205-970-7316
Email: david.stephenson@encompasshealth.com

With a copy to: Bradley Arant Boult Cummings LLP
1819 Fifth Avenue North
Birmingham, AL 35203
Attn: Dawn Helms Sharff
Phone: 205-521-8200
Email: dsharff@bradley.com

If to Title Company: First American Title Insurance Company
Six Concourse Parkway, Suite 200
Atlanta, GA 30328
Attn: Angie Yarbrough
Phone: 404-640-2015
Email: ayarbrough@firstam.com

All notices given in accordance with the terms hereof shall be deemed received at such time as they are actually delivered (if personally delivered) or sent by email (if delivered by email), on the next business day if sent by overnight courier, or on the third business day following deposit with the United States Mail as a registered or certified matter with postage prepaid. Either party hereto may change the address for receiving notices, requests, demands or other communication by notice sent in accordance with the terms of this Paragraph 21.

22. Number and Gender. Whenever the singular number is used herein and when required by the context, the same shall include the plural, and the masculine gender shall include the feminine and neuter genders, and the word "person" shall include a corporation, firm, partnership, joint venture, trust or estate.

23. Counterparts; Electronic Execution and Retention. This Agreement may be executed in any number of counterparts, each of which, when so executed, shall be deemed to be an original, and such counterparts shall, together, constitute and be one and the same instrument. A signature on a counterpart may be made by facsimile or otherwise electronically transmitted, and such signature shall have the same force and effect as an original signature. Further, this Agreement may be retained in any electronic format, and all electronic copies thereof shall likewise be deemed to be an original and shall have the same force and effect as an original copy of this Agreement.

24. Governing Law. This Agreement shall be governed by, construed and enforced in accordance with the laws of the State in which the Property is located, without regard to its conflicts of law provisions.

25. Assignment; Successors and Assigns.

(a) Prior to Closing, Purchaser shall have the right to assign this Agreement, without Seller's consent, to an entity of which Purchaser or its principals have a majority and controlling equitable or beneficial interest. Notwithstanding such assignment, Purchaser shall continue to be liable under this Agreement until Closing. Any other assignment of this Agreement by Purchaser shall be void and of no force or effect without the prior written consent of Seller, which consent shall be within Seller's sole discretion. Upon any permitted assignment of this Agreement, the assignee shall assume in writing all obligations of Purchaser under this Agreement (which shall include the execution of all necessary documents which Purchaser is obligated to execute pursuant to the terms and provisions of this Agreement), and Seller shall have received a copy of such assignment not later than five (5) business days prior to the Closing Date.

(b) Seller shall not assign this Agreement, in whole or in part, without the prior written consent of Purchaser.

26. Survival. Except as otherwise provided herein, any indemnities and/or representations and warranties of each of Seller and Purchaser shall survive until the expiration of the Survival Period. If there is no Survival Period associated with a representation, warranty or indemnity, the representation, warranty or indemnity shall not survive Closing.

27. Confidentiality. Except for those public disclosures required by applicable law, Seller and Purchaser hereby agree that prior to the Closing the matters contained herein shall remain confidential, and that neither party will reveal the contents of this Agreement to any third parties other than their respective agents, employees, attorneys, accountants, consultants and any prospective assignees of this Agreement. Seller further agrees that Purchaser may provide a copy of this Agreement to and/or discuss the terms herein with architects, engineers, title examiners and other third party service providers that Purchaser engages in relation to the Property, any prospective investors, and any governmental officials and utility and other non-governmental entities with whom Purchaser may deal prior to Closing in regard to the Property. Each party will have all remedies available at law or in equity in the event of a breach of this paragraph by the other party hereto or its affiliates.

28. Severability. In the event that any condition or covenant herein contained is held to be invalid or void by any court of competent jurisdiction, the same shall be deemed severable from the remainder of this Agreement and shall in no way affect any other covenant or conditions herein contained. If such condition, covenant or other provision shall be deemed invalid due to its scope or breadth, such provision shall be deemed valid to the extent of the scope or breadth permitted by law.

29. Waiver and Amendment. No breach of any provision hereof can be waived unless in writing. Waiver of any one breach shall not be deemed to be a waiver of any other breach of the same or any other provision hereof. This Agreement may be amended only by a written agreement executed by all of the parties hereto.

30. Captions and Interpretations. Paragraph titles or captions contained herein are inserted as a matter of convenience and for reference, and in no way define, limit, extend or describe the scope of this

Agreement or any provision hereof. No provision in this Agreement is to be interpreted for or against either party because that party or his legal representative drafted such provision.

31. Public Announcements. Seller and Purchaser agree that public announcements, if any, concerning the subject matter of this Agreement shall be mutually approved in advance; provided, however, Purchaser shall be allowed to make a public announcement that it intends to build an inpatient rehabilitation hospital in the market in which the Property is located without any prior approval of Seller.

32. Broker Commission. Renaissance Realty Associates (the "Broker") represents Purchaser in connection with this transaction, and if a Closing occurs pursuant to this Agreement, Purchaser shall pay the Broker a commission upon Closing pursuant to a separate agreement between Purchaser and Broker. Seller and Purchaser each warrants that, except for the Broker (who represents Purchaser), it has not been represented by a broker in conjunction with negotiating this sale. Seller and Purchaser each hereby covenants and agrees to defend, indemnify, and hold harmless the other party against and from any and all loss, expense, liability, cost, claim, demand, damage, action, cause of action, and suit arising out of or in any manner relating to the alleged employment by such party of any real estate broker or agent in connection with this transaction. The provisions of this Paragraph 32 shall survive the Closing and any termination of this Agreement.

33. Signage. After Site Plan Approval has been obtained, Purchaser shall be permitted to erect a sign at the Property, which sign shall advertise the Property as a future inpatient rehabilitation hospital location of Purchaser subject, however, to the following: (i) such sign shall be permitted by the terms of the Site Plan Approval, (ii) if the location of the sign is not designated on the Site Plan Approval, the location shall be subject to Seller's written consent not to be unreasonably withheld, and (iii) the sign shall be in compliance with all signage codes and regulations adopted by governmental authorities.

34. Business Days. In the event any period of time provided for in this Agreement ends on a day other than a business day on which banks are generally open for a full day for business, such ending date shall automatically be extended to the next business day.

35. Representations and Warranties of Seller and Purchaser. Purchaser and Seller hereby represent that the terms and conditions set forth in this Agreement were negotiated at arm's length by the parties and that, to Seller's knowledge, the Purchase Price represents a reasonable estimation of the fair market value of the Property not taking into account any former, current or future business relationships between Seller and Purchaser. The parties further represent and warrant that it is not a purpose of this Agreement or the transaction contemplated herein to induce the referral of patients. The parties acknowledge that there is no requirement nor payment under this Agreement or any agreement between the parties that either refers, recommends or arranges for any items or services paid for by Medicare or Medicaid. Either party may refer patients to any hospital providing services needed by a patient, and will make such referrals, if any, consistent with professional medical judgment and the wishes of the patient. Purchaser acknowledges that the representations and warranties made by Seller in this Paragraph 35 are done so for the sole purpose of complying with regulatory requirements applicable to Purchaser and for no other purpose. The inaccuracy or untruth of any of the representations and warranties in this Paragraph 35 shall not constitute a default under this Agreement nor have any bearing or effect on the rights, duties and obligations of the parties under this Agreement.

36. Seller's Covenants. While this Agreement is in effect, Seller will not actively market, sell or encumber the Property in any manner, will not accept, negotiate or entertain any other offers for

the Property and will maintain the Property in its current condition and in compliance with applicable laws. Seller shall not knowingly take any other action which would cause any representation, warranty or covenant set out herein to be untrue as of Closing without Purchaser's prior written consent. Without the prior written consent of Purchaser, which may be granted or denied in Purchaser's sole and absolute discretion, Seller shall not enter into any oral or written service, maintenance, employment or other contracts, leases or agreements affecting the Property which would survive the Closing or otherwise affect the use, operation or enjoyment of the Property after the Closing, it being understood that Purchaser does not intend to take an assignment of any leases, service contracts or similar agreements at Closing.

37. Contingency Regarding Adjacent Property. On or around the date hereof, Purchaser intends to be under contract to purchase from Stan L. Crooks and Evangeline C. Aguirre certain property adjacent to the Property and located at 9645 Lantana Road, as depicted on Exhibit A attached hereto and made a part hereof (the "Adjacent Property"), pursuant to the terms of a separate purchase and sale agreement. Notwithstanding anything in this Agreement to the contrary, at Purchaser's election, Purchaser's obligation to close on the purchase of the Property shall be contingent on Purchaser's closing on the Adjacent Property. Notwithstanding anything to the contrary implied in this Agreement, should Purchaser fail to close on the Adjacent Property for any reason, Purchaser shall have a right to terminate this Agreement upon written notice given to Seller and the Title Company prior to Closing. Upon receipt of such notice of termination, Escrow Agent shall immediately deliver the Earnest Money (including all Extension Deposits) to Seller.

38. Reservation of Property. The preparation and/or delivery of unsigned drafts of this Agreement shall not create any legally binding rights in the Property and/or obligations of the parties, and Purchaser and Seller acknowledge that this Agreement shall be of no effect until it is duly executed by both Purchaser and Seller.

39. No Third Party Rights; No Recording. Nothing in this Agreement, express or implied, is intended to confer upon any person, other than the parties hereto and their respective successors and permitted assigns, any rights or remedies under or by reason of this Agreement. Neither Purchaser nor Seller shall record this Agreement or a memorandum of this Agreement in any public records, and any violation of this paragraph shall be a default under this Agreement.

40. No Personal Liability of Seller or Purchaser. Purchaser acknowledges that this Agreement is entered into by Seller as a limited liability company, and Purchaser agrees that no individual member, partner, officer, or director or shareholder of Seller or any representative of Seller shall have any personal liability under this Agreement or any document executed in connection with the transactions contemplated by this Agreement, unless such document is executed in the individual capacity of such person. Seller acknowledges that this Agreement is entered into by Purchaser as a corporation and Seller agrees that no individual, officer, director or shareholder of Purchaser shall have any personal liability under this Agreement or any document executed in connection with the transactions contemplated by this Agreement, unless such document is executed in the individual capacity of such person.

41. JURY WAIVER. IN ANY CIVIL ACTION, COUNTERCLAIM, OR PROCEEDING, WHETHER AT LAW OR IN EQUITY, WHICH ARISES OUT OF, CONCERNS, OR RELATES TO THIS AGREEMENT, ANY AND ALL TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, THE PERFORMANCE OF THIS AGREEMENT, OR THE RELATIONSHIP CREATED BY THIS AGREEMENT, WHETHER SOUNDING IN CONTRACT, TORT, STRICT LIABILITY, OR OTHERWISE, TRIAL SHALL BE TO A COURT OF COMPETENT JURISDICTION AND NOT TO A JURY. EACH PARTY HEREBY

IRREVOCABLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY. ANY PARTY MAY FILE AN ORIGINAL COUNTERPART OR A COPY OF THIS AGREEMENT WITH ANY COURT, AS WRITTEN EVIDENCE OF THE CONSENT OF THE PARTIES TO THIS AGREEMENT OF THE WAIVER OF THEIR RIGHT TO TRIAL BY JURY. NEITHER PARTY HAS MADE OR RELIED UPON ANY ORAL REPRESENTATIONS TO OR BY ANY OTHER PARTY REGARDING THE ENFORCEABILITY OF THIS PROVISION. EACH PARTY HAS READ AND UNDERSTANDS THE EFFECT OF THIS JURY WAIVER PROVISION. EACH PARTY ACKNOWLEDGES THAT IT HAS BEEN ADVISED BY ITS OWN COUNSEL WITH RESPECT TO THE TRANSACTION GOVERNED BY THIS AGREEMENT AND SPECIFICALLY WITH RESPECT TO THE TERMS OF THIS SECTION.

42. Disclaimers and Limitations. Purchaser expressly acknowledges that there are no implied warranties or representations beyond those expressly set forth in Paragraph 14 of this Agreement, and Seller has no obligation to determine whether there are material matters that should be disclosed to Purchaser to the extent those matters that have not been expressly set forth herein. NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED HEREIN, PURCHASER EXPRESSLY UNDERSTANDS, ACKNOWLEDGES AND AGREES THAT THE CONVEYANCE OF THE PROPERTY SHALL BE MADE BY SELLER TO PURCHASER ON AN "AS IS, WHERE IS" BASIS, AND "WITH ALL FAULTS," AND PURCHASER ACKNOWLEDGES THAT PURCHASER HAS AGREED TO BUY THE PROPERTY IN ITS PRESENT CONDITION (SUBJECT TO SELLER'S REPRESENTATIONS CONTAINED IN PARAGRAPH 14 HEREOF AND PURCHASER'S RIGHT OF INSPECTION AND REVIEW AS PROVIDED HEREIN) AND THAT PURCHASER IS RELYING SOLELY ON ITS OWN EXAMINATION AND INSPECTIONS OF THE PROPERTY AND NOT ON ANY STATEMENTS OR REPRESENTATIONS MADE BY SELLER OR ANY AGENTS OR REPRESENTATIVES OF SELLER, EXCEPT AS OTHERWISE SPECIFICALLY SET FORTH HEREIN. ADDITIONALLY, PURCHASER HEREBY ACKNOWLEDGES THAT, EXCEPT AS OTHERWISE SPECIFIED HEREIN, SELLER MAKES NO WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED, OR ARISING BY OPERATION OF LAW, INCLUDING BUT IN NO WAY LIMITED TO, ANY WARRANTY OF CONDITION, HABITABILITY, MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE OF THE PROPERTY OR ANY PORTION THEREOF, OR WITH RESPECT TO THE ECONOMICAL, FUNCTIONAL, ENVIRONMENTAL OR PHYSICAL CONDITION, OR ANY OTHER ASPECT, OF THE PROPERTY. EXCEPT FOR SELLER'S REPRESENTATIONS AND WARRANTIES CONTAINED PARAGRAPH 14 HEREOF, SELLER HEREBY SPECIFICALLY DISCLAIMS ANY WARRANTY, GUARANTY OR REPRESENTATION, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE, OF, AS TO, OR CONCERNING: (i) THE NATURE AND CONDITION OF THE PROPERTY OR ANY PART THEREOF, INCLUDING BUT NOT LIMITED TO ITS WATER, SOIL, OR GEOLOGY, OR THE SUITABILITY THEREOF FOR ANY AND ALL ACTIVITIES AND USES WHICH PURCHASER MAY ELECT TO CONDUCT THEREON, OR ANY IMPROVEMENTS PURCHASER MAY ELECT TO CONSTRUCT THEREON, OR ANY INCOME TO BE DERIVED THEREFROM, OR ANY EXPENSES TO BE INCURRED WITH RESPECT THERETO, OR ANY OBLIGATIONS OR ANY OTHER MATTER OR THING RELATING TO OR AFFECTING THE SAME; (ii) THE ABSENCE OF ASBESTOS OR ANY ENVIRONMENTALLY HAZARDOUS SUBSTANCES ON, IN OR UNDER THE PROPERTY OR ON, IN OR UNDER ANY PROPERTY ADJACENT TO OR ABUTTING THE PROPERTY; (iii) THE MANNER OF CONSTRUCTION OR CONDITION OR STATE OF REPAIR OR LACK OF REPAIR OF ANY IMPROVEMENTS; (iv) THE NATURE OR EXTENT OF ANY EASEMENT, RESTRICTIVE COVENANT, RIGHT-OF-WAY, LEASE, POSSESSION, LIEN, ENCUMBRANCE, LICENSE, RESERVATION, CONDITION OR OTHER SIMILAR MATTER PERTAINING TO THE PROPERTY, OR PORTION THEREOF;

AND (v) THE COMPLIANCE OF THE PROPERTY OR THE OPERATION OF THE PROPERTY OR PORTION THEREOF WITH ANY LAWS, RULES, ORDINANCES OR REGULATIONS OF ANY GOVERNMENT OR OTHER BODY. THE PROVISIONS OF THIS PARAGRAPH 42 SHALL SURVIVE THE EXECUTION AND DELIVERY OF THE DEED BY SELLER AND THE CLOSING OF THE TRANSACTION CONTEMPLATED BY THIS AGREEMENT. EXCEPT AS EXPRESSLY PROVIDED OTHERWISE IN THIS AGREEMENT, PURCHASER HEREBY WAIVES AND RELEASES SELLER FROM ANY PRESENT OR FUTURE CLAIMS, WHETHER KNOWN OR UNKNOWN, ARISING FROM OR RELATING TO THE PRESENCE OR ALLEGED PRESENCE OF HAZARDOUS SUBSTANCES IN, ON, UNDER OR ABOUT THE REAL PROPERTY.

43. RADON GAS. RADON IS A NATURALLY OCCURRING RADIOACTIVE GAS WHICH, WHEN IT HAS ACCUMULATED IN A BUILDING IN SUFFICIENT QUANTITIES, MAY PRESENT HEALTH RISKS TO PERSONS WHO ARE EXPOSED TO IT OVER TIME. LEVELS OF RADON WHICH EXCEED FEDERAL AND STATE GUIDELINES HAVE BEEN FOUND IN BUILDINGS IN FLORIDA. ADDITIONAL INFORMATION REGARDING RADON AND RADON TESTING MAY BE OBTAINED FROM THE COUNTY PUBLIC HEALTH UNIT.

[REMAINDER OF PAGE LEFT BLANK; SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective duly authorized representatives as of the date set forth above.

PURCHASER:

ENCOMPASS HEALTH CORPORATION

By:_____
Name: EDMUND H BALL
Title: CHIEF REAL ESTATE OFFICER

SELLER:

EASTWOOD LANTANA, LLC

By:_____
William D. Hodges, Manager

PSA (Lake Worth, FL – Eastwood Lantana LLC) 19
ACTIVE:13083886.7

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective duly authorized representatives as of the date set forth above.

PURCHASER:

ENCOMPASS HEALTH CORPORATION

By:_____
Name:_____
Title:_____

SELLER:

EASTWOOD LANTANA, LLC

By:_____
William D. Hodges, Manager

JOINDER

First American Title Insurance Company hereby acknowledges the receipt of the initial Earnest Money described in the Agreement to which this Joinder is attached and agrees to hold all Earnest Money in accordance with the terms hereof, and in accordance with the terms of its Conditions of Escrow, a copy of which is attached hereto as Exhibit E.

FIRST AMERICAN TITLE INSURANCE COMPANY

By: _____
Name: _____
Title: _____

Date: May ___, 2021

Exhibit A

Depiction of Property and Adjacent Property

Exhibit B

Legal Description of Property

That part of the West Half of Tract 43, Block 34, lying North of the right-of-way for Lantana Road, The Palm Beach Farms Co., Plat No. 3, according to the plat thereof, as recorded in Plat Book 2, Page 45 of the Public Records of Palm Beach County, Florida, less additional right-of-way for Lantana Road conveyed to Palm Beach County in O.R. Book 11213, Page 937, Public Records of Palm Beach County, Florida

Exhibit C

Existing Due Diligence

1. Vesting Deed into Seller

2. Code Violation documents

Exhibit D

Code Violation

The Property is currently subject to a code violation (Complaint Number: C-2019-07090008) issued by the Palm Beach County Code Enforcement Division. A Code Enforcement Hearing has been scheduled for June 9, 2021.

Exhibit E

First American Title Insurance Company

Conditions of Escrow

Except as specifically modified by the written escrow instruction(s) received and accepted by the Escrow Agent, the following Conditions of Escrow shall apply to this escrow or settlement.

1. ESCROW AGENT: First American Title Insurance Company is herein referred to as the Escrow Agent.

2. DEPOSIT OF FUNDS: All checks, money orders or drafts will be processed for collection in the normal course of business. Escrow Agent may commingle funds received by it in escrow with escrow funds of others, and may, without limitation, deposit such funds in its custodial or escrow accounts with any reputable trust company, bank, savings bank, savings association, or other financial services entity, including any affiliate of Escrow Agent. It is understood that Escrow Agent shall be under no obligation, except to the extent noted on Instruction For Investment of Escrow Funds form, to invest the funds deposited with it on behalf of any depositor, nor shall it be accountable for any earnings or incidental benefit attributable to the funds which may be received by Escrow Agent while it holds such funds. Deposits held by Escrow Agent shall be subject to the provisions of applicable state statutes governing unclaimed property.

3. LIMITATIONS OF LIABILITY: Escrow Agent shall not be liable for any loss or damage resulting from the following item(s):

(a) The effect of the transaction underlying this escrow including, without limitation, any defect in the title to the real estate, any failure or delay in the surrender of possession of the property, the rights or obligations of any party in possession of the property, the financial status or insolvency of any other party, and/or any misrepresentations of fact made by any other party;

(b) The legal sufficiency of the document(s) purporting to transfer or otherwise encumber title to the real estate; provided, however, that this limitation of liability shall not affect the liability of First American Title Insurance Company under any title insurance policy which it has issued or may issue.

(c) The default, error, act or failure to act by any other party to the escrow;

(d) Any loss, loss of value or impairment of funds which have been deposited in escrow while those funds are in the course of collection or while those funds are on deposit in a depository institution if such loss, loss of value or impairment results from the failure, insolvency or suspension of a depository institution;

(e) Any defects or conditions of title to any property that is the subject of this escrow provided, however, that this limitation of liability shall not affect the liability of First American Title Insurance Company under any title insurance policy which it has issued or may issue. NOTE: No title insurance liability is created by this agreement;

(f) The expiration of any time limit or other consequences of delay, absent receipt of a properly executed escrow instruction, accepted by Escrow Agent, instructing the Escrow Agent to comply with said time limit; and

(g) Escrow Agent's compliance with any legal process including, but not limited to, subpoena, writs, orders, judgments and decrees of any court whether issued with or without jurisdiction and whether or not subsequently vacated, modified, set aside or reversed.

(NOTE: This paragraph shall not be construed to limit Escrow Agent's liability for its own gross negligence or willful misconduct.)

4. DEFAULT AND/OR DISPUTES: In the event any party to the transaction underlying this escrow shall tender any performance after the time when such performance was due, Escrow Agent may proceed under this escrow, unless one of the parties to this escrow shall give to the Escrow Agent a written direction to stop the further performance of the Escrow Agent's functions hereunder. In the event of written notice of default or dispute is given to the Escrow Agent by any party, Escrow Agent will promptly notify all other parties of such notice. Thereafter, Escrow Agent will decline to disburse funds or to deliver any instrument or otherwise continue to perform its escrow functions, except upon receipt of a mutual written agreement of the parties or upon an appropriate order of court.

5. ACCOUNTING: Escrow Agent shall account to the parties for all funds received and disbursed hereunder at the time of final settlement and closing of this escrow. Escrow Agent shall not be liable for the accuracy of information furnished to it by other persons in the normal course of business, or the failure to adjust items not designated in writing. Adjustment items shall be prorated on the basis of a calendar year and a thirty day month. Escrow Agent shall account for adjustments, credits and charges of expense items according to the custom and usage of the community. Absent specific written instructions to the contrary, signed approval of settlement statements or other accounting of funds shall constitute the authority to Escrow Agent to disburse funds as shown thereon, and deliver instruments held in escrow as set forth in the escrow instruments. Upon completion of the disbursement of funds and delivery of instruments, Escrow Agent shall be released and discharged of its escrow obligations hereunder.

6. FEES, CHARGES AND/OR OTHER EXPENSES: Escrow Agent shall charge for its service hereunder in accordance with its current schedule of fees (which includes annual maintenance fees) unless otherwise provided. Unless otherwise directed, such fees shall be charged to the Purchaser and seller equally. All fees, charges and expenses are due and payable at settlement and such amounts may be deducted by Escrow Agent from any funds held in escrow due to the party from whom such amounts are due and owing. Additional amounts which may become due for any reason shall be promptly paid to Escrow Agent by the party owing such amounts. Escrow Agent shall not be required to advance its own funds for any purpose provided that any such advance, made at its option, shall be promptly reimbursed by the party for whom it is advanced, and such optional advance shall not be an admission of liability on the part of Escrow Agent.

7. APPLICABILITY: These conditions of escrow shall apply to and be for the benefit of agents, if any, of the Escrow Agent so employed by it for services in connection with this escrow.

8. ATTORNEYS' FEES: In the event that litigation is initiated relating to this escrow, the parties hereto agree that Escrow Agent shall be held harmless from any and all attorneys' fees, court costs and expenses relating to that litigation to the extent that litigation does not arise as a result of the Escrow Agent's gross negligence or willful misconduct. The parties hereto agree to indemnify Escrow Agent for all such attorneys' fees, court costs and expenses.

Attachment D

Project Summary: Lake Worth, FL

Lake Worth

	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Yr. 5
Projected FTE [*], [┬]	88.73	102.60	121.98	127.08	133.20
Average Wages [┬]	$ 70,471.39	$ 71,655.88	$ 72,855.83	$ 74,262.42	$ 75,691.03

Investment	
Land	$ 8,500,000
Building	
Construction	$ 27,340,175
Site Work	$ 5,187,500
A&E fees	$ 2,549,961
Permits, State/Local Fees	$ 637,915
Total	$ 35,715,551
Equipment	$ 5,524,459
Est. Total Capitalized Investment	$ 49,740,010 **

[*] FTE = Full time equivalent employees. Actual full-time employees won't be determined until close to facility opening.

[┬] - To be conservative, projected FTE and Average Wages are reflected as 90% of actual pro forma.

** Investment excludes estimated amounts for "Range of Uncertainty" and "Capitalized Interest".

Attachment E

RESOLUTION NO. R-2022- 0630

RESOLUTION APPROVING ZONING APPLICATION Z/CA-2021-01817
(CONTROL NO. 1997-00048)
an Official Zoning Map Amendment
APPLICATION OF Eastwood Lantana LLC, Stan Crooks, Encompass Health Rehabilitation Hospital
BY Gentile Glas Holloway O'Mahoney & Assoc Inc., AGENT
(Encompass Health Rehabilitation Hospital of Lake Worth)

WHEREAS, the Board of County Commissioners, as the governing body of Palm Beach County, Florida, pursuant to the authority vested in Chapter 163 and Chapter 125, Florida Statutes, is authorized and empowered to consider applications relating to zoning;

WHEREAS, the notice and public hearing requirements pursuant to Article 2 (Application Processes and Procedures) of the Palm Beach County Unified Land Development Code, Ordinance 2003-067 as amended (ULDC), have been satisfied;

WHEREAS, Zoning Application Z/CA-2021-01817 was presented to the Board of County Commissioners at a public hearing conducted on June 23, 2022;

WHEREAS, the Board of County Commissioners has considered the evidence and testimony presented by the Applicant and other interested parties, the recommendations of the various County Review Agencies, and the recommendation of the Zoning Commission;

WHEREAS, the Board of County Commissioners pursuant to Article 2 (Application Processes and Procedures) of the ULDC is authorized and empowered to consider, approve, approve with conditions or deny the request;

WHEREAS, the Board of County Commissioners hereby incorporates by reference the Findings in the staff report addressing the Standards contained in Article 2.B (Public Hearing Processes) for an Official Zoning Map Amendment;

WHEREAS, this approval is subject to Article 2.E (Monitoring), of the ULDC and other provisions requiring that development commence in a timely manner;

WHEREAS, the issuance of this Development Permit does not in any way create any rights on the part of the Applicant and/or Property Owner to obtain a permit from a state or federal agency and does not create any liability on the part of the County for issuance of the permit if the Applicant fails to obtain requisite approvals or fulfill the obligations imposed by a state or federal agency or undertakes actions that result in a violation of state or federal law;

WHEREAS, the Palm Beach County Survey Section may administratively correct any scrivener's errors that will not significantly impact the overall boundary of the adopted legal description; and,

WHEREAS, Article 2.B.6.C (Board Action) of the ULDC requires that the action of the Board of County Commissioners be adopted by resolution.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, that Zoning Application Z/CA-2021-01817, the Application of Eastwood Lantana LLC, Stan Crooks, Encompass Health Rehabilitation Hospital, by Gentile Glas Holloway O'Mahoney & Assoc Inc., Agent, for an Official Zoning Map Amendment to allow a rezoning from the Agricultural Residential (AR) Zoning District to the Institutional and Public Facilities (IPF) Zoning District, on a parcel of land generally described as shown on the legal description in EXHIBIT A, attached hereto and made a part hereof, and generally located as shown on a vicinity sketch as indicated in EXHIBIT B, attached hereto and made a part hereof, was approved on June 23, 2022, subject to the Conditions of Approval described in EXHIBIT

C, attached hereto and made a part hereof.

Commissioner Kerner moved for the approval of the Resolution.

The motion was seconded by Commissioner Weiss and, upon being put to a vote, the vote was as follows:

Commissioner Robert S. Weinroth, Mayor	- Aye
Commissioner Gregg K. Weiss, Vice Mayor	- Aye
Commissioner Maria G. Marino	- Aye
Commissioner Dave Kerner	- Aye
Commissioner Maria Sachs	- Aye
Commissioner Melissa McKinlay	- Absent
Commissioner Mack Bernard	- Aye

The Mayor thereupon declared that the resolution was duly passed and adopted on June 23, 2022.

Filed with the Clerk of the Board of County Commissioners on June 23rd, 2022.

This resolution shall not become effective unless or until the effective date of the Small Scale Land Use Amendment No. SCA-2022-012.

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

BY: _____
COUNTY ATTORNEY

PALM BEACH COUNTY, FLORIDA
BY ITS BOARD OF COUNTY
COMMISSIONERS

JOSEPH ABRUZZO,
CLERK & COMPTROLLER

BY: _____
DEPUTY CLERK

BOARD OF COUNTY COMMISSIONERS PALM BEACH COUNTY FLORIDA

EXHIBIT A

LEGAL DESCRIPTION

PARCEL 1
THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS THE SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS CO. PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.
LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 475, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

TOGETHER WITH:

PARCEL 2
THAT PART OF THE WEST HALF OF TRACT 43, BLOCK 34, LYING NORTH OF THE RIGHT-OF-WAY FOR LANTANA ROAD, THE PALM BEACH FARMS CO., PLAT NO. 3, ACCORDING TO THE PLAT THEREOF, AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, LESS ADDITIONAL RIGHT-OF-WAY FOR LANTANA ROAD CONVEYED TO PALM BEACH COUNTY IN OFFICIAL RECORDS BOOK 11213, PAGE 937, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

SAID LANDS SITUATE IN PALM BEACH COUNTY, FLORIDA AND CONTAINING 357,759 SQUARE FEET OR 8.213 ACRES, MORE OR LESS.

SUBJECT TO EASEMENTS, RESTRICTIONS, RESERVATIONS, COVENANTS, AND RIGHTS-OF-WAY OF RECORD.

EXHIBIT B

VICINITY SKETCH

Location Map

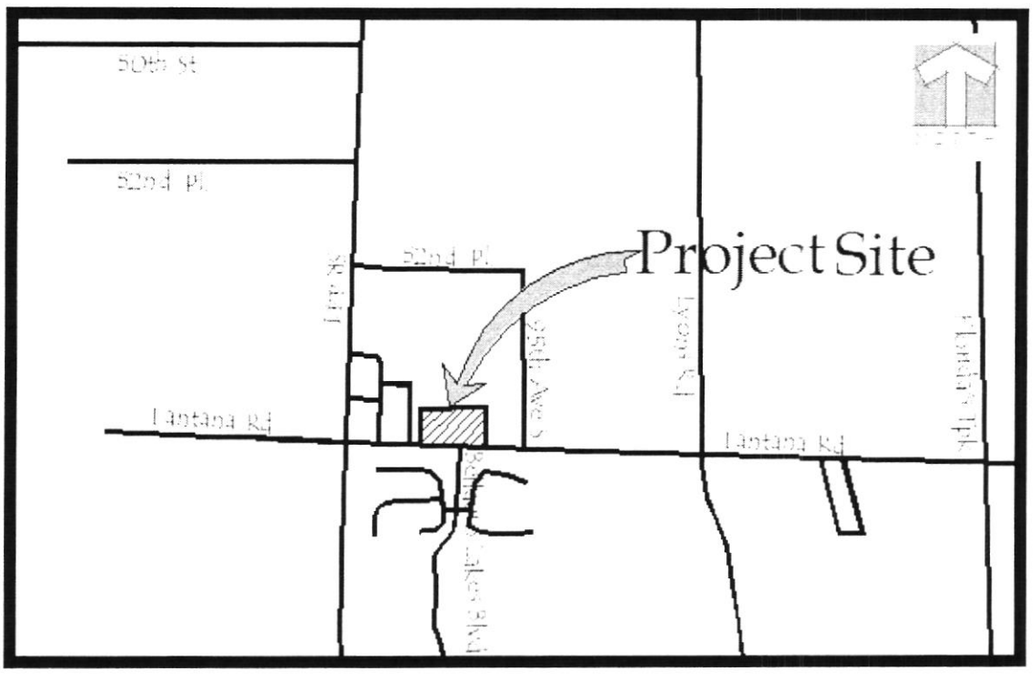


EXHIBIT C

CONDITIONS OF APPROVAL

DISCLOSURE

1. All applicable state or federal permits shall be obtained before commencement of the development authorized by this Development Permit.

