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FORM 10-K
(Annual Report)

Filed 02/20/14 for the Period Ending 12/31/13

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CIK	0000785161
Symbol	HLS
SIC Code	8060 - Hospitals
Industry	Healthcare Facilities
Sector	Healthcare
Fiscal Year	12/31

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

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

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

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

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

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

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

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

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

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

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

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

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

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $2.5 billion . For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There wer e 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.

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NOTE TO READERS

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

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 negative of these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties, many of which are beyond our control. Any forward-looking statement is based on information current as of the date of this report and speaks only as of the date on which such statement is made. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ 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.

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.

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.

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

- 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

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.

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.

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 10 th 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

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.

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

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.

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

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

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.

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

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

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.

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

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.

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

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.

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

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)

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.

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

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.

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.

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

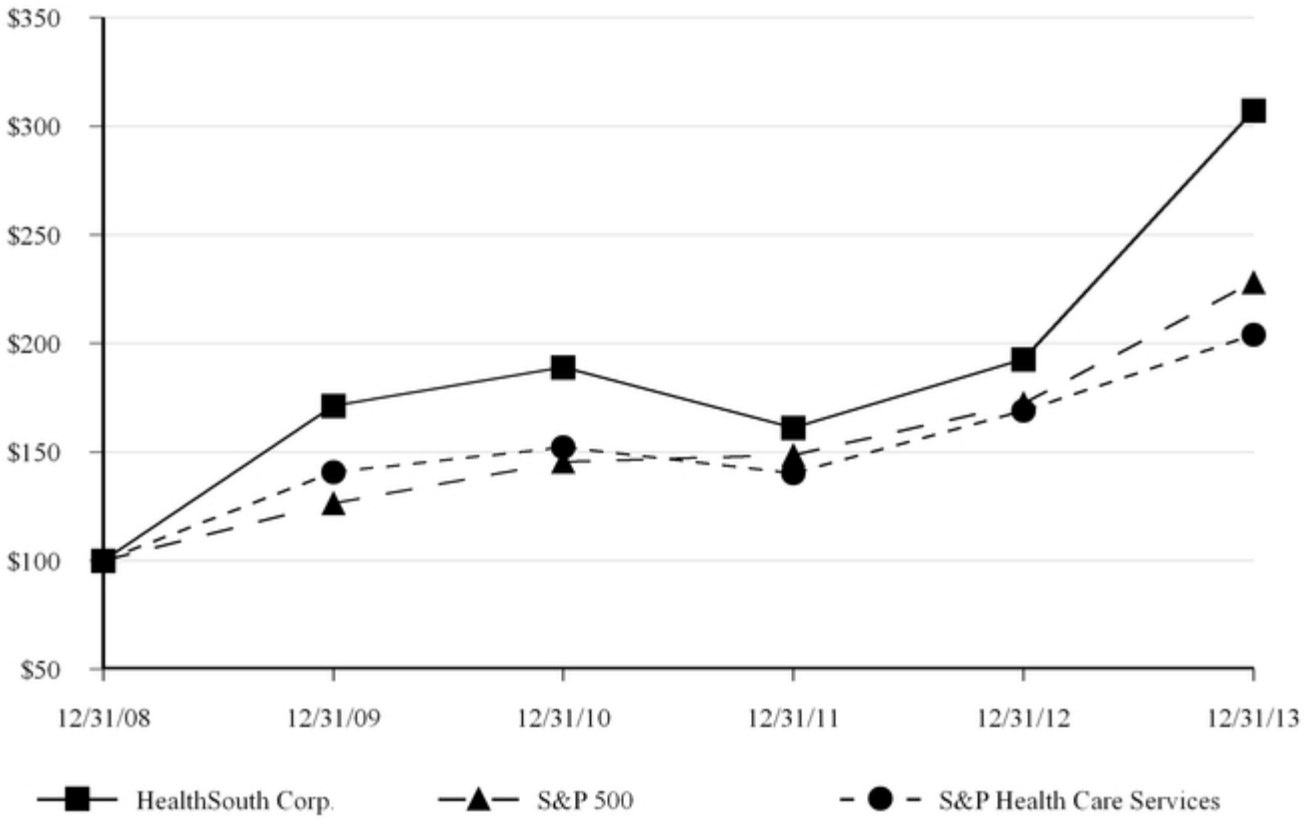
capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2008 in our common stock and each of the indices. The returns below 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

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

	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* .

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

• 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

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.

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

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.

- 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%

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.

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 %
Hospital-related expenses:					
Other operating expenses	323.0	303.8	288.3	6.3 %	5.4 %
Occupancy costs	47.0	48.6	48.4	(3.3)%	0.4 %
Supplies	105.4	102.4	102.8	2.9 %	(0.4)%
General and administrative expenses	119.1	117.9	110.5	1.0 %	6.7 %
Depreciation and amortization	94.7	82.5	78.8	14.8 %	4.7 %
Government, class action, and related settlements	(23.5)	(3.5)	(12.3)	571.4 %	(71.5)%
Professional fees—accounting, tax, and legal	9.5	16.1	21.0	(41.0)%	(23.3)%
Total operating expenses	1,764.9	1,718.0	1,619.5	2.7 %	6.1 %
Loss on early extinguishment of debt	2.4	4.0	38.8	(40.0)%	(89.7)%
Interest expense and amortization of debt discounts and fees	100.4	94.1	119.4	6.7 %	(21.2)%
Other income	(4.5)	(8.5)	(2.7)	(47.1)%	214.8 %
Equity in net income of nonconsolidated affiliates	(11.2)	(12.7)	(12.0)	(11.8)%	5.8 %
Income from continuing operations before income tax expense	395.2	340.0	242.9	16.2 %	40.0 %
Provision for income tax expense	12.7	108.6	37.1	(88.3)%	192.7 %
Income from continuing operations	382.5	231.4	205.8	65.3 %	12.4 %
(Loss) income from discontinued operations, net of tax	(1.1)	4.5	48.8	(124.4)%	(90.8)%
Net income	381.4	235.9	254.6	61.7 %	(7.3)%
Less: Net income attributable to noncontrolling interests	(57.8)	(50.9)	(45.9)	13.6 %	10.9 %
Net income attributable to HealthSouth	$ 323.6	$ 185.0	$ 208.7	74.9 %	(11.4)%

