HEALTHSOUTH CORP
Form 10-K
February 20, 2014

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, 2013
Commission File Number 001-10315

HealthSouth Corporation (Exact Name of Registrant as Specified in its Charter)	
Delaware (State or Other Jurisdiction of Incorporation or Organization)	63-0860407 (I.R.S. Employer Identification No.)
3660 Grandview Parkway, Suite 200 Birmingham, Alabama (Address of Principal Executive Offices)	35243 (Zip Code)
(205) 967-7116 (Registrant's telephone number)	

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

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

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

Indicate by check mark if the registrant is a well-known seasoned issuer as defined in Rule 405 of the Securities Act.

Yes x No o
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 o No x
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 x No o
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting

company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer x Accelerated filer o Non-Accelerated filer o Smaller reporting company o

Indicate by check mark whether the registrant is a shell company (as defined in Exchange Act Rule 12b-2).

Yes o No x

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 $2.5 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 88,000,335 shares of common stock of the registrant outstanding, net of treasury shares, as of February 13, 2014.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2014 annual meeting of stockholders is incorporated by reference in Part III to the extent described therein.

Table of Contents

TABLE OF CONTENTS

NOTE TO READERS

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

Table of Contents

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to, among other things, future events, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy, our dividend and stock repurchase strategies, our financial plans, our growth plans, our future financial performance, our projected business results, or our projected capital expenditures. In some cases, you can identify forward-looking statements by terminology such as “may,” “will,” “should,” “expects,” “plans,” “anticipates,” “believes,” “estimates,” “predicts,” “targets,” “potential,” or “continue” or the nega 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 materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, Risk Factors; as well as uncertainties and factors discussed elsewhere in this Form 10-K, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;
- changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction such as the reinstatement of the “75% Rule” or the introduction of site neutral payments with skilled nursing facilities for certain conditions, and related increases in the costs of complying with such changes;
- reductions or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors;
- increased costs of regulatory compliance and compliance monitoring in the healthcare industry, including the costs of investigating and defending asserted claims, whether meritorious or not;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on our labor expenses from potential union activity and staffing recruitment and retention;
- competitive pressures in the healthcare industry and our response to those pressures;
- our ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with our growth strategy, including realization of anticipated revenues, cost savings, and productivity improvements arising from the related operations;
- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including the ongoing investigations initiated by the U.S. Department of Health and Human Services, Office of the Inspector General;
- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to such claims;
- potential incidents affecting the proper operation, availability, or security of our information systems;
- the price of our common or preferred 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 attract and retain key management personnel; and
- general conditions in the economy and capital markets, including any instability or uncertainty related to governmental impasse over approval of the United States federal budget or an increase to the debt ceiling.

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.

Table of Contents

PART I

Item 1. Business

Overview of the Company

General

HealthSouth is the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. While our national network of inpatient hospitals stretches across 28 states and Puerto Rico, our inpatient hospitals are concentrated in the eastern half of the United States and Texas. The table below provides detail on our hospitals and selected operating data. Additional detail can be found in the table in Item 2, Properties, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Results of Operations."

	For the Year Ended December 31,		
	2013	2012	2011
	(Actual Amounts)		
Consolidated data:			
Number of inpatient rehabilitation hospitals [1]	103	100	99
Number of outpatient rehabilitation satellite clinics	20	24	26
Number of hospital-based home health agencies	25	25	25
Number of inpatient rehabilitation units managed by us through management contracts	3	3	3
Discharges	129,988	123,854	118,354
Outpatient visits	806,631	880,182	943,439
Number of licensed beds [2]	6,825	6,656	6,461
	(In Millions)		
Net operating revenues:			
Net patient revenue - inpatient	$2,130.8	$2,012.6	$1,866.4
Net patient revenue - outpatient and other	142.4	149.3	160.5
Net operating revenues	$2,273.2	$2,161.9	$2,026.9

(1) Including 2, 2, and 3 hospitals as of December 31, 2013, 2012, and 2011, respectively, that operate as joint ventures which we account for using the equity method of accounting.

(2) Excluding 151, 151, and 234 licensed beds as of December 31, 2013, 2012, and 2011, respectively, of hospitals that operate as joint ventures which we account for using the equity method of accounting.

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across a wide array of diagnoses and deliver comprehensive, high-quality, cost-effective patient care services. Substantially all (93%) of the patients we serve are admitted from acute care hospitals following physician referrals for specific acute inpatient rehabilitative care. The majority of those patients have experienced significant physical and cognitive disabilities or injuries due to medical conditions, such as strokes, hip fractures, and a variety of debilitating neurological conditions, that are generally nondiscretionary in nature and require rehabilitative healthcare services in an inpatient setting. Our teams of highly skilled nurses and physical, occupational, and speech therapists utilize proven technology and clinical protocols with the objective of returning patients to home and work. Patient care is provided by nursing and therapy staff as directed by physician orders while case managers monitor each patient's progress and provide documentation and oversight of patient status, achievement of goals, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leads to a higher level of care and superior outcomes.

HealthSouth Corporation was organized as a Delaware corporation in February 1984. Our principal executive offices are located at 3660 Grandview Parkway, Birmingham, Alabama 35243, and the telephone number of our principal executive offices is (205) 967-7116.

Table of Contents

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

Competitive Strengths

As the nation's largest owner and operator of inpatient rehabilitation hospitals and with our business focused primarily on those services, we believe we differentiate ourselves from our competitors based on our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of rehabilitative technology. Our strengths can also be described in the following ways:

- People. We believe our 23,600 employees, in particular our highly skilled clinical staff, share a steadfast commitment to providing outstanding rehabilitative care to our patients. We also undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality rehabilitative care in the most cost-effective manner.
- Quality. Our hospitals provide a broad base of clinical experience from which we have developed best practices and protocols. We believe these clinical best practices and protocols help ensure the delivery of consistently high-quality rehabilitative healthcare services across all of our hospitals. We have developed a program called "TeamWorks," which is a series of operations-focused initiatives using identified best practices to reduce inefficiencies and improve performance across a wide spectrum of operational areas. We believe these initiatives have enhanced, and will continue to enhance, patient-employee interactions and coordination of care and communication among the patient, the patient's family, the hospital's treatment team, and payors, which, in turn, improves outcomes and patient satisfaction.

  Additionally, our hospitals participate in The Joint Commission's Disease-Specific Care Certification Program. Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based, clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care. Currently, 96 of our hospitals hold one or more disease-specific certifications. We also account for approximately 80% of all Joint Commission disease-specific certifications in stroke nationwide.
- Efficiency and Cost Effectiveness. Our size helps us provide inpatient rehabilitative healthcare services on a cost-effective basis. Specifically, because of our large number of inpatient hospitals, we can utilize proven staffing models and take advantage of certain supply chain efficiencies. In addition, our proprietary management reporting system aggregates data from each of our key business systems into a comprehensive reporting package used by the management teams in our hospitals as well as executive management. This system allows users to analyze data and trends and create custom reports on a timely basis.

- Strong Cash Flow Generation and Balance Sheet. We have a proven track record, even in the challenging regulatory and economic environment of the last several years, of generating strong cash flows from operations that have allowed us to successfully reduce our financial leverage, implement our growth strategy, and make significant shareholder value-enhancing distributions. As of December 31, 2013, we have a flexible balance sheet with relatively low financial leverage, no significant debt maturities prior to 2018, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide excellent support for our business strategy.

- Technology. As a market leader in inpatient rehabilitation, we have devoted substantial effort and expertise to leveraging technology to improve patient care and operating efficiencies. Specific rehabilitative technology, such as our internally-developed therapeutic device called the "AutoAmbulator," utilized in our facilities allows us to effectively treat patients with a wide variety of significant physical disabilities or injuries. Our commitment to technology also includes information technology, such as our rehabilitation-specific electronic clinical information system ("CIS") and our internally-developed management reporting system described above. To date, we have installed

the CIS in 36 hospitals with another 20 installations scheduled for 2014. We expect to complete installation in our existing hospitals by the end of 2017. We believe the CIS will improve patient care and safety and enhance operational efficiency. Given the increased emphasis on coordination across the patient care spectrum, we also believe the CIS sets the stage for connectivity with referral sources and health information exchanges. Ultimately, we believe the CIS can be a key competitive differentiator and impact patient choice.

Table of Contents

Patients and Demographic Trends

Demographic trends, such as population aging, will increase long-term demand for inpatient rehabilitative services. While we treat patients of all ages, most of our patients are persons 65 and older (the average age of a HealthSouth patient is 72 years). We believe the demand for inpatient rehabilitative healthcare services will continue to increase as the U.S. population ages and life expectancies increase. The number of Medicare-eligible patients is expected to grow approximately 3% per year for the foreseeable future, creating an attractive market. We believe these factors align with our strengths in, and focus on, inpatient rehabilitative care. Unlike many of our competitors that may offer inpatient rehabilitation as one of many secondary services, inpatient rehabilitation is our core business. In addition, we believe we can address the demand for inpatient rehabilitative services in markets where we currently do not have a presence by constructing or acquiring new hospitals.

Strategy

Our 2013 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals;
- continuing to expand our services to more patients who require inpatient rehabilitative services by constructing and opportunistically acquiring new hospitals in new markets; and
- considering additional shareholder value-enhancing strategies such as repurchases of our common and preferred stock and common stock dividends, recognizing that some of these actions may increase our leverage ratio.

Total discharges grew 5.0% from 2012 to 2013. Our same-store discharges grew 2.5% during 2013 compared to 2012. This growth includes the increase of 68 licensed beds in our existing hospitals in 2013. Our quality and outcome measures, as reported through the Uniform Data System for Medical Rehabilitation (the “UDS”), remained well above the average for hospitals included in the UDS database, and they did so while we continued to increase our market share throughout 2013. As discussed in Item 7, Management’s Discussion and Analysis of Financial Condition and Results of Operations, “Results of Operations,” not only did our hospitals treat more patients and enhance outcomes, they did so in a highly cost-effective manner. We also achieved incremental efficiencies evidenced by the decrease in Total operating expenses as a percentage of Net operating revenues.