Attachment F

ORDINANCE NO. 2022 - 014

AN ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA AMENDING THE 1989 COMPREHENSIVE PLAN AS ADOPTED BY ORDINANCE NO. 89-17, AS AMENDED; AMENDING THE FUTURE LAND USE ATLAS (FLUA) FOR THE SITE SPECIFIC AMENDMENT **ENCOMPASS HEALTH REHABILITATION HOSPITAL OF LAKE WORTH (SCA 2022-012),** MODIFYING PAGE 81 OF THE FLUA FOR APPROXIMATELY 8.21 ACRES OF LAND, GENERALLY LOCATED ON THE NORTH SIDE OF LANTANA ROAD, APPROXIMATELY 0.25 MILES EAST OF STATE ROAD 7, BY CHANGING THE FUTURE LAND USE DESIGNATION FROM LOW RESIDENTIAL, 2 UNITS PER ACRE (LR-2) TO INSTITUTIONAL AND PUBLIC FACILITIES WITH AN UNDERLYING 2 UNITS PER ACRE (INST/2); AND AMENDING ALL ELEMENTS AS NECESSARY; PROVIDING FOR REPEAL OF LAWS IN CONFLICT; PROVIDING FOR SEVERABILITY; PROVIDING FOR INCLUSION IN THE 1989 COMPREHENSIVE PLAN; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, on August 31, 1989, the Palm Beach County Board of County Commissioners adopted the 1989 Comprehensive Plan by Ordinance No. 89-17;

WHEREAS, the Palm Beach County Board of County Commissioners amends the 1989 Comprehensive Plan as provided by Chapter 163, Part II, Florida Statutes; and

WHEREAS, Section 163.3187(2), Florida Statutes, provides that small scale development amendments require only one public hearing before the governing board which shall be an adoption public hearing; and

WHEREAS, a property owner has requested an amendment to the Future Land Use Atlas of the 1989 Comprehensive Plan; and

WHEREAS, the proposed amendment meets the criteria of a small scale development amendment per Section 163.3187(1), Florida Statutes; and

WHEREAS, the Palm Beach County Local Planning Agency conducted its public hearing on May 13, 2022 to review the proposed amendment to the Palm Beach County Comprehensive Plan and made recommendations regarding the proposed amendment to the Palm Beach County Board of County Commissioners pursuant to Chapter 163, Part II, Florida Statutes; and

WHEREAS, the Palm Beach County Board of County Commissioners, as the governing body of Palm Beach County, conducted a public hearing pursuant to Chapter 163, Part II, Florida Statutes, on June 23, 2022 to review the recommendations of the Local Planning Agency and to consider adoption of the amendment; and

WHEREAS, the Palm Beach County Board of County Commissioners has determined that the amendments comply with the requirements of the Community Planning Act.

NOW, THEREFORE, BE IT ORDAINED BY THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, that:

Part I. Amendments to the 1989 Comprehensive Plan

Amendments to the 1989 Comprehensive Plan are hereby adopted and attached to this Ordinance as Exhibit 1:

A. Future Land Use Atlas page 81 is amended as follows:

Application: **Encompass Health Rehabilitation Hospital of Lake Worth (SCA 2022-012)**

Amendment: From Low Residential, 2 units per acre (LR-2) to Institutional and Public Facilities with an underlying 2 units per acre (INST/2),

Location: North side of Lantana Road, approximately 0.25 miles east of State Road 7,

Size: 8.21 acres approximately,

Conditions: None;

Part II. Repeal of Laws in Conflict

All local laws and ordinances applying to the unincorporated area of Palm Beach County in conflict with any provision of this ordinance are hereby repealed to the extent of such conflict.

Part III. Severability

If any section, paragraph, sentence, clause, phrase, or word of this Ordinance is for any reason held by the Court to be unconstitutional, inoperative or void, such holding shall not affect the remainder of this Ordinance.

Part IV. Inclusion in the 1989 Comprehensive Plan

The provision of this Ordinance shall become and be made a part of the 1989 Palm Beach County Comprehensive Plan. The Sections of the Ordinance may be renumbered or re-lettered to accomplish such, and the word "ordinance" may be changed to "section," "article," or any other appropriate word.

Part V. Effective Date

This amendment shall not become effective until 31 days after adoption. If challenged within 30 days after adoption, this amendment shall not become effective until the state land planning agency or the Administration Commission, respectively, enters a final order determining the adopted amendment is in compliance.

APPROVED AND ADOPTED by the Board of County Commissioners of Palm Beach County, on the 23rd day of June, 2022.

ATTEST:
JOSEPH ABRUZZO, CLERK
& COMPTROLLER

By _____
Deputy Clerk

PALM BEACH COUNTY, FLORIDA,
BY ITS BOARD OF COUNTY COMMISSIONERS

By _____
Robert Weinroth, Mayor

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

By _____
County Attorney

Filed with the Department of State on the 23rd day of June, 2022.

T:\Planning\AMEND\22-SCA\Ordinances\Ord-EncompassHealth.docx

EXHIBIT 1

A. Future Land Use Atlas page **81** is amended as follows:

Amendment No:	**Encompass Health Rehabilitation Hospital of Lake Worth (SCA 2022-012)**
Amendment:	From Low Residential, 2 units per acre (LR-2) to Institutional and Public Facilities with an underlying 2 units per acre (INST/2)
Location:	North side of Lantana Road, approximately 0.25 miles east of State Road 7
Size:	8.21 acres approximately
Property No:	00-42-43-27-05-034-0431 & 00-42-43-27-05-034-0432
Conditions: None	

Legal Description

PARCEL 1

THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS THE SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

TOGETHER WITH

PARCEL 2

THAT PART OF THE WEST HALF OF TRACT 43, BLOCK 34, LYING NORTH OF THE RIGHT-OF-WAY FOR LANTANA ROAD, THE PALM BEACH FARMS CO., PLAT NO. 3, ACCORDING TO THE PLAT THEREOF, AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, LESS ADDITIONAL RIGHT-OF-WAY FOR LANTANA ROAD CONVEYED TO PALM BEACH COUNTY IN OFFICIAL RECORDS BOOK 11213, PAGE 937, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

SAID LANDS SITUATE IN PALM BEACH COUNTY, FLORIDA AND CONTAINING 357,759 SQUARE FEET OR 8.213 ACRES, MORE OR LESS.

SUBJECT TO EASEMENTS, RESTRICTIONS, RESERVATIONS, COVENANTS, AND RIGHTS-OF-WAY OF RECORD.

FLORIDA DEPARTMENT *of* STATE

RON DESANTIS
Governor

CORD BYRD
Secretary of State

June 23, 2022

Honorable Joseph Abruzzo
Clerk of the Circuit Court and Comptroller
Palm Beach County
301 North Olive Avenue
West Palm Beach, Florida 33401

Attn: Biaggia Jenkins

Dear Honorable Joseph Abruzzo:

Pursuant to the provisions of Section 125.66, Florida Statutes, this will acknowledge receipt of your electronic copy of Palm Beach County Ordinance No 2022-014, which was filed in this office on June 23, 2022.

Sincerely,

Anya Owens
Program Administrator

ACO/mas

R. A. Gray Building • 500 South Bronough Street • Tallahassee, Florida 32399-0250
Telephone: (850) 245-6270

Attachment G

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, 2021

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 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. ☒

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

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $7.6 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 99,438,215 shares of common stock of the registrant outstanding, net of treasury shares, as of February 11, 2022.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2022 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, including the planned separation of our home health and hospice business, 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 and Planned Spin Off of Our Home Health and Hospice Business

- Our ongoing strategic review and planned spin off of our 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 the planned separation or transaction; increased difficulties in attracting, retaining or motivating key management personnel; exposure to potential litigation; and inability to complete or realize anticipated benefits from the planned separation 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.

- If the spin off is completed, both the remaining company and the new company will be highly concentrated in their respective primary lines of business, particularly with respect to Medicare regulations and reimbursement, and each will be a less diversified company than we currently are.

- If the spin off is completed, there may be changes in our stockholder base, which may cause volatility in the price of our common stock.

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 limitations on elective procedures, vaccine mandates, shelter-in-place orders, new workplace regulations, facility closures and quarantines, could reduce volumes, lead to staffing shortages, increase staffing costs, and otherwise impair our ability to operate and provide care and in many instances already have done so.

- Our inability 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) 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, including those related to data privacy and security, anti-trust, and employment practices, 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, such as the CMS vaccine mandate, 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 staffing costs 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 provide a consistently high quality of care, including as represented in metrics publish by Medicare, could decrease our revenues.
- 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 or 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 national leader in integrated healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2021, our national footprint spans 42 states and Puerto Rico and includes 145 hospitals and 251 home health and 96 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. As a result of this process, we expect to separate the home health and hospice business from Encompass Health into an independent public company through a spin-off distribution in the first half of 2022. On January 19, 2022, we announced the home health and hospice business would be rebranded and operate under the name Enhabit Home Health & Hospice. The rebranding of agency locations is expected to begin in mid-April 2022 and to be largely completed by the consummation of the spin off.

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 currently 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,		
	2021	2020	2019
Consolidated data:		(Actual Amounts)	
Inpatient rehabilitation:			
Number of hospitals	145	137	133
Discharges	197,639	181,897	186,842
Number of licensed beds	9,924	9,505	9,249
Home health and hospice:			
Number of home health locations [(1)]	251	241	245
Home health total admissions	200,626	194,249	194,498
Number of hospice locations	96	82	83
Hospice admissions	13,113	12,878	10,452
Net operating revenues:		(In Millions)	
Inpatient	$ 3,918.1	$ 3,496.1	$ 3,423.5
Outpatient and other	96.9	70.1	89.5
Total inpatient rehabilitation	4,015.0	3,566.2	3,513.0
Home health	897.3	877.6	918.0
Hospice	209.3	200.6	174.0
Total home health and hospice	1,106.6	1,078.2	1,092.0
Net operating revenues	$ 5,121.6	$ 4,644.4	$ 4,605.0

(1) These amounts include one and two locations as of December 31, 2020, and 2019, 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 three 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 twelfth largest provider of Medicare-certified hospice services in terms of revenues. We operate home health and hospice agencies in 34 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, 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. Our home health patients are typically older adults with three or more chronic conditions and significant functional limitations, who require greater than ten medications. Our home health business benefits from a diversity of referral sources, with patients arriving from acute care hospitals, inpatient rehabilitation facilities, surgery centers, assisted living facilities and skilled nursing facilities, as well as community physicians. 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, their families and physicians to deliver care plans focused on patient needs and goals.

We also provide hospice services to terminally ill patients and their families. Hospice care focuses on the quality of life for patients who are experiencing an advanced, life limiting illness while treating the person and symptoms of the disease, rather than the disease itself. 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. From time to time in specific markets, 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 COVID-19 infection. The pandemic and governmental responses to it have created and continue to exacerbate staffing challenges for us and other healthcare providers, including our referral sources. Quarantines and vaccine mandates as well as apprehension and stress related to the pandemic have led to staffing shortages which in turn have led to increased labor costs. We have also experienced 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 has undertaken 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 evolving and its future 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 and the severity of the symptoms of the variants; the rates of vaccination and therapeutic remedies; the legal, regulatory, and administrative developments related to the pandemic at federal, state, and local levels, such as vaccine mandates, anti-mandate laws and orders, 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;
- ✓ implementing work-at-home policies for many home office employees; and
- ✓ halting all non-essential travel when appropriate.

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. In light of well-publicized challenges to hire and retain qualified personnel in the healthcare industry, we believe our award-winning culture is essential to attracting and retaining talent. For further discussion of our human capital management and our award-winning culture, 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. 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. We believe consistent and disciplined operating models allow us to be nimble and responsive to change.

- 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.

  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.

- Home Health and Hospice Well-Positioned for Value-Based Care. Value-based contracts are a growing focus for us, and as payors emphasize reimbursement models driven by value, we believe they will continue to seek out our clinical outcomes and appreciate our cost-efficient services. Our history and participation in these programs have allowed us to collaborate with approximately 160 alternative payment models, including Next Generation accountable care organizations ("ACOs"), Medicare Shared Savings Program ACOs, and Direct Contracting Models. In the fourth quarter of 2020, we executed a new national contract with UnitedHealthcare for our home health services.

- 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 our well-trained clinicians and 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 scale, density, data-driven business practices, consistent and disciplined operating model, 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, 2021, we have a strong, well-capitalized balance sheet, including ownership of approximately 74% of our hospital real estate, no significant debt maturities prior to 2024, 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, reaching approximately 73 million people over the age of 65 by 2030. 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 2022 *Strategic Priorities*

The following discussion of strategy and strategic priorities assumes the continuation of operations under a single ownership structure for a portion of 2022. As discussed above, we plan to separate our home health and hospice business into an independent public company.

Our overall 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 2022.

Inpatient Rehabilitation. In pursuit of our strategy, we established the following strategic priorities for 2022 for our inpatient rehabilitation segment.

- **Growth**. We target the addition of 6 to 10 new inpatient rehabilitation hospitals per year. We also believe we will continue to have organic growth opportunities in our inpatient rehabilitation segment based on our pre-pandemic track record of consistent growth, planned bed additions at a number of existing hospitals, and the maturation of newly opened and acquired 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. We will have to make some changes to our collaboration process in light of the pending separation of our businesses.

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, 2021, 125 of our 145 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 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, such as our fall prevention model rolled out to hospitals in late 2021.

We will seek to expand efforts and initiatives to recruit and retain a qualified clinical workforce.

Home Health and Hospice. Our home health and hospice segment has the following strategic priorities for 2022.

- **Growth**. We believe we will continue to have organic growth opportunities in our home health and hospice segment based on our pre-pandemic track record of consistent growth and the maturation of acquired locations.

  We target $50 million to $100 million in home health and hospice acquisitions per year. In 2022, we will again identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position and increase our referral base. We plan to continue to focus on building overlap between our home health and hospice segments, as well as identifying attractive new geographies in which we currently do not have a home health and hospice presence.

  We will work to expand relationships with health systems through clinical collaboration and care transition programs and joint venture arrangements. We have a strong foundation of working with health systems, and we now will have a strategic focus on leveraging our historical success with health systems to identify, evaluate and develop joint venture arrangements.

  We will continue to execute on our *de novo* strategy to complement the organic growth of our home health and hospice businesses. In 2022, we plan to open *de novo* agencies in 10 markets. We also believe the ability to co-locate home health and hospice will allow us to grow with minimal incremental infrastructure costs while also leveraging our existing referral sources and brand.

- **Operational Initiatives**. We believe participation in the Centers for Medicare & Medicaid Services' Innovation Center alternative delivery payments models will remain a key strategic initiative in 2022 and beyond. We will seek to increase our participation in these risk-based payment models.

  We believe our expertise in delivering high-quality and cost-efficient care positions us favorably to capture future Medicare Advantage volumes for our home health and hospice businesses. We will seek to negotiate additional value-based payment arrangements with Medicare Advantage payors.

  We have historically focused on skilled home health and hospice services. However, evolving alternatives for in-home care may present opportunities for us to develop adjacent service offerings. In 2022, we plan to seek to expand on existing and identify new collaborative arrangements with private duty home care providers, who deliver non-skilled patient care, to allow us to entertain strategic initiatives such as "SNF at Home" or "Hospital at Home" within specific markets.

We will continue to integrate effective technologies and evidence-based data tools into our delivery of patient care. We are also piloting telehealth in the form of virtual visits and text messaging.

We will work to enhance and grow our care transition program in both home health and hospice which fosters collaboration with other healthcare organizations including short-term acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and ambulatory surgical centers.

We will prioritize efforts and initiatives to recruit and retain a qualified clinical workforce.

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 2022, 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. Since the start of the pandemic in 2020, our employees have 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, 2021, we employed approximately 43,400 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 44 employees at one hospital (approximately 14% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2021. The chart below includes a breakdown of our employees by segment.

	Inpatient Rehabilitation	Home Health and Hospice
Total Employees	32,463	10,899
Full-time Employees	19,914	8,086
Part-time Employees	2,377	210
Pool/Per-diem Employees	10,172	2,603

In some markets, the shortage of clinical personnel is a significant operating issue facing healthcare providers. The Centers for Medicare & Medicaid Services ("CMS") vaccine mandate applicable to Medicare and Medicaid-certified healthcare providers has and will continue to exacerbate staffing shortages. 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 diversity, equity, and inclusion; 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 380 in 2021) at various levels, including non-executive management, to foster a strong sense of ownership and align the interests of management with those of our stockholders.

Diversity, Equity, and Inclusion. We believe fostering a strong culture that values diversity, equity, and inclusion, or DE&I, allows us to be competitive in recruiting and retaining employees. We maintain a DE&I program that is overseen by a committee of diverse individuals committed to our mission of a better way to care and supported by a dedicated DE&I specialist role. The program is further supported by four distinct sub-committees comprised of a broad and cross-functional group, including our leadership and front line staff. The key components of our DE&I program are:

- **Workforce Attraction and Development** – We are committed to ensuring that all of our employees are trained on DE&I as a foundational element of our employee and leadership development curriculum. Our other DE&I initiatives include: scholastic partnerships with historically black colleges, recruitment tools to help identify diverse talent, a website career tool to help veterans find jobs that closely align with their specific skills, and ongoing and policy reviews to incorporate language that supports DE&I. In our home health and hospice segment, we also have a *Welcome Ambassador* program to ensure all employees are welcomed and aware of our organizational commitment to DE&I and to accelerate onboarding.

- **Community Partnership –** We partner with groups in our communities to establish and maintain relationships in an effort to improve health outcomes in those communities. One example of this type of partnership is our arrangement with Holy Family Cristo Rey Catholic High School in Birmingham. This partnership allows adolescents from disadvantaged groups to gain tangible working experience in our corporate office while earning funds for school tuition. In 2021, we sponsored six students. Our other community initiatives include a quarterly DE&I digest that provides information on our DE&I initiatives to people outside the company; membership in the National Association of Health Service Executives ("NAHSE"), an organization that promotes the advancement and development of minority healthcare leaders; participation in NAHSE's minority male leadership academy; and participation in a regional working group of Alabama-based businesses convened to discuss and share DE&I best practices.

- **Support and Equip** – We use our weekly blasts and podcasts to educate our employees about DE&I topics, such as unconscious bias. This education supports our employees by equipping them with the informational tools necessary to better foster an inclusive and diverse workplace. We also provide annual training on DE&I to our employees, which 95% of our employees successfully completed in 2021. This training seeks to encourage conversations between employees and managers around ways to promote DE&I throughout the organization.

- **Opportunity** – We are pursuing further specific initiatives, including a leadership DE&I program in our inpatient rehabilitation business, to identify and create opportunities for diverse leaders.

- **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 DE&I. For example, 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 DE&I 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. We have 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 DE&I.

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 2021 and 2020.

	2021	2020
Therapist (IRF)	7.9%	5.3%
Nurse (IRF)	27.4%	23.0%
Overall (HH&H)	33.3%	26.7%

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 1,365 of our nurses have taken advantage of this opportunity. Additionally, our full-time inpatient nursing and therapy staff have unlimited access to online education and training to ensure continuing education units are available at no cost.

- **Tuition Reimbursement/Scholarship Programs.** Employees also have the opportunity to advance their education through our tuition reimbursement and scholarship programs. We reimbursed over $1.4 million in tuition and paid over $3 million toward employees' student loan debt in 2021. We also provide over 100 scholarships each year to employees seeking to improve professional licensing or certifications or achieve new academic degrees.

- **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.

- **Employee Development Center**. We offer extensive on-site and remote courses to develop our employees in our home health and hospice segment. Courses include clinical, sales, operations, and leadership development programs that help our employees stay current on best practices, ensure compliance with policies and process, and promote continued growth and development at all levels of the organization. Two state-of-the-art classrooms have been designed to enhance the educational environment to support adult learning principles and sustained impact of our educational programs.

- **Other Employee Development Programs:**

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

    * formal coaching 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 2021, 78% of our employees participated in the survey, which measures perceptions based on responses to 39 questions. In 2021, we scored above healthcare benchmarks as a company in each of the following categories on the survey:

- ethics and compliance
- culture of safety
- diversity, equity, and inclusion
- work environment
- leadership
- teamwork
- engagement
- culture of trust
- individual value
- communication

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 1,900 outpatient clinics, but also operates approximately 30 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. In 2020, there were more than 11,300 home health agencies and more than 5,000 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 two other public healthcare companies with significant presences in the Medicare-certified home health industry, and one insurance company that owns one of the largest providers of Medicare-certified skilled home health services. That insurance company not only owns one of the largest home health providers but, by nature of being a payor, can designate which home health and hospice agencies are in or out of the participating provider networks and can set reimbursement rates for network participants. The primary competitive factors

in any given market include the quality and cost 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, and other referral sources in the market, and the regulatory barriers to entry in certificate of need states. The entities that participate in these types of models are growing in their ability to influence the patient referral landscape in the geographies they cover. 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 December 31, 2021, our home health and hospice segment is collaborating with approximately 160 alternative payment models, including Next Generation ACOs, Medicare Shared Savings Program 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 82% 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,		
	2021	**2020**	**2019**
Medicare	64.4 %	66.7 %	72.2 %
Medicare Advantage	15.2 %	15.3 %	10.7 %
Managed care	12.1 %	10.4 %	9.8 %
Medicaid	4.1 %	3.9 %	3.1 %
Other third-party payors	1.1 %	1.2 %	1.2 %
Workers' compensation	0.6 %	0.6 %	0.8 %
Patients	0.5 %	0.5 %	0.7 %
Other income	2.0 %	1.4 %	1.5 %
Total	100.0 %	100.0 %	100.0 %

Home Health and Hospice

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Medicare	81.9 %	83.1 %	84.2 %
Medicare Advantage	10.6 %	10.8 %	10.2 %
Managed care	5.9 %	4.4 %	3.6 %
Medicaid	1.4 %	1.4 %	1.7 %
Workers' compensation	— %	0.1 %	0.1 %
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 "ACA"). In December 2018, a federal district court in Texas invalidated the ACA 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. On June 17, 2021, the Supreme Court issued an opinion in the case of *California v. Texas*, upholding the ACA. With respect to Medicare reimbursement, the ACA provides 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 2030 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, 2022, as discussed further below. Additional Medicare payment reductions are also possible under the Statutory Pay-As-You-Go Act of 2010 ("Statutory PAYGO"). Statutory PAYGO requires, among other things, that mandatory spending and revenue legislation not increase the federal budget deficit over a 5- or 10-year period. If the Office of Management and Budget (the "OMB") finds there is a deficit in the federal budget, Statutory PAYGO requires OMB to order sequestration of Medicare. The Congressional Budget Office estimated that the American Rescue Plan Act would result in budget deficits necessitating a 4% reduction in Medicare program payments for 2022 under the Statutory PAYGO, but the Protecting Medicare and American Farmers from Sequester Cuts Act suspended until 2023 the Statutory PAYGO reductions that would have gone into effect.

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, national debt levels and the solvency of the Medicare trust fund could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both. Healthcare will almost certainly be the subject of significant regulatory and legislative changes regardless of the party in control of the executive and legislative branches of state and federal governments.

From time to time, Medicare regulations, including reimbursement methodologies and rates, can be further modified by CMS. CMS, subject to its statutory authority, may make some prospective payment system changes, including in response to MedPAC recommendations. For example, CMS changed the IRF-PPS, effective October 1, 2019, to replace 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. 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 ACA, 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 2022, we do not expect any of our home health and hospice agencies experience a reduction in 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 and the admission to the IRF must be reviewed and approved by a specialized rehabilitation physician. 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 novel or 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 accept any CARES Act relief funds. The Consolidated Appropriations Act, 2021 (the "2021 Budget Act"), signed into law on December 27, 2020, provided for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the 2021 Budget Act or other legislation.

The sequestration suspension has been extended a number of times. Sequestration is currently scheduled to resume as of April 1, 2022 but will only be a 1% payment reduction through June 30, 2022. Thereafter, the full 2% Medicare payment reduction will resume. Federal legislation, including the CARES Act and 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, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. For example, a physician must approve admission of 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, including the exclusion of COVID-19 admissions from the compliance calculation under the 60% Rule. 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 August 4, 2020, CMS released its notice of final rulemaking for fiscal year 2021 IRF-PPS (the "2021 IRF Rule"). The 2021 IRF Rule implemented a net 2.4% market basket increase effective for discharges between October 1, 2020 and September 30, 2021. The 2021 IRF Rule also included changes that impacted our hospital-by-hospital base rate for Medicare reimbursement. Such changes included, but were 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 codified certain inpatient rehabilitation coverage documentation requirements, and, under certain conditions, allowed 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.

On July 29, 2021, CMS released its notice of final rulemaking for fiscal year 2022 IRF-PPS (the "2022 IRF Rule"). The 2022 IRF Rule implements a net 1.9% market basket increase (market basket update of 2.6% reduced by a productivity adjustment of 0.7%) effective for discharges between October 1, 2021 and September 30, 2022. The productivity adjustment equals the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The 2022 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, updates to outlier payments and updates to the case-mix group relative weights and average lengths of stay values. The 2022 IRF Rule will also add one new quality reporting measure and update the denominator of another measure. Based on our analysis, which utilizes, among other things, the acuity of our patients annualized over a six-month prior period, our experience with outlier payments over that same time frame, and other factors, we believe the 2022 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2021.

Unlike our inpatient services, our outpatient services are primarily reimbursed under the Medicare Part B physician fee schedule. On November 2, 2021, 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 2022. The updates to the fee schedule are not expected to be material to us. The rule also amended the hospital price transparency rule, discussed further below, by increasing the civil monetary penalties imposed on non-compliant hospitals and updating the list of activities that present barriers to allow access to the machine-readable file(s) enabling automated searches and direct downloads.

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 are 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 29, 2020, CMS released its notice of final rulemaking for calendar year 2021 for home health agencies under the HH-PPS (the "2021 HH Rule"). The 2021 HH Rule implemented 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 authorized 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.

On November 2, 2021, CMS released its notice of final rulemaking for calendar year 2022 for home health agencies under the HH-PPS (the "2022 HH Rule"). The 2022 HH Rule implements a net 2.6% market basket increase (market basket update of 3.1% reduced by a productivity adjustment of 0.5%) and makes changes to the underlying wage index system. The 2022 HH Rule does not modify the current behavioral adjustment of 4.36% while they continue to analyze home health payments to ensure budget neutrality under PDGM. The 2022 HH Rule makes permanent previously temporary pandemic-related changes to Medicare home health conditions of participation, and expands the Home Health Value-Based Purchasing ("HHVBP") Model to all Medicare-certified home health agencies in the 50 States, territories, and District of Columbia (with a maximum payment adjustment, upward or downward of 5%). Based on 2023 performance data, calendar year 2025 will be the first year in which payments may be impacted under HHVBP. Based on our preliminary analysis, which utilizes, among other things, our patient mix annualized over an eleven-month prior period, our specific geographic coverage area, and other factors, we believe the 2022 HH Rule will result in a net increase to our Medicare payment rates of approximately 3.4% effective for 30-day payment periods ending on or after January 1, 2022.

On July 16, 2021, CMS announced the full implementation of the home health Review Choice Demonstration will begin effective September 1, 2021 in North Carolina and Florida. CMS will discontinue exercising the existing phased-in approach for these two states.

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, 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 implemented a net 2.4% market basket increase from October 1, 2020 through September 30, 2021.

On July 29, 2021, CMS released its notice of final rulemaking for fiscal year 2022 for hospice agencies under the Hospice-PPS (the "2022 Hospice Rule"). The 2022 Hospice Rule implements a net 2.0% market basket increase from October 1, 2021 through September 30, 2022. The 2022 Hospice Rule also makes permanent certain changes to Medicare hospice conditions of participation that were previously temporarily in effect in response to the pandemic.

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."

Medicare Advantage, 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 2021, 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.

As the percentage of Medicare-eligible beneficiaries choosing Medicare Advantage over traditional Medicare has grown, we have seen the percentage of our revenue derived from Medicare Advantage payors grow. In 2021, approximately 42% of Medicare beneficiaries enrolled in Medicare Advantage plans. This percentage has steadily increased over time since 2003. The Congressional Budget Office projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to about 51% by 2030. We expect the percentage of our total revenues attributable to Medicare Advantage plans to continue to grow as well. Typically, Medicare Advantage and other managed care plans reimburse us less than traditional Medicare for the same type of care and patient.

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, 2021, Medicaid payments represented only 3.5% 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 ACA. 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, 2021, approximately 40% of our licensed beds and 35% 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. We believe CON-related legislation and regulation changes, including both repeal and expansion of CON requirements, will continue to be proposed in various states for the foreseeable future.

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 have hundreds of thousands of claims 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 ACA 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. A violation of the FCA 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. 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 ACA 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 ACA, 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, 2021, 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.

Regulation of Home Health-related Services

There are several currently evolving alternatives for home-based post-acute patient care that we believe could complement our existing home health and hospice services, including "skilled nursing facility-at-home" (or "SNF-at-home"), palliative care and "hospital-at-home." However, the regulatory and reimbursement landscape for these services remains subject to uncertainty.

While some healthcare industry stakeholders and clinicians believe that providing SNF-level care in patients' homes under certain circumstances may lead to improved patient outcomes and lower costs of care for payors, the licensure and reimbursement status of the SNF-at-home delivery model are generally undefined at this time. A combination of federal and state regulatory action, as well as payor reimbursement policies, will likely be needed in order to develop a framework and funding for SNF-at-home services. Unless and until such actions are taken, home-based services designed to approximate the level of care furnished in skilled nursing facilities would need to be delivered in compliance with the existing Medicare certification, state licensure, and payor reimbursement frameworks.

Palliative care focuses on improving quality of life for patients, making the patient as comfortable as possible by anticipating, preventing, diagnosing and treating their symptoms, but does not seek to cure the patient's underlying illness. Unlike hospice services, which are also palliative in nature, palliative care services are not limited to patients with terminal illnesses. While the nature of the patient care is substantially similar, palliative care services and hospice are distinct from a state licensure and Medicare reimbursement perspective because patients have not yet elected (or have not qualified) to receive the Medicare hospice benefit. Medicare does not recognize palliative care services as a separate reimbursement category, but rather subjects palliative care services delivered by physicians and non-physician practitioners to the normal Medicare Part B coverage and reimbursement rules. Individual categories of professionals, such as nurses, must comply with state professional licensure regulations concerning the scope of practice as applied to palliative care services. In addition, some states may require an entity- or facility-level license, distinct from the hospice license, to provide palliative care services. Payor coverage and reimbursement policies may vary greatly depending on the state, payor, and the patient's health plan.

Hospital-at-home refers to the provision of acute care hospital services in patients' homes. The concept received significant industry attention following a March 2020 announcement by CMS allowing Medicare-certified hospitals to request waivers of applicable Medicare Conditions of Participation to provide acute care hospital services in patients' homes during the COVID-19 public health emergency. On November 25, 2020, CMS expanded and modified this program, which is now called the Acute Hospital Care at Home program. Hospital-at-home care under Medicare still requires the provider to meet all of the Medicare Conditions of Participation applicable to hospitals and involves a much higher intensity of care than home health agencies are generally equipped to provide. In order to provide hospital-at-home care, we would need to enter into an arrangement with a Medicare-certified hospital that has received one of these Acute Hospital Care at Home waivers from CMS to be able to provide home acute care services on behalf of the hospital. Furthermore, because the Acute Hospital Care at Home program is a Medicare program designed to address the COVID-19 public health emergency, non-Medicare payor reimbursement policies are unclear and would have to be addressed individually with each payor.

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 and the Resulting Planned Spin Off of Our Home Health and Hospice Business

Following our review of strategic alternatives for our home health and hospice business, we plan to effect a spin off of our home health and hospice business into an independent public company, but there can be no assurance that we will be successful in consummating the spin off or any other strategic alternatives, that the spin off or any other strategic alternatives will yield additional value for our stockholders, or that the planned spin off 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 a result of this process, we expect to effect a spin off of the home health and hospice business into an independent, publicly traded company by the end of the second quarter of 2022. Our board of directors believes that the separation of the inpatient rehabilitation business and the home health and hospice business into two independent, publicly traded companies will provide significant benefits to both businesses and their stakeholders, including improving the strategic and operational flexibility of each business, increasing the focus of each management team on its business strategy and operations, allowing each business to adopt a capital structure and investment policy best suited to its financial profile and business needs, and providing each company with its own equity currency to facilitate acquisitions and to better incentivize management. However, we cannot guarantee the spin off will occur. Speculation regarding the separation or any other developments related to the review of strategic alternatives for our home health and hospice business and perceived uncertainties related to the future of that business or Encompass Health could cause our stock price to fluctuate significantly.

Our exploration of strategic alternatives and the resulting plan to spin off our home health and hospice business exposes us to a number of risks and uncertainties, including the risk that we may not be able to consummate any separation transaction successfully or at all; diversion of management's time to the process; the incurrence of significant expenses associated with the review and pursuit of the spin off or any other 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 the spin off or any other strategic alternative involving our home health and hospice business. There can be no assurance that the spin off 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 spin off of our home health and hospice business at any time. The spin off or any 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.

The rebranding of the home health and hospice business will involve substantial costs and may not be favorably received by our referral sources, business partners, or investors.

Historically, we have conducted our home health and hospice business under the Encompass brand as an integrated post-acute healthcare provider. In anticipation of the spin off, we expect the home health and hospice business will begin operating under the new "Enhabit" brand as soon as April in some locations. The new brand name may not improve upon the brand recognition associated with the "Encompass" name that we previously established with referral sources and business partners over a long period of time. In addition, the rebranding will involve significant costs and require the dedication of significant time and effort by management and other personnel. We cannot predict the impact of the rebranding on the business. However, if the home health and hospice business fails to establish, maintain, or enhance brand recognition associated with the

"Enhabit" name, it may affect patient referrals, which may adversely affect our ability to generate revenues and could impede the Enhabit business plan. Additionally, the costs and the dedication of time and effort associated with the rebranding may negatively affect our profitability.

If the spin off is completed, both Encompass Health's and Enhabit's operational and financial profiles will change and each will be a less diversified company than Encompass as it exists currently.

The spin off of our home health and hospice business will result in Encompass and Enhabit being less diversified companies with more limited businesses concentrated in their respective industries. As a result, each company may be more vulnerable to changing market and regulatory conditions, which could have a material adverse effect on its business, financial condition and results of operations. In addition, the diversification of revenues, costs, and cash flows will diminish, such that each company's results of operations, cash flows, working capital, effective tax rate, and financing requirements may be subject to increased volatility and its ability to fund capital expenditures and investments, pay dividends and service debt may be diminished. It is anticipated that the effective tax rate for each separate company will differ from the current consolidated effective tax rate. The regulatory and reimbursement risk for Encompass will be significantly concentrated in the Medicare inpatient rehabilitation rules and regulations. The regulatory and reimbursement risk for Enhabit will be significantly concentrated in the Medicare home health rules and regulations. For 2021, Medicare payments under the inpatient rehabilitation facility prospective payment system represented approximately 64% of the inpatient rehabilitation segment total revenue, and Medicare payments under the home health prospective payment system represented approximately 63% of the home health and hospice segment total revenue. A significant change in Medicare regulations governing either inpatient rehabilitation or home health could have a material adverse effect on business, financial condition and results of operations of the respective separate company.