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

	For the Year Ended December 31,		
	2013	2012	2011
Provision for doubtful accounts	1.1 %	1.2 %	1.0 %
Operating expenses:			
Salaries and benefits	47.9 %	48.6 %	48.4 %
Hospital-related expenses:			
Other operating expenses	14.2 %	14.1 %	14.2 %
Occupancy costs	2.1 %	2.2 %	2.4 %
Supplies	4.6 %	4.7 %	5.1 %
General and administrative expenses	5.2 %	5.5 %	5.5 %
Depreciation and amortization	4.2 %	3.8 %	3.9 %
Government, class action, and related settlements	(1.0)%	(0.2)%	(0.6)%
Professional fees—accounting, tax, and legal	0.4 %	0.7 %	1.0 %
Total operating expenses	77.6 %	79.5 %	79.9 %

Additional information regarding our operating results for the years ended December 31, 2013 , 2012 , and 2011 is as follows:

	For the Year Ended December 31,			Percentage Change	
	2013	2012	2011	2013 v. 2012	2012 v. 2011
		(In Millions)			
Net patient revenue - inpatient	$ 2,130.8	$ 2,012.6	$ 1,866.4	5.9 %	7.8 %
Net patient revenue - outpatient & other	142.4	149.3	160.5	(4.6)%	(7.0)%
Net operating revenues	$ 2,273.2	$ 2,161.9	$ 2,026.9	5.1 %	6.7 %
		(Actual Amounts)			
Discharges	129,988	123,854	118,354	5.0 %	4.6 %
Net patient revenue per discharge	$ 16,392	$ 16,250	$ 15,770	0.9 %	3.0 %
Outpatient visits	806,631	880,182	943,439	(8.4)%	(6.7)%
Average length of stay (days)	13.3	13.4	13.5	(0.7)%	(0.7)%
Occupancy %	69.3%	68.2%	67.7%	1.6 %	0.7 %
# of licensed beds	6,825	6,656	6,461	2.5 %	3.0 %
Full-time equivalents*	16,093	15,453	15,089	4.1 %	2.4 %
Employees per occupied bed	3.42	3.42	3.47	— %	(1.4)%

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

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

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

2013 Compared to 2012

Net Operating Revenues

Net patient revenue from our hospitals was 5.9% higher for the year ended December 31, 2013 than the year ended December 31, 2012. This increase was attributable to a 5.0% increase in patient discharges and a 0.9% increase in net patient revenue per discharge. Discharge growth included a 2.5% increase in same-store discharges. Same-store discharges were negatively impacted by the divestiture of 41 skilled nursing facility beds in the first quarter of 2013. Approximately 60 basis points of discharge growth from new stores resulted from the consolidation of St. Vincent Rehabilitation Hospital beginning in the third quarter of 2012, as discussed in Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , to the accompanying consolidated financial statements. The increase in net patient revenue per discharge resulted from pricing adjustments, higher patient acuity, and a higher percentage of Medicare patients, as shown in the above payor mix table. Net patient revenue per discharge was negatively impacted in 2013 by sequestration (became effective for all discharges after April 1, 2013), the impact of post-payment claim reviews (as discussed below), and the ramping up of three new hospitals. New hospitals are required to treat a minimum of 30 patients for zero revenue as part of the Medicare certification process.

As discussed in Item 1, *Business* , and the “Critical Accounting Estimates—Revenue Recognition” section of this Item, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. 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 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.

Decreased outpatient volumes in 2013 compared to 2012 resulted from the closure of outpatient clinics and continued competition from physicians offering physical therapy services within their own offices. We had 20 and 24 outpatient rehabilitation satellite clinics as of December 31, 2013 and 2012, respectively. Outpatient and other revenues for the years ended December 31, 2013 and 2012 included $15 million and $9 million, respectively, of state provider tax refunds. These refunds are explained in more detail in the “2012 Compared to 2011 — Net Operating Revenues” section of this Item.

Provision for Doubtful Accounts

For several years, under programs designated as “widespread probes,” certain of our MACs have conducted pre-payment claim reviews of our billings and denied payment for certain diagnosis codes based on medical necessity. We dispute, or “appeal,” most of these denials, and we have historically collected approximately 58% of all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 70% success rate. The resolution of these disputes can take in excess of two years, and we cannot provide assurance as to our ongoing and future success of these disputes. As such, we make provisions against these receivables in accordance with our accounting policy that necessarily considers historical collection trends of the receivables in this review process as part of our *Provision for doubtful accounts* . Therefore, as we experience increases or decreases in these denials, or if our actual collections of these denials differs from our estimated collections, we may experience volatility in our *Provision for doubtful accounts* . See also Item 1, *Business* , “Sources of Revenues—Medicare Reimbursement,” to this report.

The change in our *Provision for doubtful accounts* as a percent of *Net operating revenues* in 2013 compared 2012 was primarily the result of a decrease in pre-payment claim denials by MACs.

Salaries and Benefits

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

Salaries and benefits increased in 2013 compared to 2012 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2012 and 2013 development activities, and increased costs associated with medical plan benefits. Because merit increases were foregone in 2012, as discussed below, management determined the Company would absorb all of the increased costs associated with medical plan benefits to employees in 2013.

These cost increases were offset by adjustments to our workers' compensation accruals in 2013 due to favorable trends in claims and industry-wide loss development trends. As a result of these continued favorable trends, we also lowered the statistical confidence level used to determine our self-insurance reserves in 2013. See the "Critical Accounting Estimates—Self-Insured Risks" section of this Item.

Salaries and benefits as a percent of *Net operating revenues* decreased in 2013 compared to 2012 due to our increasing revenue base, the favorable adjustments to our workers' compensation accruals discussed above, and the one-time, merit-based, year-end bonus paid in the fourth quarter of 2012 to all eligible nonmanagement employees in lieu of an annual merit increase. The fourth quarter of 2013 included a 2.2% merit increase whereas the fourth quarter of 2012 included an approximate $10 million bonus in lieu of a merit increase resulting in a year-over-year benefit of approximately $5.5 million in *Salaries and benefits* in 2013. The positive impact of all of the above items were offset by sequestration.

Hospital-related Expenses

Other Operating Expenses

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

Other operating expenses increased during 2013 compared to 2012 primarily as a result of increased patient volumes, including new hospitals, and the ongoing implementation of our clinical information system. *Other operating expenses* associated with the ongoing implementation of our clinical information system were approximately $3 million higher in 2013 than in 2012.

As a percent of *Net operating revenues* , *Other operating expenses* increased during 2013 compared to 2012 due to the effects of sequestration, the ramping up of operations at three new hospitals, and higher expenses associated with the ongoing implementation of our clinical information system offset by growth in our revenue base and a reduction in general and professional liability reserves due to favorable trends in claims and industry-wide loss development trends. As a result of these continued favorable trends, we also lowered the statistical confidence level used to determine our self-insurance reserves in 2013. See the "Critical Accounting Estimates—Self-Insured Risks" section of this Item.