Likewise, our growth efforts continued to yield positive results in 2013. Specifically, we:

- acquired Walton Rehabilitation Hospital, a 58-bed inpatient rehabilitation hospital in Augusta, Georgia, in April 2013;
- began accepting patients at our newly built, 40-bed inpatient rehabilitation hospital in Littleton, Colorado, in May 2013;
- began accepting patients at our newly built, 34-bed inpatient rehabilitation hospital in Stuart, Florida in June 2013. This hospital is a joint venture with Martin Health System;
- completed the relocation of patients to our new 53-bed HealthSouth Rehabilitation Hospital of Western Massachusetts in Ludlow, Massachusetts in December 2013, which replaced a leased facility; and

Table of Contents

- continued development of the following de novo hospitals:

Location	# of Beds	Actual / Expected Construction Start Date	Expected Operational Date
Altamonte Springs, Florida	50	Q4 2013	Q4 2014
Newnan, Georgia	50	Q4 2013	Q4 2014
Middletown, Delaware	34	Q4 2013	Q4 2014
Modesto, California	50	Second Half - 2014	Q4 2015
Franklin, Tennessee*	40	TBD	TBD

* A certificate of need has been awarded, but it is currently under appeal.

In 2013, we followed through on our announced intention to implement additional shareholder value-enhancing strategies. Namely, we:

- completed a tender offer for our common stock in March 2013 in which we repurchased approximately 9.1 million shares at a price of $25.50 per share;
- initiated a quarterly cash dividend on our common stock of $0.18 per share. The first quarterly dividend was paid in October 2013; and
- received authorization from our board of directors in October 2013 for the repurchase of up to an additional $200 million of our common stock.

For additional discussion of these actions, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Liquidity and Capital Resources."

While implementing those shareholder value-enhancing strategies, we took additional steps to increase the strength and flexibility of our balance sheet. We:

- entered into closing agreements with the IRS in April 2013 which settled various matters for tax years through December 31, 2008 and resulted in an increase to our deferred tax assets, including an approximate $283 million increase to our federal net operating loss carryforward on a gross basis, and a net income tax benefit of approximately $115 million;
- amended our credit agreement in June 2013 to, among other things, permit unlimited restricted payments so long as the senior secured leverage ratio remains less than or equal to 1.5x and extend the revolver maturity from August 2017 to June 2018;
- purchased the real estate previously subject to leases associated with four of our hospitals in the third quarter of 2013;
- redeemed $30.2 million and $27.9 million of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022, respectively, in November 2013; and
- exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock in November 2013.

For further discussion of these transactions, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and Note 8, Long-term Debt, and Note 16, Income Taxes, to the accompanying consolidated financial statements.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2018. Over the past few years, we have redeemed our most expensive debt and reduced our interest expense. We have invested in our core business and created an infrastructure that enables us to provide high-quality care on a cost-effective basis. Our balance sheet remains strong. Our leverage ratio is within our target range, we have ample availability under our revolving credit facility, and we continue to generate strong cash flows from operations. Importantly, we have flexibility with how we

Table of Contents

choose to invest our cash and return value to shareholders, including bed additions, construction of de novo hospitals, acquisitions of other inpatient rehabilitation hospitals, purchases of leased properties, repurchases of our common and preferred stock, common stock dividends, and repayments of long-term debt. Specifically, on February 14, 2014, our board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million.

In conclusion, we believe our proven track record of producing superior clinical results for a lower average Medicare reimbursement payment than other inpatient rehabilitation providers will allow us to adjust to future Medicare reimbursement initiatives. We also believe the regulatory and reimbursement risks discussed below which we have historically faced and will likely continue to face may present us with opportunities to grow by acquiring or consolidating the operations of other inpatient rehabilitation providers in our highly fragmented industry. We have invested considerable resources into clinical and management systems and protocols that have allowed us to consistently gain market share and realize better outcomes than our competitors while allowing us to consistently contain cost growth. Additionally, we believe continued growth in our Adjusted EBITDA and our strong cash flows from operations as well as our flexible balance sheet will permit us to continue to invest in our core business and in growth opportunities. Our growth strategy in 2014 will again focus on organic growth and development activities. For additional discussion of our strategy, business outlook, Adjusted EBITDA, and shareholder value-enhancing strategies, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview" and "Liquidity and Capital Resources."

Employees

As of December 31, 2013, we employed approximately 23,600 individuals, of whom approximately 13,900 were full-time employees. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 56 employees at one hospital (about 14% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2013. Like most healthcare providers, our labor costs are rising faster than the general inflation rate. In some markets, the lack of availability of medical personnel is a significant operating issue facing healthcare providers. To address this challenge, we will continue to focus on maintaining the competitiveness of our compensation and benefit programs and improving our recruiting, retention, and productivity. The shortage of nurses and other medical personnel, including therapists, may, from time to time, require us to increase utilization of more expensive temporary personnel, which we refer to as "contract labor."

Competition

The inpatient rehabilitation industry is highly fragmented, and we have no single, similar direct competitor. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units, many of which are within acute care hospitals, in the markets we serve. For a list of our markets by state, see the table in Item 2, Properties. Smaller privately held companies compete with us primarily in select geographic markets in Texas and the West. In addition, there are public companies that own primarily long-term acute care hospitals but own or operate a small number of inpatient rehabilitation facilities as well, one of which also manages the operations of inpatient rehabilitation facilities as part of its business model. Other providers of post acute-care services may attempt to become competitors in the future. For example, over the past few years, the number of nursing homes marketing themselves as offering certain rehabilitation services has increased even though nursing homes are not required to offer the same level of care, or be licensed, as hospitals. Also, acute care hospitals, including those owned or operated by large public companies, may choose to expand their post-acute rehabilitation services in our markets. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, and the relationship with the acute care hospitals in the market, including physician-owned providers. However, the previously enacted ban on new, or expansion of existing, physician-owned hospitals should limit to some degree that competitive factor going forward. See the "Regulation—Relationships with Physicians and Other Providers" section below for further discussion. Additionally, for a discussion regarding the effects of certificate of need requirements on competition in some states, see the "Regulation—Certificates of Need" section below.

We rely significantly on our ability to attract, develop, and retain nurses, therapists, and other clinical personnel for our hospitals. We compete for these professionals with other healthcare companies, hospitals, and potential clients and

partners. In addition, physicians and others have opened inpatient rehabilitation hospitals in direct competition with us, particularly in states in which a certificate of need is not required to build a hospital, which has occasionally made it more difficult and expensive to hire the necessary personnel for our hospitals in those markets.

Table of Contents

Regulatory and Reimbursement Challenges

Healthcare, including the inpatient rehabilitation sector, has always been a highly regulated industry. Currently, the industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"), to identify and implement workable coordinated care delivery models. Successful healthcare providers are those who provide high-quality, cost-effective care and have the ability to adjust to changes in the regulatory and operating environments. We believe we have the necessary capabilities - scale, infrastructure, balance sheet, and management - to adapt to and succeed in a highly regulated industry, and we have a proven track record of doing so. For more in-depth discussion of the primary challenges and risks related to our business, particularly the changes in Medicare reimbursement (including sequestration), increased federal compliance and enforcement burdens, and changes to our operating environment resulting from healthcare reform, see "Regulation" below in this section as well as Item 1A, Risk Factors, and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, "Executive Overview—Key Challenges."

Sources of Revenues

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

	For the Year Ended December 31,		
	2013	2012	2011
Medicare	74.5 %	73.4 %	72.0 %
Medicaid	1.2 %	1.2 %	1.6 %
Workers' compensation	1.2 %	1.5 %	1.6 %
Managed care and other discount plans, including Medicare Advantage	18.5 %	19.3 %	19.8 %
Other third-party payors	1.8 %	1.8 %	2.0 %
Patients	1.1 %	1.3 %	1.2 %
Other income	1.7 %	1.5 %	1.8 %
Total	100.0 %	100.0 %	100.0 %

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services that are included in "Managed care and other discount plans" in the table above, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care plans. Medicare, through its Medicare Advantage program, offers Medicare-eligible individuals an opportunity to participate in a managed care plan. Revenues from Medicare and Medicare Advantage represent approximately 80% of total revenues.

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

Medicare Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare facilities and services. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems

including the inpatient rehabilitation facility (“IRF”) prospective payment system (the “IRF-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. For example, in recent years, Congress has not adopted any of the recommendations on the annual market basket update to Medicare payment rates under the IRF-PPS, which updates are discussed in greater detail below.

Table of Contents

These statutes and regulations are subject to change from time to time. For example, in March 2010, President Obama signed the 2010 Healthcare Reform Laws. With respect to Medicare reimbursement, the 2010 Healthcare Reform Laws provided for certain reductions to healthcare providers' annual market basket updates. In August 2011, President Obama signed into law the Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012 and the Bipartisan Budget Act of 2013, that provided for an automatic 2% reduction, or "sequestration," of Medicare program payments for all healthcare providers. Sequestration took effect April 1, 2013 and will continue through 2023 unless Congress and the President take further action. Additionally, concerns held by federal policymakers about the federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both, in 2014 and beyond.

From time to time, these reimbursement methodologies and rates can be further modified by the United States Centers for Medicare and Medicaid Services ("CMS"). In some instances, these modifications can have a substantial impact on existing healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems, including the IRF-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS currently requires IRFs to submit data on urinary catheter-related infections and pressure ulcers for the IRF Quality Reporting Program. Beginning October 1, 2014, we will be required to collect and report influenza vaccination data for our clinical staff. In future years, we will also be required to collect and report influenza vaccination data for our patients. A facility's failure to submit the required quality data will result 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 met the reporting deadlines occurring on or before December 31, 2012 resulting in no corresponding reimbursement reductions.

CMS has also adopted final rules that require healthcare providers to update and supplement diagnosis and procedure codes to the International Classification of Diseases 10th Edition ("ICD-10"), effective October 1, 2014. We are currently modifying our systems to accommodate the adoption of ICD-10. We expect to be in compliance on a timely basis. Although this adoption process will result in system conversion expenses and may result in some disruptions to the billing process and delays in the receipt of some payments, we do not believe there will be a material impact on our business. We will continue to monitor this implementation carefully.