If the spin off is completed, there may be changes in our stockholder base, which may cause volatility in the price of our common stock.

Investors holding our common stock may hold our common stock because of a decision to invest in a company that provide a diverse or integrated healthcare services. If the spin off is completed, shares of Encompass common stock will represent an investment in a business concentrated in inpatient rehabilitation, and shares of the common stock of Enhabit will represent an investment in businesses concentrated in home health and hospice. These changes may not match some stockholders' investment strategies, which could cause them to sell their shares of our common stock or the common stock of Enhabit, and excessive selling pressure could cause the respective market prices to decrease following the consummation of the spin. Additionally, we cannot predict whether the combined market value of our common stock and the common stock of Enhabit after the spin off will be equal to or greater than the market value of our common stock prior to the spin off.

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 provision of healthcare services and the supplies for those services 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 and the severity of the symptoms of the variants; the status of testing capabilities; the rates of vaccination and therapeutic remedies for COVID-19 and any variant strains; the legal, regulatory and administrative developments related to the pandemic at federal, state, and local levels, such as vaccine mandates, anti-mandate laws and orders, 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 from the pandemic on our operations and financial results in March 2020. The most pronounced negative impacts occurred with the initial wave of the pandemic and the governmental reactions to it in the first half of 2020. Since then, our operational and financial performance has improved, but subsequent localized surges in case counts, particularly ones involving new COVID-19 variants, have also had a negative impact on us. 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, particularly in specific markets most affected by a new surge.

Legal and Regulatory Environment

Future federal, state or local laws, regulations, orders, or other governmental or regulatory actions addressing the pandemic have, and could in the the future, adversely affect our financial condition, results of operations and cash flow, including by exacerbating staffing shortages, increasing staffing and supply costs, reducing patient volumes, and increasing compliance costs and the associated risks of losing a license to operate. The Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") imposed a COVID-19 vaccination requirement (the "CMS Vax Mandate") as a condition of participating in the Medicare and Medicaid programs. The CMS Vax Mandate recognizes potential medical and religious exemptions but does not allow for testing as an alternative for employees that do not get the vaccine. Pursuant to CMS guidance, a healthcare provider must have policies and procedures in place to ensure all employees are vaccinated and 100% of employees must be fully vaccinated or have been granted qualifying exemption on or before the deadline for the provider's state, the latest of which is March 21, 2022. Compliance with the CMS Vax Mandate will be assessed as part of initial certification, standard recertification or re-accreditation performed by existing surveying agencies and contractors. As is customary in the surveying process, non-compliance does not necessarily lead to termination, and providers will generally be given opportunities to return to compliance. If noncompliance is not resolved in the notice and remediation period, providers may as a final measure be subject to termination of participation from the Medicare and Medicaid programs. Home health and hospice agencies are also subject to civil monetary penalties and claims denials. Some states have adopted more onerous vaccine mandate requirements than CMS. Other states, including Florida and Texas, have promulgated laws and executive orders that purport to prohibit employers from instituting vaccine mandates for employees or to prevent state authorities from aiding in enforcement of federal vaccine mandates. It is unclear how these conflicting anti-mandate laws and orders might impact the administration of the CMS Vax Mandate or employers' attempts to comply with the CMS Vax Mandate.

State and local executive actions in response to the pandemic, such as limitations on elective procedures, vaccine mandates, 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. To date, six lawsuits have been filed on behalf of former patients alleging COVID-19 exposure during stays in 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 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, 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 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, the 2021 Budget Act or the American Rescue Plan Act.

Patient Volumes and Related Risks

For various quarterly periods during the pandemic, we experienced decreased patient volumes in one or more of our business lines when compared to the prior year periods. We believe reduced patient volumes resulted, and will 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, policies in assisted living facilities that limit our staff

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 in our home health business.

Staffing and Related Risks

Our operations and financial results have been and may in the future be adversely affected by staffing shortages and costs. The pandemic and governmental responses to it have created and continue to exacerbate staffing challenges for us and other healthcare providers, including our referral sources. Quarantines and vaccine mandates as well as employee apprehension and stress related to the pandemic have led to staffing shortages which in turn have led to increased staffing costs. We have, and the healthcare industry in general has, experienced staffing shortages at individual hospitals and agencies from time to time. Staffing shortages have limited, and may in the future limit, our ability to admit additional patients at a given facility or agency. Shortages in nurse staffing have led to significant increases in agency nursing and the compensation costs for nursing staff, both agency and employee. The CMS Vax Mandate may lead to the loss of some employees. In addition to staffing shortages, significant outbreaks of COVID-19 or PPE shortages in our markets or hospitals may reduce employee morale and create labor unrest or other workforce disruptions. Staffing shortages or employee relations issues related to COVID-19 may lead to limitations on the ability to admit new patients. 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.

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 in 2022. 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.

Other Factors

The foregoing 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 CMS Vax Mandate and numerous other federal, state and local regulatory changes and formulating our responses to those regulatory changes and the effects of the pandemic has required, and will likely continue to require, extensive management involvement and company resources, which may negatively affect our ability to implement our business plan and respond to opportunities 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 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 ACA as a significant healthcare reform. Many provisions within the ACA 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 nature and substance of state and federal healthcare laws are always subject to change, occasionally by means of both broad base healthcare reform legislation, like the ACA, and targeted legislative and regulatory action. Any future legislative and regulatory changes may ultimately impact the provisions of the ACA 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 ACA 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 ACA directed CMS to improve home health payment accuracy through rebasing home health payments over four years starting in 2014. In addition, the ACA requires 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.

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. Under current law, for each year through fiscal year 2030, 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 extended the sequestration suspension through March 31, 2021, and a subsequent bill signed into law on April 14, 2021 continued the suspension of sequestration until the end of 2021. On December 10, 2021 President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act, which suspends sequestration cuts until April 1, 2022. Sequestration is scheduled to resume at that time but will only be a 1% payment reduction through June 30, 2022 before resuming the 2% reduction.

Additional Medicare payment reductions are also possible under the Statutory Pay-As-You-Go Act of 2010 ("Statutory PAYGO"). Statutory PAYGO requires, among other things, that mandatory spending and revenue legislation not increase the federal budget deficit over a 5- or 10-year period. If the Office of Management and Budget (the "OMB") finds there is a deficit in the federal budget, Statutory PAYGO requires OMB to order sequestration of Medicare. In March 2021, President Biden signed the American Rescue Plan Act of 2021 (the "American Rescue Plan Act"). The Congressional Budget Office estimated that the American Rescue Plan Act would result in budget deficits necessitating a 4% reduction in Medicare program payments for 2022 under the Statutory PAYGO unless Congress and the President take action to waive the Statutory PAYGO reductions. The Protecting Medicare and American Farmers from Sequester Cuts Act suspends until 2023 the Statutory PAYGO reductions that would have gone into effect as a result of the American Rescue Plan Act.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, or healthcare spending specifically, including solvency of the Medicare trust fund, could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and 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 (the "HH-PPS"), and the hospice payment system (the "Hospice-PPS"). MedPAC also provides comments to CMS on proposed rules, including the prospective payment system rules. Congress is not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. However, MedPAC's recommendations have, and could in the future, become the basis for 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 its March 2021 report, MedPAC again recommended elimination of the update for the hospice-PPS base payment rate and reduction of the base payment rates under the HH-PPS and the IRF-PPS by 5%.

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 (a "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 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 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 Patient-Driven Groupings Model ("PDGM"), and set out in the final rule for the 2019 HH-PPS. Beginning in 2020, the 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 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 will almost certainly be new or alternative healthcare reforms in the future which may change these initiatives and other healthcare laws and regulations. We cannot predict the nature or timing of any changes to the 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 2022, 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 ACA, 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 ACA, 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. All of our home health and hospice agencies met the reporting deadlines resulting in no corresponding reimbursement reductions for 2022.

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 18 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 assesses performance based on several process, outcome, and care satisfaction measures. In the 2022 HH Rule, CMS expanded the model to apply nationwide. The first performance year under the expanded, nationwide home health value-based purchasing model will be 2023 and any associated payment adjustments, capped at 5%, would occur in 2025.

To date, we have not experienced a decrease in *Net operating revenues* in excess of $0.5 million in any year. 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, 2021, 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. RAC audits of IRFs initially focused on coding errors but subsequently expanded to include medical necessity and billing accuracy reviews. CMS has, however, authorized RACs to conduct complex reviews of the medical records associated with both IRF and home health reimbursement claims. 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.

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 2021 related to denials received in 2015 and 2016. 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 frequently exceeds the number of appeals resolved in a given year (CMS suspended payment reviews for several months because of the public health emergency in 2020) 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)	
2021	$0.8	$29.3	$0.4
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

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 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.

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). The reimbursement rates we receive from traditional Medicare fee-for-service are generally higher than those received from other payors, although the difference between traditional Medicare and Medicare Advantage payments for inpatient rehabilitation care has decreased in the last several years. Over the same period, we have seen a shift in the payor mix for both segments from traditional Medicare to Medicare

Advantage and other managed care providers. In our home health and hospice segment, we are attempting to grow the number of Medicare Advantage networks in which we participate, so we would expect the payor mix to continue to shift with that growth. Not only do Medicare Advantage and managed care payors generally pay us less, but we would expect bad debt to be slightly higher for patients covered by Medicare Advantage and managed care as patients typically retain more payment responsibility under those arrangements.

In our inpatient rehabilitation segment, we have also experienced a shift in recent years to a slightly larger percentage of Medicaid patients. 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 could also experience a shift to a lower average patient acuity. During the pandemic, the average acuity of our patients has frequently been higher than pre-pandemic averages, which has, in turn, had a positive impact on the reimbursement rates we have received. We would expect patient acuity to return to pre-pandemic levels once the public health effects of the pandemic subside. Both a shift in our payor mix away from Medicare fee-for-service and a shift to a lower patient acuity would likely 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.* We cannot predict the extent to which our payor mix may shift to lower reimbursement rate payors. We have in recent years experienced, and in the future may, experience shifts in our payor mix or the acuity of our patients that could adversely affect our pricing, *Net operating revenues,* and profitability.

Delays in collection or non-collection of our accounts receivable could adversely affect our business, financial position, results of operations and liquidity.

Reimbursement is typically conditioned on our documenting medical necessity and correctly applying diagnosis codes. Incorrect or incomplete documentation and billing information could result in non-payment for services rendered. Billing and collection of our accounts receivable with Medicare and Medicaid are further subject to the complex regulations that govern Medicare and Medicaid reimbursement and rules imposed by nongovernment payors. Our inability to bill and collect on a timely basis pursuant to these regulations and rules could subject us to payment delays that could have a material adverse effect on our business, financial position, results of operations and liquidity.

In addition, timing delays in billings and collections may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in our financial position and results of operations and in maintaining liquidity. It is possible that Medicare, Medicaid, documentation support, system problems or other provider issues or industry trends, particularly with respect to newly acquired entities for which we have limited operational experience, may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

The timing of payments made under the Medicare and Medicaid programs is subject to governmental budgetary constraints, which may result in an increased period of time between submission of claims and subsequent payment under specific programs, most notably under the Medicare and Medicaid managed care programs, which in many cases pay claims significantly slower than traditional Medicare or state Medicaid programs do as a result of more complicated authorization, billing and collecting processes that are required by Medicare and Medicaid managed care programs. In addition, we may experience delays in reimbursement as a result of the failure to receive prompt approvals related to change of ownership applications for acquired or other facilities or from delays caused by our or other third parties' information system failures. Furthermore, the proliferation of Medicare and Medicaid managed care programs could have a material adverse impact on the results of our operations as a result of more complicated authorization, billing and collection requirements implemented by such programs.

A change in our estimates of collectability or a delay in collection of accounts receivable could adversely affect our results of operations and liquidity. The estimates are based on a variety of factors, including the length of time receivables are past due, significant one-time events, contractual rights, client funding, political pressures, discussions with clients, and historical experience. A delay in collecting our accounts receivable, or the non-collection of accounts receivable, including, without limitation, in connection with our transition and integration of acquired companies, and the attendant movement of underlying billing and collection operations from legacy systems to future systems, could have a material negative impact on our results of operations and liquidity and could be required to record impairment charges on our financial statements.

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 as those settings are reimbursed at lower rates due to the amount of care they are required to provide. 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.

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 ACA 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)
2022	483	11.0
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 December 31, 2021, our home health and hospice segment is collaborating with approximately 160 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. CMS suspended the initial implementation of GDCM and currently has the program under review.

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. CJR has not had a material impact on our 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*.

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 ACA provides 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 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 are 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. 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%. Effective September 1, 2021, CMS ended its phased-in approach to participation in the RCD in Florida and North Carolina and fully implemented the RCD in those states.

We operate agencies (representing approximately 42% 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. The proposed timing of this demonstration is not known. We operate 46 inpatient rehabilitation hospitals (representing approximately 33% of our IRF Medicare claims) in those four states. After the initial four states, CMS intends to 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, 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 how or when 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 audit to review 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. Following this audit, the HHS-OIG announced in December 2021 its recommendation to establish an IRF transfer payment policy for early discharges to home health care in which the IRF would only receive a per diem rate in lieu of the full case-mix payment. The HHS-OIG estimated the policy could have reduced total Medicare payments to IRFs in 2017 and 2018 by between 6% and 7%. In July 2020, the HHS-OIG issued an audit report concluding that a signficant number of home health claims for episodes of care slightly above the Low Utilization payment Adjustment threshold (four visits per payment episode) because MACs failed to adequately audit home health claims with between five and seven visits per payment episode. The HHS-OIG directed MACs to target this category of claims for

additional review. 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 ACA, 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. The maximum penalty for violations is as much as $2 million per hospital, so our failure to maintain compliance with this rule could adversely affect our financial position, results of operations, and cash flows.

Efforts to comply with regulatory mandates to increase the use of electronic health data and health system interoperability may lead to 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 began 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 25 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 used to share it, which risk is discussed above. Additionally, interoperability and the sharing of health information have 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. The Medicare conditions of participation include the newly instituted CMS Vax Mandate discussed above in "—Novel Coronavirus Disease 2019 ("COVID-19") Pandemic Risks." If any of our hospitals or agencies 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.

If we are found to have violated applicable privacy and security laws and regulations or our contractual obligations, we could be subject to sanctions, fines, damages and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operation and liquidity.

There are a number of federal and state laws, rules and regulations, as well as contractual obligations, relating to the protection, collection, storage, use, retention, security, disclosure, transfer and other processing of confidential, sensitive and personal information, including certain patient health information, such as patient records. There are also foreign laws, rules and regulations that address these matters and have extraterritorial application. We do not believe we are currently subject to these non-United States regulatory regimes but that could change in the future. Existing laws and regulations are constantly evolving, and new laws and regulations that apply to our business are being enacted at every level of government in the United States. In many cases, these laws and regulations apply not only to third-party transactions, but also to transfers of information between or among us, our affiliates and other parties with whom we conduct business. These laws and regulations may be interpreted and applied differently over time and from jurisdiction to jurisdiction, and it is possible that they will be interpreted and applied in ways that may have a material adverse effect on our business. We monitor legal developments in data privacy and security regulations at the local, state and federal level, however, the regulatory framework for data privacy and security worldwide is continuously evolving and developing and, as a result, interpretation and implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future.

The management of protected health information ("PHI") is subject to several regulations at the federal level, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HITECH Act. The HIPAA privacy and security regulations protect medical records and other personal health information by limiting their use and disclosure, giving individuals the right to access, amend, and seek accounting of their own health information, and limiting most uses and disclosures of health information to the minimum amount reasonably necessary to accomplish the intended purpose. The HITECH Act strengthened HIPAA enforcement provisions and authorized state attorneys general to bring civil actions for HIPAA violations. It also permits HHS to conduct audits of HIPAA compliance and impose significant civil monetary penalties even if we did not know and could not reasonably have known about a violation. If we are found to have violated the HIPAA privacy or security regulations or other federal or state laws protecting the confidentiality of patient health or personal information, including but not limited to the HITECH Act, we could be subject to litigation, sanctions, fines, damages and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation, and have a material adverse effect on our business, financial position, results of operations and liquidity.

Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity and security of PHI. For example, various states, including Virginia, California, Massachusetts, Florida, and Colorado, have implemented privacy laws and regulations that impose restrictive requirements regulating the use and disclosure of personally identifiable information, including PHI, and many other states have proposed similar laws and regulations. These laws in many cases are more restrictive than, and may not be preempted by, the HIPAA rules, apply to employees as well as patients, and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues and potentially exposing us to additional expense, adverse publicity and liability. We also expect that there will continue to be new laws, regulations and industry standards concerning privacy, data protection and information security proposed and enacted in various jurisdictions. The U.S. Congress has considered, but not yet passed, several comprehensive federal data privacy bills over the past few years, such as the CONSENT Act, which was intended to be similar to the landmark 2018 European Union General Data Protection Regulation. We expect federal data privacy laws to continue to evolve.

At the state and local level, there is increased focus on regulating the collection, storage, use, retention, security, disclosure, transfer and other processing of confidential, sensitive and personal information. In recent years, we have seen significant changes to data privacy regulations across the United States. New legislation proposed or enacted will continue to shape the data privacy environment. Certain state laws may be more stringent or broader in scope, or offer greater individual rights, with respect to confidential, sensitive and personal information than federal, international or other state laws, and such laws may differ from each other, which significantly complicates compliance efforts.

In addition, all 50 U.S. states and the District of Columbia have enacted breach notification laws that may require us to notify patients, employees or regulators in the event of unauthorized access to or disclosure of personal or confidential information experienced by us or our service providers. These laws are not consistent, and compliance in the event of a widespread data breach is difficult and may be costly. Moreover, states have been frequently amending existing laws, requiring attention to changing regulatory requirements.

We also may be contractually required to notify patients or other counterparties of a security breach. Although we have contractual protections with many of our service providers, any actual or perceived security breach could harm our reputation and brand, expose us to potential liability or require us to expend significant resources on data security and in responding to any such actual or perceived breach. Any contractual protections we may have from our service providers may not be sufficient to adequately protect us from any such liabilities and losses, and we may be unable to enforce any such contractual protections.

In addition to government regulation, privacy advocates and industry groups have and may in the future propose self-regulatory standards from time to time. These and other industry standards may legally or contractually apply to us, or we may elect to comply with such standards.

Complying with these various laws, rules, regulations and standards could cause us to incur substantial costs that are likely to increase over time, require us to change our business practices in a manner adverse to our business, divert resources from other initiatives and projects, and restrict the way products and services involving data are offered, all of which may have a material adverse effect on our business. Given the rapid development of cybersecurity and data privacy laws, we expect to encounter inconsistent interpretation and enforcement of these laws and regulations, as well as frequent changes to these laws and regulations which may expose us to significant penalties or liability for noncompliance, the possibility of fines, lawsuits (including class action privacy litigation), regulatory investigations, criminal or civil sanctions, audits, adverse media coverage, public censure, other claims, significant costs for remediation and damage to our reputation, or otherwise have a material adverse effect on our business and operations. Any allegations of a failure to adequately address data privacy or security-related concerns, even if unfounded, or to comply with applicable laws, regulations, standards and other obligations relating to data

privacy and security, could result in additional cost and liability to us, damage our relationships with patients and have a material adverse effect on our business.

We make public statements about our use and disclosure of personal information through our privacy policies, information provided on our website and press statements. Although we endeavor to comply with our public statements and documentation about patient privacy, we may at times fail to do so or be accused of having failed to do so. The publication of our privacy policies and other statements that provide promises and assurances about data privacy and security can subject us to potential government or legal action if they are found to be deceptive, unfair or misrepresentative of our actual practices. Moreover, from time to time, concerns may be expressed about whether our products and services compromise the privacy of patients and others. Any concerns about our data privacy and security practices, even if unfounded, could damage the reputation of our businesses, discourage potential patients from our products and services and have a material adverse effect on our business.

We are subject to federal, state and local laws and regulations that govern our employment practices, including minimum wage, overtime, living wage and paid-time-off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal, state and locals laws and regulations relating to employment, including occupational safety and health requirements, minimum staffing, wage and hour, overtime and other compensation requirements, employee benefits and other leave and sick pay requirements, proper classification of workers as employee or independent contractors, and immigration and equal employment opportunity laws, among others. These laws and regulations can vary significantly among jurisdictions, can change, and can be highly technical and involve strict liability for noncompliance with a seemingly mundane technical detail. Costs and expenses related to these requirements are a significant operating expense and may increase as laws and regulations change. Any failure to comply with these requirements can result in significant penalties or litigation exposure and could have a material adverse effect on our business.

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 HIPAA and the HITECH 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 advanced 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. There have been other recent significant incidents of software vendor compromises.

Threat actors continue to attempt to exploit commonly used software and services to gain remote access to a large number of their customers' information systems. For example, in August 2021, Microsoft reported a vulnerability within their email exchange services which attackers can use to remotely bypass the access control list then elevate privileges. In December 2021, vulnerable logging software installed within thousands of applications and services gave threat actors the ability to execute code remotely and gain unrestricted control over the victims' systems. We conducted forensics investigations on our systems containing these software applications 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 each of these situations 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 data, 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, or the failure of one or more of our key partners, vendors, or other counterparties to do these things, 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 the 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 a large insurance company, 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. The insurance company not only owns one of the largest providers of Medicare-certified skilled home health services but, by nature of being a payor, can designate which home health and hospice agencies are in or out of the participating provider networks and can set reimbursement rates for network participants. Other large health insurance companies have publicly announced their intentions to enter the home health business. Our largest competitors 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. 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. 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 provide a consistently high quality of care, our business will be adversely impacted.

Providing quality patient care is fundamental to our business. We believe hospitals, physicians and other referral sources refer patients to us in large part because of our reputation for delivering quality care. Clinical quality is becoming increasingly important within our industry. Effective October 2012, Medicare began to impose a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this regulation provides a competitive advantage to post-acute providers who can differentiate themselves based upon quality, particularly by achieving low acute-care hospital readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. If we should fail to attain our goals regarding acute-care hospital readmission rates and other quality metrics, we expect our ability to generate referrals would be adversely impacted, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

Additionally, Medicare has established consumer-facing websites, Home Health Compare and Hospice Compare, that present data regarding our performance on certain quality measures compared to state and national averages. Failure to achieve or exceed these averages may adversely affect our ability to generate referrals, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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 are increasing faster than reimbursement rates and 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.

Changes in federal laws or regulations may also materially adversely impact our ability to acquire hospitals or agencies or open *de novo* hospitals or agencies. For example, CMS has adopted a regulation known as the "36-Month Rule" that is applicable to home health agency acquisitions. Subject to certain exceptions, the 36-Month Rule prohibits buyers of certain home health agencies—those that either enrolled in Medicare or underwent a change in ownership fewer than 36 months prior to the acquisitions—from assuming the Medicare billing privileges of the acquired agency. Instead, the acquired home health agencies must enroll as new providers with Medicare. As a result, the 36-Month Rule may further increase competition for acquisition targets that are not subject to the rule and may cause significant Medicare billing delays for the purchases of home health agencies that are subject to the rule.

Under the Biden administration, DOJ has announced its intention to be much more aggressive in challenging mergers and acquisitions it believes present anti-trust concerns. In a speech in January 2022, the head of DOJ's anti-trust enforcement stated that negotiated settlements are frequently inadequate remedies and that DOJ needs to be more aggressive in its litigation to block business combinations. He also stated that litigation is preferable to settlements because it represents a chance to extend legal precedent for what constitutes unlawful anticompetitive activity. Increased DOJ enforcement of antitrust laws will likely increase the time, effort and expense associated with acquisitions and may ultimately make it less likely to consummate acquisitions. With respect to healthcare combinations specifically, President Biden issued an Executive Order on July 9, 2021 that encourages DOJ and the Federal Trade Commission to review and revise their merger guidelines for hospitals to ensure patients are not harmed by such mergers.

These factors and others 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 as well as risks and liabilities related to previously compromised information systems.

As part of our development activities, we intend to open new, or *de novo*, inpatient rehabilitation hospitals and home health and hospice agencies. 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 and agencies 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 and agencies as profitably as expected, and those hospitals and agencies 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 Healthcare, Alacare Home Health and Hospice and Frontier Home Health and Hospice in 2018, 2019, and 2021, 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, and financial and administrative practices yet to be fully integrated. To the extent we are attempting to integrate multiple businesses at the same time, we may not be able to do so as efficiently or effectively as we initially anticipate. The failure to successfully integrate on a timely basis any acquired business with our existing business could have an adverse effect on our business, financial position, results of operations, and cash flows.

We anticipate our acquisitions will result in benefits including, among other things, increased revenues. 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 staffing costs and reduce profitability.

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This issue may be exacerbated if immigration is limited in the future. As discussed above in "—Novel Coronavirus Disease 2019 ("COVID-19") Pandemic Risks," the pandemic has significantly affected the availability of clinical staff. 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 staffing 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 staffing costs is limited. In particular, if staffing costs rise at an annual rate greater than our net annual market basket update from Medicare, as is expected to happen in 2022, 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 staffing costs. We currently have a minimal number of union employees, so an increase in labor union activity could have a significant impact on our staffing costs. Our failure to recruit and retain qualified medical personnel, or to control our staffing 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, 2021, we have approximately $2.9 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $386.8 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:

- prohibiting us from completing the spin off of our home health and hospice business;
- 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, 2021, 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, 2021, approximately 73% 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*.

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our patients, and a regional or global socio-political or other catastrophic event could severely disrupt our business.

We believe the majority of our patients are individuals with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or other public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable patients. For example, if another pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Enrollment for our services could experience sharp declines if families decide healthcare workers should not be brought into their homes during a health pandemic. Local, regional or national governments might limit or ban public interactions to halt or delay the spread of diseases causing business disruptions and the temporary suspension of our services. Accordingly, certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

Other unforeseen events, including acts of violence, war, terrorism and other international, regional or local instability or conflicts (including labor issues), embargoes, natural disasters such as earthquakes, whether occurring in the United States or abroad, could restrict or disrupt our operations.

Our ability to develop adjacent service offerings for our home health and hospice business is subject to a number of risks.

Because our home health and hospice business has historically focused mainly on the skilled home health and hospice industries, developing adjacent service offerings such as SNF-at-home, palliative care services, care management services, private duty services, and hospital-at-home care involves a number of risks, including reimbursement risks, regulatory risks, and staffing and operational risks, among others. The lack of well-developed regulations for these adjacent services magnifies those risks. Any of these risks could impact our ability to enter these service areas, or the attractiveness of these opportunities for our home health and hospice business. Furthermore, because these are new services that we have not previously provided, we may not be able to do so efficiently or effectively if we do develop these service areas.

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, we leased or owned hospital and agency locations as noted in the table below. All 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, 2021:

		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 *+	436	2	3	2	7	56
Alaska	—	—	—	—	—	2
Arizona	396	1	2	3	6	5
Arkansas +	368	3	1	1	5	5
California	234	3	—	1	4	—
Colorado	124	1	—	1	2	8
Connecticut *	—	—	—	—	—	1
Delaware *	40	—	1	—	1	—
Florida	1,093	12	1	1	14	21
Georgia *+	280	4 [(1)]	1	—	5	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	87	2	—	—	2	3
Maine *	100	—	—	1	1	—
Maryland *+	74	1	—	—	1	3
Massachusetts *	529	2	—	2	4	5
Mississippi *+	43	—	—	1	1	20
Missouri *	191	—	2	—	2	2
Montana +	—	—	—	—	—	8
Nevada *	219	2	—	1	3	4
New Hampshire	50	—	1	—	1	—
New Jersey *+	199	1	1	1	3	—

		Number of Hospitals				
New Mexico	87	1	—	—	1	8
North Carolina *+	68	1	—	—	1	6
Ohio	260	2	1	1	4	1
Oklahoma	60	—	1	—	1	21
Oregon *	—	—	—	—	—	2
Pennsylvania	709	5	—	4	9	4
Puerto Rico *+	75	—	—	2	2	—
Rhode Island *+	—	—	—	—	—	1
South Carolina *+	496	3	4	1	8	4
South Dakota	40	1	—	—	1	—
Tennessee *+	493	6	3	—	9	8
Texas	1,726	13	3	10	26	65
Utah	84	1	—	—	1	12
Virginia *	297	2	1	3	6	12
Washington +	—	—	—	—	—	2
West Virginia *+	258	2	2	—	4	—
Wyoming	—	—	—	—	—	8
	9,924	76	31	38	145	347 [(2)]

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

\+ 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 251 locations where we provide home health services and 96 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.

On October 26, 2021, we filed suit in the district court of Dallas County, Texas against April K. Anthony, a former executive officer in our home health and hospice segment ("HH&H"), for breach of her contractual noncompete, nonsolicitation, and nondisclosure obligations to us and for trade secret misappropriation. Ms. Anthony's senior management agreement, dated October 7, 2019, provides, among other things, that she shall not (i) directly or indirectly engage in the provision of home health or hospice services in any state in which we are operating for a period one year following her departure, (ii) directly or indirectly induce or attempt to induce any of our employees to leave our employ or in any way interfere with the relationship between us and any employee for a period of two years following her departure, or (iii) disclose to any unauthorized person or directly or indirectly use for her own account any information, observations and data concerning our business and affairs. Ms. Anthony resigned from her position with HH&H on June 18, 2021. In September 2021, we learned of evidence that Ms. Anthony during her tenure with us had engaged in, and was continuing to engage in, solicitation of

certain HH&H employees to join a competing home health and hospice venture. In this suit, we seek injunctions from the court ordering Ms. Anthony to comply with her senior management agreement, including its noncompete, nonsolicitation, and nondisclosure covenants, and to cease and desist all activities in furtherance of violations of those covenants. The trial is scheduled to begin April 18, 2022.

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 11, 2022, there were 99,438,215 shares of Encompass Health common stock issued and outstanding, net of treasury shares, held by approximately 6,863 holders of record (participant positions at The Depository Trust Corporation plus record holders).

Dividends

On February 25, 2022, our board of directors declared a cash dividend of $0.28 per share, payable on April 18, 2022 to stockholders of record on April 1, 2022. We expect comparable 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, 2021, 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	2,400,926	[2]	$ 54.33	8,119,284	[3]
Plans not approved by stockholders	86,830	[4]		—	
Total	2,487,756		$ 54.33	8,119,284	

[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, 2021:

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, 2021	496	$ 69.57	—	198,053,924
November 1 through November 30, 2021	—	—	—	198,053,924
December 1 through December 31, 2021	—	—	—	198,053,924
Total	496		—	

(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, 288 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

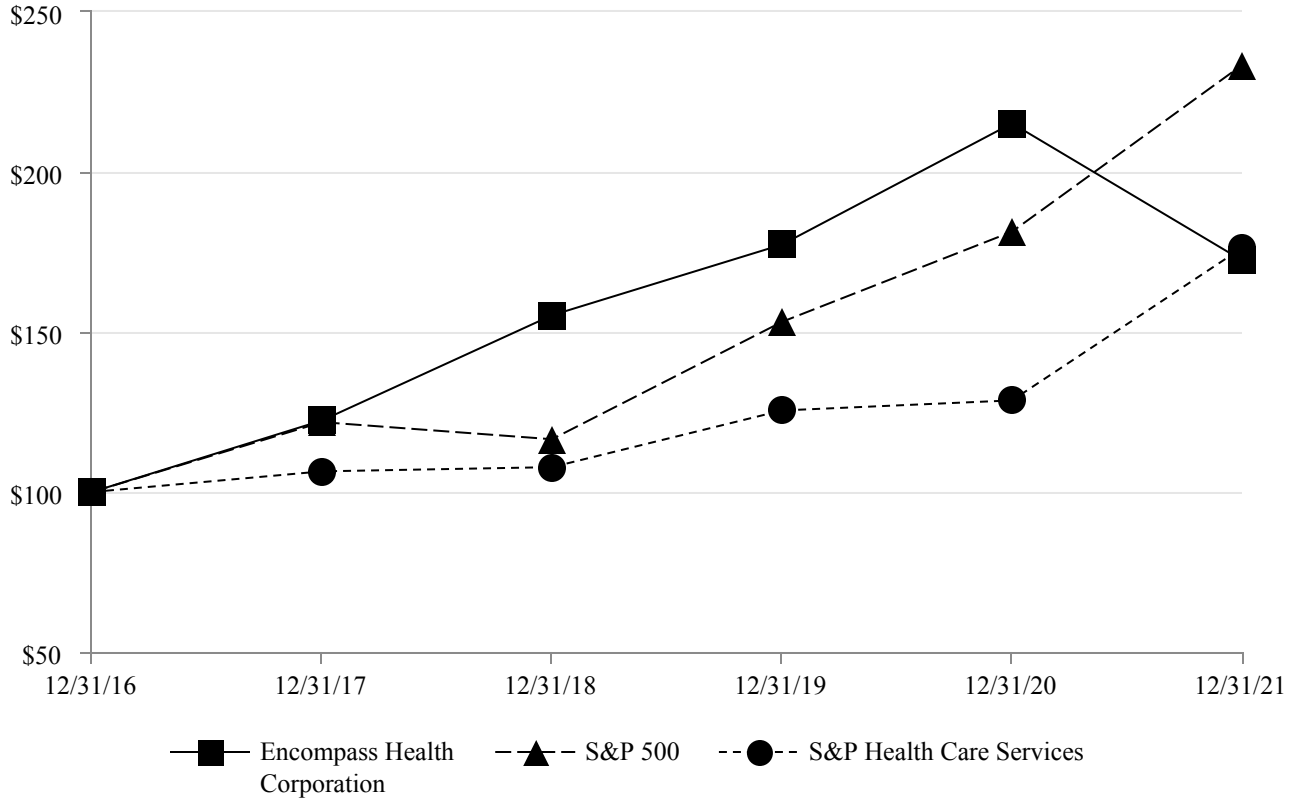
Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor's 500 Index ("S&P 500"), and the S&P Health Care Services Select Industry Index ("SPSIHP"), an equal-weighted index of at least 35 companies in healthcare services that are also part of the S&P Total 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, 2016 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	2016	2017	2018	2019	2020	2021
Encompass Health Corporation	100.00	122.35	155.23	177.32	215.20	172.41
Standard & Poor's 500 Index	100.00	121.83	116.49	153.17	181.35	233.41
S&P Health Care Services Select Industry Index	100.00	106.45	107.77	125.48	128.63	176.26

Item 6. [Reserved]

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, 2020 compared to the year ended December 31, 2019 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, 2020, filed with the Securities and Exchange Commission on February 26, 2021.