Occupancy costs

Occupancy costs include amounts paid for rent associated with leased hospitals and outpatient rehabilitation satellite clinics, including common area maintenance and similar charges. These costs decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due to our purchases of the real estate previously subject to operating leases at certain of our hospitals in 2013 and 2012. See the "Liquidity and Capital Resources" section of this Item. *Occupancy costs* are expected to continue to decrease as a percent of *Net operating revenues* going forward.

Supplies

Supplies expense includes all costs associated with supplies used while providing patient care. Specifically, these costs include pharmaceuticals, food, needles, bandages, and other similar items. *Supplies* expense decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due to our supply chain efforts and continual focus on monitoring and actively managing pharmaceutical costs offset by sequestration.

General and Administrative Expenses

General and administrative expenses primarily include administrative expenses such as information technology services, human resources, corporate accounting, legal services, and internal audit and controls that are managed from our corporate headquarters in Birmingham, Alabama. These expenses also include stock-based compensation expenses. *General and administrative expenses* decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due primarily to our increasing revenue base.

In March 2008, we sold our corporate campus to Daniel Corporation ("Daniel"), a Birmingham, Alabama-based real estate company. The sale included a deferred purchase price component related to an incomplete 13-story building located on the property, often referred to as the Digital Hospital. Under the agreement, Daniel was obligated upon sale of its interest in the building to pay to us 40% of the net profit realized from the sale. In June 2013, Daniel sold the building to Trinity Medical Center. In the third quarter of 2013, we received $10.8 million in cash from Daniel in connection with the sale of the building. The gain associated with this transaction is being deferred and amortized over five years, which is the remaining life of our

lease agreement with Daniel for the portion of the property we continue to occupy with our corporate office, as a component of *General and administrative expenses* . Approximately $1 million of this gain was included in *General and administrative expenses* in 2013.

Depreciation and Amortization

Depreciation and amortization increased during 2013 compared to 2012 due to our increased capital expenditures throughout 2012 and 2013. We expect *Depreciation and amortization* to increase going forward as a result of our recent and ongoing capital investments.

Government, Class Action, and Related Settlements

The gain included in *Government, class action, and related settlements* in 2013 resulted from a noncash reduction in the estimated liability associated with the apportionment obligation to the plaintiffs in the January 2007 comprehensive settlement of the consolidated securities action, the collection of final judgments against former officers, and the recovery of assets from former officers, as discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements. The gain included in *Government, class action, and related settlements* in 2012 resulted from the recovery of assets from former officers.

Professional Fees — Accounting, Tax, and Legal

Professional fees—accounting, tax, and legal for 2013 and 2012 related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements. These expenses in 2012 also included legal and consulting fees for the pursuit of our remaining income tax benefits as discussed in Note 16, *Income Taxes* , to the accompanying consolidated financial statements.

Loss on Early Extinguishment of Debt

The *Loss on early extinguishment of debt* in 2013 resulted from the redemption of 10% of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022 in November 2013. The *Loss on early extinguishment of debt* in 2012 resulted from the amendment to our credit agreement in August 2012 and the redemption of 10% of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022 in October 2012. See Note 8, *Long-term Debt* , to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* during 2013 compared to 2012 resulted from an increase in our average borrowings outstanding offset by a decrease in our average cash interest rate. Average borrowings outstanding increased during 2013 compared to 2012 primarily as a result of our issuance of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 in September 2012. Our average cash interest rate approximated 7.1% and 7.2% during 2013 and 2012, respectively. The decrease in our average cash interest rate primarily resulted from the August 2012 amendment to our credit agreement that lowered the interest rate spread on our revolving credit facility by 50 basis points.

In November 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 preferred stock. Due to discounts and financing costs, the effective interest rate on the convertible notes is 6.0%. As a result of this exchange, interest expense is expected to increase in 2014.

See Note 8, *Long-term Debt* , to the accompanying consolidated financial statements.

Other Income

Other income is primarily comprised of interest income and gains and losses on sales of investments. In 2012, *Other income* included a $4.9 million gain as a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. See Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

The increase in our pre-tax income from continuing operations in 2013 compared to 2012 resulted from increased *Net operating revenues* and continued disciplined expense management. Pre-tax income in 2013 and 2012 included gains of $23.5 million and $3.5 million , respectively, related to *Government, class action, and related settlements* , as discussed above. Pre-tax income for 2012 also included a $4.9 million gain on the consolidation of St. Vincent Rehabilitation Hospital, as discussed above.

Provision for Income Tax Expense

Due to our federal and state NOLs, our cash income taxes approximated $8 million, net of refunds, in 2013. These payments resulted primarily from state income tax expense of subsidiaries which have separate state filing requirements, alternative minimum taxes, and federal income taxes for subsidiaries not included in our federal consolidated income tax return. In 2014, we estimate we will pay approximately $10 million to $15 million of cash income taxes, net of refunds. In 2013 and 2012, current income tax expense was $6.3 million and $5.9 million , respectively.

In April 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. As a result of these closing agreements, we increased our deferred tax assets, primarily our federal 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.

Our effective income tax rate for 2013 was 3.2% . Our *Provision for income tax expense* in 2013 was less than the federal statutory rate of 35.0% primarily due to: (1) the IRS settlement discussed above, (2) the impact of noncontrolling interests, and (3) a decrease in our valuation allowance offset by (4) state income tax expense. The decrease in our valuation allowance in 2013 related primarily to our capital loss carryforwards, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws. During the second quarter of 2013, we determined a valuation allowance related to our capital loss carryforwards was no longer required as sufficient positive evidence existed to substantiate their utilization. This evidence included our partial utilization of these assets as a result of realizing capital gains in 2013 and the identification of sufficient taxable capital gain income within the available capital loss carryforward period. See also Note 1, *Summary of Significant Accounting Policies* , “Income Taxes,” to the accompanying consolidated financial statements for a discussion of the allocation of income or loss related to pass-through entities, which we refer to as the impact of noncontrolling interests in this discussion.

Our effective income tax rate for 2012 was 31.9% . Our *Provision for income tax expense* in 2012 was less than the federal statutory rate of 35.0% primarily due to: (1) the impact of noncontrolling interests and (2) a decrease in the valuation allowance offset by (3) state income tax expense.

