Encompass Health Corp
Form 10-Q
October 31, 2018
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

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FORM 10-Q

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

For the quarterly period ended September 30, 2018
OR

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

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Encompass Health Corporation
(Exact name of Registrant as specified in its Charter)

Delaware	63-0860407
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
9001 Liberty Parkway Birmingham, Alabama	35242
(Address of Principal Executive Offices)	(Zip Code)

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 ý No o

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

Large accelerated filer ý Accelerated filer o Non-Accelerated filer o
Smaller reporting company o Emerging growth company o
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. o

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

The registrant had 98,928,266 shares of common stock outstanding, net of treasury shares, as of October 25, 2018.

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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.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This quarterly report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to, among other things, future events, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy, our dividend and stock repurchase strategies, our financial plans, our growth plans, our future financial performance, our projected business results, or our projected capital expenditures. In some cases, the reader can identify forward-looking statements by terminology such as “may,” “will,” “should,” “could,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “predicts,” “targets,” “potential,” or “conti negative of these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties, many of which are beyond our control. Any forward-looking statement is based on information current as of the date of this report and speaks only as of the date on which such statement is made. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ, such as decreases in revenues or increases in costs or charges, materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, Risk Factors, of our Annual Report on Form 10-K for the year ended December 31, 2017, as well as uncertainties and factors, if any, discussed elsewhere in this Form 10-Q, including in the “Executive Overview—Key Challenges” section of Part I, Item 2, Management’s Discussion and Analysis of Financial Condition and Results of Operations, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;
- changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction (such as the re-basing of payment systems, the introduction of site neutral payments or case-mix weightings across post-acute settings, or other payment system reforms), which may decrease revenues and increase the costs of complying with such changes;
- reductions or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors;
- restrictive interpretations of the regulations governing the claims that are reimbursable by Medicare;
- our ability to comply with extensive and changing healthcare regulations as well as the increased costs of regulatory compliance and compliance monitoring in the healthcare industry, including the costs of investigating and defending asserted claims, whether meritorious or not;
- the use by governmental agencies and contractors of statistical sampling and extrapolation to expand claims of overpayment or noncompliance;
- delays in the administrative appeals process associated with denied Medicare reimbursement claims, including from various Medicare audit programs, and our exposure to the related delay or reduction in the receipt of the reimbursement amounts for services previously provided;
- the ongoing evolution of the healthcare delivery system, including alternative payment models and value-based purchasing initiatives, which may decrease our reimbursement rate or increase costs associated with our operations;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on our labor expenses from potential union activity and staffing recruitment and retention;
- competitive pressures in the healthcare industry, including from other providers that may be participating in integrated delivery payment arrangements in which we do not participate, and our response to those pressures;
- changes in our payor mix or the acuity of our patients affecting reimbursement rates;
- our ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with our growth strategy, including realization of anticipated revenues, cost savings, productivity improvements arising from the related operations and avoidance of unanticipated difficulties, costs or liabilities that could arise from acquisitions or integrations;

- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including the ongoing investigations initiated by the U.S. Departments of Justice and of Health and Human Services, Office of the Inspector General;
- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to claims;
- potential incidents affecting the proper operation, availability, or security of our information systems, including the patient information stored there;
- our ongoing rebranding and name change initiative and the impact on our existing operations, including our ability to attract patient referrals to our hospitals as well as the associated costs of rebranding;
- new or changing quality reporting requirements impacting operational costs or our Medicare reimbursement;
- the price of our common stock as it affects our willingness and ability to repurchase shares and the financial and accounting effects of any repurchases;
- our ability and willingness to continue to declare and pay dividends on our common stock;
- our ability to maintain proper local, state and federal licensing, including compliance with the Medicare conditions of participation, which is required to participate in the Medicare program;
- our ability to attract and retain key management personnel; and
- general conditions in the economy and capital markets, including any instability or uncertainty related to armed conflict or an act of terrorism, governmental impasse over approval of the United States federal budget, an increase to the debt ceiling, or an international sovereign debt crisis.