Executive Overview

Our Business

We are a national leader in integrated healthcare services, offering both facility-based and home-based patient care through our network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. As of December 31, 2021, our national footprint spans 42 states and Puerto Rico. As discussed in this Item, "Segment Results of Operations," we currently 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. As a result of this process, we expect to separate the home health and hospice business from Encompass Health into an independent public company through a spin-off distribution in the first half of 2022. On January 19, 2022, we announced the home health and hospice business would be rebranded and operate under the name Enhabit Home Health & Hospice. The rebranding of agency locations is expected to begin in mid-April 2022 and to be largely completed by the consummation of the spin off.

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, 2021, we operate 145 inpatient rehabilitation hospitals and manage three inpatient rehabilitation units through management contracts. Our inpatient rehabilitation segment represented approximately 78% of our *Net operating revenues* for the year ended December 31, 2021.

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 twelfth largest provider of Medicare-certified hospice services in terms of revenues. Hospice care focuses on the quality of life for patients who are experiencing an advanced, life limiting illness while treating the person and symptoms of the disease, rather than the disease itself. As of December 31, 2021, we provide home health services in 251 locations and hospice services in 96 locations across 34 states, with a concentration in the southern half of the United States. Our home health and hospice segment represented approximately 22% of our *Net operating revenues* for the year ended December 31, 2021.

2021 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 2021. In our inpatient rehabilitation segment, we:

- began operating our new 40-bed inpatient rehabilitation hospital in San Angelo, Texas with our joint venture partner Shannon Health in March 2021;
- began operating our new 50-bed inpatient rehabilitation hospital in North Tampa, Florida in April 2021;
- began operating our new 50-bed inpatient rehabilitation hospital in Cumming, Georgia in June 2021;
- began operating our new 40-bed inpatient rehabilitation hospital in Waco, Texas in August 2021;
- began operating our new 40-bed inpatient rehabilitation hospital in Shreveport, Louisiana in August 2021;
- began operating our new 40-bed inpatient rehabilitation hospital in Greenville, South Carolina in August 2021;
- began operating our new 40-bed inpatient rehabilitation hospital in Pensacola, Florida in September 2021;
- began operating our new 50-bed inpatient rehabilitation hospital in Henry County, Georgia in October 2021;
- continued our capacity expansions by adding 117 new beds to existing hospitals; and
- announced or continued the development of the following hospitals:

	Number of New Beds		
	2022	**2023**	**2024**
Shiloh, Illinois[(1)]	40	—	—
St. Augustine, Florida	40	—	—
Libertyville, Illinois	60	—	—
Lakeland, Florida	50	—	—
Cape Coral, Florida	40	—	—
Jacksonville, Florida	50	—	—
Moline, Illinois[(1)]	40	—	—
Naples, Florida	50	—	—
Grand Forks, North Dakota[(1)]	40	—	—
Eau Claire, Wisconsin[(1)]	—	36	—
Owasso, Oklahoma[(1)]	—	40	—
Clermont, Florida	—	50	—
Knoxville, Tennessee[(1)]	—	73	—
Bowie, Maryland	—	60	—
Columbus, Georgia[(1)(2)]	—	40	—
Prosper, Texas	—	40	—
Strongville, Ohio	—	40	—
Fitchburg, Wisconsin	—	40	—
Louisville, Kentucky[(1)]	—	40	—
Kissimmee, Florida	—	—	50
Fort Mill, South Carolina	—	—	39
Amarillo, Texas	—	—	40
Atlanta, Georgia[(1)(2)]	—	—	40
Palm Beach Gardens, Florida	—	—	50
Lake Worth, Florida	—	—	50

[(1)] Expected joint venture
[(2)] Piedmont Healthcare, our joint venture partner in these hospitals, assumed 50% ownership in our existing hospital in Newnan, Georgia during the second quarter of 2021.

We also continued our expansion efforts in our home health and hospice segment. On June 1, 2021, we completed the acquisition of the home health and hospice assets of Frontier Home Health and Hospice ("Frontier") in Alaska, Colorado, Montana, Washington, and Wyoming for a cash purchase price of approximately $99 million. The Frontier acquisition included the purchase of a 50% equity interest in the Heart of the Rockies Home Health joint venture and a 90% equity interest in the Hospice of Southwest Montana joint venture (inclusive of an additional 40% equity interest purchased for approximately $4 million). We consolidate both of these joint ventures. On the acquisition date, nine home health and eleven hospice locations became part of our national network of home health and hospice locations. This acquisition was made to expand our existing presence in Colorado and Wyoming and extend our services to Alaska, Montana and Washington. We funded this transaction using cash on hand and borrowings under our revolving credit facility. For additional information regarding this transaction, see Note 2, *Business Combinations*, to the accompanying consolidated financial statements. In addition to the Frontier acquisition, we began accepting patients at our new hospice locations in Las Cruces, New Mexico (May 2021), Abilene, Texas (September 2021), and Tyler, Texas (November 2021).

During 2021, *Net operating revenues* increased 10.3% over 2020 due primarily to volume and pricing growth in our inpatient rehabilitation 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. 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, reaching approximately 73 million people over the age of 65 by 2030. 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. 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 2022 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, former President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the "CARES Act"), which suspended sequestration, an automatic 2% reduction of Medicare program payments for all healthcare providers, for the period of May 1 through December 31, 2020. On December 27, 2020, the Consolidated Appropriations Act, 2021 (the "2021 Budget Act") extended the sequestration suspension through March 31, 2021. On April 14, 2021, Congress further extended the sequestration suspension period through December 31, 2021. On December 10, 2021 President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act, which suspends sequestration cuts until April 1, 2022, set sequestration at 1% for the period April 1, 2022 through June 30, 2022 and reinstated the full 2% sequestration effective July 1, 2022. During 2021, the sequestration suspension provided additional revenues in our inpatient rehabilitation segment and home health and hospice segment of approximately $62 million and $20 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 accept any CARES Act relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the 2021 Budget Act or other legislation. 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. Additional Medicare payment reductions are also possible under the Statutory Pay-As-You-Go Act of 2010 ("Statutory PAYGO"). For further discussion of Statutory PAYGO, see Item 1, *Business*, "Sources of Revenue," and Item 1A, *Risk Factors.*

- Changes to Our Operating Environment Resulting from Healthcare Reform. Concerns held by federal policymakers about the federal deficit, national debt levels, and the solvency of the Medicare trust fund, 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 Patient Protection and Affordable Care Act (as subsequently amended, the "ACA") have impacted or could in the future impact our business, including 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*, healthcare will almost certainly be the subject of significant regulatory and legislative changes regardless of party in control of the executive and legislative branches of state and federal governments. We will continue to evaluate these laws and regulations and position the Company for this industry shift. Based on our track record, we believe we can adapt to these regulatory and industry changes. Further, we have engaged, and will continue to engage, actively in discussions with key legislators and regulators to attempt to ensure any healthcare laws or regulations adopted or amended promote our goal of high-quality, cost-effective care.

  Each year, CMS adopts rules that update pricing and otherwise amend the respective payment systems. On July 29, 2021, CMS released its notice of final rulemaking for fiscal year 2022 under the inpatient rehabilitation facility prospective payment system (the "2022 IRF Rule"). Based on our analysis that utilizes, among other things, the acuity of our patients annualized over a six-month prior period, our experience with outlier payments over this same time frame, and other factors, we believe the 2022 IRF Rule will result in a net increase to our Medicare payment rates of approximately 1.9% effective October 1, 2021. On November 2, 2021, CMS released its notice of final rulemaking for calendar year 2022 for home health agencies under the home health prospective payment system (the "2022 HH Rule"). Based on our preliminary analysis, which utilizes, among other things, our patient mix annualized over an eleven-month prior period, our specific geographic coverage area, and other factors, we believe the 2022 HH Rule will result in a net increase to our Medicare payment rates of approximately 3.4% effective for 30-day payment periods ending on or after January 1, 2022. For additional details of the 2022 IRF Rule, 2022 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, we believe a number of factors related to the pandemic negatively impacted volumes in 2021, predominately in the home health and hospice segment as discussed in the "Results of Operations" and "Segment Results of Operations" sections of this Item. While we continue to see our volumes recover in our inpatient rehabilitation segment, a current or future resurgence of COVID-19 infections could cause disruptions to our volume growth in both segments.

- 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. These factors have resulted in increased labor costs and increased use of contract labor as discussed in the "Results of Operations" and "Segment Results of Operations" sections of this Item.

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 2021, 2020, and 2019, we derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Medicare	68.2 %	70.5 %	75.1 %
Medicare Advantage	14.2 %	14.2 %	10.6 %
Managed care	10.7 %	9.0 %	8.3 %
Medicaid	3.5 %	3.4 %	2.8 %
Other third-party payors	0.9 %	0.9 %	0.9 %
Workers' compensation	0.5 %	0.5 %	0.7 %
Patients	0.4 %	0.4 %	0.5 %
Other income	1.6 %	1.1 %	1.1 %
Total	100.0 %	100.0 %	100.0 %

Our payor mix is weighted heavily towards Medicare. We receive Medicare reimbursements under 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.

Our Results

From 2019 through 2021, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2021	2020	2019	2021 vs. 2020	2020 vs. 2019
	(In Millions)				
Net operating revenues	$ 5,121.6	$ 4,644.4	$ 4,605.0	10.3 %	0.9 %
Operating expenses:					
Salaries and benefits	2,886.5	2,682.0	2,573.0	7.6 %	4.2 %
Other operating expenses	685.2	634.4	623.6	8.0 %	1.7 %
Occupancy costs	80.2	81.2	82.3	(1.2)%	(1.3)%
Supplies	209.3	200.5	167.9	4.4 %	19.4 %
General and administrative expenses	197.3	155.5	247.0	26.9 %	(37.0)%
Depreciation and amortization	256.6	243.0	218.7	5.6 %	11.1 %
Government, class action, and related settlements	—	2.8	—	(100.0)%	N/A
Total operating expenses	4,315.1	3,999.4	3,912.5	7.9 %	2.2 %
Loss on early extinguishment of debt	1.0	2.3	7.7	(56.5)%	(70.1)%
Interest expense and amortization of debt discounts and fees	164.6	184.2	159.7	(10.6)%	15.3 %
Other income	(12.3)	(10.6)	(30.5)	16.0 %	(65.2)%
Equity in net income of nonconsolidated affiliates	(4.0)	(3.5)	(6.7)	14.3 %	(47.8)%
Income from continuing operations before income tax expense	657.2	472.6	562.3	39.1 %	(16.0)%
Provision for income tax expense	139.6	103.8	115.9	34.5 %	(10.4)%
Income from continuing operations	517.6	368.8	446.4	40.3 %	(17.4)%
Loss from discontinued operations, net of tax	(0.4)	—	(0.6)	N/A	(100.0)%
Net income	517.2	368.8	445.8	40.2 %	(17.3)%
Less: Net income attributable to noncontrolling interests	(105.0)	(84.6)	(87.1)	24.1 %	(2.9)%
Net income attributable to Encompass Health	$ 412.2	$ 284.2	$ 358.7	45.0 %	(20.8)%

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2021	2020	2019
Operating expenses:			
Salaries and benefits	56.4 %	57.7 %	55.9 %
Other operating expenses	13.4 %	13.7 %	13.5 %
Occupancy costs	1.6 %	1.7 %	1.8 %
Supplies	4.1 %	4.3 %	3.6 %
General and administrative expenses	3.9 %	3.3 %	5.4 %
Depreciation and amortization	5.0 %	5.2 %	4.7 %
Government, class action, and related settlements	— %	0.1 %	— %
Total operating expenses	84.3 %	86.1 %	85.0 %

In the discussion that follows, we use “same-store” comparisons to explain the changes in certain performance metrics and line items within our financial statements. We calculate same-store comparisons based on hospitals and 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.

2021 Compared to 2020

Net Operating Revenues

Our consolidated *Net operating revenues* increased in 2021 compared to 2020 primarily from volume and pricing growth in our inpatient rehabilitation segment. See additional discussion in the "Segment Results of Operations" section of this Item.

For various quarterly periods during the pandemic, we experienced decreased patient volumes in one or more of our business lines when compared to the prior year periods. Beginning in mid-March 2020, 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, policies in assisted living facilities that prevent staff 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. Inpatient rehabilitation patient census and home health starts of episodes reached a low point the week ended April 12, 2020 (Easter weekend). 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 in our home health business.

Salaries and Benefits

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

Salaries and benefits in terms of dollars increased in 2021 compared to 2020 primarily due to salary and benefit cost increases for our employees, increased contract labor to meet higher patient volumes, and the ramping up of new stores. *Salaries and benefits* as a percent of *Net operating revenues* decreased in 2021 compared to 2020 primarily due to the additional paid-time-off awarded to employees in the second quarter of 2020 (discussed below) and improved labor productivity partially offset by higher clinician compensation costs due to staffing challenges resulting from the pandemic. See additional discussion in the "Segment Results of Operations" section of this Item.

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. 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).

Other Operating Expenses

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

Other operating expenses decreased as a percent of *Net operating revenues* during 2021 compared to 2020 primarily due to the increase in *Net operating revenues* as discussed above.

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* decreased as a percent of *Net operating revenues* during 2021 compared to 2020 primarily due to the increase in *Net operating revenues* as discussed above. We expect to continue to see elevated utilization and cost of medical supplies in 2022 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 and transaction costs.

General and administrative expenses increased in terms of dollars and as a percent of *Net operating revenues* during 2021 compared to 2020 primarily due to the transaction costs associated with the spin off of our home health and hospice business and higher costs associated with incentive compensation. See the "Executive Overview" section of this Item for additional information on the spin off.

Depreciation and Amortization

Depreciation and amortization increased during 2021 compared to 2020 due to our capital expenditures and development activities throughout 2020 and 2021. 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 decrease in *Interest expense and amortization of debt discounts and fees* in 2021 compared to 2020 primarily resulted from the redemption of approximately $700 million in November 2020 for the remaining 5.75% Senior Notes due 2024 (the "2024 Notes") as well as the April and June 2021 redemptions of $100 million in outstanding principal amount of the 5.125% Senior Notes due 2023 (the "2023 Notes"). Cash paid for interest approximated $168 million in 2021 and 2020, respectively. For additional information, see Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations in 2021 increased compared to 2020 primarily due to the increase 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* increased in 2021 compared to 2020 primarily due to higher *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, 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 and 2021, although it has impacted the timing of future cash payments for taxes.

Our cash payments for income taxes approximated $130 and $33 million, net of refunds, in 2021 and 2020, respectively. These payments were based on estimates of taxable income. We estimate we will pay approximately $80 million to $100 million of cash income taxes, net of refunds, in 2022. These payments are expected to primarily result from federal and state income tax expenses based on estimates of taxable income for 2022. In 2021 and 2020, current income tax expense was $111.8 million and $51.4 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.

Net Income Attributable to Noncontrolling Interests

The increase in *Net income attributable to noncontrolling interests* during 2021 compared to 2020 resulted from increased profitability of our existing joint ventures due to the impact of the pandemic on 2020.

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.

See Item 1A, *Risk Factors*, for additional information.

Relationships and Transactions with Related Parties

Related party transactions were not material to our operations in 2021, 2020, or 2019, 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, 2021, 2020, and 2019, our inpatient rehabilitation segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Medicare	64.4 %	66.7 %	72.2 %
Medicare Advantage	15.2 %	15.3 %	10.7 %
Managed care	12.1 %	10.4 %	9.8 %
Medicaid	4.1 %	3.9 %	3.1 %
Other third-party payors	1.1 %	1.2 %	1.2 %
Workers' compensation	0.6 %	0.6 %	0.8 %
Patients	0.5 %	0.5 %	0.7 %
Other income	2.0 %	1.4 %	1.5 %
Total	100.0 %	100.0 %	100.0 %

Additional information regarding our inpatient rehabilitation segment's operating results for the years ended December 31, 2021, 2020, and 2019, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2021	2020	2019	2021 vs. 2020	2020 vs. 2019
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Inpatient	$ 3,918.1	$ 3,496.1	$ 3,423.5	12.1 %	2.1 %
Outpatient and other	96.9	70.1	89.5	38.2 %	(21.7)%
Inpatient rehabilitation segment revenues	4,015.0	3,566.2	3,513.0	12.6 %	1.5 %
Operating expenses:					
Salaries and benefits	2,127.3	1,903.8	1,813.1	11.7 %	5.0 %
Other operating expenses	594.8	534.7	521.9	11.2 %	2.5 %
Supplies	184.2	171.0	147.0	7.7 %	16.3 %
Occupancy costs	59.0	61.4	64.8	(3.9)%	(5.2)%
Other income	(6.9)	(8.0)	(10.5)	(13.8)%	(23.8)%
Equity in net income of nonconsolidated affiliates	(3.4)	(3.0)	(5.5)	13.3 %	(45.5)%
Noncontrolling interests	103.2	83.3	82.6	23.9 %	0.8 %
Segment Adjusted EBITDA	$ 956.8	$ 823.0	$ 899.6	16.3 %	(8.5)%
	(Actual Amounts)				
Discharges	197,639	181,897	186,842	8.7 %	(2.6)%
Net patient revenue per discharge	$ 19,825	$ 19,220	$ 18,323	3.1 %	4.9 %
Outpatient visits	161,070	186,257	375,525	(13.5)%	(50.4)%
Average length of stay (days)	12.8	12.9	12.6	(0.8)%	2.4 %
Occupancy %	70.0%	67.7%	69.5%	3.4 %	(2.6)%
# of licensed beds	9,924	9,505	9,249	4.4 %	2.8 %
Full-time equivalents*	23,193	22,076	21,967	5.1 %	0.5 %
Employees per occupied bed	3.34	3.43	3.42	(2.6)%	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,		
	2021	2020	2019
Operating expenses:			
Salaries and benefits	53.0 %	53.4 %	51.6 %
Other operating expenses	14.8 %	15.0 %	14.9 %
Supplies	4.6 %	4.8 %	4.2 %
Occupancy costs	1.5 %	1.7 %	1.8 %

2021 Compared to 2020

Net Operating Revenues

Inpatient revenue increased during 2021 compared to 2020 primarily due to increased volumes and favorable pricing. Discharge growth included a 6.2% increase in same-store discharges. Discharge growth from new stores during 2021 resulted from our joint ventures in Coralville, Iowa (June 2020), San Angelo, Texas (March 2021), and Henry County, Georgia (October 2021), as well as wholly owned hospitals in Murrieta, California (February 2020), Sioux Falls, South Dakota (June 2020), Toledo, Ohio (November 2020), North Tampa, Florida (April 2021), Cumming, Georgia (June 2021), Waco, Texas (August 2021), Shreveport, Louisiana (August 2021), Greenville, South Carolina (August 2021), and Pensacola, Florida (September 2021). Growth in net patient revenue per discharge during 2021 compared to 2020 primarily resulted from an increase in reimbursement rates, a higher acuity patient mix and the suspension of sequestration starting in May 2020.

The increase in outpatient and other revenue during 2021 compared to 2020 primarily resulted from an increase of $29.7 million in provider tax revenues (offset by $17.8 million of provider tax expense increases included in *Other operating expenses*).

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

Adjusted EBITDA

The increase in Adjusted EBITDA during 2021 compared to 2020 primarily resulted from the increase in net patient revenue as discussed above. *Salaries and benefits* as a percent of *Net operating revenues* decreased in 2021 compared to 2020 due to the additional paid-time-off awarded to employees in the second quarter of 2020 (discussed above) and improved labor productivity (contributed to lower employees per occupied bed) partially offset by higher clinician compensation costs due to staffing shortages resulting from the pandemic. *Other operating expenses, Supplies,* and *Occupancy costs* as a percent of *Net operating revenues* decreased during 2021 compared to 2020 primarily due the increase in net patient revenue.

Home Health and Hospice

During the years ended December 31, 2021, 2020, and 2019, our home health and hospice segment derived its *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Medicare	81.9 %	83.1 %	84.2 %
Medicare Advantage	10.6 %	10.8 %	10.2 %
Managed care	5.9 %	4.4 %	3.6 %
Medicaid	1.4 %	1.4 %	1.7 %
Workers' compensation	— %	0.1 %	0.1 %
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, 2021, 2020, and 2019, is as follows:

	For the Year Ended December 31,			Percentage Change	
	2021	2020	2019	2021 vs. 2020	2020 vs. 2019
	(In Millions, Except Percentage Change)				
Net operating revenues:					
Home health	$ 897.3	$ 877.6	$ 918.0	2.2 %	(4.4)%
Hospice	209.3	200.6	174.0	4.3 %	15.3 %
Home health and hospice segment revenues	1,106.6	1,078.2	1,092.0	2.6 %	(1.3)%
Operating expenses:					
Cost of services (excluding depreciation and amortization)	489.3	511.3	506.2	(4.3)%	1.0 %
Support and overhead costs	406.2	402.8	381.7	0.8 %	5.5 %
Other income	(1.6)	—	—	N/A	— %
Equity in net income of nonconsolidated affiliates	(0.6)	(0.5)	(1.2)	20.0 %	(58.3)%
Noncontrolling interests	1.8	1.3	9.5	38.5 %	(86.3)%
Segment Adjusted EBITDA	$ 211.5	$ 163.3	$ 195.8	29.5 %	(16.6)%
		(Actual Amounts)			
Home health:					
Total admissions	200,626	194,249	194,498	3.3 %	(0.1)%
Episodic admissions	155,357	158,912	159,727	(2.2)%	(0.5)%
Total recertifications	131,259	128,698	129,989	2.0 %	(1.0)%
Episodic recertifications	111,394	114,775	116,084	(2.9)%	(1.1)%
Episodes	264,581	268,508	275,578	(1.5)%	(2.6)%
Total starts of care	331,885	322,947	324,487	2.8 %	(0.5)%
Revenue per episode	$ 2,954	$ 2,905	$ 2,972	1.7 %	(2.3)%
Episodic visits per episode	15.4	16.4	17.1	(6.1)%	(4.1)%
Total visits	4,969,699	5,139,472	5,431,621	(3.3)%	(5.4)%
Cost per visit	$ 79	$ 80	$ 77	(1.3)%	3.9 %
Hospice:					
Admissions	13,113	12,878	10,452	1.8 %	23.2 %
Patient days	1,372,980	1,367,060	1,197,927	0.4 %	14.1 %
Average daily census	3,762	3,735	3,282	0.7 %	13.8 %
Revenue per day	$ 152	$ 147	$ 145	3.4 %	1.4 %

Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2021	2020	2019
Operating expenses:			
Cost of services (excluding depreciation and amortization)	44.2 %	47.4 %	46.4 %
Support and overhead costs	36.7 %	37.4 %	35.0 %

2021 Compared to 2020

Net Operating Revenues

Revenue growth during 2021 compared to 2020 was driven by increased volumes and pricing. Total starts of care increased during 2021 compared to 2020 primarily due to the acquisition of Frontier on June 1, 2021 and increased non-episodic admissions and recertifications as a result of our national contract with United Healthcare. Episodic admissions declined during 2021 compared to 2020 primarily due to the conversion of admissions to non-episodic under the national contract discussed above. The increase in revenue per episode during 2021 compared to 2020 resulted from an increase in reimbursement rates and the suspension of sequestration partially offset by the mix between early and late payment periods.

Adjusted EBITDA

The increase in Adjusted EBITDA during 2021 compared to 2020 resulted from the increase in net patient revenues as discussed above and a decrease in *Cost of services* as a percent of revenue. *Cost of services* decreased as a percent of revenues for 2021 compared to 2020 primarily due to lower visits per episode and lower cost per visit resulting from additional paid-time-off awarded to employees in the second quarter of 2020 (discussed above) partially offset by higher clinician compensation due to staffing shortages.

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 both April and June 2021, we redeemed $100 million in outstanding principal amount of the 2023 Notes using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of the 2023 Notes, these optional redemptions were made at a price of par. As a result of this redemption, we recorded a $1.0 million *Loss on early extinguishment of debt* in 2021. In February 2022, we issued notice for redemption of the remaining $100 million in outstanding principal amount of the 2023 Notes. Pursuant to the terms of the 2023 Notes, this full redemption will settle on March 15, 2022 and will be made at a price of par. We plan to use cash on hand and capacity under our revolving credit facility to fund the redemption. We expect to record an approximate $0.3 million *Loss on early extinguishment of debt* in the first quarter of 2022.

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 2020.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2024. 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, 2021, we had $54.8 million in *Cash and cash equivalents*. This amount excludes $65.5 million in restricted cash ($65.1 million included in *Restricted cash* and $0.4 million included in *Other long-term assets* in our consolidated balance sheet) and $82.2 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, 2021, we had approximately $762 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, 2021, the maximum leverage ratio requirement per our credit agreement was 5.0x and the minimum interest coverage ratio requirement was 2.0x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2021 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2021, 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.

On December 9, 2021, we announced the commencement of a consent solicitation of holders of our 2025 Notes, 2028 Notes, 2030 Notes, and 2031 Notes (collectively the "Notes") for the adoption of certain amendments to the Indenture, which will provide us with greater flexibility in effecting the spin off discussed in the "Executive Overview" section of this Item. Each Indenture contains restrictive covenants that, among other things, limit our ability and the ability of certain of our subsidiaries to make certain asset dispositions, investments, and distributions to holders of our capital stock. The amendments to the Indentures permit us, subject to the leverage ratio condition set forth below, to distribute to our equity holders in one or more transactions (a "Distribution") some or all of the common stock of a subsidiary that holds substantially all of the assets of our home health and hospice business. We may make any such distribution so long as the Leverage Ratio (as defined in each Indenture) is no more than 3.5 to 1.0 on a pro forma basis after giving effect thereto. The amendments also reduce the capacity under our restricted payments builder basket under each existing Indenture by $200 million and amends the definition of "Consolidated Net Income" to allow us to exclude from Consolidated Net Income (a component of the Leverage Ratio) any fees, expenses or charges related to any Distribution and the solicitation of consents from the holders of the Notes. In December 2021 and January 2022, we received the requisite consents for the adoption of these amendments. Under the terms of the amendments, we agreed to pay the holders of the Notes a total of $40.5 million, excluding fees. We paid $20 million of this amount in January 2022. The remaining payment is contingent upon the execution of a Distribution and will be paid at such time.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2024, and after the March 2022 redemption of the 2023 Notes discussed above, our bonds all mature in 2025 and beyond. See the "Contractual Obligations" section below for information related to our contractual obligations as of December 31, 2021.

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, 2021, 2020, and 2019 (in millions):

	For the Year Ended December 31,		
	2021	2020	2019
Net cash provided by operating activities	$ 715.8	$ 704.7	$ 635.3
Net cash used in investing activities	(666.3)	(407.5)	(657.4)
Net cash (used in) provided by financing activities	(240.1)	(145.9)	48.2
Increase in cash, cash equivalents, and restricted cash	$ (190.6)	$ 151.3	$ 26.1

2021 Compared to 2020

Operating activities. The increase in *Net cash provided by operating activities* during 2021 compared to 2020 primarily resulted from the increase in *Net income* (see the "Results of Operations" section of this Item) partially offset by the decrease in payroll accruals. The decrease 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. Half of the payroll taxes were paid in December 2021, with the remaining half due in December 2022.

Investing activities. The increase in *Net cash used in investing activities* during 2021 compared to 2020 primarily resulted from the acquisition of assets from Frontier and increased purchases of property and equipment. For additional information on the Frontier acquisition, see Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

Financing activities. The increase in *Net cash used in financing activities* during 2021 compared to 2020 primarily resulted from increased net debt payments partially offset by the purchase of equity interests held by the home health and hospice management team during the first quarter of 2020. See also Note 12, *Redeemable Noncontrolling Interest* and Note 10, *Long-term Debt*, to the accompanying consolidated financial statements.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2021 are as follows (in millions):

	Total	Current	Long-term
Long-term debt obligations:			
Long-term debt, excluding revolving credit facility and finance lease obligations [(a)]	$ 2,699.9	$ 19.7	$ 2,680.2
Revolving credit facility	200.0	—	200.0
Interest on long-term debt [(b)]	814.5	130.6	683.9
Finance lease obligations [(c)]	606.3	52.1	554.2
Operating lease obligations [(d)]	326.6	51.4	275.2
Purchase obligations [(e)]	148.8	55.4	93.4
Total	$ 4,796.1	$ 309.2	$ 4,486.9

(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, 2021. 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 10% 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.

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, 2021, we made capital expenditures of approximately $551 million for property and equipment, intangible assets, and capitalized software. These expenditures in 2021 are exclusive of approximately $119 million in net cash related to our acquisition activity. During 2022, we expect to spend approximately $570 million to $660 million for capital expenditures using cash on hand and borrowings under our revolving credit facility. Approximately $200 million to $250 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 2022. 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 2020, February 2021, May 2021, July 2021, and October 2021, our board of directors declared cash dividends of $0.28 per share that were paid in January 2021, April 2021, July 2021, October 2021, and January 2022, 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, 2021, 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.

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, 2021
	(In Millions)
Net operating revenues	$ 3,692.7
Intercompany revenues generated from non-guarantor subsidiaries	19.0
Total net operating revenues	$ 3,711.7
Operating expenses	$ 3,184.5
Intercompany expenses incurred in transactions with non-guarantor subsidiaries	30.8
Total operating expenses	$ 3,215.3
Income from continuing operations	$ 258.8
Net income	$ 258.4
Net income attributable to Encompass Health	$ 258.7

	As of December 31, 2021
	(In Millions)
Total current assets	$ 664.3
Property and equipment, net	$ 1,896.1
Goodwill	2,053.2
Intercompany receivable due from non-guarantor subsidiaries	166.1
Other noncurrent assets	662.9
Total noncurrent assets	$ 4,778.3
Total current liabilities	$ 624.7
Long-term debt, net of current portion	$ 3,194.5
Other noncurrent liabilities	327.9
Total noncurrent liabilities	$ 3,522.4
Redeemable noncontrolling interests	$ 2.3

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, 2021, 2020, and 2019 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Net income	$ 517.2	$ 368.8	$ 445.8
Loss from discontinued operations, net of tax, attributable to Encompass Health	0.4	—	0.6
Provision for income tax expense	139.6	103.8	115.9
Interest expense and amortization of debt discounts and fees	164.6	184.2	159.7
Loss on early extinguishment of debt	1.0	2.3	7.7
Government, class action, and related settlements	—	2.8	—
Loss on disposal or impairment of assets	0.4	11.6	11.1
Depreciation and amortization	256.6	243.0	218.7
Stock-based compensation expense	32.8	29.5	114.4
Net income attributable to noncontrolling interests	(105.0)	(84.6)	(87.1)
Costs associated with the strategic alternatives review	22.9	—	—
Costs associated with the Frontier acquisition	1.3	—	—
Transaction costs	—	—	2.1
Gain on consolidation of joint venture formerly accounted for under the equity method of accounting	(3.2)	(2.2)	(19.2)
SARs mark-to-market impact on noncontrolling interests	—	—	(5.0)
Change in fair market value of equity securities	(0.6)	(0.4)	(0.8)
Payroll taxes on SARs exercise	—	1.5	1.0
Adjusted EBITDA	$ 1,028.0	$ 860.3	$ 964.9

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,		
	2021	**2020**	**2019**
Net cash provided by operating activities	$ 715.8	$ 704.7	$ 635.3
Interest expense and amortization of debt discounts and fees	164.6	184.2	159.7
Equity in net income of nonconsolidated affiliates	4.0	3.5	6.7
Net income attributable to noncontrolling interests in continuing operations	(105.0)	(84.6)	(87.1)
Amortization of debt-related items	(7.8)	(7.2)	(4.5)
Distributions from nonconsolidated affiliates	(2.9)	(3.8)	(6.6)
Current portion of income tax expense	111.8	51.4	75.9
Change in assets and liabilities	118.0	7.3	180.1
Cash used in operating activities of discontinued operations	0.5	0.2	4.4
Costs associated with the strategic alternatives review	22.9	—	—
Costs associated with the Frontier acquisition	1.3	—	—
Transaction costs	—	—	2.1
SARs mark-to-market impact on noncontrolling interests	—	—	(5.0)
Change in fair market value of equity securities	(0.6)	(0.4)	(0.8)
Payroll taxes on SARs exercise	—	1.5	1.0
Other	5.4	3.5	3.7
Adjusted EBITDA	$ 1,028.0	$ 860.3	$ 964.9

For additional information see the “Results of Operations” and “Segment Results of Operations” sections of this Item.

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, 2021 and 2020. 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,	
	2021	2020
	(In Millions)	
Current:		
0 - 30 Days	$ 469.6	$ 409.4
31 - 60 Days	70.1	54.3
61 - 90 Days	37.6	30.6
91 - 120 Days	21.1	16.9
120 + Days	68.2	51.8
Patient accounts receivable	666.6	563.0
Other accounts receivable	13.7	9.8
	680.3	572.8
Noncurrent patient accounts receivable	83.5	123.8
Accounts receivable	$ 763.8	$ 696.6

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, 2021 and 2020, $77.8 million and $117.8 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, 2021:	
As reported, with 50% statistical confidence level	139.4
With 70% statistical confidence level	148.6

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 quantitative analysis.