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

We recognize the financial statement effects of uncertain tax positions when it is more likely than not, based on the technical merits, a position will be sustained upon examination by and resolution with the taxing authorities. Total remaining gross unrecognized tax benefits were $1.1 million and $78.0 million as of December 31, 2013 and 2012, respectively. The amount of gross unrecognized tax benefits changed during 2013 primarily due to the settlement with the IRS discussed above.

See Note 16, *Income Taxes* , to the accompanying consolidated financial statements and the “Critical Accounting Estimates” section of this Item.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests represents the share of net income or loss allocated to members or partners in our consolidated affiliates. Fluctuations in these amounts are primarily driven by the financial performance of the applicable hospital population each period. Approximately $4 million of the increase in noncontrolling interests in 2013 compared to 2012 was due to changes at two of our existing hospitals. During 2013, we entered into an agreement to convert our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare, as discussed in Note 11,

Redeemable Noncontrolling Interests , to the accompanying consolidated financial statements. In addition, our share of profits from our joint venture hospital in Memphis, Tennessee decreased in 2013 from 70% to 50% pursuant to the terms of that partnership agreement entered into in 1993.

2012 Compared to 2011

Net Operating Revenues

Net patient revenue from our hospitals was 7.8% higher for the year ended December 31, 2012 than the year ended December 31, 2011. This increase was attributable to a 4.6% increase in patient discharges and a 3.0% increase in net patient revenue per discharge. Discharge growth was comprised of 1.7% growth from new stores and a 2.9% increase in same-store discharges. Discharge growth was enhanced during 2012 compared to 2011 by the additional day in February due to leap year as well as a 60 basis point increase in discharges resulting from the consolidation of St. Vincent Rehabilitation Hospital beginning in the third quarter of 2012, as discussed in Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , to the accompanying consolidated financial statements. Net patient revenue per discharge in 2012 benefited from pricing adjustments, higher patient acuity, and a higher percentage of Medicare patients (as shown in the above payor mix table).

Outpatient and other revenues include the receipt of state provider taxes. A number of states in which we operate hospitals assess a provider tax to certain healthcare providers. Those tax revenues at the state level are generally matched by federal funds. In order to induce healthcare providers to serve low income patients, many states redistribute a substantial portion of these funds back to the various providers. These redistributions are based on different metrics than those used to assess the tax, and are thus in different amounts and proportions than the initial tax assessment. As a result, some providers receive a net benefit while others experience a net expense. See the discussion of *Other operating expenses* below for information on state provider tax expenses.

While state provider taxes are a regular component of our operating results, during 2011, a new provider tax was implemented in Pennsylvania where we operate nine inpatient hospitals. As a result of the implementation of this new provider tax in Pennsylvania, we recorded approximately $5 million in revenues related to the period from July 1, 2010 through December 31, 2010 when we were notified by Pennsylvania of the specific provider tax refund to be issued to us after Pennsylvania had received approval from CMS on its amended state plan relative to these taxes.

Excluding the state provider tax refunds discussed above, outpatient and other revenues decreased during 2012 compared to 2011 due to the decrease in outpatient volumes, the closure of outpatient satellite clinics in prior periods, and a reduction in home health pricing related to the 2012 Medicare home health rule. Outpatient volumes in the fourth quarter of 2012 were negatively impacted by the implementation of therapy caps to all hospital-based outpatient programs. The Middle Class Tax Relief and Job Creation Act of 2012 applied therapy caps limiting how much Medicare will pay for medically necessary outpatient therapy services per Medicare patient in any one calendar year starting October 1, 2012. When this was implemented in October 2012, many Medicare beneficiaries had already reached their cap limit for 2012 and chose not to receive additional outpatient therapy services since such services would not be covered by Medicare. The decrease in outpatient volumes was slightly offset by an increase in the number of home health visits included in these volume metrics.

Provision for Doubtful Accounts

The change in the *Provision for doubtful accounts* as a percent of *Net operating revenues* in 2012 compared to 2011 was primarily the result of an increase in Medicare claim denials and a lengthening in the related adjudication process.

Salaries and Benefits

Salaries and benefits increased in 2012 compared to 2011 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2012 and 2011 development activities and the consolidation of St. Vincent Rehabilitation Hospital discussed above, an approximate 2% merit increase provided to employees on October 1, 2011, a change in the skills mix of employees at our hospitals, and a one-time, merit-based, year-end bonus paid in the fourth quarter of 2012 to all eligible nonmanagement employees. As part of the standardization of our labor practices across all of our hospitals and as part of our efforts to continue to provide high-quality inpatient rehabilitative services, our hospitals are utilizing more registered nurses and certified rehabilitation registered nurses, which increases our average cost per full-time equivalent, and fewer licensed practical nurses. These increases were offset by reductions in self-insured workers' compensation costs primarily due to revised actuarial estimates resulting from better-than-expected claims experience in prior years and a reduction in group medical costs due to favorable claim trends.

We did not grant a merit increase to our employees on October 1, 2012. Rather, we replaced merit increases in 2012 with a one-time, merit-based, year-end bonus paid in the fourth quarter of 2012 to all eligible nonmanagement employees. We did this to reward our nonmanagement employees for their performance in 2012 while not carrying the additional costs associated with a merit increase into 2013 and beyond where we face the impact of sequestration and the risk of potential additional Medicare reimbursement reductions. *Salaries and benefits* increased by approximately $10 million in the fourth quarter of 2012 as a result of this special bonus. This bonus was approximately $4.5 million more than would have been included in our fourth quarter 2012 results had we given a 2.25% merit increase to all nonmanagement employees effective October 1, 2012.

Salaries and benefits as a percent of *Net operating revenues* increased in 2012 compared to 2011. This increase was primarily attributable to the higher skills mix of our employees in 2012 compared to 2011, the one-time bonus discussed above, and the ramping up of operations at our newly opened hospital in Ocala, Florida (i.e., costs with no to little revenues) offset by continued improvement in labor productivity, as shown in our EPOB metric above.

Hospital-related Expenses

Other Operating Expenses

As a percent of *Net operating revenues* , *Other operating expenses* decreased during 2012 compared to 2011 due primarily to our increasing revenue base as well as a decrease in self-insurance costs in 2012. As disclosed previously, we update our actuarial estimates surrounding our self-insurance reserves in June and December of each year. Self-insurance costs associated with professional and general liability risks were less in 2012 than in 2011 due to revised actuarial estimates resulting from better-than-expected claims experience in prior years. See Note 9, *Self-Insured Risks* , to the accompanying consolidated financial statements.

Other operating expenses in 2011 included approximately $3 million of expenses associated with the implementation of the new Pennsylvania state provider tax program, as discussed above, offset by a $2.4 million nonrecurring franchise tax recovery. *Other operating expenses* associated with the implementation of our electronic clinical information system were approximately $3 million higher in 2012 than in 2011.