We cannot predict the adjustments to Medicare payment rates Congress or CMS may make in the future. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. Any additional downward adjustment to rates for the types of facilities we operate could have a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of the risks associated with our concentration of revenues from the federal government or with potential changes to the statutes or regulations governing Medicare reimbursement, see Item 1A, Risk Factors.

A basic summary of current Medicare reimbursement in our primary service areas follows:

Inpatient Rehabilitation Hospitals. As discussed above, our hospitals receive fixed payment reimbursement amounts per discharge under IRF-PPS based on certain rehabilitation impairment categories established by the United States Department of Health and Human Services ("HHS"). In order to qualify for reimbursement under IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, preadmission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. With IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers.

Under IRF-PPS, CMS is required to adjust the payment rates based on a market basket index, known as the rehabilitation, psychiatric, and long-term care hospital market basket. The market basket update is designed to reflect changes over time in the prices of a mix of goods and services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units. The market basket 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.

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for inpatient rehabilitation providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to healthcare providers. For example, on May 7, 2004, CMS issued a final rule, known as the “75% Rule,” stipulating that to qualify as an inpatient rehabilitation hospital under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any inpatient rehabilitation hospital that failed to meet its requirements would be subject to prospective

Table of Contents

reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. On December 29, 2007, the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") was signed, setting the compliance threshold at 60% instead of 75% and allowing hospitals to continue using a patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitative care under the rule. The long-term impact of the freeze at the 60% compliance threshold is positive because it allowed patient volumes to stabilize. In another example, the 2007 Medicare Act included an elimination of the IRF-PPS market basket adjustment for the period from April 1, 2008 through September 30, 2009 causing a reduction in the pricing of services eligible for Medicare reimbursement to a pricing level that existed in the third quarter of 2007, or a Medicare pricing "roll-back," which resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs.

On July 25, 2012, CMS released its notice of final rulemaking for the fiscal year 2013 IRF-PPS. This rule was effective for Medicare discharges between October 1, 2012 and September 30, 2013. The pricing changes in this rule included a 2.7% market basket update that was reduced by 0.1% to 2.6% under the requirements of the 2010 Healthcare Reform Laws, as well as other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. The 2010 Healthcare Reform Laws also require the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustments equal the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective October 1, 2012 decreased the market basket update by 70 basis points.

On July 31, 2013, CMS released its notice of final rulemaking for fiscal year 2014 IRF-PPS (the "2014 Rule"). The final rule would implement a net 1.8% market basket increase effective for discharges between October 1, 2013 and September 30, 2014, calculated as follows:

Market basket update	2.6%
Healthcare reform reduction	30 basis points
Productivity adjustment reduction	50 basis points

The final rule also includes other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, updates to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, teaching status adjustment factor, and updates to the outlier fixed loss threshold. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the final rule, we believe the 2014 Rule will result in a net increase to our Medicare payment rates of approximately 1.95% effective October 1, 2013 before sequestration. The sequestration reduction will anniversary for purposes of year-over-year Net operating revenues beginning with payments received after April 1, 2014, so the net year-over-year decrease in our Net operating revenues is expected to be approximately $8 million in 2014.

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 coverage rules and determinations. 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 qualified rehabilitation physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide required rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services. For individual claims, Medicare contractors make coverage determinations regarding medical necessity which can represent more restrictive interpretations of the CMS coverage rules. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

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. These audits are in addition to those conducted by existing Medicare Administrative Contractors ("MACs"). Some contractors are paid a percentage of the overpayments recovered. One type of audit contractor, the Recovery

Audit Contractors (”RACs”), began post-payment audit processes in late 2009 for providers in general. The RACs receive claims data directly from MACs on a monthly or quarterly basis and are authorized to review claims up to three years from the date a claim was paid, beginning with claims filed on or after October 1, 2007. The 2010 Healthcare Reform Laws extended the RAC program to Medicare, Parts C and D, and Medicaid. RAC audits initially focused on coding errors. CMS subsequently expanded the program to medical necessity reviews for IRFs.

Table of Contents

In connection with CMS approved and announced RAC audits related to IRFs, we received requests in 2013 to review certain patient files for discharges occurring from 2010 to 2013. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient files requests have resulted in payment denial determinations by the RACs.

These post-payment RAC audits are focused on medical necessity requirements for admission to IRFs rather than targeting a specific diagnosis code as in previous pre-payment audits. Medical necessity is a subjective assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of our patients, we currently intend to appeal substantially all RAC denials arising from these audits.

While we make provisions for these claims based on our historical experience and success rates in the claim adjudication process, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be reviewed. During 2013, we reduced our Net operating revenues by approximately $8 million for post-payment claims that are part of this review process.

Unlike the pre-payment denials of certain diagnosis codes by MACs that have been part of our operations for several years, we have not had any experience with RACs in the context of post-payment reviews of this nature. Along with our significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules, we also have a formal process for complying with RAC audits, and we are cooperating fully with the RACs during this process. However, due to additional delays announced by CMS in the related adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years.

On August 27, 2012, CMS launched its three-year demonstration project that expanded the RAC program to include prepayment review of Medicare fee-for-service claims. Currently, acute care hospitals are the primary subject to this review project, but CMS could expand it to inpatient post-acute providers. This demonstration project will identify specific diagnosis codes for review, and the RAC contractors will review the selected claims to determine if they are proper before payment has been made to the provider. The project covers 11 states, including 8 states in which we operate – Florida, California, Texas, Louisiana, Illinois, Pennsylvania, Ohio, and Missouri. Providers with claims identified for RAC prepayment reviews will have 30 days to respond to requests for additional documentation. If they do not respond timely, the claim will be denied. Providers receive determinations within 45 days of submitting the relevant documentation.

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

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

Outpatient Services. Our outpatient services are primarily reimbursed under Medicare's physician fee schedule. By statute, the physician fee schedule is subject to annual automatic adjustment by a sustainable growth rate formula that has resulted in reductions in reimbursement rates every year since 2002. However, in each instance, Congress has acted to suspend or postpone the effectiveness of these automatic reimbursement reductions. For example, under the

CMS final notice of rulemaking for the physician fee schedule for calendar year 2014, released on November 27, 2013, a statutory reduction of 20.1% would have been implemented. However, the Bipartisan Budget Act of 2013 increased the current Medicare physician fee schedule payment rates by 0.5% from January 1, 2014 through March 31, 2014, further postponing the statutory reduction. If Congress does not again extend relief as it has done since 2002 or permanently modify the sustainable growth rate formula by April 1, 2014, payment levels for outpatient services under the physician fee schedule will be reduced at that point by more than 20.1%. We currently estimate that a reduction of that size, before taking into account our efforts to mitigate these changes, which would likely include closure of additional outpatient satellite clinics, would result in a net decrease in our Net operating revenues of approximately $5 million annually. However, we cannot predict what action, if any, Congress will take on the

Table of Contents

physician fee schedule and other reimbursement matters affecting our outpatient services or what future rule changes CMS will implement.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed unable to afford healthcare. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of certain services. Continuing downward pressure on Medicaid payment rates could cause a decline in that portion of our Net operating revenues. However, for the year ended December 31, 2013, Medicaid payments represented only 1.2% of our consolidated Net operating revenues. Although the 2010 Healthcare Reform Laws contain provisions intended to expand Medicaid coverage, part of which were invalidated by the U.S. Supreme Court, we do not believe the expanded coverage will have a material impact on our consolidated Net operating revenues given our current patient mix.

Managed Care and Other Discount Plans

All of our hospitals offer discounts from established charges to certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms of 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. While some of our contracts provide for annual rate increases of two to four percent and our average rate increase in 2013 was 4.1%, we cannot provide any assurance we will continue to receive increases. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

Cost Reports

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

Regulation

The healthcare industry in general 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 hospitals, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth.

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

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

10

Table of Contents

Licensure and Certification

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

In addition, hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. 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.

Failure to comply with applicable certification requirements may make our hospitals ineligible for Medicare or Medicaid reimbursement. In addition, Medicare or Medicaid may seek retroactive reimbursement from noncompliant facilities or otherwise impose sanctions on noncompliant facilities. Non-governmental payors often have the right to terminate provider contracts if a facility loses its Medicare or Medicaid certification.

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

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

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities, or the introduction of new beds or 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, 2013, approximately 49% of our licensed beds are located in states or U.S. territories that have CON laws. CON laws often require a reviewing agency to determine the public need for additional or expanded healthcare facilities and services. These laws generally require approvals for capital expenditures involving inpatient rehabilitation hospitals, if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any time a CON is required, we must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility or starting a new healthcare program.

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

False Claims

The federal False Claims Act prohibits the knowing presentation of a false claim to the United States government and provides for penalties equal to three times the actual amount of any overpayments plus up to $11,000 per claim. In addition, the False Claims Act 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. Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties under the False Claims Act. Many states have also adopted similar laws relating to state

Table of Contents

government payments for healthcare services. The 2010 Healthcare Reform Laws amended the federal False Claims Act 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 a violation of the False Claims Act. For additional discussion, see Item 1A, Risk Factors, and Note 18, Contingencies and Other Commitments, to the accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

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

Some of our rehabilitation hospitals are owned through joint ventures with institutional healthcare providers that may be in a position to make or influence referrals to our hospitals. In addition, we have a number of relationships with physicians and other healthcare providers, including management or service contracts. Some of these investment relationships and contractual relationships may not meet all of the regulatory requirements to fall within the protection offered by a relevant 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 that our defense against any such assertion would be successful.

For example, we have entered into agreements to manage our hospitals that are owned by partnerships. 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, or radiology 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 for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $15,000 for

each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.

Under the 2010 Healthcare Reform Laws, the exception to the Stark law that currently permits physicians to refer patients to hospitals in which they have an investment or ownership interest has been dramatically limited by providing that only physician-owned hospitals with a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the physician ownership percentage in the hospital after March 23, 2010. Additionally, physician-owned hospitals are prohibited from increasing the number of licensed

Table of Contents

beds after March 23, 2010, except when certain market and regulatory approval conditions are met. Currently, we have no hospitals that would be considered physician-owned under this law.