In the fourth quarter of 2021, 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, 2021, we decreased our valuation allowance by $(3.1) million. As of December 31, 2021, we had a remaining valuation allowance of $43.1 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, 2021 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, 2021, our primary variable rate debt outstanding related to $200 million in advances under our revolving credit facility and $238.5 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 $4.0 million over the next 12 months, while a 1% decrease in interest rates, assuming a floor of zero in the variable rate index, would result in an incremental positive cash flow of approximately $1.3 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, 2021		December 31, 2020	
Financial Instrument:	**Book Value**	**Market Value**	**Book Value**	**Market Value**
5.125% Senior Notes due 2023				
Carrying Value	$ 99.6	$ —	$ 298.1	$ —
Unamortized debt discount and fees	0.4	—	1.9	—
Principal amount	100.0	100.2	300.0	302.6
5.75% Senior Notes due 2025				
Carrying Value	347.0	—	346.3	—
Unamortized debt discount and fees	3.0	—	3.7	—
Principal amount	350.0	357.9	350.0	361.4
4.50% Senior Notes due 2028				
Carrying Value	786.8	—	785.0	—
Unamortized debt discount and fees	13.2	—	15.0	—
Principal amount	800.0	823.0	800.0	840.0
4.75% Senior Notes due 2030				
Carrying Value	784.7	—	783.2	—
Unamortized debt discount and fees	15.3	—	16.8	—
Principal amount	800.0	824.0	800.0	856.0
4.625% Senior Notes due 2031				
Carrying Value	393.7	—	393.2	—
Unamortized debt discount and fees	6.3	—	6.8	—
Principal amount	400.0	407.0	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, 2021, 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, 2021. 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, 2021, our internal control over financial reporting was effective.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2021 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, 2021 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections

None applicable.

PART III

We expect to file a definitive proxy statement relating to our 2022 Annual Meeting of Stockholders (the "2022 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 2022 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 2022 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 2022 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 2022 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 2022 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 2022 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-62 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 25, 2022

[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 25, 2022
/s/ DOUGLAS E. COLTHARP **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 25, 2022
/s/ ANDREW L. PRICE **Andrew L. Price**	Chief Accounting Officer	February 25, 2022
/s/ LEO I. HIGDON, JR. **Leo I. Higdon, Jr.**	Chairman of the Board of Directors	February 25, 2022
/s/ GREG D. CARMICHAEL **Greg D. Carmichael**	Director	February 25, 2022
/s/ JOHN W. CHIDSEY **John W. Chidsey**	Director	February 25, 2022
/s/ DONALD L. CORRELL **Donald L. Correll**	Director	February 25, 2022
/s/ YVONNE M. CURL **Yvonne M. Curl**	Director	February 25, 2022
/s/ CHARLES M. ELSON **Charles M. Elson**	Director	February 25, 2022
/s/ JOAN E. HERMAN **Joan E. Herman**	Director	February 25, 2022
/s/ LESLYE G. KATZ **Leslye G. Katz**	Director	February 25, 2022
/s/ PATRICIA A. MARYLAND **Patricia A. Maryland**	Director	February 25, 2022
/s/ CHRISTOPHER R. REIDY **Christopher R. Reidy**	Director	February 25, 2022
/s/ JOHN E. MAUPIN, JR. **John E. Maupin, Jr.**	Director	February 25, 2022
/s/ NANCY M. SCHLICHTING **Nancy M. Schlichting**	Director	February 25, 2022
/s/ L. EDWARD SHAW, JR. **L. Edward Shaw, Jr.**	Director	February 25, 2022
/s/ TERRANCE WILLIAMS **Terrance Williams**	Director	February 25, 2022

Item 15. Financial Statements

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Encompass Health Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Encompass Health Corporation and its subsidiaries (the "Company") as of December 31, 2021 and 2020, 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, 2021, 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, 2021, 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, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021 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, 2021, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

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 $763.8 million as of December 31, 2021. 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, 2021, $77.8 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 Medicare appeals adjudication process, which is administered by the Office of Medicare Hearings and Appeals ("OMHA"), has been subject to significant delay resulting in a backlog of claims awaiting hearing, the resolution of which may take several years. As disclosed in Note 1, the Company's historical experience and success in the adjudication of these appeals is a component of management's estimate of the transaction price.

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 25, 2022

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,		
	2021	**2020**	**2019**
	(In Millions, Except Per Share Data)		
Net operating revenues	**$ 5,121.6**	$ 4,644.4	$ 4,605.0
Operating expenses:			
Salaries and benefits	**2,886.5**	2,682.0	2,573.0
Other operating expenses	**685.2**	634.4	623.6
Occupancy costs	**80.2**	81.2	82.3
Supplies	**209.3**	200.5	167.9
General and administrative expenses	**197.3**	155.5	247.0
Depreciation and amortization	**256.6**	243.0	218.7
Government, class action, and related settlements	**—**	2.8	—
Total operating expenses	**4,315.1**	3,999.4	3,912.5
Loss on early extinguishment of debt	**1.0**	2.3	7.7
Interest expense and amortization of debt discounts and fees	**164.6**	184.2	159.7
Other income	**(12.3)**	(10.6)	(30.5)
Equity in net income of nonconsolidated affiliates	**(4.0)**	(3.5)	(6.7)
Income from continuing operations before income tax expense	**657.2**	472.6	562.3
Provision for income tax expense	**139.6**	103.8	115.9
Income from continuing operations	**517.6**	368.8	446.4
Loss from discontinued operations, net of tax	**(0.4)**	—	(0.6)
Net and comprehensive income	**517.2**	368.8	445.8
Less: Net and comprehensive income attributable to noncontrolling interests	**(105.0)**	(84.6)	(87.1)
Net and comprehensive income attributable to Encompass Health	**$ 412.2**	$ 284.2	$ 358.7
Weighted average common shares outstanding:			
Basic	**99.0**	98.6	98.0
Diluted	**100.2**	99.8	99.4
Earnings per common share:			
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 4.15**	$ 2.87	$ 3.66
Discontinued operations	**—**	—	(0.01)
Net income	**$ 4.15**	$ 2.87	$ 3.65
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	**$ 4.11**	$ 2.85	$ 3.62
Discontinued operations	**—**	—	(0.01)
Net income	**$ 4.11**	$ 2.85	$ 3.61
Amounts attributable to Encompass Health:			
Income from continuing operations	**$ 412.6**	$ 284.2	$ 359.3
Loss from discontinued operations, net of tax	**(0.4)**	—	(0.6)
Net income attributable to Encompass Health	**$ 412.2**	$ 284.2	$ 358.7

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,	
	2021	**2020**
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 54.8**	$ 224.0
Restricted cash	**65.1**	65.4
Accounts receivable	**680.3**	572.8
Prepaid expenses and other current assets	**121.2**	86.4
Total current assets	**921.4**	948.6
Property and equipment, net	**2,601.6**	2,206.6
Operating lease right-of-use assets	**242.0**	245.7
Goodwill	**2,427.9**	2,318.7
Intangible assets, net	**417.5**	431.3
Other long-term assets	**254.5**	295.0
Total assets[(1)]	**$ 6,864.9**	$ 6,445.9
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	**$ 42.8**	$ 38.3
Current operating lease liabilities	**38.4**	44.8
Accounts payable	**137.6**	115.0
Accrued payroll	**265.8**	253.8
Accrued interest payable	**44.5**	47.1
Other current liabilities	**219.7**	218.3
Total current liabilities	**748.8**	717.3
Long-term debt, net of current portion	**3,243.9**	3,250.6
Long-term operating lease liabilities	**213.1**	209.6
Self-insured risks	**123.8**	121.2
Deferred income tax liabilities	**86.7**	51.8
Other long-term liabilities	**49.4**	93.8
	4,465.7	4,444.3
Commitments and contingencies		
Redeemable noncontrolling interests	**42.2**	31.6
Shareholders' equity:		
Encompass Health shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 114,211,057 in 2021; 113,835,708 in 2020	**1.1**	1.1
Capital in excess of par value	**2,289.6**	2,326.6
Accumulated income (deficit)	**141.8**	(242.3)
Treasury stock, at cost (14,719,662 shares in 2021 and 14,428,235 shares in 2020)	**(521.2)**	(497.4)
Total Encompass Health shareholders' equity	**1,911.3**	1,588.0
Noncontrolling interests	**445.7**	382.0
Total shareholders' equity	**2,357.0**	1,970.0
Total liabilities[(1)] **and shareholders' equity**	**$ 6,864.9**	$ 6,445.9

(1) Our consolidated assets as of December 31, 2021 and December 31, 2020 include total assets of variable interest entities of $226.2 million and $221.2 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of December 31, 2021 and December 31, 2020 include total liabilities of the variable interest entities of $38.2 million and $46.8 million, respectively. See Note 3, *Variable Interest Entities.*

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

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	Encompass Health Common Shareholders						
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated (Deficit) Income	Treasury Stock	Noncontrolling Interests	Total
				(In Millions)			
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
Net income	**—**	**—**	**—**	**412.2**	**—**	**96.0**	**508.2**
Receipt of treasury stock	**(0.2)**	**—**	**—**	**—**	**(16.4)**	**—**	**(16.4)**
Dividends declared ($1.12 per share)	**—**	**—**	**(83.8)**	**(28.1)**	**—**	**—**	**(111.9)**
Stock-based compensation	**—**	**—**	**32.8**	**—**	**—**	**—**	**32.8**
Distributions declared	**—**	**—**	**—**	**—**	**—**	**(87.8)**	**(87.8)**
Capital contributions from consolidated affiliates	**—**	**—**	**—**	**—**	**—**	**72.5**	**72.5**
Other	**0.3**	**—**	**14.0**	**—**	**(7.4)**	**(17.0)**	**(10.4)**
December 31, 2021	**99.5**	**$ 1.1**	**$ 2,289.6**	**$ 141.8**	**$ (521.2)**	**$ 445.7**	**$ 2,357.0**

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,		
	2021	**2020**	**2019**
		(In Millions)	
Cash flows from operating activities:			
Net income	**$ 517.2**	$ 368.8	$ 445.8
Loss from discontinued operations, net of tax	**0.4**	—	0.6
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for government, class action, and related settlements	**—**	2.8	—
Depreciation and amortization	**256.6**	243.0	218.7
Amortization of debt-related items	**7.8**	7.2	4.5
Loss on early extinguishment of debt	**1.0**	2.3	7.7
Equity in net income of nonconsolidated affiliates	**(4.0)**	(3.5)	(6.7)
Distributions from nonconsolidated affiliates	**2.9**	3.8	6.6
Stock-based compensation	**32.8**	29.5	114.4
Deferred tax expense	**27.8**	52.4	40.0
Gain on consolidation of Yuma Rehabilitation Hospital	**—**	—	(19.2)
Other, net	**(8.2)**	5.9	7.4
Changes in assets and liabilities, net of acquisitions —			
Accounts receivable	**(64.3)**	(38.1)	(22.9)
Prepaid expenses and other assets	**(42.0)**	0.1	(35.4)
Accounts payable	**14.9**	13.6	(6.1)
Accrued payroll	**(38.1)**	92.0	13.2
Other liabilities	**11.5**	(74.9)	(128.9)
Net cash used in operating activities of discontinued operations	**(0.5)**	(0.2)	(4.4)
Total adjustments	**198.2**	335.9	188.9
Net cash provided by operating activities	**715.8**	704.7	635.3
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	**(118.6)**	(1.1)	(231.5)
Purchases of property and equipment	**(528.9)**	(396.0)	(372.4)
Additions to capitalized software costs	**(15.8)**	(8.7)	(13.0)
Purchases of intangible assets	**(6.5)**	(3.5)	(18.7)
Proceeds from sale of restricted investments	**—**	12.6	17.6
Purchases of restricted investments	**(9.0)**	(8.7)	(32.9)
Other, net	**12.5**	(2.1)	(6.5)
Net cash used in investing activities	**(666.3)**	**(407.5)**	**(657.4)**

(Continued)

Encompass Health Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2021	**2020**	**2019**
		(In Millions)	
Cash flows from financing activities:			
Proceeds from bond issuance	**—**	992.5	1,000.0
Principal payments on debt, including pre-payments	**(214.5)**	(718.3)	(519.5)
Borrowings on revolving credit facility	**300.0**	330.0	635.0
Payments on revolving credit facility	**(100.0)**	(375.0)	(620.0)
Principal payments under finance lease obligations	**(51.8)**	(22.5)	(19.5)
Debt amendment and issuance costs	**—**	(20.3)	(21.5)
Repurchases of common stock, including fees and expenses	**—**	(6.1)	(45.9)
Dividends paid on common stock	**(112.4)**	(111.9)	(108.7)
Purchase of equity interests in consolidated affiliates	**—**	(162.3)	(162.9)
Distributions paid to noncontrolling interests of consolidated affiliates	**(102.9)**	(72.2)	(79.8)
Taxes paid on behalf of employees for shares withheld	**(16.4)**	(15.7)	(16.6)
Contributions from noncontrolling interests of consolidated affiliates	**57.2**	34.9	15.9
Other, net	**0.7**	1.0	(8.3)
Net cash (used in) provided by financing activities	**(240.1)**	(145.9)	48.2
(Decrease) increase in cash, cash equivalents, and restricted cash	**(190.6)**	151.3	26.1
Cash, cash equivalents. and restricted cash at beginning of year	**310.9**	159.6	133.5
Cash, cash equivalents, and restricted cash at end of year	**$ 120.3**	$ 310.9	$ 159.6
Reconciliation of Cash, Cash Equivalents, and Restricted Cash			
Cash and cash equivalents at beginning of period	$ 224.0	$ 94.8	$ 69.2
Restricted cash at beginning of period	65.4	57.4	59.0
Restricted cash included in other long-term assets at beginning of period	21.5	7.4	5.3
Cash, cash equivalents, and restricted cash at beginning of period	$ 310.9	$ 159.6	$ 133.5
Cash and cash equivalents at end of period	$ 54.8	$ 224.0	$ 94.8
Restricted cash at end of period	65.1	65.4	57.4
Restricted cash included in other long-term assets at end of period	0.4	21.5	7.4
Cash, cash equivalents, and restricted cash at end of period	$ 120.3	$ 310.9	$ 159.6
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	**$ (168.4)**	$ (168.4)	$ (155.7)
Income tax refunds	**1.8**	1.4	0.1
Income tax payments	**(131.4)**	(34.3)	(104.2)
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 a national leader in integrated healthcare services, offering both facility-based and home-based post-acute services in 42 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*.

On December 9, 2020, we announced a formal process to explore strategic alternatives for our home health and hospice business. As a result of this process, we expect to separate the home health and hospice business from Encompass Health into an independent public company through a spin-off distribution in the first half of 2022. On January 19, 2022, we announced the home health and hospice business would be rebranded and operate under the name Enhabit Home Health & Hospice. The rebranding of agency locations is expected to begin in mid-April 2022 and to be largely completed by the consummation of the spin off.

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. From time to time in specific markets, 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. For various quarterly periods during the pandemic, we experienced decreased patient volumes in one or more of our business lines when compared to the prior year periods. We believe reduced patient volumes 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, policies in assisted living facilities that limit our staff 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, former 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 accept any CARES Act relief funds. The Consolidated Appropriations Act, 2021 (the "2021 Budget Act"), signed into law on December 27, 2020 provided for additional provider relief funds. We intend to refuse any additional provider relief funds distributed in the future whether authorized under the 2021 Budget Act or other legislation. The sequestration suspension has been extended a number of times. Sequestration is currently scheduled to resume as of April 1, 2022 but will only be a 1% payment reduction through June 30, 2022. Thereafter, the full 2% Medicare payment reduction will resume. Federal legislation, including the CARES Act and 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 and waiver of certain of the requirements, including the exclusion of COVID-19 admissions from the compliance calculation under the 60% Rule. 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,		
	2021	2020	2019	2021	2020	2019	2021	2020	2019
Medicare	$2,589.7	$2,375.5	$2,537.3	$ 906.5	$ 896.0	$ 920.0	$3,496.2	$3,271.5	$3,457.3
Medicare Advantage	609.6	544.9	375.5	117.4	116.2	111.9	727.0	661.1	487.4
Managed care	484.5	371.4	342.7	65.4	47.8	39.1	549.9	419.2	381.8
Medicaid	163.1	140.1	110.3	15.5	15.6	18.4	178.6	155.7	128.7
Other third-party payors	46.0	43.0	43.4	—	—	—	46.0	43.0	43.4
Workers' compensation	23.1	21.5	29.2	0.3	1.0	1.0	23.4	22.5	30.2
Patients	19.3	19.2	23.3	0.8	0.9	0.6	20.1	20.1	23.9
Other income	79.7	50.6	51.3	0.7	0.7	1.0	80.4	51.3	52.3
Total	$4,015.0	$3,566.2	$3,513.0	$1,106.6	$1,078.2	$1,092.0	$5,121.6	$4,644.4	$4,605.0

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. The current OMHA practice has resulted in a reduction in our success in the adjudication of these appeals, but have increased the pace of recovery of these claims.

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 2021 to review certain patient files for discharges occurring from 2010 to 2021. 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 2021. 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 2021, 2020, and 2019, 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, 2021 and December 31, 2020, 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, 2021 and December 31, 2020.

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, 2021 and December 31, 2020.

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,	
	2021	2020
Medicare	63.6 %	66.5 %
Managed care and other discount plans, including Medicare Advantage	27.4 %	25.0 %
Medicaid	3.7 %	3.7 %
Other third-party payors	2.6 %	2.7 %
Workers' compensation	1.5 %	1.2 %
Patients	1.2 %	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 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, 2021, 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 certain members of the home health and hospice management team's put rights regarding their interests in our home health and hospice business 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 entities is determined primarily using the income approach. The income approach includes the use of the joint venture entities' projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable joint venture entity, 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 $5.6 million, $4.6 million, and $6.1 million in each of the years ended December 31, 2021, 2020, and 2019, 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 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 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.

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recent Accounting Pronouncements—

In 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. The new guidance was effective for us beginning January 1, 2021, including interim periods within that reporting period. The adoption of this guidance did not 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:

2021 Acquisitions

Inpatient Rehabilitation

During 2021, we completed the following inpatient rehabilitation acquisitions, none of which were individually material to our financial position, results of operations, or cash flows. Each acquisition was made to enhance our position and ability to provide inpatient rehabilitation services to patients in the applicable geographic areas.

- In April 2021, we acquired 51% of the operations of a 14-bed inpatient rehabilitation unit in San Angelo, Texas when Shannon Medical contributed those operations to our existing joint venture entity.
- In June 2021, we acquired 75% of the operations of a 16-bed inpatient rehabilitation unit in McKees Rocks, Pennsylvania through our existing joint venture with Heritage Valley Health System, Inc. The acquisition was funded using cash on hand.
- In July 2021, we acquired 65% of the operations of a 22-bed inpatient rehabilitation unit in Odessa, Texas when ECHD Ventures contributed those operations to our existing joint venture entity.

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 at the acquisition dates were as follows (in millions):

Identifiable intangible assets:		
Noncompete agreements (useful lives of 3 to 5 years)	$	1.0
Trade name (useful life of 20 years)		0.3
Goodwill		8.8
Other long-term assets		0.1
Total assets acquired	$	10.2

Information regarding the net cash paid for the acquisitions during 2021 is as follows (in millions):

Fair value of assets acquired	$	1.4
Goodwill		8.8
Fair value of noncontrolling interest owned by joint venture partner		(9.1)
Net cash paid for acquisitions	$	1.1

Home Health and Hospice

Frontier Acquisition

On June 1, 2021, we completed the acquisition of the home health and hospice assets of Frontier Home Health and Hospice ("Frontier") in Alaska, Colorado, Montana, Washington, and Wyoming. The Frontier acquisition included the purchase of a 50% equity interest in the Heart of the Rockies Home Health joint venture and a 90% equity interest in the Hospice of Southwest Montana joint venture (inclusive of an additional 40% equity interest purchased for approximately $4 million). We consolidate both of these joint ventures. On the acquisition date, nine home health and eleven hospice locations became part of our national network of home health and hospice locations. This acquisition was made to expand our existing presence in Colorado and Wyoming and extend our services to Alaska, Montana and Washington. We funded this transaction using 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 Frontier from its date of acquisition. Assets acquired, liabilities assumed, and noncontrolling interests were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for the noncompete and license intangible assets; 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 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 reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends. All of the goodwill recorded as a result of this transaction is deductible for federal income tax purposes.

The fair values recorded were based upon a preliminary valuation. Estimates and assumptions used in such valuation are subject to change, which could be significant, within the measurement period (up to one year from the acquisition date). We expect to continue to obtain information to assist us in determining the fair value of the net assets acquired at the acquisition date during the measurement period.

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

Cash and cash equivalents	$	0.8
Accounts receivable, net		0.9
Prepaid expenses and other current assets		0.2
Property and equipment		0.1
Operating lease right-of-use-assets		0.9
Identifiable intangible assets:		
Noncompete agreement (useful life of 5 years)		1.7
Trade name (useful life of 3 months)		0.2
Certificates of need (useful lives of 10 years)		3.1
Licenses (useful lives of 10 years)		4.8
Goodwill		92.4
Total assets acquired		105.1
Liabilities assumed:		
Current operating lease liabilities		0.3
Accounts payable		0.2
Accrued payroll		0.8
Long-term operating lease liabilities		0.7
Total liabilities assumed		2.0
Noncontrolling interests		3.9
Net assets acquired	$	99.2

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

Fair value of assets acquired, net of $0.8 million of cash acquired in 2021	$	11.9
Goodwill		92.4
Fair value of liabilities assumed		(2.0)
Fair value of noncontrolling interest owned by joint venture partner		(3.9)
Net cash paid for acquisition	$	98.4

Other Home Health and Hospice Acquisitions

In December 2021, using cash on hand, we acquired an additional 29% equity interest from Baptist Outpatient Services, Inc. in our existing Encompass Health Home Health of South Florida, LLC joint venture. This transaction increased our ownership interest from 51% to 80% and resulted in change in accounting for this joint venture from the equity method of accounting to a consolidated entity. As a result of our consolidation of this entity and the remeasurement of our previously held equity interest to fair value, *Goodwill* increased $8.0 million, and we recorded a $3.2 million gain as part of *Other income* during 2021. This transaction was made to increase our ownership in a profitable entity and continue to grow our business. This acquisition was funded using cash on hand and was individually 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 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 an income approach using primarily discounted cash flow techniques for the noncompete and 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. 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 the community and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in this market. The amount of goodwill recorded as a result of these transactions that is deductible for federal income tax purposes is $3.9 million.

The fair values recorded were based upon a preliminary valuation. Estimates and assumptions used in such valuation are subject to change, which could be significant, within the measurement period (up to one year from the acquisition date). We expect to continue to obtain information to assist us in determining the fair value of the net assets acquired at the acquisition date during the measurement period.

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

Cash and cash equivalents	$	0.8
Accounts receivable, net		2.0
Identifiable intangible assets:		
Noncompete agreement (useful life of 2 years)		0.1
Licenses (useful lives of 10 years)		1.7
Goodwill		8.0
Total assets acquired		12.6
Liabilities assumed:		
Accounts payable		0.2
Accrued payroll		0.3
Other current liabilities		0.4
Other long-term liabilities		0.1
Total liabilities assumed		1.0
Redeemable noncontrolling interests		2.3
Net assets acquired	$	9.3

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

Fair value of assets acquired, net of $0.8 million of cash acquired	$	3.8
Goodwill		8.0
Fair value of liabilities assumed		(1.0)
Fair value of redeemable noncontrolling interest owned by joint venture partner		(2.3)
Fair value of equity interest prior to acquisition		(5.3)
Net cash paid for acquisition	$	3.2

On January 1, 2022, we acquired a 50% equity interest from Frontier in a joint venture with Saint Alphonsus System ("Saint Alphonsus") which operates home health and hospice locations in Boise, Idaho. The total purchase price was $15.9 million and was funded on December 31, 2021. This payment is included in *Acquisition of business, net of cash acquired* on the consolidated statement of cash flow for the year end December 31, 2021. This transaction was not material to our financial position, results of operations, or cash flows.

2021 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, 2020 (in millions):

	Net Operating Revenues	Net Income Attributable to Encompass Health
Acquired entities only: Actual from acquisition date to December 31, 2021		
Inpatient Rehabilitation	$ —	$ —
Home Health and Hospice	20.6	0.6
Combined entity: Supplemental pro forma from 01/01/2021-12/31/2021 (unaudited)	5,152.2	413.0
Combined entity: Supplemental pro forma from 01/01/2020-12/31/2020 (unaudited)	4,705.2	286.8

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 2020 period.

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 asset:		
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 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 reporting 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. Information regarding the net cash paid for all 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. 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. 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, 2019 (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

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 reporting period.

3. Variable Interest Entities:

As of December 31, 2021 and December 31, 2020, we consolidated ten and nine, 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 90.0% as of December 31, 2021. 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, 2021	December 31, 2020
Assets		
Current assets:		
Cash and cash equivalents	$ —	$ 0.1
Accounts receivable	36.3	33.1
Other current assets	7.7	8.6
Total current assets	44.0	41.8
Property and equipment, net	116.3	121.1
Operating lease right-of-use assets	3.2	4.7
Goodwill	28.3	19.2
Intangible assets, net	3.3	3.3
Deferred income tax assets	0.6	0.5
Other long-term assets	30.5	30.6
Total assets	$ 226.2	$ 221.2
Liabilities		
Current liabilities:		
Current portion of long-term debt	$ 1.0	$ 0.9
Current operating lease liabilities	1.5	1.5
Accounts payable	5.9	6.1
Accrued payroll	10.2	11.3
Other current liabilities	9.2	11.7
Total current liabilities	27.8	31.5
Long-term debt, net of current portion	8.6	9.6
Long-term operating lease liabilities	1.8	3.3
Other long-term liabilities	—	2.4
Total liabilities	$ 38.2	$ 46.8

4. Cash and Marketable Securities:

The components of our investments as of December 31, 2021 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 54.8	$ 65.5	$ —	$ 120.3
Equity securities	—	—	82.2	82.2
Total	$ 54.8	$ 65.5	$ 82.2	$ 202.5

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

Restricted Cash—

Restricted cash consisted of the following (in millions):

	As of December 31,	
	2021	2020
Current:		
Affiliate cash	$ 17.3	$ 17.5
Self-insured captive funds	47.8	47.9
	65.1	65.4
Noncurrent:		
Self-insured captive funds	0.4	21.5
Total restricted cash	$ 65.5	$ 86.9

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 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, 2021 and 2020, $82.2 million and $72.6 million, respectively, of restricted marketable securities are included in *Other long-term assets* in our

consolidated balance sheets. During the years ended December 31, 2021, 2020, and 2019, $0.6 million, $0.4 million, and $1.2 million, respectively, of unrealized net gains were recognized in our consolidated statements of comprehensive income on marketable securities still held at the reporting date.

Investing information related to our available-for-sale marketable securities is as follows (in millions):

	For the Year Ended December 31,		
	2021	2020	2019
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,	
	2021	2020
Current:		
Patient accounts receivable	$ 666.6	$ 563.0
Other accounts receivable	13.7	9.8
	680.3	572.8
Noncurrent patient accounts receivable	83.5	123.8
Accounts receivable	$ 763.8	$ 696.6

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,	
	2021	2020
Land	$ 259.8	$ 217.2
Buildings	2,632.8	2,357.0
Leasehold improvements	254.1	232.5
Vehicles	35.0	33.9
Furniture, fixtures, and equipment	606.1	537.9
	3,787.8	3,378.5
Less: Accumulated depreciation and amortization	(1,539.4)	(1,374.4)
	2,248.4	2,004.1
Construction in progress	353.2	202.5
Property and equipment, net	$ 2,601.6	$ 2,206.6

As of December 31, 2021, approximately 73% 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,		
	2021	2020	2019
Depreciation expense	$ 166.2	$ 151.1	$ 130.0
Interest capitalized	$ 8.9	$ 6.0	$ 8.3

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,		
	2021	2020	2019
Operating lease cost	$ 66.0	$ 68.5	$ 72.9
Finance lease cost:			
Amortization of right-of-use assets	34.0	32.1	30.3
Interest on lease liabilities	30.9	29.3	29.5
Total finance lease cost	64.9	61.4	59.8
Short-term and variable lease cost	3.0	3.7	1.5
Sublease income	(3.1)	(3.2)	(3.2)
Total lease cost	$ 130.8	$ 130.4	$ 131.0

Supplemental consolidated balance sheet information related to leases is as follows (in millions):

		As of December 31,	
	Classification	2021	2020
Assets			
Operating lease	Operating lease right-of-use assets	$ 242.0	$ 245.7
Finance lease [1]	Property and equipment, net	309.6	322.8
Total leased assets		$ 551.6	$ 568.5
Liabilities			
Current liabilities:			
Operating lease	Current operating lease liabilities	$ 38.4	$ 44.8
Finance lease	Current portion of long-term debt	23.1	23.8
Noncurrent liabilities:			
Operating lease	Long-term operating lease liabilities	213.1	209.6
Finance lease	Long-term debt, net of current portion	363.7	367.9
Total leased liabilities		$ 638.3	$ 646.1

[1] Finance lease assets are recorded net of accumulated amortization of $147.8 million and $129.6 million as of December 31, 2021 and 2020, respectively.

	As of December 31,	
	2021	2020
Weighted Average Remaining Lease Term		
Operating lease	8.3 years	8.6 years
Finance lease	11.8 years	11.7 years
Weighted Average Discount Rate		
Operating lease	5.8 %	6.1 %
Finance lease	7.9 %	8.1 %

Maturities of lease liabilities as of December 31, 2021 are as follows (in millions):

Year Ending December 31,	Operating Leases	Finance Leases
2022	$ 51.4	$ 52.1
2023	50.7	51.2
2024	44.0	50.5
2025	34.8	50.7
2026	29.2	51.5
2027 and thereafter	116.5	350.3
Total lease payments	326.6	606.3
Less: Interest portion	(75.1)	(219.5)
Total lease liabilities	$ 251.5	$ 386.8

Supplemental cash flow information related to our leases is as follows (in millions):

	For the Year Ended December 31,		
	2021	2020	2019
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows from operating leases	$ 61.5	$ 66.9	$ 70.4
Operating cash flows from finance leases	31.3	29.6	30.0
Financing cash flows from finance leases	51.8	22.5	19.5
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	$ 51.1	$ 39.0	$ 43.8
Finance leases	50.5	29.6	34.2

8. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* (in millions):

	Inpatient Rehabilitation	Home Health and Hospice	Consolidated
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
Acquisitions	8.8	92.4	101.2
Consolidation of joint venture formerly accounted for under the equity method of accounting	—	8.0	8.0
Goodwill as of December 31, 2021	$ 1,236.9	$ 1,191.0	$ 2,427.9

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. *Goodwill* increased in 2021 as a result of our acquisitions of Frontier and other inpatient and home health and hospice operations as well as our consolidation of the Home Health of South Florida joint venture 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, 2021, 2020, and 2019 and concluded no *Goodwill* impairment existed. As of December 31, 2021, 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:			
2021	$ 204.5	$ (68.8)	$ 135.7
2020	197.3	(54.5)	142.8
Licenses:			
2021	$ 194.5	$ (121.0)	$ 73.5
2020	187.9	(107.4)	80.5
Noncompete agreements:			
2021	$ 78.5	$ (69.0)	$ 9.5
2020	75.2	(65.8)	9.4
Trade name - Encompass:			
2021	$ 135.2	$ —	$ 135.2
2020	135.2	—	135.2
Trade names - all other:			
2021	$ 45.0	$ (27.0)	$ 18.0
2020	44.3	(25.5)	18.8
Internal-use software:			
2021	$ 209.0	$ (164.9)	$ 44.1
2020	184.2	(141.4)	42.8
Market access assets:			
2021	$ 13.2	$ (11.7)	$ 1.5
2020	13.2	(11.4)	1.8
Total intangible assets:			
2021	$ 879.9	$ (462.4)	$ 417.5
2020	837.3	(406.0)	431.3

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

	For the Year Ended December 31,		
	2021	2020	2019
Amortization expense	$ 56.4	$ 59.8	$ 58.4

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
2022	$ 53.7
2023	45.9
2024	37.0
2025	24.9
2026	21.3

9. Investments in and Advances to Nonconsolidated Affiliates:

Investments in and advances to nonconsolidated affiliates as of December 31, 2021 represents our investment in three partially owned subsidiaries, of which two 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 5% to 50%. 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,	
	2021	2020
Equity method investments:		
Capital contributions	$ 0.8	$ 0.9
Cumulative share of income	68.5	68.7
Cumulative share of distributions	(66.9)	(66.1)
	2.4	3.5
Measurement alternative investments:		
Capital contributions, net of distributions and impairments	1.6	2.0
Total investments in and advances to nonconsolidated affiliates	$ 4.0	$ 5.5

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,	
	2021	2020
Assets—		
Current	$ 3.0	$ 2.9
Noncurrent	4.2	7.7
Total assets	$ 7.2	$ 10.6
Liabilities and equity—		
Current liabilities	$ 0.2	$ 0.3
Noncurrent liabilities	—	0.2
Partners' capital and shareholders' equity—		
Encompass Health	2.3	3.5
Outside partners	4.7	6.6
Total liabilities and equity	$ 7.2	$ 10.6

Condensed statements of comprehensive income (in millions):

	For the Year Ended December 31,		
	2021	2020	2019
Net operating revenues	$ 11.1	$ 16.0	$ 32.6
Operating expenses	(3.1)	(8.1)	(19.1)
Income from continuing operations, net of tax	8.0	7.9	13.4
Net income	8.0	7.9	13.4

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.

See also Note 2, *Business Combinations.*

10. Long-term Debt:

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

	As of December 31,	
	2021	2020
Credit Agreement—		
Advances under revolving credit facility	$ 200.0	$ —
Term loan facilities	238.5	251.6
Bonds payable—		
5.125% Senior Notes due 2023	99.6	298.1
5.75% Senior Notes due 2025	347.0	346.3
4.50% Senior Notes due 2028	786.8	785.0
4.75% Senior Notes due 2030	784.7	783.2
4.625% Senior Notes due 2031	393.7	393.2
Other notes payable	49.6	39.8
Finance lease obligations	386.8	391.7
	3,286.7	3,288.9
Less: Current portion	(42.8)	(38.3)
Long-term debt, net of current portion	$ 3,243.9	$ 3,250.6

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2022	$ 42.8	$ 42.8
2023	143.6	143.2
2024	453.8	452.7
2025	384.8	381.8
2026	29.9	29.9
Thereafter	2,271.1	2,236.3
Total	$ 3,326.0	$ 3,286.7

As a result of the redemptions discussed below, we recorded a $1.0 million, $2.3 million, and $7.7 million *Loss on early extinguishment of debt* in 2021, 2020, and 2019, respectively.