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

PART I. FINANCIAL INFORMATION

Item 1. Financial Statements (Unaudited)

Encompass Health Corporation and Subsidiaries

Condensed Consolidated Statements of Operations

(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In Millions, Except Per Share Data)			
Net operating revenues	$1,067.6	$981.6	$3,181.3	$2,905.1
Operating expenses:				
Salaries and benefits	592.3	542.1	1,740.7	1,600.0
Other operating expenses	142.9	136.2	433.5	393.3
Occupancy costs	19.6	18.6	57.7	54.8
Supplies	38.6	36.5	117.8	110.6
General and administrative expenses	49.9	39.7	165.9	128.6
Depreciation and amortization	51.2	46.2	146.8	137.2
Total operating expenses	894.5	819.3	2,662.4	2,424.5
Loss on early extinguishment of debt	—	0.3	—	10.7
Interest expense and amortization of debt discounts and fees	37.3	36.8	110.6	118.5
Other income	(1.7)	(1.0)	(2.9)	(2.9)
Equity in net income of nonconsolidated affiliates	(2.1)	(2.1)	(6.4)	(6.2)
Income from continuing operations before income tax expense	139.6	128.3	417.6	360.5
Provision for income tax expense	30.2	43.1	89.5	111.4
Income from continuing operations	109.4	85.2	328.1	249.1
Loss from discontinued operations, net of tax	(0.1)	(0.1)	(0.4)	(0.2)
Net income	109.3	85.1	327.7	248.9
Less: Net income attributable to noncontrolling interests	(20.7)	(19.2)	(63.5)	(53.2)
Net income attributable to Encompass Health	$88.6	$65.9	$264.2	$195.7
Weighted average common shares outstanding:				
Basic	98.0	97.8	97.9	92.3
Diluted	100.0	99.0	99.7	99.1
Earnings per common share:				
Basic earnings per share attributable to Encompass Health common shareholders:				
Continuing operations	$0.90	$0.67	$2.69	$2.11
Discontinued operations	—	—	—	—
Net income	$0.90	$0.67	$2.69	$2.11
Diluted earnings per share attributable to Encompass Health common shareholders:				
Continuing operations	$0.89	$0.67	$2.65	$2.08
Discontinued operations	—	—	—	—
Net income	$0.89	$0.67	$2.65	$2.08
Cash dividends per common share	$0.27	$0.25	$0.77	$0.73

Amounts attributable to Encompass Health common shareholders:				
Income from continuing operations	$88.7	$66.0	$264.6	$195.9
Loss from discontinued operations, net of tax	(0.1)	(0.1)	(0.4)	(0.2)
Net income attributable to Encompass Health	$88.6	$65.9	$264.2	$195.7

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

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In Millions)			
COMPREHENSIVE INCOME				
Net income	$109.3	$85.1	$327.7	$248.9
Other comprehensive income, net of tax:				
Net change in unrealized gain on available-for-sale securities:				
Unrealized net holding gain arising during the period	—	0.1	—	0.5
Other comprehensive income before income taxes	—	0.1	—	0.5
Provision for income tax expense related to other comprehensive income items	—	(0.1)	—	(0.2)
Other comprehensive income, net of tax	—	—	—	0.3
Comprehensive income	109.3	85.1	327.7	249.2
Comprehensive income attributable to noncontrolling interests	(20.7)	(19.2)	(63.5)	(53.2)
Comprehensive income attributable to Encompass Health	$88.6	$65.9	$264.2	$196.0

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

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

	September 30, 2018	December 31, 2017
	(In Millions)	
Assets		
Current assets:		
Cash and cash equivalents	$56.9	$ 54.4
Restricted cash	62.1	62.4
Accounts receivable	458.0	472.1
Other current assets	61.0	113.3
Total current assets	638.0	702.2
Property and equipment, net	1,591.0	1,517.1
Goodwill	2,081.1	1,972.6
Intangible assets, net	443.2	403.1
Deferred income tax assets	82.6	63.6
Other long-term assets	296.0	235.1
Total assets[1]	$5,131.9	$ 4,893.7
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	$37.1	$ 32.3
Accounts payable	86.0	78.4
Accrued expenses and other current liabilities	486.5	406.8
Total current liabilities	609.6	517.5
Long-term debt, net of current portion	2,503.9	2,545.4
Other long-term liabilities	198.2	185.3
	3,311.7	3,248.2
Commitments and contingencies		
Redeemable noncontrolling interests	236.5	220.9
Shareholders' equity:		
Encompass Health shareholders' equity	1,318.5	1,181.7
Noncontrolling interests	265.2	242.9
Total shareholders' equity	1,583.7	1,424.6
Total liabilities[1] and shareholders' equity	$5,131.9	$ 4,893.7

(1) Our consolidated assets as of September 30, 2018 and December 31, 2017 include total assets of variable interest entities of $288.6 million and $264.1 million, respectively, which cannot be used by us to settle the obligations of other entities. Our consolidated liabilities as of September 30, 2018 and December 31, 2017 include total liabilities of the variable interest entities of $81.5 million and $52.5 million, respectively. See Note 3, Variable Interest Entities.