CMS has issued several phases of final regulations implementing the Stark law. While these regulations help clarify the requirements of the exceptions to the Stark law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Because many of these laws and their implementing regulations are relatively new, we 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 an exception 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 that our defense against any such assertion would be successful or that new federal or state laws governing physician relationships, or new interpretations of existing laws governing such relationships, might not adversely affect relationships we have established with physicians or result in the imposition of penalties on us or on particular HealthSouth hospitals. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA,” broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare or Medicaid beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties.

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

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

On January 17, 2013, HHS Office for Civil Rights issued a final rule, with a compliance date of September 23, 2013, to implement the HITECH Act and make other modifications to the HIPAA and HITECH regulations. This rule expanded the potential liability for a breach involving protected health information to cover some instances where a subcontractor is responsible for the breaches and that individual or entity was acting within the scope of delegated

authority under the related contract or engagement. The final rule generally defines “breach” to mean the acquisition, access, use or disclosure of protected health information in a manner not permitted by the HIPAA privacy standards, which compromises the security or privacy of protected health information. Under the final rule, improper acquisition, access, use, or disclosure is presumed to be a reportable breach, unless the potentially breaching party can demonstrate a low probability that protected health information has been compromised. On the whole, it appears the changes to the breach reporting rules could increase breach reporting in the healthcare industry.

Table of Contents

In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. Any actual or perceived violation of privacy-related laws and regulations, including HIPAA and the HITECH Act, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Available Information

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

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and you should take such risks into account in evaluating HealthSouth or any investment decision involving HealthSouth. This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of certain material risk factors. More detailed information concerning other risk factors as well as those described below is contained in other sections of this annual report.

Reductions or changes in reimbursement from government or third-party payors and other legislative and regulatory changes affecting our industry could adversely affect our 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. Historically, 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.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). Many provisions within the 2010 Healthcare Reform Laws have impacted or could in the future impact our business, including: (1) reducing annual market basket updates to providers, which include annual productivity adjustment reductions; (2) the possible combining, or "bundling," of reimbursement for a Medicare beneficiary's episode of care at some point in the future; (3) implementing a voluntary program for accountable care organizations ("ACOs"); and (4) creating an Independent Payment Advisory Board. Most notably for us, these laws include a reduction in annual market basket updates to hospitals. In accordance with Medicare laws and statutes, the United States Centers for Medicare and Medicaid Services ("CMS") makes annual adjustments to Medicare reimbursement rates by what is commonly known as a "market basket update." The reductions in our annual market basket updates continue through 2019 for each CMS fiscal year, which for us begins October 1, as follows:

2014	2015-16	2017-19
0.3%	0.2%	0.75%

In addition, the 2010 Healthcare Reform Laws require the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustments equal the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective from October 1, 2013 to September 30, 2014 is a decrease to the market basket update of 50 basis points. We estimate the adjustment effective October 1, 2014 will be a decrease to the market basket update of approximately 100 basis points, but we cannot predict it with certainty.

The 2010 Healthcare Reform Laws also directed the United States Department of Health and Human Services ("HHS") to examine the feasibility of bundling, including conducting a voluntary, multi-year bundling pilot program to test and

Table of Contents

evaluate alternative payment methodologies. On January 31, 2013, CMS announced the selection of participants in the initial phase of limited-scope, voluntary bundling pilot projects. There are four project types: acute care only, acute/post-acute, post acute only, and acute and physician services. In the initial phase, pilot participants along with their provider partners exchange data with CMS on care patterns and engage in shared learning in how to improve care. The second phase requires participants in that phase, pending contract finalization and completion of the standard CMS program integrity reviews, to take on financial risk for episodes of care. If participants have not transitioned from the first phase to the second by fall 2014, their participation will terminate. CMS selected as participants a small number of acute care hospitals with which we have relationships. To date, we have agreed to participate in a few bundling projects as a post-acute rehabilitation provider, some of which have not yet experienced much activity and none of which have transitioned to the risk sharing second phase. We will continue to evaluate on a case by case basis the appropriateness of bundling opportunities for our hospitals and patients.

Similarly, in October 2011, CMS established, per the 2010 Healthcare Reform Laws, a voluntary ACO program in which hospitals, physicians, and other care providers develop entities to pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs will 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. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. As with bundling, we are currently evaluating on a case by case basis appropriate participation opportunities in the ACO pilots for our hospitals and patients. We have expressed interest in participating in several ACOs and have executed one participation agreement as of December 31, 2013.

The bundling and ACO initiatives have served as motivating factors for regulators and healthcare industry participants to identify and implement workable coordinated care delivery models. Broad-based implementation of a new delivery model would represent a significant transformation for us and the healthcare industry generally. The nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain and will likely remain so for some time. The development of new delivery and payment systems will almost certainly take significant time and expense. Many of the alternative approaches being explored may not work. For further discussion of the associated challenges and our efforts to respond to them, see “Executive Overview—Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform” section of Item 7, Management Discussion and Analysis of Financial Condition and Results of Operations.

Another provision of the 2010 Healthcare Reform Laws establishes an Independent Payment Advisory Board appointed by the President that is charged with presenting proposals, beginning in 2014, to Congress to reduce Medicare expenditures upon the occurrence of Medicare expenditures exceeding a certain level. This board will have broad authority to develop new Medicare policies (including changes to provider reimbursement). In general, unless Congress acts to block the proposals of this board, CMS will implement the policy recommendations. However, due to the market basket reductions that are also part of these laws, certain healthcare providers, including us, will not be subject to payment reduction proposals developed by this board and presented to Congress until 2020. While we may not be subject to its payment reduction proposals for a period of time, based on the scope of this board’s directive to reduce Medicare expenditures and the significance of Medicare as a payor to us, other decisions made by this board may adversely impact our results of operations.

Many aspects of implementation and interpretation of the 2010 Healthcare Reform Laws remain uncertain. Given the complexity and the number of changes in these laws as well as subsequent regulatory developments and delays, we cannot predict the ultimate impact of these laws. However, we believe the provisions discussed above are the issues with the greatest potential impact on us.

The 2010 Healthcare Reform Laws include other provisions that could adversely affect us as well. They include the expansion of the federal Anti-Kickback Law and the False Claims Act that, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the False Claims Act, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension

period can be extended almost indefinitely if the matter is under investigation by the HHS Office of Inspector General (the "HHS-OIG") or the United States Department of Justice (the "DOJ"). Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Further, under the 2010 Healthcare Reform Laws, CMS established new quality data reporting, effective October 1, 2012, for all inpatient rehabilitation facilities ("IRFs"). A facility's failure to submit the required quality data will result in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in the subsequent fiscal year. IRFs began submitting quality data to CMS in October 2012. All of our hospitals met the reporting requirements for the period ending December 31, 2012 resulting in no corresponding reductions for the fiscal year beginning October 1, 2014. There can be no assurance that all of our hospitals will do so for future periods which may result in one or

Table of Contents

more of our hospitals seeing a reduction in its reimbursements. For additional discussion of general healthcare regulation, see Item 1, Business, “Regulatory and Reimbursement Challenges” and “Regulation.”

Some states in which we operate have also undertaken, or are considering, healthcare reform initiatives that address similar issues. For example, there is a referendum on the November 2014 ballot in Massachusetts that would, if approved, impose several new requirements on hospitals in that state, including setting minimum staffing ratios and maximum operating margins (8%). 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, 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 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. We currently estimate this automatic reduction, known as “sequestration,” which began affecting payments received after April 1, 2013, will reduce the payments we receive under the IRF prospective payment system (the “IRF-PPS”) resulting in a net year-over-year decrease in our Net operating revenues of approximately $8 million in 2014. The effect of sequestration on year-over-year comparisons of Net operating revenues will cease on April 1, 2014.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, and reforming the sustainable growth rate formula used to pay physicians who treat Medicare beneficiaries (the so called “Doc Fix”) could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. For example, the Health Subcommittee of the Ways and Means Committee of the United States House of Representatives held a hearing in June 2013 to examine legislative proposals contained in President Obama’s fiscal year 2014 budget submission to Congress that would affect post-acute care providers including, among other issues, elevating the 60% Rule to a 75% Rule and paying rehabilitation hospitals nursing home-based rates for certain conditions (also referred to as “site-neutral payment”). As a point of follow-up to this hearing, we provided constructive input to the Ways and Means Health Subcommittee on legislative and regulatory initiatives as well as information on the quality of care and value that inpatient rehabilitation hospitals bring to the Medicare program and its beneficiaries, and we will continue providing such input to policymakers. We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post acute care reforms, if any, will ultimately be enacted into law, or the timing or effect any such initiatives or reductions will have on us. If enacted, such initiatives or reductions would likely be challenging for all providers, would likely have the effect of limiting Medicare beneficiaries’ access to healthcare services, and could have an adverse impact on our financial position, results of operations, and cash flows.

If we are not able to maintain increased case volumes or reduce operating costs to offset any future pricing roll-back, reduction, freeze, or increased costs associated with new regulatory compliance obligations, our operating results could be adversely affected. Our results could be further adversely affected by other changes in laws or regulations governing the Medicare program, as well as possible changes to or expansion of the audit processes conducted by Medicare contractors or Medicare recovery audit contractors. 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.”

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

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 that substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity

determinations.

Table of Contents

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.

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 2007 Medicare Act;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements. Those changes could also affect reimbursements as well as future training and staffing costs. Of note, the HHS-OIG each year releases a work plan that identifies areas of compliance focus for the coming year. The 2012 and 2013 work plans for IRFs continue to focus on timely submissions of patient assessment instruments, the examination of the level of therapy being provided, and the appropriate utilization of concurrent and group therapy. The 2014 work plan provides that the HHS-OIG will review matters related to adverse and temporary harm events occurring in IRFs. For further discussion of certain important healthcare laws and regulations, including updates regarding increases in Medicare payment audit activity, see Item 1, Business, “Sources of Revenue—Medicare Reimbursement” and “Regulation.”