Occupancy costs

Occupancy costs decreased as a percent of *Net operating revenues* in 2012 compared to 2011 due to our purchase of the land and building previously subject to an operating lease associated with our joint venture hospital in Fayetteville, Arkansas.

Supplies

Supplies expense decreased as a percent of *Net operating revenues* in 2012 compared to 2011 due to our increasing revenue base, our supply chain efforts, and our continual focus on monitoring and actively managing pharmaceutical costs.

General and Administrative Expenses

The increase in *General and administrative expenses* during 2012 compared to 2011 primarily resulted from increased expenses associated with stock-based compensation. Our restricted stock awards contain vesting requirements that include a service condition, market condition, performance condition, or a combination thereof. Due to the Company’s operating performance, our noncash expenses associated with these awards increased in 2012.

Depreciation and Amortization

While our capital expenditures increased during the latter half of 2011 and all of 2012, the majority of these expenditures related to land and construction in progress for our de novo hospitals and capitalized software costs associated with the implementation of our electronic clinical information system at our hospitals. Depreciation on these assets, excluding land which is nondepreciable, does not begin until the applicable assets are placed in service. Therefore, while we expect depreciation and amortization to increase going forward, we did not experience a significant increase in these charges during 2012.

Government, Class Action, and Related Settlements

The gain included in *Government, class action, and related settlements* in 2012 and 2011 resulted from the recovery of assets from former officers, as discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements.

Professional Fees — Accounting, Tax, and Legal

In 2012 and 2011, *Professional fees—accounting, tax, and legal* related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements. These fees in 2012 and 2011 specifically included $1.4 million and $5.2 million, respectively, related to our obligation to pay 35% of any recovery from Richard Scrushy to the attorneys for the derivative shareholder plaintiffs. These expenses in 2012 also included legal and consulting fees for the pursuit of our remaining income tax benefits, as discussed in Note 16, *Income Taxes* , to the accompanying consolidated financial statements.

Loss on Early Extinguishment of Debt

The *Loss on early extinguishment of debt* in 2012 resulted from the amendment to our credit agreement in August 2012 and the redemption of 10% of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022 in October 2012. The *Loss on early extinguishment of debt* in 2011 was the result of our redemption of all of our 10.75% Senior Notes due 2016 in June and September of 2011. See Note 8, *Long-term Debt* , to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The decrease in *Interest expense and amortization of debt discounts and fees* during 2012 compared to 2011 was due to a decrease in our average borrowings outstanding and a decrease in our average cash interest rate.

During 2011, we reduced total debt by approximately $257 million, including the redemption of our 10.75% Senior Notes due 2016. Our average cash interest rate was 7.2% during 2012 compared to 8.0% for 2011. Our average cash interest rate decreased as a result of the redemption of the 10.75% Senior Notes due 2016 during 2011, which was our most expensive debt, as well as the amendment to our credit agreement in May 2011 which reduced by 100 basis points each of the various applicable interest rates for any outstanding balance on our revolving credit facility. In addition, pricing on our term loan and revolving credit facility declined an additional 25 basis points in the third quarter of 2011 in conformity with our credit agreement's leverage grid. In addition, the August 2012 amendment to our credit agreement lowered the interest rate spread on our revolving credit facility by an additional 50 basis points. See Note 8, *Long-term Debt* , to the accompanying consolidated financial statements.

Other Income

In 2012, *Other income* included a $4.9 million gain as a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. See Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Excluding the *Loss on early extinguishment of debt* during 2011, the increase in our pre-tax income from continuing operations in 2012 compared to 2011 resulted from increased *Net operating revenues* , improved operating leverage and labor productivity, and a decrease in interest expense.

Provision for Income Tax Expense

Our effective income tax rate for 2012 was 31.9%. Our *Provision for income tax expense* in 2012 was less than the federal statutory rate of 35.0% primarily due to: (1) the impact of noncontrolling interests and (2) a decrease in the valuation allowance offset by (3) state income tax expense.

Our effective income tax rate for 2011 was 15.3%. The *Provision for income tax expense* in 2011 was less than the federal statutory rate primarily due to: (1) an approximate $28 million benefit associated with a current period net reduction in the valuation allowance and (2) an approximate $18 million net benefit associated with settlements with various taxing authorities including the settlement of federal income tax claims with the Internal Revenue Service for tax years 2007 and 2008 offset by (3) approximately $7 million of net expense primarily related to corrections to 2010 deferred tax assets associated

with our NOLs and corresponding valuation allowance. See Note 1, *Summary of Significant Accounting Policies* , "Out-of-Period Adjustments," to the accompanying consolidated financial statements.

In 2012, we paid approximately $10 million of cash income taxes, net of refunds. In 2011, we received $0.5 million of net income tax refunds. In 2012 and 2011, current income tax expense was $5.9 million and $0.6 million , respectively.

See Note 16, *Income Taxes* , to the accompanying consolidated financial statements.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests increased in 2012 compared to 2011 due to the financial performance of the applicable hospital population each period, bed additions at joint venture hospitals, the consolidation of St. Vincent Rehabilitation Hospital beginning in the third quarter of 2012 (see Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , to the accompanying consolidated financial statements), and the purchase of the land and building previously subject to an operating lease associated with our joint venture hospital in Fayetteville, Arkansas.

Impact of Inflation

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

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

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

Relationships and Transactions with Related Parties

Related party transactions are not material to our operations, and therefore, are not presented as a separate discussion within this Item.

Results of Discontinued Operations

The operating results of discontinued operations are as follows (in millions):

	For the Year Ended December 31,		
	2013	**2012**	**2011**
Net operating revenues	$ 0.2	$ 1.0	$ 95.7
Less: Provision for doubtful accounts	0.3	—	(1.5)
Net operating revenues less provision for doubtful accounts	0.5	1.0	94.2
Costs and expenses	0.2	0.2	66.3
Impairments	1.1	—	6.8
(Loss) income from discontinued operations	(0.8)	0.8	21.1
(Loss) gain on disposal of assets/sale of investments of discontinued operations	(0.4)	5.0	65.6
Income tax benefit (expense)	0.1	(1.3)	(37.9)
(Loss) income from discontinued operations, net of tax	$ (1.1)	$ 4.5	$ 48.8

Our results of discontinued operations primarily included the operations of six long-term acute care hospitals ("LTCHs"). In August 2011, we completed a transaction to sell five LTCHs to certain subsidiaries of LifeCare Holdings, Inc. for an aggregate purchase price of $117.5 million . We closed the sixth LTCH in August 2011 and sold the associated real estate in December 2013.