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

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

	Nine Months Ended September 30, 2018 (In Millions)							
	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Loss	Treasury Stock	Noncontrolling Interests	Total
Balance at beginning of period	98.3	$ 1.1	$2,791.4	$(1,191.0)	$ (1.3)	$(418.5)	$ 242.9	$1,424.6
Net income	—	—	—	264.2	—	—	53.2	317.4
Receipt of treasury stock	(0.2)	—	—	—	—	(8.3)	—	(8.3)
Dividends declared on common stock	—	—	(76.7)	—	—	—	—	(76.7)
Stock-based compensation	—	—	20.6	—	—	—	—	20.6
Stock options exercised	0.1	—	3.2	—	—	—	—	3.2
Distributions declared	—	—	—	—	—	—	(53.7)	(53.7)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	22.8	22.8
Fair value adjustments to redeemable noncontrolling interests, net of tax	—	—	(66.1)	—	—	—	—	(66.1)
Other	0.7	—	0.8	(1.3)	1.3	(0.9)	—	(0.1)
Balance at end of period	98.9	$ 1.1	$2,673.2	$(928.1)	$ —	$(427.7)	$ 265.2	$1,583.7

	Nine Months Ended September 30, 2017 (In Millions)							
	Encompass Health Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Loss	Treasury Stock	Noncontrolling Interests	Total
Balance at beginning of period	88.9	$ 1.1	$2,799.1	$(1,448.4)	$ (1.2)	$(614.7)	$ 192.8	$928.7
Net income	—	—	—	195.7	—	—	43.3	239.0
Receipt of treasury stock	(0.9)	—	—	—	—	(19.8)	—	(19.8)
Dividends declared on common stock	—	—	(70.3)	—	—	—	—	(70.3)
Stock-based compensation	—	—	15.2	—	—	—	—	15.2
Stock options exercised	1.1	—	20.4	—	—	(19.3)	—	1.1
Stock warrants exercised	0.7	—	26.6	—	—	—	—	26.6
Distributions declared	—	—	—	—	—	—	(37.1)	(37.1)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	37.8	37.8
Fair value adjustments to redeemable noncontrolling	—	—	(44.4)	—	—	—	—	(44.4)

interests, net of tax								
Repurchases of common stock in open market	(0.9)	—	—	—	—	(38.1)	—	(38.1)
Conversion of convertible debt, net of tax	8.9	—	53.7	—	—	274.5	—	328.2
Other	0.5	—	5.7	1.1	0.3	(0.8)	—	6.3
Balance at end of period	98.3	$ 1.1	$2,806.0	$(1,251.6)	$ (0.9)	$(418.2)	$ 236.8	$1,373.2

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

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

	Nine Months Ended September 30,	
	2018	2017
	(In Millions)	
Cash flows from operating activities:		
Net income	$327.7	$248.9
Loss from discontinued operations, net of tax	0.4	0.2
Adjustments to reconcile net income to net cash provided by operating activities—		
Depreciation and amortization	146.8	137.2
Loss on early extinguishment of debt	—	10.7
Equity in net income of nonconsolidated affiliates	(6.4)	(6.2)
Stock-based compensation	65.6	37.9
Deferred tax (benefit) expense	(8.0)	51.3
Other, net	11.5	16.4
Change in assets and liabilities, net of acquisitions—		
Accounts receivable	12.3	(11.5)
Other assets	15.3	(7.4)
Accounts payable	—	6.1
Accrued payroll	(6.7)	3.1
Accrued interest payable	8.2	7.3
Other liabilities	18.0	13.6
Net cash used in operating activities of discontinued operations	(0.7)	(0.7)
Total adjustments	255.9	257.8
Net cash provided by operating activities	584.0	506.9
Cash flows from investing activities:		
Purchases of property and equipment	(171.5)	(155.7)
Additions to capitalized software costs	(13.2)	(14.6)
Acquisitions of businesses, net of cash acquired	(135.8)	(36.6)
Other, net	(5.8)	7.6
Net cash used in investing activities	(326.3)	(199.3)