Senior Secured Credit Agreement—

The credit agreement, as amended in November 2019, 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 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 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, 2021, $200 million were drawn under the revolving credit facility with an interest rate of 2.6%. As of December 31, 2020, no amount was drawn under the revolving credit facility. As of December 31, 2021 and 2020, $38.2 million and $36.7 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—

Senior 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.

On December 9, 2021, we announced the commencement of a consent solicitation of holders of our 2025 Notes, 2028 Notes, 2030 Notes, and 2031 Notes (collectively the "Notes") for the adoption of certain amendments to the Indenture, which will provide us with greater flexibility in effecting the spin off discussed in Note 1, *Summary of Significant Accounting Policies*, "Organization and Description of Business." Each Indenture contains restrictive covenants that, among other things, limit our ability and the ability of certain of our subsidiaries to make certain asset dispositions, investments, and distributions to holders of our capital stock. The amendments to the Indentures permit us, subject to the leverage ratio condition set forth below, to distribute to our equity holders in one or more transactions (a "Distribution") some or all of the common stock of a subsidiary that holds substantially all of the assets of our home health and hospice business. We may make any such distribution so long as the Leverage Ratio (as defined in each Indenture) is no more than 3.5 to 1.0 on a pro forma basis after giving effect thereto. The amendments also reduce the capacity under our restricted payments builder basket under each existing Indenture by $200 million and amends the definition of "Consolidated Net Income" to allow us to exclude from Consolidated Net Income (a component of the Leverage Ratio) any fees, expenses or charges related to any Distribution and the solicitation of consents from the holders of the Notes. In December 2021 and January 2022, we received the requisite consents for the adoption of these amendments. Under the terms of the amendments, we agreed to pay the holders of the Notes a total of $40.5 million, excluding fees. We paid $20 million of this amount in January 2022. The remaining payment is contingent upon the execution of a Distribution and will be paid at such time.

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.

In both April and June 2021, we redeemed $100 million in outstanding principal amount of the 2023 Notes using cash on hand and capacity under our revolving credit facility. Pursuant to the terms of the 2023 Notes, these optional redemptions were made at a price of par.

In February 2022, we issued notice for redemption of the remaining $100 million in outstanding principal amount of the 2023 Notes. Pursuant to the terms of the 2023 Notes, this full redemption will settle on March 15, 2022 and will be made at a price of par. We plan to use cash on hand and capacity under our revolving credit facility to fund the redemption. We expect to record an approximate $0.3 million *Loss on early extinguishment of debt* in the first quarter of 2022.

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, 2021, at the redemption prices set forth below:

Period	Redemption Price*
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,		
	2021	2020	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 28.0	$ 28.0	6.1% to 11.2%
Construction of a new hospital	11.0	11.8	5.0%
Software contracts	10.6	—	2.8%
Other notes payable	$ 49.6	$ 39.8	

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 the first $36 million of insurance and an additional $4 million of insurance in excess of $46 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, 2021, 2020, and 2019 (in millions):

	2021	2020	2019
Balance at beginning of period, gross	$ 165.2	$ 157.3	$ 160.9
Less: Reinsurance receivables	(28.3)	(26.4)	(25.6)
Balance at beginning of period, net	136.9	130.9	135.3
Increase for the provision of current year claims	46.9	52.5	46.9
Decrease for the provision of prior year claims	(6.8)	(15.0)	(12.6)
Expenses related to discontinued operations	(0.2)	(0.2)	(0.1)
Payments related to current year claims	(7.0)	(8.4)	(7.5)
Payments related to prior year claims	(30.4)	(22.9)	(31.1)
Balance at end of period, net	139.4	136.9	130.9
Add: Reinsurance receivables	30.0	28.3	26.4
Balance at end of period, gross	$ 169.4	$ 165.2	$ 157.3

As of December 31, 2021 and 2020, $45.6 million and $44.0 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 1,200 and 1,600 individual claims at December 31, 2021 and 2020, 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,		
	2021	2020	2019
Balance at beginning of period	$ 31.6	$ 239.6	$ 261.7
Net income attributable to noncontrolling interests	9.0	7.4	12.6
Distributions declared	(8.0)	(8.5)	(9.2)
Contribution to joint ventures	—	3.1	1.0
Reclassification to noncontrolling interests	—	—	(11.2)
Purchase of redeemable noncontrolling interests	—	(162.3)	(162.9)
Exchange transaction	—	(46.3)	—
Change in fair value	4.5	(1.4)	147.6
Other	5.1	—	—
Balance at end of period	$ 42.2	$ 31.6	$ 239.6

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,		
	2021	2020	2019
Net income attributable to nonredeemable noncontrolling interests	$ 96.0	$ 77.2	$ 74.5
Net income attributable to redeemable noncontrolling interests	9.0	7.4	12.6
Net income attributable to noncontrolling interests	$ 105.0	$ 84.6	$ 87.1

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 2, *Business Combinations* and 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, 2021	**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	$ 82.2	$ 4.1	$ 78.1	$ —	M
Redeemable noncontrolling interests	42.2	—	—	42.2	I
As of December 31, 2020					
Other long-term assets:					
Equity securities	$ 72.6	$ —	$ 72.6	$ —	M
Redeemable noncontrolling interests	31.6	—	—	31.6	I

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

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 certain joint venture entities and the remeasurement of our previously held equity interest at fair value, we recorded gains of $3.2 million, $2.2 million, and $19.2 million as part of *Other income* during the years ended December 31, 2021, 2020, and 2019, respectively. 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 2, *Business Combinations* and Note 9, *Investments in and Advances to Nonconsolidated Affiliates* for additional information.

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, 2021		As of December 31, 2020	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 200.0	$ 200.0	$ —	$ —
Term loan facilities	238.5	239.6	251.6	253.1
5.125% Senior Notes due 2023	99.6	100.2	298.1	302.6
5.75% Senior Notes due 2025	347.0	357.9	346.3	361.4
4.50% Senior Notes due 2028	786.8	823.0	785.0	840.0
4.75% Senior Notes due 2030	784.7	824.0	783.2	856.0
4.625% Senior Notes due 2031	393.7	407.0	393.2	424.9
Other notes payable	49.6	49.6	39.8	39.8
Financial commitments:				
Letters of credit	—	38.2	—	36.7

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 2021, 2020, and 2019 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, 2021, 2020, and 2019 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,		
	2021	2020	2019
Expected volatility	28.4 %	24.8 %	25.3 %
Risk-free interest rate	1.1 %	1.0 %	2.7 %
Expected life (years)	7.1	7.1	7.1
Dividend yield	1.9 %	2.0 %	2.1 %

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, the Black-Scholes option-pricing model requires the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our officers and 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, 2021, 2020, and 2019 was $19.21, $15.48, and $15.45, 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, 2020	628	$ 50.65		
Granted	109	80.40		
Exercised	(8)	69.23		
Forfeitures	(18)	77.01		
Outstanding, December 31, 2021	711	54.33	5.9	$ 10.4
Exercisable, December 31, 2021	510	45.65	4.8	10.4

We recognized approximately $2.3 million, $1.5 million, and $1.4 million of compensation expense related to our stock options for the years ended December 31, 2021, 2020, and 2019, respectively. As of December 31, 2021, there was $1.4 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 19 months. The total intrinsic value of options exercised during the years ended December 31, 2021, 2020, and 2019 was $0.1 million, $2.3 million, and $3.6 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 did 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 and $81.9 million of compensation expense related to our SARs for the years ended December 31, 2020 and 2019, respectively.

Restricted Stock—

The RSAs granted in 2021, 2020, and 2019 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, 2020	731	$ 61.75
Granted	368	73.89
Vested	(560)	57.83
Forfeited	(85)	72.18
Nonvested shares at December 31, 2021	454	74.46

The weighted-average grant-date fair value of restricted stock granted during the years ended December 31, 2020 and 2019 was $61.81 and $49.84 per share, respectively. We recognized approximately $28.4 million, $25.8 million, and $29.5 million of compensation expense related to our restricted stock awards for the years ended December 31, 2021, 2020, and 2019, respectively. As of December 31, 2021, there was $37.1 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 21 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2021, 2020, and 2019 was $46.0 million, $44.2 million, and $45.2 million, respectively. We accrue dividends on outstanding RSAs, which are paid upon vesting.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2021, 2020, and 2019, 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, 2021, 2020, and 2019, we issued 24,043, 32,196, and 23,270 RSUs, respectively, with a fair value of $84.83, $65.39, and $64.48, respectively, per unit. We recognized approximately $2.0 million, $2.1 million, and $1.5 million, respectively, of compensation expense upon their issuance in 2021, 2020, and 2019. There was no unrecognized compensation related to unvested shares as of December 31, 2021. During the years ended 2021, 2020, and 2019, we issued an additional 8,577, 8,987, and 8,876, respectively, of RSUs as dividend equivalents. As of December 31, 2021, 610,461 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 2021, 2020, and 2019, costs associated with these plans, net of amounts paid by employees and stop-loss recoveries, approximated $207.6 million, $189.2 million, and $178.4 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 $28.8 million, $25.4 million, and $23.4 million in 2021, 2020, and 2019, respectively. In 2021, 2020, and 2019, approximately $1.3 million, $1.5 million, and $1.4 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 2022, we expect to pay approximately $27.8 million under the program for the year ended December 31, 2021. In March 2021 and February 2020, we paid $17.4 million and $18.4 million, respectively, under the program for the years ended December 31, 2020 and 2019.

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,		
	2021	2020	2019
Current:			
Federal	$ 86.8	$ 37.7	$ 58.1
State and other	25.0	13.7	17.8
Total current expense	111.8	51.4	75.9
Deferred:			
Federal	23.6	39.5	32.0
State and other	4.2	12.9	8.0
Total deferred expense	27.8	52.4	40.0
Total income tax expense related to continuing operations	$ 139.6	$ 103.8	$ 115.9

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,		
	2021	2020	2019
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	3.8 %	4.2 %	4.3 %
(Decrease) increase in valuation allowance	(0.5)%	1.7 %	0.8 %
Government, class action, and related settlements	— %	— %	(1.2)%
Noncontrolling interests	(3.3)%	(3.7)%	(3.0)%
Share-based windfall tax benefits	(0.5)%	(1.0)%	(1.0)%
Other, net	0.7 %	(0.2)%	(0.3)%
Income tax expense	21.2 %	22.0 %	20.6 %

The *Provision for income tax expense* in 2021 was greater than the federal statutory rate primarily due to: (1) state and other income tax expense offset by (2) the impact of noncontrolling interests, (3) share-based windfall tax benefits and (4) the decrease in valuation allowance. 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.

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 years ended December 31, 2020 and 2021, although it has impacted the timing of 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,	
	2021	2020
Deferred income tax assets:		
Net operating loss	$ 50.4	$ 57.6
Property, net	—	6.6
Insurance reserve	18.7	17.8
Stock-based compensation	15.2	15.2
Operating lease liabilities	18.2	22.1
Other accruals	35.1	43.4
Tax credits	10.9	10.5
Other	—	0.1
Total deferred income tax assets	148.5	173.3
Less: Valuation allowance	(43.1)	(46.2)
Net deferred income tax assets	105.4	127.1
Deferred income tax liabilities:		
Revenue reserves	(0.7)	(5.7)
Intangibles	(102.9)	(99.7)
Operating lease right-of-use assets	(17.7)	(21.7)
Property, net	(3.4)	—
Carrying value of partnerships	(67.0)	(51.4)
Other	(0.4)	(0.4)
Total deferred income tax liabilities	(192.1)	(178.9)
Net deferred income tax liabilities	$ (86.7)	$ (51.8)

We have state NOLs of $50.4 million that expire in various amounts at varying times through 2031. For the years ended December 31, 2021 and 2020, the net (decrease) increase in our valuation allowance was $(3.1) million and $7.8 million, respectively. The decrease in our valuation allowance in 2021 related primarily to changes in forecasted income. The increase in our valuation allowance in 2020 related primarily to our expected ability to use related net operating losses prior to their expiration.

As of December 31, 2021, we have a remaining valuation allowance of $43.1 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.

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 2021, 2020, and 2019 was not material. Accrued interest income related to income taxes as of December 31, 2021 and 2020 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 and have renewed this agreement each year since. 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. The IRS is currently examining the 2020, 2021, and 2022 tax years. In September 2021, the IRS issued a no-change letter effectively closing our 2019 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 2019. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are currently under audit by two states for tax years ranging from 2017 - 2019.

For the tax years that remain open under the applicable statutes of limitations, management considered potential unrecognized tax benefits and determined there are no material unrecognized tax benefits that would impact prior years' income taxes.

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,		
	2021	2020	2019
Basic:			
Numerator:			
Income from continuing operations	$ 517.6	$ 368.8	$ 446.4
Less: Net income attributable to noncontrolling interests included in continuing operations	(105.0)	(84.6)	(87.1)
Less: Income allocated to participating securities	(1.8)	(1.0)	(1.3)
Income from continuing operations attributable to Encompass Health common shareholders	410.8	283.2	358.0
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.4)	—	(0.6)
Net income attributable to Encompass Health common shareholders	$ 410.4	$ 283.2	$ 357.4
Denominator:			
Basic weighted average common shares outstanding	99.0	98.6	98.0
Basic earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 4.15	$ 2.87	$ 3.66
Discontinued operations	—	—	(0.01)
Net income	$ 4.15	$ 2.87	$ 3.65
Diluted:			
Numerator:			
Income from continuing operations	$ 517.6	$ 368.8	$ 446.4
Less: Net income attributable to noncontrolling interests included in continuing operations	(105.0)	(84.6)	(87.1)
Income from continuing operations attributable to Encompass Health common shareholders	412.6	284.2	359.3
Loss from discontinued operations, net of tax, attributable to Encompass Health common shareholders	(0.4)	—	(0.6)
Net income attributable to Encompass Health common shareholders	$ 412.2	$ 284.2	$ 358.7
Denominator:			
Diluted weighted average common shares outstanding	100.2	99.8	99.4
Diluted earnings per share attributable to Encompass Health common shareholders:			
Continuing operations	$ 4.11	$ 2.85	$ 3.62
Discontinued operations	—	—	(0.01)
Net income	$ 4.11	$ 2.85	$ 3.61

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,		
	2021	2020	2019
Basic weighted average common shares outstanding	99.0	98.6	98.0
Restricted stock awards, dilutive stock options, and restricted stock units	1.2	1.2	1.4
Diluted weighted average common shares outstanding	100.2	99.8	99.4

Options to purchase approximately 0.2 million, 0.2 million, and 0.1 million shares of common stock were outstanding as of December 31, 2021, 2020, and 2019, respectively, but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

In February 2014, our board of directors approved an increase in our common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. On July 24, 2018, the Company's board approved resetting the aggregate common stock repurchase authorization to $250 million. There were no repurchases of our common stock during 2021. 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.

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 2022. 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 alleged 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 sought compensatory and punitive damages. On June 9, 2021, the trial court granted our renewed motion for summary judgment on all of the plaintiff's claims. The plaintiff did not appeal, so the matter has concluded. The conclusion of this matter did not have any impact on our consolidated financial statements.

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 $55.4 million in 2022, $35.0 million in 2023, $25.2 million in 2024, $11.2 million in 2025, $9.0 million in 2026, and $13.0 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, 2021, we operate 145 inpatient rehabilitation hospitals. We are the sole owner of 91 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 54 jointly owned hospitals. In addition, we manage three 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, 2021, we provide home health services in 251 locations and hospice services in 96 locations across 34 states with a concentration in the southern half of the United States. We are the sole owner of 336 of these locations. We retain 50.0% to 90.0% ownership in the remaining 11 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. Hospice care focuses on the quality of life for patients who are experiencing an advanced, life limiting illness while treating the person and symptoms of the disease, rather than the disease itself.

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,		
	2021	2020	2019	2021	2020	2019
Net operating revenues	$ 4,015.0	$ 3,566.2	$ 3,513.0	$ 1,106.6	$ 1,078.2	$ 1,092.0
Operating expenses:						
Inpatient rehabilitation:						
Salaries and benefits	2,127.3	1,903.8	1,813.1	—	—	—
Other operating expenses	594.8	534.7	521.9	—	—	—
Supplies	184.2	171.0	147.0	—	—	—
Occupancy costs	59.0	61.4	64.8	—	—	—
Home health and hospice:						
Cost of services (excluding depreciation and amortization)	—	—	—	489.3	511.3	506.2
Support and overhead costs	—	—	—	406.2	402.8	381.7
	2,965.3	2,670.9	2,546.8	895.5	914.1	887.9
Other income	(6.9)	(8.0)	(10.5)	(1.6)	—	—
Equity in net income of nonconsolidated affiliates	(3.4)	(3.0)	(5.5)	(0.6)	(0.5)	(1.2)
Noncontrolling interests	103.2	83.3	82.6	1.8	1.3	9.5
Segment Adjusted EBITDA	$ 956.8	$ 823.0	$ 899.6	$ 211.5	$ 163.3	$ 195.8
Capital expenditures	$ 545.6	$ 404.6	$ 391.4	$ 5.6	$ 3.6	$ 12.7

	Inpatient Rehabilitation	Home Health and Hospice	Encompass Health Consolidated
As of December 31, 2021			
Total assets	$ 5,143.0	$ 1,721.9	$ 6,864.9
Investments in and advances to nonconsolidated affiliates	2.4	1.6	4.0
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

Segment reconciliations (in millions):

	For the Year Ended December 31,		
	2021	2020	2019
Total Segment Adjusted EBITDA	$ 1,168.3	$ 986.3	$ 1,095.4
General and administrative expenses	(197.3)	(155.5)	(247.0)
Depreciation and amortization	(256.6)	(243.0)	(218.7)
Loss on disposal or impairment of assets	(0.4)	(11.6)	(11.1)
Government, class action, and related settlements	—	(2.8)	—
Loss on early extinguishment of debt	(1.0)	(2.3)	(7.7)
Interest expense and amortization of debt discounts and fees	(164.6)	(184.2)	(159.7)
Net income attributable to noncontrolling interests	105.0	84.6	87.1
SARs mark-to-market impact on noncontrolling interests	—	—	5.0
Change in fair market value of equity securities	0.6	0.4	0.8
Gain on consolidation of joint venture formerly accounted for under the equity method of accounting	3.2	2.2	19.2
Payroll taxes on SARs exercise	—	(1.5)	(1.0)
Income from continuing operations before income tax expense	$ 657.2	$ 472.6	$ 562.3

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

	For the Year Ended December 31,		
	2021	2020	2019
Inpatient rehabilitation:			
Inpatient	$ 3,918.1	$ 3,496.1	$ 3,423.5
Outpatient and other	96.9	70.1	89.5
Total inpatient rehabilitation	4,015.0	3,566.2	3,513.0
Home health and hospice:			
Home health	897.3	877.6	918.0
Hospice	209.3	200.6	174.0
Total home health and hospice	1,106.6	1,078.2	1,092.0
Total net operating revenues	$ 5,121.6	$ 4,644.4	$ 4,605.0

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).
4.1.12	Eleventh Supplemental Indenture, dated as of December 15, 2021, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 5.75% Notes due 2025 (incorporated by reference to Exhibit 4.3 to the Encompass Health's Current Report on Form 8-K filed on December 17, 2021).
4.1.13	Twelfth Supplemental Indenture, dated as of January 24, 2022, among Encompass Health Corporation, the guarantors party thereto and Wells Fargo Bank, National Association, as trustee, relating to the 4.500% Notes due 2028, 4.750% Notes due 2030 and 4.625% Notes due 2031 (incorporated by reference to Exhibit 4.5 to the Encompass Health's Current Report on Form 8-K filed on January 25, 2022).
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 26, 2021).+
10.6	Description of the annual compensation arrangement for non-employee directors of Encompass Health Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in Encompass Health's Definitive Proxy Statement on Schedule 14A, filed on March 26, 2021).+
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 10.8 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).+
10.16	Letter Agreement, dated June 21, 2021, between Encompass Health Corporation and Barbara A. Jacobsmeyer (incorporated by reference to Exhibit 10.1 to Encompass Health's Quarterly Report on Form 10-Q filed on August 3, 2021).+
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, 2021, 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.

Attachment H

PHASE I ENVIRONMENTAL SITE ASSESSMENT

EHC LANTANA PROPERTY

9645 AND 9719 LANTANA ROAD

LAKE WORTH, PALM BEACH COUNTY, FLORIDA

Prepared for:

Encompass Health Rehabilitation Hospital of Lake Worth, LLC
9001 Liberty Parkway
Birmingham, AL 35242

August 30, 2022

Viability Date: January 29, 2023

Prepared By:

Kimley»Horn

Kimley-Horn Project No. 048028042

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EXECUTIVE SUMMARY

Kimley-Horn and Associates, Inc. (Kimley-Horn) was retained by Encompass Health Rehabilitation Hospital of Lake Worth, LLC (the "Client") to conduct a Phase I Environmental Site Assessment (ESA) for two parcels of land totaling approximately 8.35-acres, located at 9645 and 9719 Lantana Road, Lake Worth, Palm Beach County, Florida (referred to herein as the "subject property"). This Phase I ESA was performed in accordance with (1) the United States Environmental Protection Agency (USEPA) Standards and Practices for All Appropriate Inquiries (AAI), 40 CFR Part 312 and (2) guidelines established by the American Society for Testing and Materials (ASTM) in the *Standard Practice for Environmental Site Assessments: Phase I Environmental Site Assessment Process/Designation E 1527-13* (ASTM Standard Practice E 1527-13). EPA has recently adopted a new standard practice (ASTM 1527-21) on March 12, 2022; however, the ASTM 1527-13 standard is still viable for meeting the All Appropriate Inquiry requirements. Kimley-Horn is in the process of creating a template report to meet the requirements of the ASTM 1527-21 standard. Therefore, this report was prepared under the ASTM 1527-13 standard, under the supervision or responsible charge of Jamin Frommel, Environmental Professional.

The Phase I ESA summary is provided below. It should be recognized that specific details were not included or fully developed in this section, and the Phase I ESA must be reviewed in its entirety for a comprehensive understanding of the results. This report represents our service to you as of the report date and constitutes our final document; its text may not be altered after final issuance. Findings in this report are based upon the subject property's current utilization, information derived from the most recent reconnaissance and from other activities described herein; such information is subject to change. Certain indicators of the presence of hazardous substances or petroleum products may have been latent, inaccessible, unobservable, or not present during the most recent reconnaissance and may subsequently become observable (such as after property renovation or development). Further, these services are not to be construed as legal interpretation or advice.

Due to changing environmental regulatory conditions and potential on-site or adjacent activities occurring after this assessment, the continuing applicability of the conclusions in this assessment for the subject property may not be presumed for more than 180 days, per ASTM Standard Practice E 1527-13, which is January 29, 2023.

Subject Property Description and Use

The subject property consists of approximately 8.35 acres of land composed of two parcels located at 9645 and 9719 Lantana Road, Lake Worth, Palm Beach County, Florida. The eastern portion of the subject property contains Auction America and a single family residence, and the western portion of the subject property contains Eastwood Mulch, Inc. The subject property is bound to the north by undeveloped, vegetated land with trails, to the east by undeveloped, vegetated land, to the south by Lantana Road followed by single-family residential development, and to the west by Target (big box retail store).

Historical Information

Based on a review of the historical information, the subject property contained undeveloped land with several open water features indicative of landfilling operations since before the 1940s to the early 1950s. From the late 1950s to the mid-1980s, long pond formations (landfilling operations) spanned the extent of the subject property, and one building was present. By the mid-1990s, 9719 Lantana Road was primarily forested, and by the mid-2000s it was developed into a mulch company with truck storage and parking areas. A parking lot was constructed at 9645 Lantana Road by the mid-1990s, and by the late 1990s the land was used as a single-family residence with small buildings and parking areas.

From before the 1940s and into the early 1950s, the surrounding area was depicted as undeveloped with several open water features (landfilling operations) and one small building with a driveway to the west. By the late 1950s, landfilling operations (long pond formations) are visible to the north, east, and west, and some land is cleared to the south. By the late 1960s, five (5) large buildings are constructed to the west of the subject property, and by the mid-1970s more land is cleared to the south and additional ponds are constructed, and more land is cleared to the west of Route 7. By the mid-1990s, landfilling operations (long pond formations) are no longer depicted and are replaced by vegetated land and a large stormwater pond to the north. Land to the east and west is cleared by the mid-2000s, a Target (big box retail store) is constructed to the west, and another development with a parking lot and two small buildings is constructed to the east. Also, by the mid-2000s there is a large residential development to the south.

Records Review

Kimley-Horn reviewed select federal and state environmental regulatory databases, as well as responses from state and local regulatory agencies. The subject property was identified in the RCRA NON-GEN (EPA Handler ID FLR0000081489), FINDS/FRS, and ERIC (ERIC ID 18020) databases. No RCRA violations were identified for this facility. Kimley-Horn prepared a Phase I and Phase II ESA in August and September 2021 that documented soil and groundwater impacts across the site. Supplemental Phase II sampling in December 2021 attempted to delineate the soil and groundwater impacts. Just after this time period, due diligence activities were ceased to continue with the property sale and redevelopment plans. Sometime in April 2022, the Florida Department of Environmental Protection (FDEP) became aware of the results of due diligence activities and sent a letter notifying Encompass Health Corporation (EHC) of their responsibilities under Chapter 62-780, F.A.C. During the due diligence period, Terracon, a geotechnical firm, identified historical buried debris in the central and western portion of the subject property. Currently, site assessment is ongoing. The contaminants of concern (COCs) consist of polycyclic aromatic hydrocarbons (PAHs), total range petroleum hydrocarbons (TRPH), and RCRA 8 metals in soil and organochlorinated pesticides (OCPs), and RCRA 8 metals in groundwater. As such, the historical land use as an undocumented landfill, and soil and groundwater contamination identified on the subject property is considered a REC.

The subject property was also identified as historically operating as Source-Separated Organics Processing Facility (Facility ID 95163). A recent FDEP inspection checklist, completed on April 23, 2022, did not identify any violations. However, FDEP requested that the mulch pile height be lowered. Based on the regulatory status of this facility, it is not considered a REC.

The vacant property adjacent to the north of the subject property is listed on the SPILLS database (Incident No: 11361) for a release of approximately 100 gallons of fuel oil. No records of cleanup or site closure were identified for the spill. Site assessment activities conducted on the northern portion of the subject property did not identify soil or groundwater impacts associated with the incident. As such, the incident is not considered a REC.

The Target store property adjacent to the west of the subject property is listed as a TIER 2 facility (Fac. ID No. 6078256) for the storage of sulfuric acid. This facility is also listed as a RCRA NON GEN (EPA Handler ID FLR000226878) with no reported RCRA violations. The facility currently contains one (1) 2,000-gallon AST that was installed on December 6, 2019 (Fac. ID No. 9817477) containing emergency generator diesel. Palm Beach County issued a Compliance Letter, dated July 1, 2021, indicating that the facility was in compliance with storage tank rules and regulations. No discharges or violations have been documented relating to the AST. Lastly, this facility is listed as a RCRA SQG (EPA Handler ID FLR000133504) with no reported violations identified over the last twelve quarters. Lacking any reported violations, this facility is not considered a REC.

After reviewing the FDOH's EH Water Well Surveillance, South Florida Water Management District's e-Permitting database, and the USGS NWIS database, no wells were identified on the subject property.

Site Reconnaissance

The subject property consists of two parcels. The easternmost parcel (9645 Lantana Rd.) contains a single-family residence, maintenance barn, and swimming pool. An auction business, Auction America, was observed being ran out of the barn. During the site reconnaissance, aboveground storage tanks were observed within heavily vegetated areas around the barn. Several areas of debris/trash were also observed around the barn. A utility vehicle and other vehicles and trailers were observed in the tall grassy area in the northeastern portion of the property.

The western parcel (9719 Lantana Rd.) was observed to be a closed yard waste recycling and mulch processing business. Several piles of yard waste and mulch were observed throughout the property. Business operations utilized heavy equipment (excavators, front-end loaders, woodchippers and mulching equipment). This facility's operations were serviced by aboveground storage tanks (ASTs), generators, and mulching dyes. A modular office building, dumpster area, heavy equipment parking, and an irrigation well are located in the southwestern portion of the property. An unkept nursery was observed along the southern property boundary.

Adjoining Properties

The subject property is bordered to the north by undeveloped, vegetated land with trails; to the east by undeveloped, vegetated land and a stormwater pond; to the south by Lantana Road, followed by a single-family residential development; and to the west by Target, a big box retail store.

Opinions and Conclusions

Kimley-Horn has performed a Phase I Environmental Site Assessment (ESA) in conformance with the scope and limitations of ASTM Practice E1527-13 for two (2) parcels of land totaling approximately 8.35-acres, located at 9645 and 9719 Lantana Road, Lake Worth, Palm Beach County, Florida, the subject property. This assessment has revealed no evidence of recognized environmental conditions (RECs) associated with the subject property, with the exception of the following:

- The subject property is listed as a Waste Cleanup site (ERIC_18020), for soil and groundwater contamination identified during due diligence sampling activities conducted in September and December 2021. Contaminants of concern include PAHs, TRPH, and arsenic in the soil, and OCP's and arsenic in groundwater. The documented contamination and ongoing assessment activities being conducted on the subject property is considered a REC.

- Historically, the subject property contained undeveloped land with several open water features indicative of landfilling operations since the mid-1950s. From the late 1950s to the mid-1980s, long pond formations (landfill operations) spanned the extent of the subject property. The documented historic landfill operation on the subject property is considered a REC.

Kimley-Horn identified the following Business Environmental Risk (BER):

- During the site reconnaissance, Kimley-Horn observed an irrigation well, located on the southern boundary of the mulching operation. The well appeared in good condition, with no evidence of

damage. Should this well not be required for future development of the property, it will have to be properly abandoned. As such, the well is considered a BER.

- During the site reconnaissance, Kimley-Horn observed areas around the maintenance barn containing trash and debris consisting of tires, automotive parts, building materials, propane tanks, and household trash. These areas were observed to be overgrown with vegetation. Given the poor maintenance habits and observed areas of trash and debris, these materials are considered a BER.

- Kimley-Horn observed several ASTs across the subject property. In the western portion of the subject property, the mulching operation contained polyethylene ASTs for mulching dyes. The containers appeared in good condition. The dyes associated with mulching operations are biodegradable and are not considered a REC. Additionally, one diesel fuel AST was observed for mulching operation equipment. This AST was mounted on a trailer, with no secondary containment. The AST and dispensing line appeared in fair shape, with no open holes or rusting. In the eastern portion of the subject property, three, 500-gallon, petroleum ASTs were observed in the vicinity of the maintenance barn. The ASTs appeared in fair shape, with no evidence of open holes. The ASTs were stored on open grassy areas or within vegetated areas with no secondary containment. Site assessment activities conducted on the subject property did not identify soil or groundwater impacts associated with the ASTs. As such, lacking any visible evidence of spills or staining in the vicinity of the ASTs, they are not considered a REC. However, should the ASTs not be needed as part of future development of the subject property, they will need to be properly disposed. As such, the ASTs are considered a BER.

Attachment I

Suite 150
655 North Franklin Street
Tampa, Florida 33602

December 7, 2021

Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242

RE: Phase II Supplemental Environmental Site Assessment Report
EHC Lantana Property
9645 & 9719 Lantana Road
Lake Worth, Palm Beach County, Florida

Kimley-Horn and Associates, Inc. (Kimley-Horn) was retained by Encompass Health Corporation (Client) to conduct a Phase II Supplemental Environmental Site Assessment for two parcels of land, totaling approximately 8.35-acres of land, located at 9645 and 9719 Lantana Road, Lake Worth, Palm Beach County, Florida (referred to herein as the "subject property"). (**Figure 1**).

1.0 INTRODUCTION

Kimley-Horn completed a Phase I Environmental Site Assessment (ESA) for the subject property that identified the following Recognized Environmental Conditions (RECs):

- The property adjacent to the north was listed on the ERIS database as a SPILLS incident (Incident No. 11361) that occurred on February 1, 2001. Details regarding the spill are summarized in the table below. No records of cleanup or site closure were identified for the four spills. Due to the proximity of the spill to the subject property and the lack of documented cleanup or closure, this facility is considered a REC to the subject property.

Spill Details

Pollutant Name	Pollutant Actual Volume (gallons)	Description
Fuel oil	100	Complaint/Abandoned Containers/Dumping/Spill

- During the site reconnaissance, Kimley-Horn observed several ASTs across the subject property. The mulching operation contained ASTs for mulching dyes. The containers appeared in good condition. The dyes associated with mulching operations are biodegradable and are not

considered a REC. Additionally, one diesel fuel AST was observed in use for mulching operation equipment. This AST was mounted on a trailer, with no secondary containment. The AST and dispensing line appeared in fair shape, with no open holes or rusting. Lacking any secondary containment, any potential releases associated with this AST may impact the underlying soils and shallow groundwater. As such, the AST is considered a REC.

Three, 500-gallon, petroleum ASTs were observed on the eastern portion of the subject property, in the vicinity of the maintenance barn. The ASTs appeared in fair shape, with no evidence of open holes. The ASTs were stored on open grassy areas or within vegetated areas with no secondary containment. It could not be determined if the ASTs were in service during the site reconnaissance. Lacking secondary containment and the potential for the ASTs to discharge product during fueling operations, the ASTs are considered a REC.

- Kimley-Horn observed the areas around the maintenance barn containing trash and debris consisting of tires, automotive parts, building materials, propane tanks, and household trash. These areas were observed to be overgrown with vegetation. Given the poor maintenance habits and observed areas of trash and debris, these materials are considered a REC

Kimley-Horn subsequently completed a Phase II Environmental Site Assessment (ESA) for the subject property to evaluate the identified RECs in the Phase I ESA report. The field work conducted at the Site on September 7th & 8th, 2021 and laboratory results are summarized below:

- Nine (9) soil borings were conducted across the Site to evaluate soil quality. Soil borings were advanced to 4 feet below land surface (bls).

- At each soil borings, soil samples were collected at the following intervals: land surface to 0.5 ft., 0.5 ft. to 2 ft., and 2 ft. to 4 ft bls.