On March 4, 2013, we received document subpoenas addressed to four of our wholly owned hospitals. Each subpoena is in connection with an HHS-OIG investigation, led by the DOJ, of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requests documents and materials relating to practices, procedures, protocols and policies, of certain pre- and post-admissions activities at these hospitals. We are cooperating fully with this investigation in connection with these subpoenas and are currently unable to predict the timing or outcome of the related investigations. Through follow-up conversations, the DOJ has indicated it intends to request files from additional hospitals but has provided no specifics on timing or the hospitals involved. For additional discussion, see Note 18, Contingencies and Other Commitments, to the accompanying consolidated financial statements.

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 rules. 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. As previously noted, the appropriate utilization of group therapy was a focus of recent HHS-OIG work plans. Additionally, the final rule for the fiscal year 2014 IRF-PPS includes changes, effective October 1, 2014, to the list of medical conditions, including a reduction in the number of conditions, that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

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

Table of Contents

example, to support the determination that a patient's IRF treatment was reasonable and necessary, the file must contain, among other things, an admitting physician's assessment of the patient as well as a post-admission assessment by the treating physician and other information from clinicians relating to the plan of care and the therapies being provided. These physicians exercise their independent medical judgment. We and our hospital medical directors, who are independent contractors, provide training to the physicians we work with on a regular basis regarding appropriate documentation. 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.

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, if we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements for discharges deemed after the fact to have not been appropriate under the IRF-PPS. We could also be subjected to other liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs, which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our Net operating revenues, it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. As discussed above in connection with the 2010 Healthcare Reform Laws, the federal government has in the last couple of years made compliance enforcement and fighting healthcare fraud top priorities. In the past few years, the DOJ and HHS as well as federal lawmakers have significantly increased efforts to ensure strict compliance with various reimbursement related regulations as well as combat healthcare fraud. The DOJ has pursued and recovered a record amount of taxpayer dollars lost to healthcare fraud. Additionally, the federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent a violation of the False Claims Act.

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.

Our hospitals face national, regional, and local competition for patients from other healthcare providers.

We operate in a highly competitive industry. Although we are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals, in any particular market we may encounter competition from local or national entities with longer operating histories or other competitive advantages. For example, acute care hospitals, including those owned and operated by large public companies, may choose to expand or begin offering post-acute rehabilitation services. Given that approximately 93% of our referrals come from acute care hospitals, that increase in competition might materially and adversely affect our admission referrals in the related markets. There can be no assurance this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, from time to time, there are efforts in states with certificate of need ("CON") laws to weaken those laws, which could potentially increase competition in those states. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations.

We may have difficulty completing acquisitions, investments, joint ventures or de novo developments or increasing capacity with bed additions at existing hospitals consistent with our growth strategy.

We selectively pursue strategic acquisitions of and joint ventures with rehabilitative healthcare providers and, in the future, may do so with other complementary post-acute healthcare operations. We may face limitations on our ability to identify sufficient acquisition or other development targets to meet goals. In many states, the need to obtain governmental approvals, such as a CON or an approval of a change in ownership, may operate as a significant obstacle to completing transactions. Additionally, in states with CON laws, it is not unusual for third-party providers to challenge initial awards of CONs or the increase in the number of approved beds in an existing CON, and the adjudication of those challenges and related appeals may take multiple years.

18

Table of Contents

We may make investments or acquisitions or enter into joint ventures that may be unsuccessful and could expose us to unforeseen liabilities.

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

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

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

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

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

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

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

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are a defendant in a number of lawsuits. The material lawsuits and investigations, including the subpoenas received from HHS-OIG, are discussed in Note 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

Table of Contents

position, results of operations, and cash flows. Additionally, the costs of defending litigation and investigations, even if frivolous or nonmeritorious, could be significant.

We insure a substantial portion of our professional liability, general liability, and workers' compensation liability risks through our captive insurance subsidiary, as discussed further in Note 9, Self-Insured Risks, to the accompanying consolidated financial statements. Changes in the number of these liability claims and the cost to resolve them impact the reserves for these risks. A variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the reserves for these liability risks, which could have an effect on our financial position and results of operations.

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

We are dependent on the proper function, availability and security of our information systems, including our new electronic clinical information system which plays a substantial role in the operations of the hospitals in which it is installed. We undertake substantial measures to protect the safety and security of our information systems and the data maintained within those systems, and we regularly test the adequacy of our security and disaster recovery measures. We have installed privacy protection systems and devices on our network and electronic devices in an attempt to prevent unauthorized access to that data, which includes patient information subject to the protections of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act. For additional discussion of these laws, see Item 1, Business, "Regulation." As part of our efforts, we may be required to expend significant capital to protect against the threat of security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems and the introduction of computer malware to our systems. However, there can be no assurance our safety and security measures or our disaster recovery plan will detect and prevent security breaches in a timely manner or otherwise prevent damage or interruption of our systems and operations. We may be vulnerable to losses associated with the improper functioning, security breach or unavailability of our information systems. We may be held liable to our patients and regulators, which could result in fines, litigation, or negative publicity. Failure to maintain proper function, security, or availability of our information systems could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Our electronic clinical information system (the "CIS") is subject to a licensing, implementation, technology hosting, and support agreement with Cerner Corporation. In June 2011, we entered into an agreement with Cerner to begin a company-wide implementation of this system in 2012. As of December 31, 2013, we had installed the CIS in 36 hospitals with another 20 installations scheduled for 2014. We expect to complete installation in our existing hospitals by the end of 2017. Our inability, or the inability of Cerner, to continue to maintain and upgrade our information systems, software, and hardware could disrupt or reduce the efficiency of our operations. 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 multiple hospitals could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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

The success of our current business plan depends in large part upon the leadership and performance of our executive management team and key employees and our ability to retain and motivate these individuals. We rely upon their ability, expertise, judgment, discretion, integrity and good faith. There can be no assurance that we will retain our key executives and employees or that we can attract or retain other highly qualified individuals in the future. If we lose key personnel, we may be unable to replace them with personnel of comparable experience in, or knowledge of, the healthcare provider industry or our specific post-acute segment. The loss of the services of any of these individuals could prevent us from successfully executing our business plan and could have a material adverse affect on our business and results of operations.

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

Although we have reduced our outstanding long-term debt substantially in recent years, we still had approximately $1.4 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $88.9 million in capital leases) as of December 31, 2013. See Note 8, 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.

Table of Contents

Our indebtedness could have important consequences, including:

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

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

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

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

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

These covenants could adversely affect our ability to finance our future operations or capital needs and pursue available business opportunities. For additional discussion of our material debt covenants, see the “Liquidity and Capital Resources” section of Item 7, Management Discussion and Analysis of Financial Condition and Results of Operations, and Note 8, 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 Discussion and Analysis of Financial Condition and Results of Operations, and Note 8, 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, 2013, 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 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

Table of Contents

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, 2013, approximately 79% of our consolidated Property and equipment, net held by HealthSouth Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 8, Long-term Debt, and Note 20, Condensed Consolidating Financial Information, to the accompanying consolidated financial statements, and Item 2, Properties.

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

The global and sovereign credit markets have experienced significant disruptions in recent years, and in 2013, the debt ceiling and federal budget disputes in the United States affected capital markets. Future market shocks could negatively affect the availability or terms of certain types of debt and equity financing, including access to revolving lines of credit. Future business needs combined with market conditions at the time may cause us to seek alternative sources of potentially less attractive financing and may require us to adjust our business plan accordingly. For example, tight credit markets, such as might result from further turmoil in the sovereign debt markets, would likely make additional financing more expensive and difficult to obtain. The inability to obtain additional financing at attractive rates or prices could have a material adverse effect on our financial performance or our growth opportunities.

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

We may not be able to fully utilize our net operating loss carryforwards.

As of December 31, 2013, we had an unused federal net operating loss carryforward (“NOL”) of approximately $325 million (approximately $929 million on a gross basis) and state NOLs of approximately $91 million. Such losses expire in various amounts at varying times through 2031. Unless they expire, these NOLs may be used to offset future taxable income and thereby reduce our income taxes otherwise payable. While we believe we will be able to use a substantial portion of these tax benefits before they expire, no such assurances can be provided. For further discussion of our NOLs, see Item 7, Management’s Discussion and Analysis of Financial Condition and Results of Operations, and Note 16, Income Taxes, to the accompanying consolidated financial statements.

As of December 31, 2013, we maintained a valuation allowance of approximately $31 million against our deferred tax assets. At the state jurisdiction level, based on the weight of the available evidence including 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, we determined it was necessary to maintain a valuation allowance due to uncertainties related to our ability to utilize a portion of our state NOLs before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence, as described above, including management’s estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable.

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.

Section 382 of the Internal Revenue Code ("Section 382") imposes an annual limit on the ability of a corporation that undergoes an "ownership change" to use its NOLs to reduce its tax liability. An "ownership change" is generally defined as any change in ownership of more than 50% of a corporation's "stock" by its "5-percent shareholders" (as defined in Section 382)

Table of Contents

over a rolling three-year period based upon each of those shareholder's lowest percentage of stock owned during such period. It is possible that future transactions, not all of which would be within our control, could cause us to undergo an ownership change as defined in Section 382. In that event, we would not be able to use our pre-ownership-change NOLs in excess of the limitation imposed by Section 382. At this time, we do not believe these limitations will affect our ability to use any NOLs before they expire. However, no such assurances can be provided. If we are unable to fully utilize our NOLs to offset taxable income generated in the future, our results of operations and cash flows could be materially and negatively impacted. Additionally, the imposition of an annual limit could result in it taking longer to utilize our NOLs, which would adversely affect the present value of those tax assets.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We maintain our principal executive office at 3660 Grandview Parkway, Birmingham, Alabama. We occupy those office premises under a long-term lease which expires in 2018 and includes options for us, at our discretion, to renew the lease for up to ten years in total beyond that date.

In addition to our principal executive office, as of December 31, 2013, we leased or owned through various consolidated entities 125 business locations to support our operations. Our hospital leases, which represent the largest portion of our rent expense, customarily have initial terms of 10 to 30 years. Most of our leases contain one or more options to extend the lease period for five additional years for each option. Our consolidated entities are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses, particularly in our leased hospitals. Other than our principal executive offices, no other individual property is materially important.