(Continued)

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

	Nine Months Ended September 30,	
	2018	2017
	(In Millions)	
Cash flows from financing activities:		
Principal payments on debt, including pre-payments	(16.1)	(125.4)
Borrowings on revolving credit facility	285.0	241.3
Payments on revolving credit facility	(315.0)	(255.3)
Repurchases of common stock, including fees and expenses	—	(38.1)
Dividends paid on common stock	(74.4)	(67.0)
Purchase of equity interests in consolidated affiliates	(65.1)	—
Proceeds from exercising stock warrants	—	26.6
Distributions paid to noncontrolling interests of consolidated affiliates	(56.5)	(38.3)
Taxes paid on behalf of employees for shares withheld	(8.3)	(19.8)
Other, net	(3.1)	5.4
Net cash used in financing activities	(253.5)	(270.6)
Increase in cash, cash equivalents, and restricted cash	4.2	37.0
Cash, cash equivalents, and restricted cash at beginning of period	116.8	101.4
Cash, cash equivalents, and restricted cash at end of period	$121.0	$138.4
Reconciliation of Cash, Cash Equivalents, and Restricted Cash		
Cash and cash equivalents at beginning of period	$54.4	$40.5
Restricted cash at beginning of period	62.4	60.9
Cash, cash equivalents, and restricted cash at beginning of period	$116.8	$101.4
Cash and cash equivalents at end of period	$56.9	$67.6
Restricted cash at end of period	62.1	70.8
Restricted cash included in other long-term assets at end of period	2.0	—
Cash, cash equivalents, and restricted cash at end of period	$121.0	$138.4
Supplemental schedule of noncash financing activity:		
Conversion of convertible debt	$—	$319.4

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

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

1. Basis of Presentation

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

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

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

See also Note 11, Segment Reporting.

Net Operating Revenues—

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

	Inpatient Rehabilitation		Home Health and Hospice		Consolidated	
	Three Months Ended September 30,		Three Months Ended September 30,		Three Months Ended September 30,	
	2018	2017	2018	2017	2018	2017
Medicare	$600.5	$576.3	$205.7	$169.9	$806.2	$746.2
Medicare Advantage	75.0	63.5	22.7	19.1	97.7	82.6
Managed care	85.1	82.8	8.6	7.8	93.7	90.6
Medicaid	25.7	25.5	4.1	0.9	29.8	26.4
Other third-party payors	11.8	12.5	—	—	11.8	12.5
Workers' compensation	6.9	7.2	0.5	—	7.4	7.2
Patients	5.3	4.6	0.1	0.2	5.4	4.8
Other income	15.3	11.1	0.3	0.2	15.6	11.3
Total	$825.6	$783.5	$242.0	$198.1	$1,067.6	$981.6

Encompass Health Corporation and Subsidiaries
Notes to Condensed Consolidated Financial Statements

	Inpatient Rehabilitation		Home Health and Hospice		Consolidated	
	Nine Months Ended September 30,		Nine Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017	2018	2017
Medicare	$1,832.1	$1,719.2	$581.8	$483.7	$2,413.9	$2,202.9
Medicare Advantage	226.2	195.4	64.5	56.4	290.7	251.8
Managed care	256.7	253.0	24.9	21.5	281.6	274.5
Medicaid	77.2	70.2	7.3	3.3	84.5	73.5
Other third-party payors	36.5	36.4	—	—	36.5	36.4
Workers' compensation	21.1	21.1	0.8	0.1	21.9	21.2
Patients	14.1	13.0	0.8	0.6	14.9	13.6
Other income	36.6	30.6	0.7	0.6	37.3	31.2
Total	$2,500.5	$2,338.9	$680.8	$566.2	$3,181.3	$2,905.1

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

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

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

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. As a matter of course, we undertake significant efforts through training and education to ensure compliance with Medicare requirements. However, audits may lead to assertions we have been underpaid or overpaid by Medicare or submitted improper

claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. In some circumstances auditors assert the authority to extrapolate denial rationales to large pools of claims not actually audited, which could increase the impact of the audit. We cannot predict when or how these audit programs will affect us.