- Twenty-seven (27) total soil samples were collected and analyzed for Volatile Organic Compounds (VOCs) (EPA Method 8260), Polycyclic Aromatic Hydrocarbons (PAHs) (EPA Method 8270), Total Range Petroleum Hydrocarbons (TRPH) (FL-PRO Method), Organochlorinated Pesticides (EPA Method 8081), and RCRA 8 Metals (EPA Method 6010).

- Nine (9) temporary groundwater monitoring wells in locations concurrent with the soil borings using Direct Push Technology (DPT) drilling equipment.

- Nine (9) total groundwater samples were collected and analyzed for Volatile Organic Compounds (VOCs) (EPA Method 8260), Polycyclic Aromatic Hydrocarbons (PAHs) (EPA Method 8270), Total Range Petroleum Hydrocarbons (TRPH) (FL-PRO Method), Organochlorinated Pesticides (EPA Method 8081), and RCRA 8 Metals (EPA Method 6010).

- Soil samples collected from the eastern side of the property contained concentrations of the congeners of benzo(a)pyrene at SB-1 (0.5-2 ft.) and SB-3 (0-0.5 ft.) exceeding the RSCTL. Additionally, TRPH was identified in soil sample SB-1 (0.5-2 ft. and SB-5 (0-0.5 ft.) at concentrations exceeding the RSCTL.

  Soil samples collected from the western side of the property (mulching business) contained concentrations of arsenic at SB-6 (2-4 ft.) and SB-8 (0-0.5 ft.) exceeding the RSCTL. Additionally, TRPH was identified in SB-8 (0-0.5 ft.) at a concentration exceeding the LSCTL.

- Groundwater samples collected from across the subject property (2 parcels) contained arsenic at TMW-3, TMW-5, TMW-7, and TMW-9 at concentrations exceeding the GCTL of 10 µg/L. Additionally, concentrations of dieldrin and beta-BHC were detected in TMW-7 at concentrations exceeding their respective GCTLs. Arsenic impacts in groundwater appear to be sporadic across the site and will require further assessment to determine the horizontal and vertical impacts. The concentrations of dieldrin and beta-BHC appear to the limited to TMW-7 in the center of the subject property and are surrounded by monitoring wells that do not have impacts, indicating that the horizontal extent of those compounds is delineated.

Based on the results of this investigation, the Phase II ESA recommended further assessment of the soil and groundwater impacts at the Site to determine the horizontal and vertical extent. Upon delineation of soil impacts, a soil management plan will be required prior to construction activities to provide direction on the characterization, handling, and transportation of impacted soil.

The Client has requested that Kimley-Horn perform this Phase II Supplemental ESA to evaluate soil and groundwater quality at the subject property with regards to the identified RECs.

2.0 FIELD SAMPLING ACTIVITIES

Field activities were conducted at the Site on November 16th, 2021. Field activities consisted of completion of soil borings, temporary groundwater monitoring wells, and soil and groundwater sampling. All sampling activities were performed in

accordance with the Florida Department of Environmental Protection (FDEP) Standard Operating Procedures (SOPs). All sampling equipment and down-hole tools were decontaminated prior to and between sample locations. All laboratory analyses were performed by an accredited member of NELAC (National Environmental Laboratories Accreditation Conference).

Sample locations are depicted on **Figure 2**.

2.1 Soil Sampling

Kimley-Horn conducted a total of twenty (20) soil borings on the subject property to laterally delineate the previously detected impacts. At each impacted soil boring location (SB-1, SB-3, SB-5, SB-6, and SB-8), four (4) additional soil borings were spaced approximately 10 feet away in each cardinal direction from the impact location. All soil borings were installed using a decontaminated stainless-steel hand auger. Soil from each boring was collected from intervals previously identified with soil impacts, with soil from each interval collected and placed in laboratory supplied containers for analysis. Soil samples delineating SB-1, SB-5, and SB-8 (36 total) were analyzed for the following:

- Total Range Petroleum Hydrocarbons (TRPH) by (FL-PRO) Method

Soil samples delineating SB-1 and SB-3 (24 total) were analyzed for the following:

- Polycyclic Aromatic Hydrocarbons (PAHs) by EPA Method 8270

Soil samples delineating SB-6 and SB-8 (24 total) were analyzed for the following:

- Arsenic by EPA Method 6010

2.2 Groundwater Sampling

Kimley-Horn utilized a GeoProbe® equipped with direct push technology (DPT) to install four (4) temporary groundwater monitoring wells in locations designed to further delineate arsenic impacts. Soil boring and temporary monitoring well locations are depicted on **Figure 2**. The temporary groundwater monitoring wells were constructed of 1-inch diameter PVC, and were installed into the water table, at a depth 13 feet below land surface. The wells consisted of 10 feet of 0.010-inch slotted screen interval, with a sand filter pack poured around the boring anulus. The temporary groundwater monitoring wells were purged until relatively free of sediment and allowed to equilibrate prior to sampling. FDEP groundwater sampling logs are included in **Appendix A**.

Groundwater samples were analyzed for the following parameters:

- Arsenic by EPA Method 6010

3.0 SAMPLING RESULTS

All samples collected from the Site were delivered under chain-of-custody protocol to Pace Environmental Laboratories, Inc. (Pace) in Tampa, Florida, a NELAC certified laboratory. The laboratory data report and chain-of-custody forms are provided in **Appendix B**. Soil and groundwater data were evaluated relative to the default cleanup target levels (CTLs) defined in Tables 1 and 2 of Chapter 62-777, F.A.C.

3.1 Soil Quality Data

A summary of the detected soil quality data is presented in **Table 1**. The following is a summary of the soil quality data collected from the Site.

Polycyclic Aromatic Hydrocarbons (PAHs)
Congeners of the benzo(a)pyrene equivalents were detected in soil sample SB-1W (0.5-2) (0.3 mg/kg) at a concentration exceeding the Residential SCTL (RSCTL) of 0.1 mg/kg. There were no other PAHs detected above the applicable SCTLs.

Total Range Petroleum Hydrocarbons (TRPH)
TRPH was detected in soil sample SB-1W (0.5-2) (784 mg/kg) at a concentration exceeding the RSCTL of 460 mg/kg and the leachability based on groundwater criteria SCTL (LSCTL) of 340 mg/kg. All other soil samples detected TRPH below the applicable SCTLs.

Arsenic
Arsenic was detected in soil samples SB-6E (2.0-4.0) (2.3 mg/kg) and SB-8W (0.0-0.5) (3.5 mg/kg) at concentrations exceeding the RSCTL of 2.1 mg/kg. There were no other metals detected above the applicable SCTLs.

3.2 Groundwater Quality Data

A summary of the detected groundwater quality data is presented in **Table 2**. The following provides a summary of groundwater sampling results.

Arsenic
Arsenic was not detected about the GCTL in any of the samples collected.

4.0 CONCLUSIONS AND RECOMMENDATIONS

This Phase II Supplemental ESA was completed for the purpose of delineating previously detected impacts to evaluate historical land use operations and potential impacts to future redevelopment of the subject property.

Soil samples collected from the eastern side of the property contained concentrations of the benzo(a)pyrene congeners at SB-1W (0.5-2 ft.) exceeding the RSCTL. Additionally, TRPH was identified in soil sample SB-1W (0.5-2 ft.) at a concentration exceeding the RSCTL and LSCTL.

Soil samples collected from the western side of the property (mulching business) contained concentrations of arsenic at SB-6E (2-4 ft.) and SB-8W (0-0.5 ft.) exceeding the RSCTL.

Groundwater samples collected from the delineation wells did not detect arsenic above the GCTL, completing the horizontal delineation of groundwater impacts.

Based on the results of this investigation, soil impacts have not been fully delineated and will require further assessment in localized areas. Groundwater impacts have been horizontally delineated; however, a deeper well will be required to complete the vertical delineation of arsenic impacts.

The temporary wells installed as part of this investigation remain intact; however, the initial temporary wells were removed after the first sampling event. In the event further groundwater sampling is required for regulatory closure, these wells will have to be reestablished.

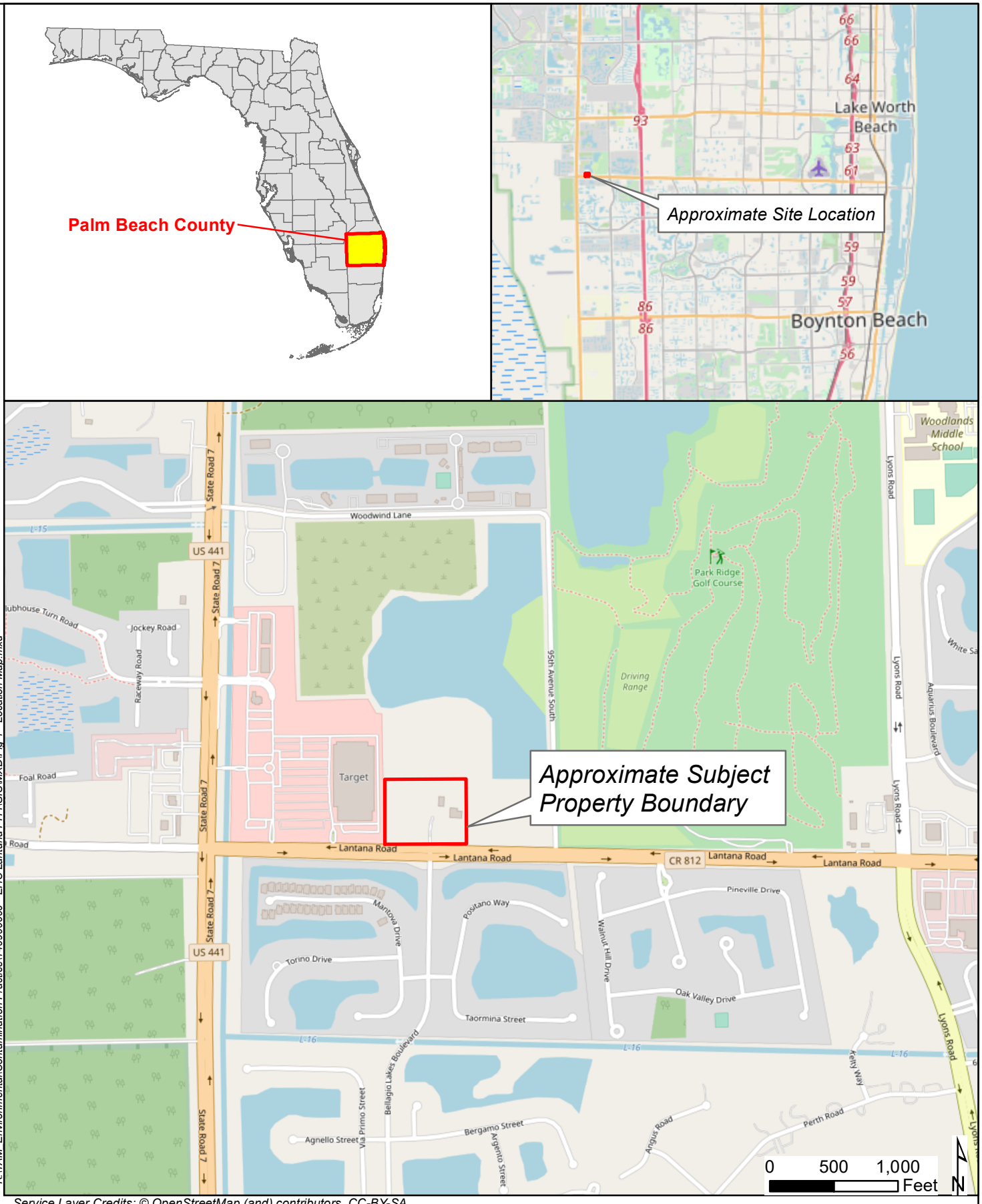
Thank you for the opportunity to assist you with this project. Should you have any questions or need additional information, please contact me at 813-635-1460 or by email bill.spinner@kimley-horn.com.

Sincerely,
KIMLEY-HORN AND ASSOCIATES, INC.

William Spinner, P.G.
Florida Registration No. 2570

Attachments:
- Figures
- Tables
- Appendix A – Field Logs
- Appendix B – Laboratory Analytical Reports

FIGURES



K:\TAM_Environmental\Contamination Practice\140900000 - EHC Lantana PH I\GIS\MXD\Fig 1 - Location Map.mxd

Service Layer Credits: © OpenStreetMap (and) contributors, CC-BY-SA

Kimley»Horn

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Tampa, FL 33602
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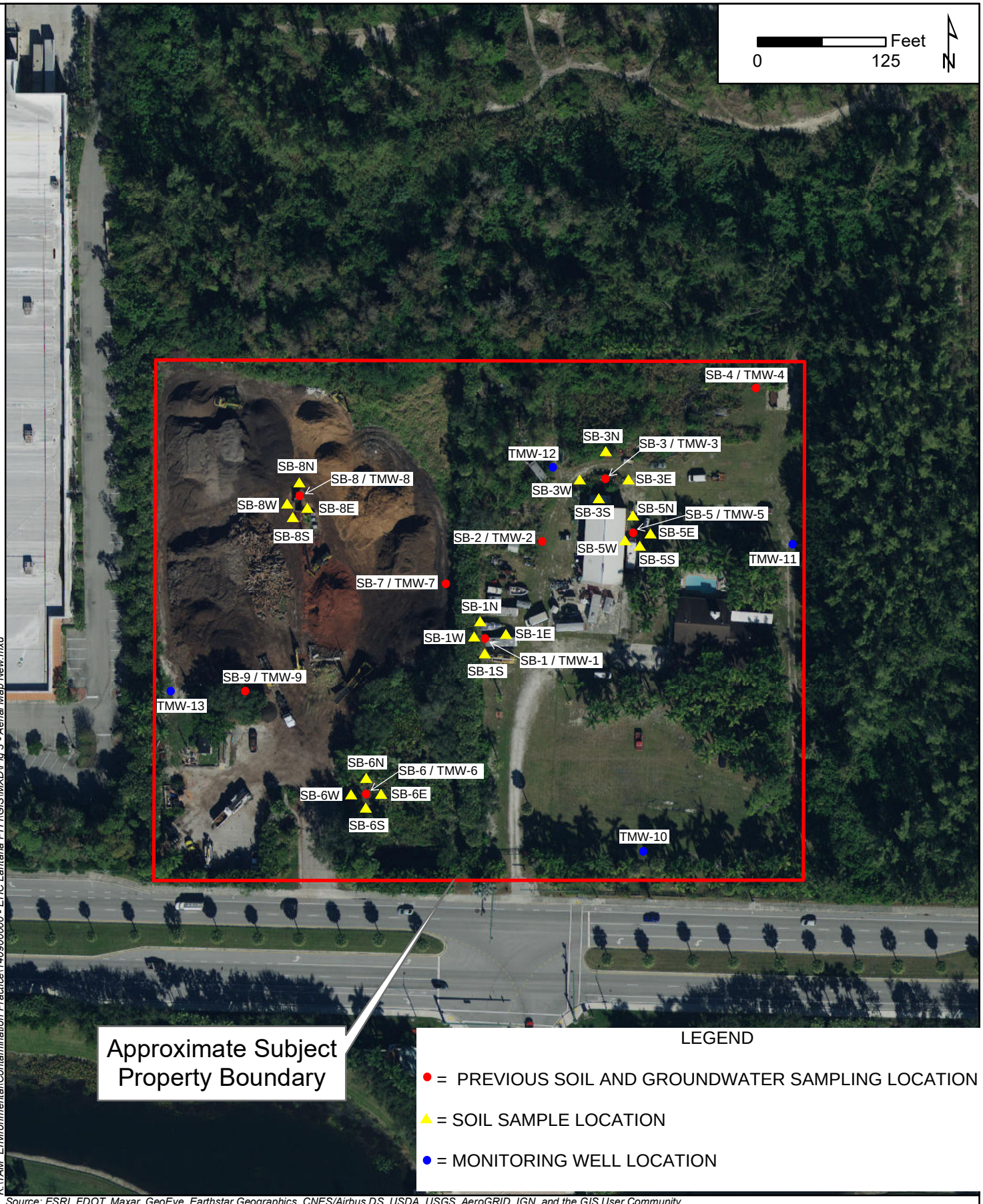
Site Location Map

EHC Lantana Property Phase I
9645 & 9719 Lantana Road,
Lake Worth, Florida

1 inch = 1,000 feet	PROJECT NUMBER: 140900000	JUNE 2021	FIGURE 1



K:\TAM_Environmental\Contamination Practice\140900000 - EHC Lantana PH I\GIS\MXD\Fig 3 - Aerial Map New.mxd

Source: ESRI, FDOT, Maxar, GeoEye, Earthstar Geographics, CNES/Airbus DS, USDA, USGS, AeroGRID, IGN, and the GIS User Community

SAMPLE LOCATION MAP

EHC Lantana Property Phase II
9645 & 9719 Lantana Road,
Lake Worth, Florida

1 inch = 125 feet	PROJECT NUMBER: 140900000	SEPT. 2021	FIGURE 2

Kimley»Horn

655 North Franklin Street, Suite 150
Tampa, FL 33602
Phone (813) 620-1460
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TABLES

TABLE 1A
SOIL ANALYTICAL RESULTS - DETECTIONS ONLY
EHC LANTANA PROPERTY
LAKE WORTH, FLORIDA

Boring	Depth (ft.)	Date Collected	VOCs		OCPs	Metals							TRPH
			2-Butanone (MEK)	Acetone	4,4'-DDT	Arsenic	Barium	Cadmium	Chromium	Lead	Mercury	Selenium	TRPH
RSCTL			16000	11000	2.9	2.1	120	82	210	400	3	440	460
CSCTL			110000	68000	15	12	130000	1700	470	1400	17	11000	2700
LSCTL			17	25	11	*	1600	7.5	38	*	2.1	5.2	340
SB-1	0.0-0.5	9/7/2021	0.0058 U	0.030 U	0.0067 U	0.32 U	15.5	0.063 U	5.7	1.6	0.0073 I	1.0	62.5
	0.5-2.0		0.0048 U	0.025 U	0.0075 U	0.22 U	9.3	0.045 U	28.4	151	0.0058 I	1.4	706
	2.0-4.0		0.012 I	0.075	0.0084 U	0.31 U	6.1	0.056 I	3.4	5.9	0.014	0.47 U	61.3
SB-1N	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	23.5
	0.5-2.0		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	7.1
SB-1S	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	5.9 U
	0.5-2.0		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	5.9 U
SB-1E	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	5.3 U
	0.5-2.0		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	5.8 U
SB-1W	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	784
	0.5-2.0		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	255
SB-2	0.0-0.5	9/7/2021	0.0051 U	0.026 U	0.0073 U	0.29 I	6.0	0.031 I	3.6	4.9	0.011 I	0.43 I	10.6 I
	0.5-2.0		0.0054 U	0.028 U	0.0074 U	0.29 U	7.7	0.029 U	4.6	4.5	0.013	0.43 U	16.5
	2.0-4.0		0.0052 U	0.027 U	0.0077 U	0.27 U	6.4	0.054 U	6.2	1.3	0.015	0.41 U	5.36 I
SB-3	0.0-0.5	9/7/2021	0.0048 U	0.025 U	0.0070 U	0.93	8.8	0.080	6.2	11.5	0.022	0.49 U	336
	0.5-2.0		0.0053 U	0.027 U	0.0072 U	0.32 U	3.6	0.032 U	1.8	1.4	0.0056 U	0.48 U	5.25 I
	2.0-4.0		0.0045 U	0.051	0.0075 U	0.43 I	3.2	0.030 U	5.5	6.6	0.010 I	0.44 U	32.5
SB-4	0.0-0.5	9/7/2021	0.0058 U	0.030 U	0.0077 U	0.65 I	9.8	0.046 I	16.4	5.9	0.014	0.58 U	19.9
	0.5-2.0		0.0048 U	0.025 U	0.0073 U	0.54 I	8.1	0.032 U	5.5	3.9	0.015	0.48 U	17.3
	2.0-4.0		0.0053 U	0.030 I	0.0075 U	0.31 U	4.2	0.031 U	3.1	5.5	0.0099 I	0.47 U	24.6
SB-5	0.0-0.5	9/7/2021	0.0052 U	0.027 U	0.0075 U	0.63	4.2	0.080	3.4	2.8	0.0098 I	0.45 U	639
	0.5-2.0		0.0052 U	0.027 U	0.0074 U	0.50 I	4.6	0.12	3.2	7.3	0.014	0.45 U	98.3
	2.0-4.0		0.0073 U	0.074	0.0088 U	0.45 U	41.1	0.045 U	2.6	8.3	0.0073 U	1.7	31.8
SB-5N	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	109
SB-5S	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	30.7
SB-5E	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	44.9
SB-5W	0.0-0.5	11/16/2021	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	6.9
SB-6	0.0-0.5	9/7/2021	0.0055 U	0.029 U	0.0079 U	0.33 U	10.0	0.066 U	4.2	2.3	0.013	1.1	95.1
	0.5-2.0		0.0050 U	0.026 U	0.0070 U	0.32 U	7.0	0.16 U	3.3	1.2	0.0089 I	1.7	8.86 I
	2.0-4.0		0.082 I	0.60	0.0079 U	2.3	18.4	0.18	4.7	29.9	0.049	0.90 U	172
SB-6N	0.0-0.5	11/16/2021	NS	NS	NS	0.32 U	NS	NS	NS	NS	NS	NS	NS
	0.5-2.0		NS	NS	NS	0.27 U	NS	NS	NS	NS	NS	NS	NS
	2.0-4.0		NS	NS	NS	0.95	NS	NS	NS	NS	NS	NS	NS
SB-6S	0.0-0.5	11/16/2021	NS	NS	NS	0.29 U	NS	NS	NS	NS	NS	NS	NS
	0.5-2.0		NS	NS	NS	0.39 I	NS	NS	NS	NS	NS	NS	NS
	2.0-4.0		NS	NS	NS	0.93 I	NS	NS	NS	NS	NS	NS	NS
SB-6E	0.0-0.5	11/16/2021	NS	NS	NS	2.0	NS	NS	NS	NS	NS	NS	NS
	0.5-2.0		NS	NS	NS	0.79	NS	NS	NS	NS	NS	NS	NS
	2.0-4.0		NS	NS	NS	2.3	NS	NS	NS	NS	NS	NS	NS
SB-6W	0.0-0.5	11/16/2021	NS	NS	NS	0.90	NS	NS	NS	NS	NS	NS	NS
	0.5-2.0		NS	NS	NS	1.9	NS	NS	NS	NS	NS	NS	NS
	2.0-4.0		NS	NS	NS	0.71	NS	NS	NS	NS	NS	NS	NS
SB-7	0.0-0.5	9/7/2021	0.0057 U	0.030 U	0.0081 U	0.60 I	8.4	0.046 I	5.4	6.3	0.013	0.52 U	36.1
	0.5-2.0		0.0072 U	0.037 U	0.0081 U	1.5	9.4	0.11	4.7	8.7	0.033	0.72 U	55.5
	2.0-4.0		0.0060 I	0.066	0.0075 U	0.37 U	4.2	0.30	2.8	8.7	0.018	0.55 U	23.8
SB-8	0.0-0.5	9/7/2021	0.023 U	0.16 I	0.011 U	4.5	18.3	0.26	19.8	12.8	0.047	1.7 U	351
	0.5-2.0		0.020 I	0.12 I	0.011 U	0.37 I	10.9	0.032 U	3.5	0.98	0.017	0.48 U	103
	2.0-4.0		0.0057 U	0.048 I	0.0075 U	0.39 I	10.7	0.028 U	4.2	3.0	0.0055 U	0.66 I	11.9 I
SB-8N	0.0-0.5	11/16/2021	NS	NS	NS	2.1	NS	NS	NS	NS	NS	NS	11.3 I
SB-8S	0.0-0.5	11/16/2021	NS	NS	NS	1.4	NS	NS	NS	NS	NS	NS	136
SB-8E	0.0-0.5	11/16/2021	NS	NS	NS	1.8	NS	NS	NS	NS	NS	NS	23.1
SB-8W	0.0-0.5	11/16/2021	NS	NS	NS	3.5	NS	NS	NS	NS	NS	NS	286
SB-9	0.0-0.5	9/7/2021	0.0050 U	0.026 U	0.0075 U	1.6	11.5	0.11	9.3	10.4	0.019	0.55 U	11.9 I
	0.5-2.0		0.0047 U	0.025 U	0.0077 U	0.49 I	3.5	0.026 U	3.7	4.7	0.016	0.38 U	32.7
	2.0-4.0		0.0050 U	0.026 U	0.0170 I	0.53 I	3.2	0.083	3.3	10.4	0.021	0.54 U	17.2

Notes:
NA = Not Analyzed
* = Leachability value may be determined using the Synthetic Precipitation Leaching Procedure (SPLP)
MDL = Method Detection Level
RSCTL = Residential Direct Exposure Soil Cleanup Target Level
CSCTL = Commercial Direct Exposure Soil Cleanup Target Level
LSCTL = Groundwater Leachability Soil Cleanup Target Level
Red Bold values exceed the RSCTL
Red Bold & shaded values exceed CSCTL
Shaded values exceed LSCTL

TABLE 1B
PAH SOIL ANALYTICAL RESULTS - DETECTIONS ONLY
EHC LANTANA PROPERTY
LAKE WORTH, FLORIDA

Boring	Depth (ft.)	Date Collected	PAHs															
			Acenaphthene	Acenaphthylene	Anthracene	Benzo(g,h,i)perylene	Fluoranthene	Fluorene	Phenanthrene	Pyrene	Benzo(a)pyrene	Benzo(a)anthracene	Benzo (b) fluoranthene	Benzo (k) fluoranthene	Chrysene	Dibenz (a,h) anthracene	Indeno (1,2,3-cd) pyrene	Benzo (a) pyrene equivalent
RSCTL			2400	1800	21000	2500	3200	2600	2200	2400	0.1	#	#	#	#	#	#	0.1
CSCTL			20000	20000	300000	52000	59000	33000	36000	45000	0.7	#	#	#	#	#	#	0.7
LSCTL			2.1	27	2500	32000	1200	160	250	880	8	0.8	2.4	24	77	0.7	6.6	**
SB-1	0.0-0.5	9/7/2021	0.0022 U	0.0023 U	0.0025 U	0.0180	0.0024 U	0.0022 U	0.0025 U	0.00200 I	0.00300 I	0.0018 U	0.00500 I	0.0023 U	0.0025 U	0.0018 U	0.00500 I	<0.1
	0.5-2.0		0.0025 U	0.00400 I	0.0110	0.101	0.0110	0.0025 U	0.00300 I	0.209	**0.117**	**0.0110**	**0.135**	**0.0330**	**0.0028 U**	**0.0280**	**0.0950**	**0.2**
	2.0-4.0		0.0028 U	0.0029 U	0.0031 U	0.00400 I	0.00700 I	0.0028 U	0.0031 U	0.00600 I	0.00300 I	0.00300 I	0.00600 I	0.0029 U	0.00300 I	0.0023 U	0.00400 I	<0.1
SB-1N	0.0-0.5	11/16/2021	0.017 U	0.0057 U	0.0049 U	0.0091 U	0.012 U	0.013 U	0.0051 U	0.0048 U	0.0090 U	0.0048 U	0.0096 U	0.0096 U	0.0048 U	0.0083 U	0.0082 U	<0.1
	0.5-2.0		0.017 U	0.0058 U	0.0050 U	0.0092 U	0.012 U	0.013 U	0.0052 U	0.0049 U	0.0091 U	0.0049 U	0.0098 U	0.0098 U	0.0049 U	0.0085 U	0.0084 U	<0.1
SB-1S	0.0-0.5	11/16/2021	0.018 U	0.0061 U	0.0053 U	0.0098 U	0.013 U	0.014 U	0.0055 U	0.0052 U	0.0097 U	0.0052 U	0.010 U	0.010 U	0.0052 U	0.0090 U	0.0089 U	<0.1
	0.5-2.0		0.019 U	0.0062 U	0.0054 U	0.010 U	0.013 U	0.014 U	0.0056 U	0.0088 I	0.0099 U	0.011 I	0.011 U	0.011 U	0.0061 I	0.0092 U	0.0090 U	<0.1
SB-1E	0.0-0.5	11/16/2021	0.017 U	0.0056 U	0.0049 U	0.0090 U	0.012 U	0.013 U	0.0051 U	0.0048 U	0.0089 U	0.0048 U	0.0095 U	0.0095 U	0.0048 U	0.0083 U	0.0081 U	<0.1
	0.5-2.0		0.018 U	0.0060 U	0.0052 U	0.030 I	0.012 U	0.013 U	0.0054 U	0.012 I	0.013 I	0.011 I	0.019 I	0.010 U	0.0092 I	0.0088 U	0.0087 U	<0.1
SB-1W	0.0-0.5	11/16/2021	0.085 U	0.028 U	0.025 U	0.047 I	0.059 U	0.064 U	0.026 U	0.024 U	0.045 U	0.024 U	0.048 U	0.048 U	0.024 U	0.042 U	0.041 U	<0.1
	0.5-2.0		0.53 U	0.18 U	0.15 U	0.28 U	0.37 U	0.40 U	0.16 U	0.15 U	0.28 U	0.15 U	0.30 U	0.30 U	0.15 U	0.26 U	0.26 U	**0.3**
SB-2	0.0-0.5	9/7/2021	0.0024 U	0.0025 U	0.0027 U	0.00300 I	0.0026 U	0.0024 U	0.0027 U	0.0023 U	0.0021 U	0.0020 U	0.00300 I	0.0025 U	0.0027 U	0.0020 U	0.00300 I	<0.1
	0.5-2.0		0.0025 U	0.0026 U	0.0027 U	0.00400 I	0.0027 U	0.0024 U	0.0027 U	0.0024 U	0.0021 U	0.0020 U	0.00300 I	0.0025 U	0.0027 U	0.0020 U	0.00300 I	<0.1
	2.0-4.0		0.0026 U	0.0027 U	0.0028 U	0.0022 U	0.0028 U	0.0025 U	0.0028 U	0.0025 U	0.0022 U	0.0021 U	0.0019 U	0.0026 U	0.0028 U	0.0021 U	0.0022 U	<0.1
SB-3	0.0-0.5	9/7/2021	0.0023 U	0.00800	0.0150	0.362	0.0810	0.0023 U	0.0170	0.0880	**0.174**	**0.0640**	**0.267**	**0.0710**	**0.0720**	**0.0440**	**0.269**	**0.3**
	0.5-2.0		0.0024 U	0.0025 U	0.0026 U	0.00300 I	0.0026 U	0.0024 U	0.0027 U	0.0023 U	0.0021 U	0.0020 U	0.0018 U	0.0025 U	0.0027 U	0.0020 U	0.0021 U	<0.1
	2.0-4.0		0.0025 U	0.0026 U	0.0028 U	0.00900	0.0100	0.0025 U	0.0028 U	0.00900	0.00700	0.00600 I	0.0130	0.00400 I	0.00800	0.0021 U	0.00800	<0.1
SB-3N	0.0-0.5	11/16/2021	0.017 U	0.0057 U	0.0050 U	0.0092 U	0.012 U	0.013 U	0.0052 U	0.0063 I	0.0090 U	0.0048 U	0.0097 U	0.0097 U	0.0053 I	0.0084 U	0.0083 U	<0.1
SB-3S	0.0-0.5	11/16/2021	0.018 U	0.0060 U	0.0052 U	0.017 I	0.021 I	0.014 U	0.0054 U	0.023 I	0.015 I	0.011 I	0.021 I	0.010 U	0.011 I	0.0088 U	0.0099 I	<0.1
SB-3E	0.0-0.5	11/16/2021	0.018 U	0.0059 U	0.0051 U	0.0094 U	0.012 U	0.013 U	0.0053 U	0.0050 U	0.0093 U	0.0073 I	0.010 U	0.010 U	0.0052 I	0.0086 U	0.0085 U	<0.1
SB-3W	0.0-0.5	11/16/2021	0.017 U	0.0058 U	0.0050 U	0.0093 U	0.012 I	0.013 U	0.0052 U	0.011 I	0.0092 U	0.011 I	0.012 I	0.0098 U	0.0076 I	0.0085 U	0.0084 U	<0.1
SB-4	0.0-0.5	9/7/2021	0.0026 U	0.0026 U	0.0028 U	0.00800	0.00900	0.0025 U	0.0028 U	0.00700 I	0.00700 I	0.00600 I	0.0120	0.00400 I	0.00700 I	0.0021 U	0.00700 I	<0.1
	0.5-2.0		0.0024 U	0.0025 U	0.0027 U	0.0280	0.0270	0.0024 U	0.00300 I	0.0240	0.0280	0.0170	0.0530	0.0170	0.0300	0.00600 I	0.0310	<0.1
	2.0-4.0		0.0025 U	0.0026 U	0.0028 U	0.00200 I	0.0027 U	0.0025 U	0.0028 U	0.0024 U	0.0021 U	0.0021 U	0.00300 I	0.0026 U	0.0028 U	0.0021 U	0.00200 I	<0.1
SB-5	0.0-0.5	9/7/2021	0.0025 U	0.00300 I	0.00500 I	0.183	0.0710	0.0025 U	0.0120	0.0700	0.0970	0.0440	0.165	0.0490	0.0640	0.0200	0.109	0.1
	0.5-2.0		0.0025 U	0.0026 U	0.0027 U	0.0140	0.00900	0.0024 U	0.0027 U	0.00900	0.0100	0.00700 I	0.0170	0.00600 I	0.00700 I	0.00200 I	0.0120	<0.1
	2.0-4.0		0.0029 U	0.0030 U	0.0032 U	0.00600 I	0.0032 U	0.0029 U	0.0032 U	0.0028 U	0.00300 I	0.0024 U	0.00500 I	0.0030 U	0.0032 U	0.0024 U	0.00400 I	<0.1
SB-6	0.0-0.5	9/7/2021	0.0026 U	0.0027 U	0.00500 I	0.0400	0.0760	0.0026 U	0.0230	0.0700	0.0430	0.0390	0.0730	0.0250	0.0460	0.00800	0.0430	<0.1
	0.5-2.0		0.0024 U	0.0024 U	0.0026 U	0.0020 U	0.0026 U	0.0023 U	0.0026 U	0.0023 U	0.0020 U	0.0019 U	0.0017 U	0.0024 U	0.0026 U	0.0019 U	0.0020 U	<0.1
	2.0-4.0		0.0100	0.00700 I	0.0100	0.102	0.115	0.0160	0.0430	0.157	0.0750	0.0620	0.113	0.0330	0.0560	0.0180	0.0810	<0.1
SB-7	0.0-0.5	9/7/2021	0.0027 U	0.0028 U	0.0030 U	0.0240	0.0130	0.0026 U	0.0030 U	0.0140	0.0170	0.0120	0.0290	0.00900	0.0140	0.00400 I	0.0240	<0.1
	0.5-2.0		0.0027 U	0.0028 U	0.0030 U	0.0170	0.00700 I	0.0027 U	0.0030 U	0.00900	0.00700 I	0.00400 I	0.0110	0.00300 I	0.00300 I	0.0022 U	0.0110	<0.1
	2.0-4.0		0.0025 U	0.0026 U	0.0028 U	0.0110	0.00800	0.0025 U	0.0028 U	0.0110	0.00600 I	0.00500 I	0.00900	0.00300 I	0.00400 I	0.0021 U	0.00800	<0.1
SB-8	0.0-0.5	9/7/2021	0.0037 U	0.0038 U	0.0040 U	0.0190	0.0260	0.0036 U	0.00700 I	0.0230	0.0180	0.0150	0.0350	0.0100 I	0.0160	0.00400 I	0.0200	<0.1
	0.5-2.0		0.0037 U	0.0038 U	0.0041 U	0.0031 U	0.0100 I	0.0036 U	0.0160	0.00700 I	0.0032 U	0.00400 I	0.00700 I	0.0038 U	0.0041 U	0.0030 U	0.0032 U	<0.1
	2.0-4.0		0.0025 U	0.0026 U	0.0027 U	0.00200 I	0.00500 I	0.0024 U	0.00300 I	0.00400 I	0.00200 I	0.00200 I	0.00400 I	0.0026 U	0.0028 U	0.0020 U	0.00200 I	<0.1
SB-9	0.0-0.5	9/7/2021	0.0025 U	0.0026 U	0.0028 U	0.00300 I	0.0027 U	0.0025 U	0.0028 U	0.00200 I	0.00300 I	0.00200 I	0.00600 I	0.0026 U	0.0028 U	0.0021 U	0.00300 I	<0.1
	0.5-2.0		0.0026 U	0.0027 U	0.0028 U	0.0100	0.0100	0.0025 U	0.0028 U	0.0120	0.0100	0.00800	0.0200	0.00700 I	0.00800	0.00200 I	0.0110	<0.1
	2.0-4.0		0.0025 U	0.0026 U	0.0028 U	0.0160	0.0100	0.0025 U	0.00300 I	0.00900	0.00800	0.00500 I	0.0120	0.00400 I	0.00500 I	0.00300 I	0.0130	<0.1