Table of Contents

The following table sets forth information regarding our hospital properties (excluding the two hospitals that have 151 licensed beds and operate as joint ventures which we account for using the equity method of accounting) as of December 31, 2013:

		Number of Hospitals			
State	Licensed Beds	Building and Land Owned	Building Owned and Land Leased	Building and Land Leased	Total
Alabama *	383	1	3	2	6
Arizona	335	1	1	3	5
Arkansas	267	2	1	1	4
California	114	1	—	1	2
Colorado	104	1	—	1	2
Florida *	827	8	1	2	11
Georgia*	58	1	(1) —	—	1
Illinois *	55	—	1	—	1
Indiana	85	—	—	1	1
Kansas	242	1	—	2	3
Kentucky *	80	1	1	—	2
Louisiana	47	1	—	—	1
Maine *	100	—	—	1	1
Maryland *	54	1	—	—	1
Massachusetts *	53	1	—	—	1
Missouri*	156	—	2	—	2
Nevada	219	2	—	1	3
New Hampshire *	50	—	1	—	1
New Jersey *	199	1	1	1	3
New Mexico	87	1	—	—	1
Ohio	60	—	—	1	1
Pennsylvania	774	5	—	4	9
Puerto Rico*	72	—	—	2	2
South Carolina *	338	1	4	—	5
Tennessee *	380	3	3	—	6
Texas	1,063	11	2	2	15
Utah	84	1	—	—	1
Virginia *	271	2	1	3	6
West Virginia *	268	1	3	—	4
	6,825	48	25	28	101

* Certificate of need state or U.S. territory

(1) Walton Rehabilitation Hospital, a 58-bed inpatient rehabilitation hospital in Augusta, Georgia, is a party to an industrial development bond financing that reduces ad valorem taxes payable by the hospital. In connection with this financing, title to the real property is held by the Development Authority of Richmond County. We lease the hospital property and hold the bonds issued by the Authority, the payment on which equals the amount payable under the lease. We may terminate the bond financing and the associated lease at any time at our option without penalty, and fee title to the hospital property will return to us.

Our obligations under our existing credit agreement are secured by substantially all of (1) the real property owned by us and our subsidiary guarantors as of August 10, 2012, the date of that agreement, and (2) the current and future personal

Table of Contents

property owned by us and our subsidiary guarantors. We and the subsidiary guarantors entered into mortgages with respect to most of our material real property that we owned as of August 10, 2012 (excluding real property subject to preexisting liens and/or mortgages) to secure our obligations under the credit agreement. For additional information about our credit agreement, see Note 8, Long-term Debt, to the accompanying consolidated financial statements.

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

Item 3. Legal Proceedings

Information relating to certain legal proceedings in which we are involved is included in Note 18, Contingencies and Other Commitments, to the accompanying consolidated financial statements, which is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

Table of Contents

PART II

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

Market Information

Shares of our common stock trade on the New York Stock Exchange under the ticker symbol "HLS." The following table sets forth the high and low sales prices per share for our common stock as reported on the NYSE from January 1, 2012 through December 31, 2013.

	High	Low
2012		
First Quarter	$21.53	$16.55
Second Quarter	23.35	18.44
Third Quarter	24.99	20.99
Fourth Quarter	24.39	19.85
2013		
First Quarter	$26.40	$21.53
Second Quarter	30.95	25.07
Third Quarter	36.52	28.70
Fourth Quarter	37.01	32.97

Holders

As of February 13, 2014, there were 88,000,335 shares of HealthSouth common stock issued and outstanding, net of treasury shares, held by approximately 9,387 holders of record.

Dividends

On July 25, 2013, our board of directors approved the initiation of a quarterly cash dividend on our common stock of $0.18 per share. The first quarterly dividend has been declared and was paid on October 15, 2013 to stockholders of record as of the close of business on October 1, 2013. On January 15, 2014, we paid a cash dividend on our common stock of $0.18 per share to stockholders of record as of the close of business on January 2, 2014. 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, will be at the discretion of our board each quarter after consideration of various factors, including our capital position and the best interests of our stockholders.

The terms of our credit agreement (see Note 8, Long-term Debt, to the accompanying consolidated financial statements) allow us to declare and pay cash dividends on our common stock so long as: (1) we are not in default under our credit agreement and (2) our senior secured leverage ratio remains less than or equal to 1.5x.

Our preferred stock generally provides for the payment of cash dividends subject to certain limitations. See Note 10, Convertible Perpetual Preferred Stock, to the accompanying consolidated financial statements. Our credit agreement does not limit the payment of dividends on the preferred stock.

Recent Sales of Unregistered Securities

We originally issued 10,000,000 warrants on January 16, 2004, in a private transaction exempt from registration pursuant to Section 4(2) of the Securities Act of 1933, as amended. These warrants were originally exercisable on a one-for-one basis into shares of our common stock. Following our one-for-five reverse stock split in October 2006, these warrants were exercisable for 2.0 million shares of our common stock at an exercise price of $32.50.

From November 1, 2013 through December 23, 2013, holders exercised 7.1 million warrants by means of cash and cashless exercises resulting in our issuance of 0.5 million shares of our common stock and the receipt of $15.3 million in cash proceeds.

Table of Contents

The payment in January 2014 of an $0.18 per share dividend on our common stock triggered the antidilutive adjustment for these warrants. As of January 3, 2014, the resulting exercise price of each warrant was $32.16, and the resulting exercise rate was 0.2021 for each warrant. In January 2014, holders exercised 2.8 million warrants by means of cash and cashless exercises resulting in the issuance of 0.2 million shares of our common stock and the receipt of $6.3 million in cash proceeds. The remaining warrants expired on January 16, 2014.

Securities Authorized for Issuance Under Equity Compensation Plans

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

Purchases of Equity Securities

The following table summarizes our repurchases of equity securities during the three months ended December 31, 2013:

Period	Total Number of Shares (or Units) Purchased		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[1]
October 1 through October 31, 2013	1,842	[2]	$35.51	—	$200,000,000
November 1 through November 30, 2013	—		—	—	200,000,000
December 1 through December 31, 2013	—		—	—	200,000,000
Total	1,842		35.51	—	

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

(2) These shares were purchased pursuant to previous elections by one or more members of our board of directors to participate in our Directors’ Deferred Stock Investment Plan. This plan is a nonqualified deferral plan allowing nonemployee directors to make advance elections to defer a fixed percentage of their director fees. The plan administrator acquires the shares in the open market which are then held in a rabbi trust. The plan provides that dividends paid on the shares held for the accounts of the directors will be reinvested in shares of our common stock which will also be held in the trust. The directors’ rights to all shares in the trust are nonforfeitable, but the shares are only released to the directors after departure from our board.

On November 18, 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock, par value $0.10 per share and liquidation preference $1,000 per share, leaving 96,245 shares of the preferred stock outstanding. See Note 8, Long-term Debt and Note 10, Convertible Perpetual Preferred Stock, to the accompanying consolidated financial statements.

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 22

companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market

Table of Contents

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, 2008 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock, including for us the $0.18 per share quarterly cash dividend. Our first quarterly cash dividend on our common stock was declared in July 2013 and paid in October 2013.

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

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

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

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

	For the Year Ended December 31,					
	Base Period	Cumulative Total Return				
Company/Index Name	2008	2009	2010	2011	2012	2013
HealthSouth	100.00	171.26	188.96	161.22	192.61	307.27
Standard & Poor’s 500 Index	100.00	126.46	145.51	148.59	172.37	228.19
S&P Health Care Services Select Industry Index	100.00	140.72	152.17	140.36	168.96	203.95

Table of Contents

Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2013, 2012, and 2011 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below for the years ended December 31, 2010 and 2009, as adjusted for discontinued operations and the reclassifications discussed in Note 1, Summary of Significant Accounting Policies, to the accompanying consolidated financial statements, from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2010. You should refer to Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and the notes to the accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations.

	For the Year Ended December 31,				
	2013	2012	2011	2010	2009
	(In Millions, Except per Share Data)				
Statement of Operations Data:					
Net operating revenues	$2,273.2	$2,161.9	$2,026.9	$1,877.6	$1,784.9
Operating earnings [1]	435.7	378.7	351.4	295.9	228.7
Provision for income tax expense (benefit) [2]	12.7	108.6	37.1	(740.8)	(2.9)
Income from continuing operations	382.5	231.4	205.8	930.7	110.4
(Loss) income from discontinued operations, net of tax [3]	(1.1)	4.5	48.8	9.1	18.4
Net income	381.4	235.9	254.6	939.8	128.8
Less: Net income attributable to noncontrolling interests	(57.8)	(50.9)	(45.9)	(40.8)	(34.0)
Net income attributable to HealthSouth	323.6	185.0	208.7	899.0	94.8
Less: Convertible perpetual preferred stock dividends	(21.0)	(23.9)	(26.0)	(26.0)	(26.0)
Less: Repurchase of convertible perpetual preferred stock [4]	(71.6)	(0.8)	—	—	—
Net income attributable to HealthSouth common shareholders	$231.0	$160.3	$182.7	$873.0	$68.8
Weighted average common shares outstanding: [5]					
Basic	88.1	94.6	93.3	92.8	88.8
Diluted	102.1	108.1	109.2	108.5	103.3
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders:[6]					
Continuing operations	$2.59	$1.62	$1.39	$9.20	$0.57
Discontinued operations	(0.01)	0.05	0.52	0.10	0.20
Net income	$2.58	$1.67	$1.91	$9.30	$0.77
Diluted earnings per share attributable to HealthSouth common shareholders:					
Continuing operations	$2.59	$1.62	$1.39	$8.20	$0.57
Discontinued operations	(0.01)	0.05	0.52	0.08	0.20
Net income	$2.58	$1.67	$1.91	$8.28	$0.77
Cash dividends per common share [7]	$0.36	$—	$—	$—	$—
Amounts attributable to HealthSouth:					
Income from continuing operations	$324.7	$180.5	$158.8	$889.8	$77.1
(Loss) income from discontinued operations, net of tax	(1.1)	4.5	49.9	9.2	17.7

Net income attributable to HealthSouth	$323.6	$185.0	$208.7	$899.0	$94.8

Table of Contents

	As of December 31,				
	2013	2012	2011	2010	2009
	(In Millions)				
Balance Sheet Data:					
Working capital	$268.8	$335.9	$178.4	$111.0	$34.8
Total assets	2,534.4	2,424.2	2,271.6	2,372.5	1,681.5
Long-term debt, including current portion [4]	1,517.5	1,253.5	1,254.7	1,511.3	1,662.5
Convertible perpetual preferred stock [4]	93.2	342.2	387.4	387.4	387.4
HealthSouth shareholders' equity (deficit)	344.6	291.0	116.4	(85.8)	(972.9)

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

(2) For information related to our Provision for income tax expense (benefit), see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and Note 16, Income Taxes, to the accompanying consolidated financial statements. During the second quarter of 2013, we entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008 and recorded a net income tax benefit of approximately $115 million. During the fourth quarter of 2010, we determined it is more likely than not a substantial portion of our deferred tax assets will be realized in the future and decreased our valuation allowance by $825.4 million through our Provision for income tax benefit in our consolidated statement of operations.