In addition, as discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements, in April 2011, we entered into a definitive settlement and release agreement with the state of Delaware (the "Delaware Settlement") relating to a previously disclosed audit of unclaimed property conducted on behalf of Delaware and two other states by Kelmar Associates, LLC. During 2011, we recorded a $24.8 million gain in connection with this settlement as part of our results of discontinued operations.

The impairment charges presented in the above table for 2013 and 2011 related to the LTCH that was closed in 2011. We determined the fair value of the impaired long-lived assets at this LTCH based on offers from potential buyers of the closed facility's real estate. The impairment charges for 2011 also relate to the Dallas Medical Center that was closed in 2008. We determined the fair value of the impaired long-lived assets at this hospital based on the assets' estimated fair value using valuation techniques that included third-party appraisals and offers from potential buyers.

During 2012, we recognized gains associated with the sale of the real estate of Dallas Medical Center and an investment we had in a cancer treatment center that was part of our former diagnostic division. As a result of the transaction to sell five of our LTCHs, we recorded a $65.6 million pre-tax gain as part of our results of discontinued operations in 2011.

Income tax expense recorded as part of our results of discontinued operations in 2011 related primarily to the gain from the sale of five of our LTCHs and the Delaware Settlement.

See also Note 15, *Assets and Liabilities in and Results of Discontinued Operations* , to the accompanying consolidated financial statements.

In connection with the 2007 sale of our surgery centers division (now known as Surgical Care Affiliates, or "SCA") to ASC Acquisition LLC, an affiliate of TPG Partners V, L.P. ("TPG"), a private investment partnership, we received an option, subject to terms and conditions set forth below, to purchase up to a 5% equity interest in SCA. The price of the option is equal to the original issuance price of the units subscribed for by TPG and certain other co-investors in connection with the acquisition plus a 15% annual premium, compounded annually. The option has a term of ten years and is exercisable upon certain liquidity events, including a public offering of SCA's shares of common stock that results in 30% or more of SCA's common stock being listed or traded on a national securities exchange. On November 4, 2013, SCA announced the closing of its initial public offering, which was not a qualifying liquidity event. If there is a secondary offering that results in a qualifying liquidity event under our option agreement with TPG, we intend to exercise our rights pursuant to the option. If the option becomes exercisable, we believe it will have a strike price below the price of the asset being purchased.

Liquidity and Capital Resources

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

The objectives of our capital structure strategy are to ensure we maintain adequate liquidity and flexibility. Maintaining adequate liquidity includes supporting the execution of our operating and strategic plans and allowing us to weather temporary disruptions in the capital markets and general business environment. Maintaining flexibility in our capital structure includes limiting concentrations of debt maturities in any given year, allowing for debt prepayments without onerous penalties, and ensuring our debt agreements are limited in restrictive terms and maintenance covenants.

With these objectives in mind, in June 2013, we amended our credit agreement 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 (see Note 8, *Long-term Debt* , 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. Our balance sheet remains strong. Our leverage ratio is within our target range, and we have ample availability under our revolving credit facility. We continue to generate strong cash flows from operations, and we have flexibility with how we choose to invest our cash and return value to shareholders.

Current Liquidity

As of December 31, 2013 , we had $64.5 million in *Cash and cash equivalents* . This amount excludes $ 52.4 million in *Restricted cash* and $47.6 million of restricted marketable securities ($42.9 million of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheet). Our restricted assets pertain primarily to obligations associated with our captive insurance company, as well as obligations we have under agreements with joint venture partners. See Note 3, *Cash and Marketable Securities* , to the accompanying consolidated financial statements.

In addition to *Cash and cash equivalents* , as of December 31, 2013 , we had approximately $519 million available to us under our revolving credit facility. Our credit agreement governs the majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $75 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2013 , the maximum leverage ratio requirement per our credit agreement was 4.5x and the minimum interest coverage ratio requirement was 2.75x, and we were in compliance with these covenants.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2018, and our bonds all mature in 2018 and beyond. See the “Contractual Obligations” section below for information related to our contractual obligations as of December 31, 2013 .

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

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

Sources and Uses of Cash

The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2013 , 2012 , and 2011 (in millions):

	For the Year Ended December 31,		
	2013	**2012**	**2011**
Net cash provided by operating activities	$ 470.3	$ 411.5	$ 342.7
Net cash used in investing activities	(226.2)	(178.8)	(24.6)
Net cash used in financing activities	(312.4)	(130.0)	(336.3)
(Decrease) increase in cash and cash equivalents	$ (68.3)	$ 102.7	$ (18.2)

2013 Compared to 2012

Operating activities. Net cash provided by operating activities increased from 2012 to 2013 due primarily to increased *Net operating revenues* and continued disciplined expense management.

Investing activities . The increase in *Net cash used in investing activities* during 2013 compared to 2012 primarily resulted from increased capital expenditures and the acquisition of Walton Rehabilitation Hospital. The increase in our capital expenditures in 2013 primarily resulted from the purchase of the real estate previously subject to leases associated with four of our hospitals, as discussed below. *Net cash used in investing activities* during 2013 also included the receipt of $10.8 million related to the sale of the Digital Hospital. See Note 2, *Business Combinations* , and Note 5, *Property and Equipment* , to the accompanying consolidated financial statements.

Financing activities . The increase in *Net cash used in financing activities* during 2013 compared to 2012 primarily resulted from repurchases of our common stock as part of the tender offer completed in the first quarter of 2013. As discussed in Note 17, *Earnings per Common Share* , to the accompanying consolidated financial statements, we repurchased approximately 9.1 million shares of our common stock for $234.1 million, including fees and expenses related to the tender offer.

2012 Compared to 2011

Operating activities. The increase in *Net cash provided by operating activities* from 2011 to 2012 primarily resulted from the increase in our *Net operating revenues* , improved operating leverage, and a decrease in interest expense. *Net cash provided by operating activities* for 2011 included $26.9 million related to the premium paid in conjunction with the redemption of our 10.75% Senior Notes and a $16.2 million decrease in the liability associated with refunds due patients and

other third-party payors. The decrease in this liability primarily related to a settlement discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements.

Investing activities . *Cash flows used in investing activities* during 2011 included $107.9 million of proceeds from the sale of five of our LTCHs in August 2011. Excluding these proceeds, the increase in *Cash flows used in investing activities* resulted from increased capital expenditures, including capitalized software costs, in 2012 compared to 2011. The increase in our capital expenditures in 2012 primarily resulted from: de novo development activities including land purchases, increased hospital refresh projects, implementation of our electronic clinical information system, and the purchase of the real estate associated with our joint venture hospital in Fayetteville, Arkansas (see also “financing activities” below).