Notes:
NA = Not Analyzed
* = Leachability value may be determined using the Synthetic Precipitation Leaching Procedure (SPLP)
** = leachability value not applicable
MDL = Method Detection Level
RSCTL = Residential Direct Exposure Soil Cleanup Target Level
CSCTL = Commercial Direct Exposure Soil Cleanup Target Level
LSCTL = Groundwater Leachability Soil Cleanup Target Level
Red Bold values exceed the RSCTL
Red Bold & shaded values exceed CSCTL
Shaded values exceed LSCTL

TABLE 2
GROUNDWATER ANALYTICAL RESULTS - DETECTIONS ONLY
EHC LANTANA PROPERTY
LAKE WORTH, FLORIDA

Monitoring Well	Date Collected	METALS					VOCs		
		Arsenic	Cadmium	Chromium	Lead	Barium	Toluene	Total VOAs	Acetone
GCTL		10	5	100	15	2000	40	NA	6300
NADC		100	50	1000	150	20000	400	NA	63000
TMW-1	9/7/2021	3.4 U	0.84 I	1.7 U	4.6 U	69.0	0.33 U	0.63 U	5.3 U
TMW-2	9/7/2021	5.1 I	0.82 I	1.7 U	4.6 U	35.8	0.33 U	0.63 U	5.3 U
TMW-3	9/7/2021	**11.2**	0.33 U	1.7 U	4.6 U	29.8	0.33 U	0.63 U	5.3 U
TMW-4	9/7/2021	7.7 I	0.33 U	1.8 I	4.6 U	112	0.33 U	0.63 U	10.9 I
TMW-5	9/7/2021	**13.6**	0.33 U	1.7 U	4.6 U	23.2	0.33 U	0.63 U	5.3 U
TMW-6	9/8/2021	4.4 I	0.33 U	1.7 U	4.6 U	236	0.33 U	0.63 U	5.3 U
TMW-7	9/8/2021	**31.8**	0.33 U	9.2	13.3	66.9	0.76 I	0.76	37.0
TMW-8	9/8/2021	6.1 I	0.33 U	1.7 U	4.6 U	90.6	0.33 U	0.63 U	46.7
TMW-9	9/8/2021	**10.4**	0.33 U	2.0 I	4.6 U	46.8	0.33 U	2.1 U	5.3 U
TMW-10	11/16/2021	3.4 U	NS	NS	NS	NS	NS	NS	NS
TMW-11	11/16/2021	4.5 I	NS	NS	NS	NS	NS	NS	NS
TMW-12	11/16/2021	3.4 U	NS	NS	NS	NS	NS	NS	NS
TMW-13	11/16/2021	3.4 U	NS	NS	NS	NS	NS	NS	NS

Notes:
GCTLs = Groundwater Cleanup Target Levels specified in Table I of Chapter 62-777, F.A.C.
NADCs = Natural Attenuation Default Source Concentrations specified in Table V of Chapter 62-777, F.A.C.
Exceeds GCTL Limit
Exceeds NADC Limit

TABLE 2
GROUNDWATER ANALYTICAL RESULTS - DETECTIONS ONLY
EHC LANTANA PROPERTY
LAKE WORTH, FLORIDA

Monitoring Well	Date Collected	PAHs						OCPs			
		Acenaphthene	Acenapthylene	Anthracene	Fluoranthene	Fluorene	Phenanthrene	Dieldrin	Heptachlor	beta-BHC	delta-BHC
GCTL		20	210	2100	280	280	210	0.002	0.4	0.02	2.1
NADC		200	2100	21000	2800	2800	2100	0.2	40	2	21
TMW-1	9/7/2021	0.019 U	0.031 U	0.020 U	0.018 U	0.017 U	0.019 U	0.0019 U	0.0059 U	0.019 U	0.0045 U
TMW-2	9/7/2021	0.019 U	0.031 U	0.020 U	0.018 U	0.017 U	0.019 U	0.0019 U	0.0059 U	0.019 U	0.0045 U
TMW-3	9/7/2021	0.074 I	0.031 U	0.020 U	0.018 U	0.066 I	0.025 I	0.0038 U	0.012 U	0.038 U	0.0090 U
TMW-4	9/7/2021	0.019 U	0.10 I	0.020 U	0.018 U	0.017 U	0.019 U	0.0019 U	0.0059 U	0.019 U	0.0046 U
TMW-5	9/7/2021	0.019 U	0.031 U	0.020 U	0.018 U	0.017 U	0.019 U	0.0019 U	0.0059 U	0.019 U	0.0045 U
TMW-6	9/8/2021	0.11 I	0.031 U	0.020 U	0.039 I	0.024 I	0.040 I	0.0019 U	0.0058 U	0.019 U	0.0045 U
TMW-7	9/8/2021	0.019 U	0.031 U	0.020 U	0.018 U	0.017 U	0.019 U	**0.012**	0.0068 I	**0.021 I**	0.0096
TMW-8	9/8/2021	0.10 I	0.031 U	0.072 I	0.018 U	0.083 I	0.060 I	0.0019 U	0.0058 U	0.019 U	0.0045 U
TMW-9	9/8/2021	0.019 U	0.031 U	0.020 U	0.018 U	0.017 U	0.019 U	0.0019 U	0.0059 U	0.019 U	0.0046 U

Notes:
GCTLs = Groundwater Cleanup Target Levels specified in Table I of Chapter 62-777, F.A.C.
NADCs = Natural Attenuation Default Source Concentrations specified in Table V of Chapter 62-777, F.A.C.
Exceeds GCTL Limit
Exceeds NADC Limit
Units are in ug/L unless otherwise stated

Attachment J Supplemental Attachments

APPOINTMENT
OF SUBORDINATE OFFICERS

Pursuant to Section 4.3 of the Amended and Restated Bylaws (the "Bylaws") of Encompass Health Corporation (the "Corporation"), the undersigned, duly elected Chief Executive Officer of the Corporation, does hereby appoint the individuals listed on Schedule I attached hereto to serve in the offices designated opposite their names (the "Subordinate Officers"). The Subordinate Officers shall serve in such capacity until the earlier of their death, resignation, removal or reappointment as provided in the Bylaws. Any and all actions previously taken by or at the direction of any such Subordinate Officer is hereby adopted, ratified, confirmed and approved in all respects. The Subordinate Officers are hereby authorized to do any and all other or further things, and to execute any and all other or further documents, all on behalf of the Corporation, as each in their individual discretion deem necessary and in the best interest of the Corporation and as is permissible pursuant to the policies of the Corporation.

Dated as of the 30 day of May, 2020.

Mark J. Tarr

Mark J. Tarr, Chief Executive Officer

SCHEDULE I

Name	Subordinate Officer Title
Frank Brown Jr.	Senior Vice President and President, Southwest Region
Troy Dedecker	Senior Vice President and President, Central Region
Jerry Gray	Senior Vice President and President, West Region
Brad Kennedy	Senior Vice President and President, South Central Region
Peter M. Mantegazza	Senior Vice President and President, Northeast Region
Ed M. Mowen	Senior Vice President and President, Mid-Atlantic Region
Linda Wilder	Senior Vice President and President, Southeast Region
Crissy Carlisle	Senior Vice President and Chief Investor Relations Officer
Julie Duck	Senior Vice President, Financial Operations
Anthony Hernandez	Senior Vice President and Chief Human Resources Officer
Justin Hunter	Senior Vice President, Public Policy, Legislation & Regulations
David Klementz	Senior Vice President and Chief Strategy & Development Officer
Dawn D. Rock	Senior Vice President and Chief Compliance Officer
Robert M. Wisner	Senior Vice President, Reimbursement
Russell Yeager	Senior Vice President and Chief Information Officer
Steven Adams	Regional Vice President, Business Development
Lori A. Bedard	Regional Vice President, Operations
Aaron Bickham	Regional Vice President, Controller
Troy R. Biggs	Regional Vice President, Controller
Jennifer Brewer	Regional Vice President, Operations
Morgan Clements	Regional Vice President, Human Resources
Kevin R. Conn	Regional Vice President, Operations
Juanelle Cooper	Regional Vice President, Business Development
Kristi Crossland	Regional Vice President, Human Resources
Pamela Drake	Regional Vice President, Business Development
Craig T. Funk	Regional Vice President, Operations
Brandon L. Hay	Regional Vice President, Human Resources
Kayla Henderson	Regional Vice President, Human Resources
Bill House III	Regional Vice President, Controller
Karalea Knox	Regional Vice President, Human Resources
Aimee McCloud	Regional Vice President, Business Development
Margot G. Munger	Regional Vice President, Business Development
Lori Nation	Regional Vice President, Human Resources
Robert J.Rosene	Regional Vice President, Human Resources
Abraham Sims	Regional Vice President, Operations
Andrea J. Smart	Regional Vice President, Controller
Kimberly A. Steward	Regional Vice President, Operations
Debra Taylor	Regional Vice President, Business Development
Sheila Terry	Regional Vice President, Controller
Patrick Tuer	Regional Vice President, Operations
Tamyra Wells	Regional Vice President, Business Development
Kimberly K. White	Regional Vice President, Controller
Robert Winters	Regional Vice President, Controller
Darrell F. Bilbrey	Vice President, Corporate Systems & Business Intelligence
Mary Leesa Booth	Vice President and Associate General Counsel
Thomas Boyle	Vice President and Chief Design & Construction Officer
Patricia Davis	Vice President and Deputy Chief Compliance Officer
Kelly H. Estes	Vice President and Associate General Counsel

Name	Subordinate Officer Title
Tracy G. Foy	Vice President, Clinical Systems
Alex Goldsmith	Vice President and Associate General Counsel
Mary Ellen Hatch	Vice President, Nursing Operations
Bill Heath	Vice President, Development
Michael E. Henderson	Vice President and Associate General Counsel
Amy Inter	Vice President, Talent Acquisition
Mike Kindle	Vice President, Technical Services
Debra Larson-Monear	Vice President, Patient Revenue Systems
Stephen D. Leasure	Vice President, Deputy General Counsel and Assistant Secretary
Lynne Lee	Vice President, Risk Management
Robert Leech	Vice President, Home Health & Hospice Compliance
Melanie Lewis	Vice President, Development
Christi D. Lunsford	Vice President and Associate General Counsel
Robert W. McCallum III	Vice President and Chief Tax Officer
Carey B. McRae	Vice President and Associate General Counsel
Murray Meadows	Vice President, Corporate Accounting
Marca S. Pearson	Vice President, Employee Benefits
William W. Poynter	Vice President, Aviation
Elaine M. Prince	Vice President, Operations Support
Alison S. Pritchett	Vice President, Accounting Systems & Controls
Will Schoel	Vice President, Organizational Development
Cheryl Miller Scott	Vice President, Therapy Operations
Johnny Smith Jr.	Vice President, Marketing Services
Lisa Smith	Vice President, Assurance
David W. Stephenson	Vice President and Associate General Counsel
Joseph Vincent Stillo	Vice President, Medical Services
Dean Taggart	Vice President and Inspector General
Eileen M. Thayer	Vice President, Clinical Transformation
Mitchell Thomas	Vice President and Chief Security Officer
John Wells	Vice President, Development
Tricia A. Wells	Vice President, HR Operations
Lawrence Whatley	Vice President, Design and Construction
Donn G. Willey	Vice President, Compensation
Arthur E. Wilson Jr.	Vice President and Chief Real Estate Officer
Ryan Wilson	Vice President, Managed Care
William Wittig,	Vice President, Planning and Development
Fred Wright	Vice President, Operations Controller
Sarah Wright	Vice President and Associate General Counsel
Kenneth T. Wyatt	Vice President and Associate General Counsel

Encompass Health

Edmund M. Fay
Senior Vice President & Treasurer
9001 Liberty Parkway
Birmingham, AL 35242

205.970.7875
encompasshealth.com

September 14, 2022

Mr. Jonathan Brown, Director
Housing and Economic Development
Palm Beach County
100 Australian Avenue, 5th Floor
West Palm Beach, FL 33406

Re: Further Demonstration of Reasonable Financial Assurances in Connection with Pending Application for Brownfield Area Designation for Encompass Health Rehabilitation Hospital of Lake Worth, LLC

Dear Mr. Brown:

This letter is being submitted in connection with the pending application for brownfield area designation for Encompass Health Rehabilitation Hospital of Lake Worth, LLC (the "Company") that is being filed with Palm Beach County (the "County") by The Goldstein Environmental Law Firm, P.A. The purpose of this letter is to provide reasonable assurance that the Company has sufficient financial resources to implement the rehabilitation and redevelopment plan for the parcels identified by County parcel control numbers 00-42-43-27-05-034-0431 and 00-42-43-27-05-034-0432 (the "Subject Property"). Accordingly, please note the following:

- The Company acquired the Subject Property on August 31, 2022, and owns it outright.
- The Company is adequately capitalized.
- The Company and Encompass Health Corporation (its "Manager"), have sufficient liquidity on hand to fund the expected $41.2 million budget for the Subject Property's rehabilitation and redevelopment.

In addition, in my capacity as Treasurer for the Company and its Manager, and based upon my personal knowledge, I certify that the Company has sufficient financial resources to implement and complete the rehabilitation agreement and redevelopment plan at the Subject Property as referenced above.

Thank you in advance for your continuing assistance with this matter and for the County's support of this important project.

Very truly yours,

Edmund M. Fay
Treasurer
Encompass Health Corporation

CFN 20220380441
OR BK 33837 PG 674
RECORDED 9/14/2022 10:33 AM
AMT: $4,000,000.00
DEED DOC $28,000.00
Palm Beach County, Florida
Joseph Abruzzo, Clerk
Pgs: 674 - 676; (3pgs)

NCS 1070822

THIS INSTRUMENT PREPARED BY:
Allen Falk PA
507 N. Dixie Hwy
Lake Worth, FL 33460
Tax ID No: 65-0974158
Our File: 2022-7453
PCN: 00-42-43-27-05-034-0431

[Space Above This Line For Recording Data]

Special Warranty Deed

State of Florida)
County of Palm Beach)
)

This Special Warranty Deed made this **31st day of August 2022** between **Stan L. Crooks and Evangeline C. Aguirre**, whose post office address is **9645 Lantana Road, Lake Worth, FL 33467 ("Grantor"), and Encompass Health Rehabilitation Hospital of Lake Worth, LLC, a Delaware Limited Liability Company, with an address of 9001 Liberty Parkway, Birmingham, AL 35242, ("Grantee").**

WITNESSETH:

Grantor, for and in consideration of the sum of TEN AND NO/100 DOLLARS ($10.00) and other good and valuable consideration, receipt whereof is hereby acknowledged, does hereby grant, bargain, sell, aliens, remises, releases, conveys and confirms unto Grantee, and its successors and assigns, the following described property, situate, lying and being in Palm Beach County, Florida (The **"Property"**), to wit:

THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO.3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

SUBJECT TO real estate taxes and assessments for the year 2022 and subsequent years, not yet due and payable, and those certain exceptions listed on Exhibit "A" attached hereto (the "Permitted Exceptions"), provided that this reference shall not serve to reimpose the same.

Together with all easements, tenements, hereditaments and appurtenances belonging or in anywise appertaining to the Property.

Together with all buildings and other improvements now and hereafter located on the Property.

To Have and to Hold, the same in fee simple forever.

Grantor covenants and warrants to and with Grantee, that it is lawfully seized of said Property in fee simple: that Grantor has good right and lawful authority to sell and convey the fee simple title; that Grantor hereby fully warrants the title to said Property unto Grantee and will defend the same against the lawful claims of all persons claiming by, through or under the Grantor.

In Witness Whereof, Grantor has signed and sealed these present the date set forth on August 31, 2022.

Signed, sealed and delivered in our presence:

Witness signature

Allen Falk ALLEN FALK
Print witness name BOTH SIGNATURES

Witness signature Both Signatures

Astrid Jean
Print witness name ASTRID JEAN

Stan L. Crooks

Evangeline C. Aguirre

State of Florida
County of Palm Beach

The foregoing instrument was acknowledged before me by means of [✓] physical presence or [ ] online notarization, this 31st day of August 2022 by Stan L. Crooks and Evangeline C. Aguirre who [ ] are personally known or [✓] have produced drivers' licenses as identification.

[Seal]

ASTRID JEAN
Notary Public - State of Florida
Commission # GG 950925
My Comm. Expires Feb 2, 2024
Bonded through National Notary Assn.

Notary Public
Print Name: Astrid Jean
My Commission Expires:

Exhibit A
Permitted Exceptions

1. Reservation of a right of way for small lateral ditches as contained in that certain Deed by and between Florida Sugar and Food Products Company and Carl W. Hawkins, recorded in Deed Book 290, Page 35.

2. Reservation for canal, road, dyke and ditch purposes as shown on the Plat of Palm Beach Farms Company, Plat No. 3, recorded in Plat Book 2, Page 45, and shown on that certain ALTA/NSPS survey prepared by Caulfield & Wheeler, Incorporated dated July 19, 2021, last revised 08/25/2022 under Job No. 9526 (the "Survey")

3. Non-Use Commitment No. 903, By South Florida Water Management District on Lands Deeded by Board of Commissioners of Everglades Drainage District, recorded in Official Records Book 7621, Page 634.

4. 10 foot electrical easement granted to Florida Power & Light Company by instrument recorded in Official Records Book 7639, Page 673 and shown on the Survey.

5. 10 foot electrical easement granted to Florida Power & Light Company by instrument recorded in Official Records Book 7648, Page 332 and shown on the Survey.

6. Foundation and Aerial Easements, granted from VPS Holdings, Inc. to Palm Beach County, a political subdivision of the State of Florida, recorded in Official Records Book 20746, Page 457 and shown on the Survey.

7. Taxes and assessments for the year 2022 and subsequent years, which are not yet due and payable.

CFN 20220380439
OR BK 33837 PG 667
RECORDED 9/14/2022 10:33 AM
AMT: $4,000,000.00
DEED DOC $28,000.00
Palm Beach County, Florida
Joseph Abruzzo, Clerk
Pgs: 667 - 670; (4pgs)

NCS 1068203

Prepared by and return to:
Paul K. Hines, Esq.
Gunster, Yoakley & Stewart, P.A.
777 South Flagler Road, Suite 500 East
West Palm Beach, FL 33401

PIN: 00-42-43-27-05-034-0432

SPECIAL WARRANTY DEED

THIS SPECIAL WARRANTY DEED, made and entered into as of this 31st day of August, 2022, by Eastwood Lantana, LLC a Delaware limited liability company, whose address is 726 Presidential Drive, Boynton Beach, Florida 33425 (hereinafter referred to as "**Grantor**"), to Encompass Health Rehabilitation Hospital of Lake Worth, LLC, a Delaware limited liability company, whose address is 9001 Liberty Parkway, Birmingham, Alabama 35242, Attention: Real Estate Department (hereinafter referred to as "**Grantee**").

WITNESSETH:

That the Grantor, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration, to it in hand paid, the receipt whereof is hereby acknowledged, by these presents does hereby grant, bargain, sell, alien, remise, release, convey and confirm unto the Grantee, its successors and assigns forever, all that certain parcel of land lying and being in the County of Palm Beach, State of Florida, as more particularly described in Exhibit "A" attached hereto (the "Property").

SUBJECT TO real estate taxes and assessments for the year 2022 and subsequent years, not yet due and payable, and those certain exceptions listed on Exhibit "B" attached hereto (the "Permitted Exceptions"), provided that this reference shall not serve to reimpose the same.

TO HAVE AND TO HOLD the Property together with all easements, tenements, hereditaments and appurtenances belonging to the Property, unto the said Grantee, its successors, and assigns, in fee simple forever.

And the said Grantor hereby covenants and warrants to and with Grantee that Grantor is lawfully seized of the Property in fee simple, and has good right, full power, and lawful authority to sell and convey the Property, and hereby warrants the title to said Property, subject to the Permitted Exceptions, and will defend the same against the lawful claims of all persons whomsoever, claiming by, through or under the Grantor, but against no others.

Signature page follows.

IN WITNESS WHEREOF, the Grantor has executed this deed on the day and year first set forth above. Signed on August 30, 2022, made effective as of August 31, 2022.

Signed, sealed, and delivered
in the presence of:

1st Witness
Print Name: Kelly N. Saunders

2nd Witness
Print Name: Paul K. Hines

Eastwood Lantana, LLC,
a Delaware limited liability company

By: _____
William D. Hodges, Manager

STATE OF FLORIDA)
) ss:
COUNTY OF PALM BEACH)

The foregoing instrument was acknowledged before me by means of [X] physical presence or [ ] online notarization, this 30th day of August, 2022, by William D. Hodges, as Manager of Eastwood Lantana, LLC, a Delaware limited liability company, on behalf of said company, who [ ] is personally known to me, or [X] has produced Florida Driver License as identification.

Notary Public – State of Florida
Printed Name: Kelly Saunders
My Commission Expires: 10.20.2025

(Notary Seal)

KELLY N. SAUNDERS
MY COMMISSION # HH 189269
EXPIRES: October 20, 2025
Bonded Thru Notary Public Underwriters

Signature page to Special Warranty Deed

Exhibit "A"

Legal Description

That part of the West Half of Tract 43, Block 34, lying North of the right-of-way for Lantana Road, The Palm Beach Farms Co., Plat No. 3, according to the plat thereof, as recorded in Plat Book 2, Page 45 of the Public Records of Palm Beach County, Florida, less additional right-of-way for Lantana Road conveyed to Palm Beach County in O.R. Book 11213, Page 937, Public Records of Palm Beach County, Florida.

Exhibit "B"

Permitted Exceptions

1. Taxes and assessments for the year 2022 and all subsequent years, which are not yet due and payable.

2. Reservation of a right of way for small lateral ditches as contained in that certain Deed by and between Florida Sugar and Food Products Company and Carl W. Hawkins, recorded in Deed Book 290, Page 35, of the Public Records of Palm Beach County, Florida.

3. Embankment Easement, granted from P. W. Odums., Jr. to Palm Beach County, a political subdivision of the State of Florida, recorded in Official Records Book 11213, Page 941, of the Public Records of Palm Beach County, Florida.

4. Terms and conditions of the Non-Use Commitment No. 1261 By South Florida Water Management District on Lands Deeds By Board of Commissioners of Everglades Drainage District, recorded in Official Records Book 12250, Page 634, of the Public Records of Palm Beach County, Florida.

November 7, 2022, at 5:30 p.m.

Community Meeting Agenda
Brownfield Area Designation for Encompass Health Rehabilitation Hospital of Lake Worth

Property Location: 9719 & 9645 Lantana Road, Palm Beach County, FL 33467
Parcel Control Nos.: 00-42-43-27-05-034-0431, 00-42-43-27-05-034-0432

Meeting Location: Cafeteria at Emerald Cove Middle School, located at 9950 Stribling Way, Wellington, FL 33414

I. **Introduction**

II. **Nature and Status of Environmental Concerns and Redevelopment**

III. **Discussion of Application for Designation**

IV. **Designation Process**

V. **Questions**

Attachment 3

RESOLUTION NUMBER R2022-_____

A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, MAKING CERTAIN FINDINGS AND DESIGNATING THE REAL PROPERTY LOCATED AT 9645 AND 9719 LANTANA ROAD, WITHIN UNINCORPORATED PALM BEACH COUNTY, FLORIDA 33467, FURTHER IDENTIFIED BY PROPERTY CONTROL NUMBERS 00-42-43-27-05-034-0431 AND 00-42-43-27-05-034-0432, AS A BROWNFIELD AREA PURSUANT TO SECTION 376.80(2)(c), FLORIDA STATUTES, TO BE KNOWN AS ENCOMPASS HEALTH GREEN REUSE AREA, FOR THE PURPOSE OF REHABILITATION, JOB CREATION AND PROMOTING ECONOMIC DEVELOPMENT; PROVIDING FOR AN EFFECTIVE DATE; AND, FOR OTHER PURPOSES.

WHEREAS, the State of Florida has provided in §97-277, Laws of Florida, codified as the Brownfields Redevelopment Act, §376-77 - §376.86, *Florida Statutes* (the "Act"), for designation of a "Brownfield Area" by resolution of the local governing body at the request of the person who owns or controls the real estate parcels, to provide for environmental remediation and redevelopment, and promote economic development and revitalization generally; and

WHEREAS, Encompass Health Rehabilitation Hospital of Lake Worth, LLC (Encompass Health Hospital), controls the parcels of real property located at 9645 and 9719 Lantana Road, Palm Beach County, Florida, as depicted and more particularly described in Exhibit A, and intends to develop the subject property as an institutional development with a hospital use; and

WHEREAS, Encompass Health Hospital has requested the Board of County Commissioners of Palm Beach County, Florida designate the site as a "Brownfield Area" pursuant to §376.80(2)(c), *Florida Statutes*; and

WHEREAS, Encompass Health Hospital has provided information, and made sufficient representations and demonstrations to allow the Board of County Commissioners to make the findings required pursuant to §376.80(2)(c), *Florida Statutes*; and

WHEREAS, proper notice has been provided in accordance with §376.80(2)(c)(4) and §376.80(1)(c)(4)(b), *Florida Statutes;* and

WHEREAS, such designation shall not render the County liable for costs or site remediation, rehabilitation or source removal, which terms are defined in §376.79 (19) and (20), *Florida Statutes,* or for any other costs related to the redevelopment of the site.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, THAT;

1. The Board of County Commissioners finds that Encompass Health Hospital has presented sufficient information and testimony to satisfy the criteria set forth in §376.80(2)(c), *Florida Statutes,* and the Board of County Commissioners hereby makes all of the following findings:

a. Encompass Health Hospital controls the site and has agreed to rehabilitate and redevelop the site.

b. The rehabilitation and redevelopment of the site will result in economic productivity of the area, along with the creation of at least five new permanent full-time jobs.

c. The redevelopment of the site is consistent with the County's Comprehensive Plan, and is permissible under Palm Beach County's Unified Land Development Zoning Code.

d. Encompass Health Hospital has provided notice of the proposed rehabilitation of the site to neighbors and nearby residents, and has provided those receiving notice, the opportunity to provide comments and suggestions regarding the rehabilitation.

e. Encompass Health Hospital has provided reasonable assurance that they have sufficient financial resources to complete the rehabilitation and redevelopment of the site.

2. The Board of County Commissioners hereby designates 9645 and 9719 Lantana Road, Palm Beach County, Florida 33467, as depicted and more particularly described in Exhibit A attached hereto, as a "Brownfield Area" for purposes of the Brownfields Redevelopment Act, §376.77 – 376.86, *Florida Statutes.*

3. The Department of Housing and Economic Development shall, within thirty (30) days of adoption of this Resolution, cause a notice of this designation, along with a copy of this Resolution, to be provided to the Florida Department of Environmental Protection and any local pollution control program under s. 403.182

4. That this Resolution shall take effect upon adoption.

The foregoing Resolution was offered by Commissioner _____, who moved its adoption. The motion was seconded by Commissioner _____, and being put to a vote, the vote was as follows:

Commissioner Gregg K. Weiss, Mayor	_____
Commissioner Maria Sachs, Vice Mayor	_____
Commissioner Maria Marino	_____
Commissioner Dave Kerner	_____
Commissioner Marci Woodward	_____
Commissioner Sara Baxter	_____
Commissioner Mack Bernard	_____

The Mayor thereupon declared that the Resolution was duly passed and adopted on_____ 2022.

PALM BEACH COUNTY, FLORIDA, BY ITS BOARD OF COUNTY COMMISSIONERS

APPROVED AS LEGAL SUFFICIENCY

By: _____
Assistant County Attorney

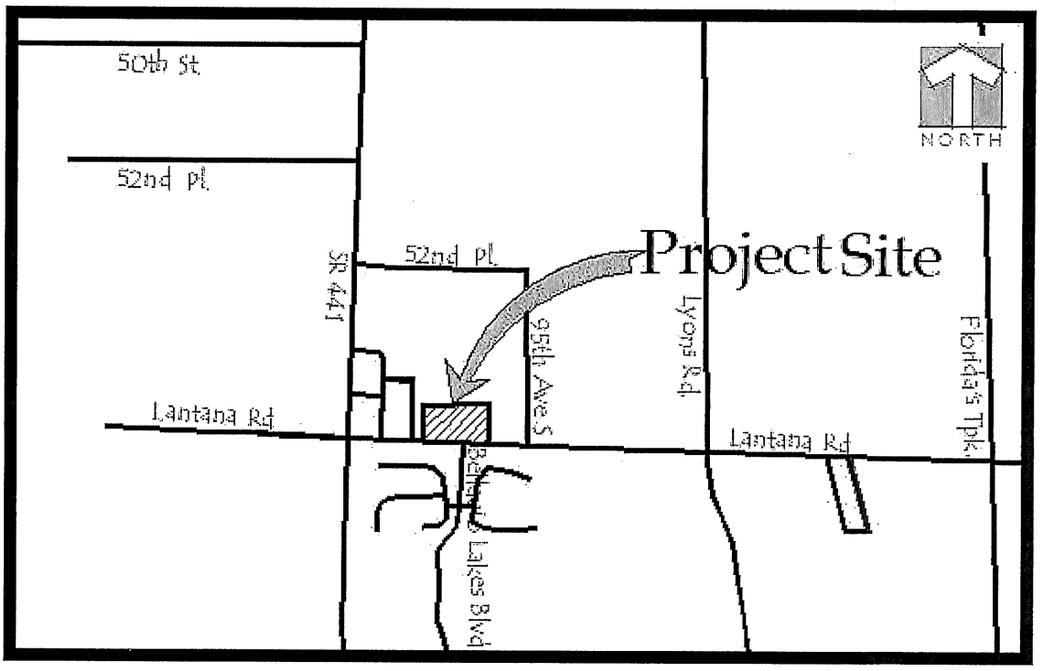
JOSEPH ABRUZZO CLERK & COMPTROLLER

By: _____
Deputy Clerk

Exhibit A

Location Map and Legal Description

Location Map



PARCEL 1
THE EAST ONE-HALF (1/2) OF TRACT FORTY-THREE (43), LESS THE SOUTH 40 FEET ROAD RIGHT-OF-WAY, BLOCK THIRTY-FOUR (34), PALM BEACH FARMS COMPANY, PLAT NO. 3; AS RECORDED IN PLAT BOOK 2, PAGE 45, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

LESS AND EXCEPT THAT PORTION DESCRIBED IN THAT ORDER OF TAKING RECORDED IN OFFICIAL RECORD BOOK 11368, PAGE 474, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

TOGETHER WITH

PARCEL 2
THAT PART OF THE WEST HALF OF TRACT 43, BLOCK 34, LYING NORTH OF THE RIGHT-OF-WAY FOR LANTANA ROAD, THE PALM BEACH FARMS CO., PLAT NO. 3, ACCORDING TO THE PLAT THEREOF, AS RECORDED IN PLAT BOOK 2, PAGE 45 OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA, LESS ADDITIONAL RIGHT-OFWAY FOR LANTANA ROAD CONVEYED TO PALM BEACH COUNTY IN OFFICIAL RECORDS BOOK 11213, PAGE 937, OF THE PUBLIC RECORDS OF PALM BEACH COUNTY, FLORIDA.

SAID LANDS SITUATE IN PALM BEACH COUNTY, FLORIDA AND CONTAINING 357,759 SQUARE FEET OR 8.213 ACRES, MORE OR LESS.

SUBJECT TO EASEMENTS, RESTRICTIONS, RESERVATIONS, COVENANTS, AND RIGHTS-OF-WAY OF RECORD.