(3) Income from discontinued operations, net of tax in 2011 included post-tax gains from the sale of five of our long-term acute care hospitals and a settlement related to a previously disclosed audit of unclaimed property. See Note 15, Assets and Liabilities in and Results of Discontinued Operations, to the accompanying consolidated financial statements.

(4) During the fourth quarter of 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. See Note 8, Long-term Debt and Note 10, Convertible Perpetual Preferred Stock, to the accompanying consolidated financial statements.

(5) In the first quarter of 2013, we completed a tender offer for our common stock whereby we repurchased approximately 9.1 million shares. See Note 17, Earnings per Common Share, to the accompanying consolidated financial statements.

(6) Previously, we reported basic earnings per share of $9.41 and $0.77 for the years ended 2010 and 2009, respectively. In conjunction with the initiation of quarterly cash dividends in the third quarter of 2013, we revised our calculation to present earnings per share using the two-class method. See Note 17, Earnings per Common Share, to the accompanying consolidated financial statements.

(7) During the third quarter of 2013, our board of directors approved the initiation of a quarterly cash dividend on our common stock of $0.18 per share. See Note 17, Earnings per Common Share, to the accompanying consolidated financial statements.

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

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

30

Table of Contents

Executive Overview

Our Business

We are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. While our national network of inpatient hospitals stretches across 28 states and Puerto Rico, our inpatient hospitals are concentrated in the eastern half of the United States and Texas. As of December 31, 2013, we operated 103 inpatient rehabilitation hospitals (including two hospitals that operate as joint ventures which we account for using the equity method of accounting), 20 outpatient rehabilitation satellite clinics (operated by our hospitals), and 25 licensed, hospital-based home health agencies. In addition to HealthSouth hospitals, we manage three inpatient rehabilitation units through management contracts. For additional information about our business, see Item 1, Business.

2013 Overview

Our 2013 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals;
- continuing to expand our services to more patients who require inpatient rehabilitative services by constructing and opportunistically acquiring new hospitals in new markets; and
- considering additional shareholder value-enhancing strategies such as repurchases of our common and preferred stock and common stock dividends, recognizing that some of these actions may increase our leverage ratio.

During 2013, discharge growth of 5.0% coupled with a 0.9% increase in net patient revenue per discharge generated 5.9% growth in net patient revenue from our hospitals compared to 2012. Discharge growth was comprised of 2.5% growth from new stores and a 2.5% increase in same-store discharges. Our quality and outcome measures, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), remained well above the average for hospitals included in the UDS database, and they did so while we continued to increase our market share throughout 2013. Not only did our hospitals treat more patients and enhance outcomes, they did so in a highly cost-effective manner. As evidenced by the decrease in our Total operating expenses as a percentage of Net operating revenues, we also achieved incremental efficiencies in our cost structure. See the "Results of Operations" section of this Item.

Likewise, our growth efforts continued to yield positive results in 2013. Specifically, we:

- acquired Walton Rehabilitation Hospital, a 58-bed inpatient rehabilitation hospital in Augusta, Georgia, in April 2013;
- began accepting patients at our newly built, 40-bed inpatient rehabilitation hospital in Littleton, Colorado in May 2013;
- began accepting patients at our newly built, 34-bed inpatient rehabilitation hospital in Stuart, Florida in June 2013. This hospital is a joint venture with Martin Health System;
- completed the relocation of HealthSouth Rehabilitation Hospital of Western Massachusetts in Ludlow, Massachusetts to a newly built, 53-bed inpatient rehabilitation hospital, which replaced a leased facility;
- added 68 beds to existing hospitals; and

Table of Contents

- continued development of the following de novo hospitals:

Location	# of Beds	Actual / Expected Construction Start Date	Expected Operational Date
Altamonte Springs, Florida	50	Q4 2013	Q4 2014
Newnan, Georgia	50	Q4 2013	Q4 2014
Middletown, Delaware	34	Q4 2013	Q4 2014
Modesto, California	50	Second Half - 2014	Q4 2015
Franklin, Tennessee*	40	TBD	TBD

*A certificate of need has been awarded, but it is currently under appeal.

In 2013, we followed through on our announced intention to implement additional shareholder value-enhancing strategies. Namely, we:

- completed a tender offer for our common stock in March 2013. As a result of the tender offer, we repurchased approximately 9.1 million shares at a price of $25.50 per share for a total cost of $234.1 million, including fees and expenses relating to the tender offer;
- initiated a quarterly cash dividend of $0.18 per share on our common stock. The first quarterly dividend was declared in July 2013 and paid in October 2013; and
- received authorization from our board of directors in October 2013 for the repurchase of up to an additional $200 million of our common stock.

While implementing those shareholder value-enhancing strategies, we took additional steps to increase the strength and flexibility of our balance sheet:

- entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008. As a result of these closing agreements, we increased our deferred tax assets, primarily our federal net operating loss carryforward ("NOL"), and recorded a net income tax benefit of approximately $115 million in the second quarter of 2013. This income tax benefit primarily resulted from an approximate $283 million increase to our federal NOL on a gross basis;
- amended our credit agreement during the second quarter of 2013 to, among other things, permit unlimited restricted payments so long as the senior secured leverage ratio remains less than or equal to 1.5x and extend the revolver maturity from August 2017 to June 2018;
- purchased the real estate previously subject to leases associated with four of our hospitals for approximately $70 million during the third quarter of 2013;
- redeemed $30.2 million and $27.9 million of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and 7.75% Senior Notes due 2022, respectively, in November 2013; and
- exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock, leaving 96,245 shares of the preferred stock outstanding, in November 2013.

See the "Liquidity and Capital Resources" section of this Item and Note 8, Long-term Debt, and Note 16, Income Taxes, to the accompanying consolidated financial statements.

Business Outlook

We believe our business outlook remains reasonably positive for two primary reasons. First, demographic trends, specifically the aging of the population, will increase long-term demand for inpatient rehabilitative services. While we treat patients of all ages, most of our patients are persons 65 and older (the average age of a HealthSouth patient is 72 years) and have conditions such as strokes, hip fractures, and a variety of debilitating neurological conditions that are generally nondiscretionary in nature. We believe the demand for inpatient rehabilitative healthcare services will continue to increase as

Table of Contents

the U.S. population ages and life expectancies increase. The number of Medicare-eligible patients is expected to grow approximately 3% per year for the foreseeable future, creating an attractive market.

Second, we are the industry leader in this growing sector. As the nation's largest owner and operator of inpatient rehabilitation hospitals, we believe we differentiate ourselves from our competitors based on our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of rehabilitative technology. We have invested considerable resources into clinical and management systems and protocols that have allowed us to consistently contain cost growth. Our commitment to technology also includes the on-going implementation of our rehabilitation-specific electronic clinical information system. We believe this system will improve patient care and safety, enhance staff recruitment and retention, and set the stage for connectivity with referral sources and health information exchanges. Our hospitals also participate in The Joint Commission's Disease-Specific Care Certification Program. Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based, clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care. Currently, 96 of our hospitals hold one or more disease-specific certifications. We also account for approximately 80% of all Joint Commission disease-specific certifications in stroke nationwide.

We believe these factors align with our strengths in, and focus on, inpatient rehabilitative care. Unlike many of our competitors that may offer inpatient rehabilitation as one of many secondary services, inpatient rehabilitation is our core business. In addition, we believe we can address the demand for inpatient rehabilitative services in markets where we currently do not have a presence by constructing or acquiring new hospitals.

Longer-term, the nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain and will likely remain so for some time. The development of new delivery and payment systems will almost certainly take significant time and expense. Many of the alternative approaches being explored may not work. As outlined in the "Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section below, we are positioning the Company in a prudent manner to be responsive to industry shifts, whatever they might be.

Healthcare has always been a highly regulated industry, and we have cautioned our stakeholders that future Medicare payment rates could be at risk. While the Medicare reimbursement environment may be challenging, HealthSouth has a proven track record of adapting to and succeeding in a highly regulated environment, and we believe we are well-positioned to continue to succeed and grow. Further, we believe the regulatory and reimbursement risks discussed throughout this report may present us with opportunities to grow by acquiring or consolidating the operations of other inpatient rehabilitation providers in our highly fragmented industry. We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2018. Over the past few years, we have redeemed our most expensive debt and reduced our interest expense. We have invested in our core business and created an infrastructure that enables us to provide high-quality care on a cost-effective basis. Our balance sheet remains strong. Our leverage ratio is within our target range, we have ample availability under our revolving credit facility, and we continue to generate strong cash flows from operations. Importantly, we have flexibility with how we choose to invest our cash and return value to shareholders, including bed additions, de novos, acquisitions of other inpatient rehabilitation hospitals, purchases of leased properties, repurchases of our common and preferred stock, common stock dividends, and repayment of long-term debt. Specifically, on February 14, 2014, our board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million. See the "Liquidity and Capital Resources - Authorizations for Returning Capital to Stakeholders" section of this Item.

For these and other reasons, we believe we will be able to adapt to changes in reimbursement and sustain our business model. We also believe we will be in a position to take action should an attractive acquisition or consolidation opportunity arise.