Financing activities . *Cash flows used in financing activities* during 2012 included the repurchase of 46,645 shares of our convertible perpetual preferred stock, distributions to noncontrolling interests of consolidated affiliates, dividends paid on our preferred stock, and net principal payments on debt offset by capital contributions from consolidated affiliates primarily associated with the purchase of the real estate associated with our joint venture hospital in Fayetteville, Arkansas. *Cash flows used in financing activities* during 2011 included net principal payments on debt, including the redemption of our 10.75% Senior Notes due 2016, distributions to noncontrolling interests of consolidated affiliates, and dividends paid on our preferred stock. Net debt payments, including debt issue costs, were approximately $21 million and $271 million for the years ended December 31, 2012 and 2011, respectively.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2013 are as follows (in millions):

	Total	2014	2015-2016	2017-2018	2019 and thereafter
Long-term debt obligations:					
Long-term debt, excluding revolving credit facility and capital lease obligations [a]	$ 1,383.6	$ 6.3	$ 4.9	$ 274.6	$ 1,097.8
Revolving credit facility	45.0	—	—	45.0	—
Interest on long-term debt [b]	682.3	89.3	177.8	172.1	243.1
Capital lease obligations [c]	175.5	12.3	27.1	26.9	109.2
Operating lease obligations [d][e]	253.9	37.9	67.0	48.3	100.7
Purchase obligations [e][f]	121.4	26.3	48.4	20.9	25.8
Other long-term liabilities [g][h]	3.8	0.2	0.4	0.4	2.8
Total	$ 2,665.5	$ 172.3	$ 325.6	$ 588.2	$ 1,579.4

[a] Included in long-term debt are amounts owed on our bonds payable and other notes payable. These borrowings are further explained in Note 8, *Long-term Debt* , to the accompanying consolidated financial statements.

[b] Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2013 . Interest related to capital lease obligations is excluded from this line. Future minimum payments, which are accounted for as interest, related to sale/leaseback transactions involving real estate accounted for as financings are included in this line (see Note 5, *Property and Equipment* , and Note 8, *Long-term Debt* , to the accompanying consolidated financial statements). Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of operations.

[c] Amounts include interest portion of future minimum capital lease payments.

[d] We lease approximately 27% of our hospitals as well as other property and equipment under operating leases in the normal course of business. Some of our hospital leases contain escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The minimum lease payments do not include contingent rental expense. Some lease agreements provide us with the option to renew the lease or purchase the leased property. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. For more information, see Note 5, *Property and Equipment* , to the accompanying consolidated financial statements.

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

(f) Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on HealthSouth and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support.

(g) Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: general liability, professional liability, and workers' compensation risks, noncurrent amounts related to third-party billing audits, and deferred income taxes. Also, as of December 31, 2013 , we had $1.1 million of total gross unrecognized tax benefits. For more information, see Note 9, *Self-Insured Risks* , Note 16, *Income Taxes* , and Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements. See also the discussion below of our purchases of the real estate associated with leased properties.

(h) The table above does not include *Redeemable noncontrolling interests* of $13.5 million because of the uncertainty surrounding the timing and amounts of any related cash outflows.

Our capital expenditures include costs associated with our hospital refresh program, de novo projects, capacity expansions, technology initiatives, and building and equipment upgrades and purchases. During the year ended December 31, 2013 , we made capital expenditures of $ 216.5 million for property and equipment and capitalized software. These expenditures included costs associated with our investment in a new hospital to replace our formerly leased hospital in Ludlow, Massachusetts as well as approximately $70 million to purchase four leased properties, as discussed below. This amount is exclusive of $28.9 million related to the acquisition of Walton Rehabilitation Hospital in Augusta, Georgia. Approximately $75 million of the total spent was considered nondiscretionary expenditures, which we may refer to in other filings as "maintenance" expenditures.

During 2014 , we expect to spend approximately $185 million to $230 million for capital expenditures. This estimated range for capital expenditures is exclusive of acquisitions. Approximately $90 million to $100 million of this budgeted amount is considered nondiscretionary expenditures. This range of nondiscretionary expenditures includes approximately $12 million of hospital and technology equipment that was received in 2013 but not paid for until 2014. These items were not reflected in our statement of cash flows for 2013. Actual amounts spent will be dependent upon the timing of construction projects.

In the third quarter of 2013, we purchased the real estate previously subject to leases associated with four of our hospitals for approximately $70 million: Tallahassee, Florida; Montgomery, Alabama; Nittany Valley, Pennsylvania; and York, Pennsylvania. In addition, we have given notice of our intent to exercise the purchase option included in one other lease agreement associated with our hospitals. We continue to negotiate with the applicable landlord to finalize the fair value purchase price under the related lease agreement.

In December 2013, we signed an agreement to acquire an additional 30% equity interest from UMass Memorial Health Care, our joint venture partner in Fairlawn Rehabilitation Hospital in Worcester, Massachusetts. This transaction, which is subject to regulatory approval and is expected to close in 2014, will increase our ownership interest from 50% to 80% and will, when completed, result in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. As a result of the consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, we expect to record a $22 million to $32 million gain during 2014.

Authorizations for Returning Capital to Stakeholders

On February 15, 2013, our board of directors approved an increase in our existing common stock repurchase authorization from $125 million to $350 million. Consistent with our strategy of deploying financial resources towards long-term, shareholder value-creating opportunities, during the first quarter of 2013, we completed a tender offer for our common stock. As a result of the tender offer, we purchased 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. We used a combination of cash on hand and availability under our revolving credit facility to fund the repurchases. The remaining repurchase authorization expired at the end of the tender offer.

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 was paid on October 15, 2013 to stockholders of record as of the close of business on October 1, 2013. On October 25, 2013, our board of directors declared a cash dividend of $0.18 per share payable on January 15, 2014 to stockholders of record 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 established by our board of directors each quarter after consideration of various factors, including our capital position and the best interests of our stockholders. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our revolving credit facility.

The payment of cash dividends on our common stock triggers antidilution adjustments, except in instances when such adjustments are deemed *de minimis*, under some of our securities that are convertible or exercisable into common stock. See Note 17, *Earnings per Common Share* , to the accompanying consolidated financial statements.

On October 25, 2013, 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. Any repurchases under this authorization are expected to be funded using a combination of cash on hand and availability under our $600 million revolving credit facility.