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

In August 2017, CMS announced the Targeted Probe and Educate ("TPE") initiative. Under the TPE initiative, MACs use data analysis to identify healthcare providers with high claim error rates and items and services that have high national error rates. Once a MAC selects a provider for claims review, the initial volume of claims review is limited to 20 to 40 claims. The TPE initiative includes up to three rounds of claims review 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 ZPIC or RAC (defined below). We cannot predict the impact of the TPE initiative on our ability to collect claims on a timely basis.

In connection with CMS approved and announced Recovery Audit Contractors ("RACs") audits related to inpatient rehabilitation facilities ("IRFs"), we received requests from 2013 to 2017 to review certain patient files for discharges occurring from 2010 to 2017. These RAC audits are focused on identifying Medicare claims that may contain improper payments. RAC contractors must have CMS approval before conducting these focused reviews which cover issues ranging from billing documentation to medical necessity. Medical necessity is an assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error as a result of ZPIC audits. We have, from time to time, received ZPIC record requests which have resulted in claim denials on paid claims. We have appealed substantially all ZPIC denials arising from these audits using the same process we follow for appealing other denials by contractors.

To date, the Medicare claims that are subject to these post-payment audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2017, and not all of these patient file requests have resulted in payment denial determinations by the audit contractor. Because we have confidence in the medical judgment of both the referring and admitting physicians who assess the treatment needs of their patients, we have appealed substantially all claim denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by MACs. Due to the delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these claim audits could take in excess of three years. In addition, because we have limited experience with ZPICs and RACs in the context of claims reviews of this nature, we cannot provide assurance as to the timing or outcomes of these disputes. As such, we make estimates for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs. The impact on our estimates of amounts determined to be due to Encompass Health as a result of these audits during the three and nine months ended September 30, 2018 and 2017 was not material.

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

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

Inpatient Rehabilitation Revenues

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

Home Health and Hospice Revenues

Home Health

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

We bill a portion of reimbursement from each Medicare episode near the start of each episode, and the resulting cash payment is typically received before all services are rendered. As we provide home health services to our patients on a scheduled basis over the episode of care in a manner that approximates a pro rata pattern, revenue for the episode of care is recorded over an average length of treatment period using a calendar day prorating method. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the pro rata number of days in the episode which have been completed as of the period end date. As of September 30, 2018 and December 31, 2017, the difference between the cash received from Medicare for a request for anticipated payment on episodes in progress and the associated estimated revenue was not material and was recorded in Other current liabilities in our condensed consolidated balance sheets.

We are subject to certain Medicare regulations affecting outlier revenue if our patient's care was unusually costly. Regulations require a cap on all outlier revenue at 10% of total Medicare revenue received by each provider during a cost reporting year. Management has reviewed the potential cap. Adjustments to the transaction price for the outlier cap were not material as of September 30, 2018 and December 31, 2017.

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

Hospice

Medicare revenues for hospice are recognized and recorded on an accrual basis using the input method based on the number of days a patient has been on service at amounts equal to an estimated daily or hourly payment rate. The performance obligation is the rendering of services to the patient during each day that they are on hospice care. The payment rate is dependent on whether a patient is receiving routine home care, general inpatient care, continuous home care or respite care.

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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 September 30, 2018 and December 31, 2017.

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

Marketable Securities—

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

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

Accounts Receivable—

We report accounts receivable from services rendered at their estimated transaction price which takes into account price concessions from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable 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:

	September 30, 2018		December 31, 2017	
Medicare	74.5	%	75.1	%
Managed care and other discount plans, including Medicare Advantage	17.8	%	17.4	%
Medicaid	2.8	%	2.4	%
Other third-party payors	2.8	%	2.9	%
Workers' compensation	1.2	%	1.3	%
Patients	0.9	%	0.9	%
Total	100.0	%	100.0	%

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

Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and

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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.

Recently Adopted Accounting Pronouncements—

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

	For the Three Months Ended September 30, 2017			For the Nine Months Ended September 30, 2017		
	As Previously Reported	Adjustment for ASC 606	Restated	As Previously Reported	Adjustment for ASC 606	Restated
Net operating revenues	$995.6	$ (14.0)	$ 981.6	$2,951.7	$ (46.6)	$2,905.1
Provision for doubtful accounts	$12.6	$ (12.6)	$ —	$42.7	$ (42.7)	$—
Other operating expenses	$137.6	$ (1.4)				