Key Challenges

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

Table of Contents

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

- Operating in a Highly Regulated Industry. We are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These rules and regulations have affected, or could in the future affect, our business activities by having an impact on the reimbursement we receive for services provided or the costs of compliance, mandating new documentation standards, requiring licensure or certification of our hospitals, 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 beds to existing hospitals. Ensuring continuous compliance with these laws and regulations is an operating requirement for all healthcare providers.

As discussed in Item 1, Business, "Sources of Revenues," the United States Centers for Medicare and Medicaid Services ("CMS") has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. One type of audit contractor, the Recovery Audit Contractors ("RACs"), began post-payment audit processes in late 2009 for providers in general. In connection with CMS approved and announced RAC audits related to inpatient rehabilitation facilities ("IRFs"), we received requests in 2013 to review certain patient files for discharges occurring from 2010 to 2013. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient file requests have resulted in payment denial determinations by the RACs. While we make provisions for these claims based on our historical experience and success rates in the claim adjudication process, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be reviewed. During 2013, we reduced our Net operating revenues by approximately $8 million for post-payment claims that are part of this review process.

Unlike the pre-payment denials of certain diagnosis codes by Medicare Administrative Contractors ("MACs") that have been part of our operations for several years, we have not had any experience with RACs in the context of post-payment reviews of this nature. Along with our significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules, we also have a formal process for complying with RAC audits, and we are cooperating fully with the RACs during this process. However, due to additional delays announced by CMS in the related adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years.

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

Another challenge relates to reduced Medicare reimbursement, which is also discussed in Item 1A, Risk Factors. We currently estimate sequestration, which began affecting payments received after April 1, 2013, will result in a net decrease in our Net operating revenues of approximately $8 million in 2014. The effect of sequestration on year-over-year comparisons will cease on April 1, 2014. However, unless the United States Congress acts to change or eliminate sequestration, it will continue to result in a 2% decrease to reimbursements otherwise due from Medicare, after taking into consideration other changes to reimbursement rates such as market basket updates.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, and reforming the sustainable growth rate formula used to pay physicians who treat Medicare beneficiaries (the so called "Doc Fix") could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. Likewise, issues related to the federal budget or the unwillingness to raise the statutory cap on the federal government's ability to issue debt, also referred to as the "debt ceiling," may have a significant impact on the economy and indirectly on our results of operations and financial position. We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post acute care reforms, if any, will ultimately be enacted into law, or the timing or effect any such initiatives or

reductions will have on us. If enacted, such initiatives or reductions would likely be challenging for all providers, would likely have the effect of limiting Medicare beneficiaries' access to healthcare services, and could have an adverse impact on our financial position, results of operations, and cash

Table of Contents

flows. However, we believe our efficient cost structure and substantial owned real estate coupled with the steps we have taken to reduce our debt and corresponding debt service obligations should allow us to absorb, adjust to, or mitigate any potential initiative or reimbursement reductions more easily than most other inpatient rehabilitation providers.

See also Item 1, Business, "Sources of Revenues" and "Regulation," and Item 1A, Risk Factors, to this report and Note 18, Contingencies and Other Commitments, "Governmental Inquiries and Investigations," to the accompanying consolidated financial statements.

Changes to Our Operating Environment Resulting from Healthcare Reform. Our challenges related to healthcare reform are discussed in Item 1, Business, "Sources of Revenue," and Item 1A, Risk Factors. Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notably for us are the reductions to our annual market basket updates, including productivity adjustments, and future payment reforms such as Accountable Care Organizations ("ACOs") and bundled payments.

In July 2013, CMS released its notice of final rulemaking for fiscal year 2014 (the "2014 Rule") for IRFs under the prospective payment system ("IRF PPS"). The final rule would implement a net 1.8% market basket increase effective for discharges between October 1, 2013 and September 30, 2014, calculated as follows:

Market basket update	2.6%
Healthcare reform reduction	30 basis points
Productivity adjustment reduction	50 basis points

The final rule also includes other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, updates to the IRF-PPS facility-level rural adjustment factor, low-income patient factor, teaching status adjustment factor, and updates to the outlier fixed loss threshold. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the final rule, we believe the 2014 Rule will result in a net increase to our Medicare payment rates of approximately 1.95% effective October 1, 2013.

The healthcare industry in general is facing uncertainty associated with the efforts, primarily arising from initiatives included in the 2010 Healthcare Reform Laws, to identify and implement workable coordinated care delivery models. In a coordinated care delivery model, hospitals, physicians, and other care providers work together to provide coordinated healthcare on a more efficient, patient-centered basis. These providers are then paid based on the overall value of the services they provide to a patient rather than the number of services they provide. While this is consistent with our goal and proven track record of being a high-quality, cost-effective provider, broad-based implementation of a new delivery model would represent a significant transformation for the healthcare industry. As the industry and its regulators explore this transformation, we are positioning the Company in preparation for whatever changes are ultimately made to the delivery system:

- 31 of our hospitals already operate as joint ventures with acute care hospitals, and we continue to pursue joint ventures as one of our growth initiatives. These joint ventures create an immediate link to an acute care system and position us to quickly and efficiently integrate our services in a coordinated care model.
- Our electronic clinical information system is capable of interfaces with all major acute care electronic medical record systems and health information exchanges making communication easier across the continuum of healthcare providers.
- We own the real estate associated with approximately 73% of our hospitals, and all but one of our hospitals are free standing. This combined with our strong balance sheet and consistent strong free cash flows enhances our flexibility to collaborate and partner with other providers.
- We have a proven track record of being a high-quality, cost-effective provider. Our FIM® Gains consistently exceed industry results, and we have the scale and operating leverage to contribute to a low cost per discharge.

Table of Contents

- We have agreed to participate in a few bundling projects as a post-acute rehabilitation provider, and we have expressed interest in participating in several ACOs. As of December 31, 2013, we have executed one ACO participation agreement.

Given the complexity and the number of changes in the 2010 Healthcare Reform Laws, we cannot predict their ultimate impact. In addition, the ultimate nature and timing of the transformation of the healthcare delivery system is uncertain, and will likely remain so for some time. We will continue to evaluate these laws and position the Company for this industry shift. Based on our track record, we believe we can adapt to these regulatory and industry changes. Further, we have engaged, and will continue to engage, actively in discussions with key legislators and regulators to attempt to ensure any healthcare laws or regulations adopted or amended promote our goal of high-quality, cost-effective care.

- Maintaining Strong Volume Growth. Various factors may impact our ability to maintain our recent volume growth rates, including competition and increasing regulatory and administrative burdens. 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 with their own rehabilitation units and other post-acute providers with relationships with referring acute care hospitals or physicians. Overly aggressive payment review practices by Medicare contractors, excessively strict enforcement of regulatory policies by government agencies, and increasingly 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 add beds to our existing hospitals 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 to our portfolio, whether de novo construction or the product of acquisitions or joint ventures, also may be difficult and take longer than expected.

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

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

These key challenges notwithstanding, we have a strong business model, a strong balance sheet, and a proven track record of achieving strong financial and operational results. We are positioning the Company to respond to any changes in the healthcare delivery system and believe we will be in a position to take advantage of any opportunities that arise as the industry moves to this new stage. We are in a position to continue to grow, adapt to external events, and create value for our shareholders in 2014 and beyond.

Results of Operations

Payor Mix

During 2013, 2012, and 2011, we derived consolidated Net operating revenues from the following payor sources:

	For the Year Ended December 31,					
	2013		2012		2011	
Medicare	74.5	%	73.4	%	72.0	%
Medicaid	1.2	%	1.2	%	1.6	%
Workers' compensation	1.2	%	1.5	%	1.6	%
Managed care and other discount plans, including Medicare Advantage	18.5	%	19.3	%	19.8	%
Other third-party payors	1.8	%	1.8	%	2.0	%
Patients	1.1	%	1.3	%	1.2	%
Other income	1.7	%	1.5	%	1.8	%
Total	100.0	%	100.0	%	100.0	%

36

Table of Contents

Our payor mix is weighted heavily towards Medicare. Our hospitals receive Medicare reimbursements under IRF-PPS. Under IRF-PPS, our hospitals receive fixed payment amounts per discharge based on certain rehabilitation impairment categories established by the United States Department of Health and Human Services. Under IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers. For additional information regarding Medicare reimbursement, see the "Sources of Revenues" section of Item 1, Business.

Managed Medicare revenues, included in the "managed care and other discount plans" category in the above table, represented approximately 8%, 8%, and 7% of our total revenues during the years ended December 31, 2013, 2012, and 2011, respectively. During 2009, we experienced an increase in managed Medicare and private fee-for-service plans. 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 ("HMO"), preferred provider organization ("PPO"), point-of-service plan, provider sponsor organization, or an insurance plan operated in conjunction with a medical savings account. Prior to 2010, private fee-for-service plans were not required to build provider networks, did not have the same quality reporting requirements to CMS as other plans, and were reimbursed by Medicare at a higher rate. In 2010, these requirements and reimbursement rates were revised to be similar to other existing payor plans. As these requirements changed, payors began actively marketing and converting their members from private-fee-for-service plans to one of their existing HMO or PPO plans, where provider networks and reporting requirements were already established, or back to traditional Medicare coverage. This shift of payors from private fee-for-service plans back to traditional Medicare can be seen in the above table.

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 nonpatient care services. These other revenues are included in "other income" in the above table.

Under IRF-PPS, hospitals are reimbursed on a "per discharge" basis. Thus, the number of patient discharges is a key metric utilized by management to monitor and evaluate our performance. The number of outpatient visits is also tracked in order to measure the volume of outpatient activity each period.

Table of Contents

Our Results

From 2011 through 2013, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2013	2012	2011	2013 v. 2012	2012 v. 2011
	(In Millions)				
Net operating revenues	$2,273.2	$2,161.9	$2,026.9	5.1 %	6.7 %
Less: Provision for doubtful accounts	(26.0)	(27.0)	(21.0)	(3.7)%	28.6 %
Net operating revenues less provision for doubtful accounts	2,247.2	2,134.9	2,005.9	5.3 %	6.4 %
Operating expenses:					
Salaries and benefits	1,089.7	1,050.2	982.0	3.8 %	6.9