Adjusted EBITDA

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

We use Adjusted EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our credit agreement, which is discussed in more detail in Note 8, *Long-term Debt* , to the accompanying consolidated financial statements. These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under our credit agreement—our interest coverage ratio and our leverage ratio—could result in our lenders requiring us to immediately repay all amounts borrowed. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might not be on terms favorable to those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, referred to as “Adjusted Consolidated EBITDA” there, allows us to add back to consolidated *Net income* interest expense, income taxes, and depreciation and amortization and then add back to consolidated *Net income* (1) all unusual or nonrecurring items reducing consolidated *Net income* (of which only up to $10 million in a year may be cash expenditures), (2) costs and expenses related to refinancing transactions (in years prior to 2012), (3) any losses from discontinued operations and closed locations, (4) costs and expenses, including legal fees and expert witness fees, incurred with respect to litigation associated with stockholder derivative litigation, including the matters related to Ernst & Young LLP and Richard Scrushy discussed in Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements, and (5) share-based compensation expense. We also subtract from consolidated *Net income* all unusual or nonrecurring items to the extent increasing consolidated *Net income* .

Under the credit agreement, the Adjusted EBITDA calculation does not include net income attributable to noncontrolling interests and includes (1) gain or loss on disposal of assets, (2) professional fees unrelated to the stockholder derivative litigation, and (3) unusual or nonrecurring cash expenditures in excess of $10 million. These items may not be indicative of our ongoing performance, so the Adjusted EBITDA calculation presented here includes adjustments for them.

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

Our Adjusted EBITDA for the years ended December 31, 2013 , 2012 , and 2011 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,		
	2013	**2012**	**2011**
Net income	$ 381.4	$ 235.9	$ 254.6
Loss (income) from discontinued operations, net of tax, attributable to HealthSouth	1.1	(4.5)	(49.9)
Provision for income tax expense	12.7	108.6	37.1
Interest expense and amortization of debt discounts and fees	100.4	94.1	119.4
Loss on early extinguishment of debt	2.4	4.0	38.8
Professional fees—accounting, tax, and legal	9.5	16.1	21.0
Government, class action, and related settlements	(23.5)	(3.5)	(12.3)
Net noncash loss on disposal or impairment of assets	5.9	4.4	4.3
Depreciation and amortization	94.7	82.5	78.8
Stock-based compensation expense	24.8	24.1	20.3
Net income attributable to noncontrolling interests	(57.8)	(50.9)	(45.9)
Gain on consolidation of St. Vincent Rehabilitation Hospital	—	(4.9)	—
Adjusted EBITDA	$ 551.6	$ 505.9	$ 466.2

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,		
	2013	**2012**	**2011**
Net cash provided by operating activities	$ 470.3	$ 411.5	$ 342.7
Provision for doubtful accounts	(26.0)	(27.0)	(21.0)
Professional fees—accounting, tax, and legal	9.5	16.1	21.0
Interest expense and amortization of debt discounts and fees	100.4	94.1	119.4
Equity in net income of nonconsolidated affiliates	11.2	12.7	12.0
Net income attributable to noncontrolling interests in continuing operations	(57.8)	(50.9)	(47.0)
Amortization of debt discounts and fees	(5.0)	(3.7)	(4.2)
Distributions from nonconsolidated affiliates	(11.4)	(11.0)	(13.0)
Current portion of income tax expense	6.3	5.9	0.6
Change in assets and liabilities	48.9	58.1	41.4
Premium received on bond issuance	—	—	(4.1)
Premium paid on bond redemption	1.7	1.9	26.9
Operating cash used in (provided by) discontinued operations	1.9	(2.0)	(9.1)
Other	1.6	0.2	0.6
Adjusted EBITDA	$ 551.6	$ 505.9	$ 466.2

Growth in Adjusted EBITDA in each year was due primarily to revenue growth and disciplined expense management. Adjusted EBITDA for 2013 benefited from $6.7 million of adjustments to self-insurance reserves resulting from our change in assumptions related to our statistical confidence level, as discussed in the “Critical Accounting Estimates—Self-Insured Risks” section of this Item. Sequestration negatively impacted Adjusted EBITDA by approximately $25 million during 2013.

Off-Balance Sheet Arrangements

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

- any obligation under certain guarantees or contracts;
- a retained or contingent interest in assets transferred to an unconsolidated entity or similar entity or similar arrangement that serves as credit, liquidity, or market risk support to that entity for such assets;
- any obligation under certain derivative instruments; and
- any obligation under a material variable interest held by the registrant in an unconsolidated entity that provides financing, liquidity, market risk, or credit risk support to the registrant, or engages in leasing, hedging, or research and development services with the registrant.

As of December 31, 2013 , we do not have any material off-balance sheet arrangements.

As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (“SPEs”), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2013 , we are not involved in any unconsolidated SPE transactions.

Critical Accounting Estimates

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

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

Revenue Recognition

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

Our patient accounting system calculates contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Other factors that are considered and could further influence the level of our reserves include the patient’s total length of stay for in-house patients, each patient’s discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors.

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

In addition, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. 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 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.

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

Allowance for Doubtful Accounts

The collection of outstanding receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. See Note 1, *Summary of Significant Accounting Policies* , “Accounts Receivable and the Allowance for Doubtful Accounts,” and Note 4, *Accounts Receivable* , to the accompanying consolidated financial statements for a complete discussion of our policies related to the allowance for doubtful accounts.

Our primary collection risks relate to patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. Changes in general economic conditions (such as increased unemployment rates or periods of recession), business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable. We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values.

For several years, under programs designated as “widespread probes,”certain of our MACs have conducted pre-payment claim reviews of our billing and denied payment for certain diagnosis codes based on medical necessity. We dispute, or “appeal,” most of these denials, and we collect approximately 58% of all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 70% success rate. Because we do not write-off receivables until all collection efforts have been exhausted, we do not write-off receivables related to denied claims while they are in this review process. The resolution of these disputes can take in excess of two years.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. As of December 31, 2013 and 2012 , $22.5 million and $20.4 million , or 7.8% , of our patient accounts receivable represented denials by MACs that were in the pre-payment medical necessity review process. During the years ended December 31, 2013 , 2012 , and 2011 , we wrote off $3.5 million , $0.2 million , and $0.5 million , respectively, of previously denied claims while we collected $1.7 million , $4.3 million , and $1.9 million , respectively, of previously denied claims.

The table below shows a summary of our net accounts receivable balances as of December 31, 2013 and 2012 . Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, *Summary of Significant Accounting Policies* , "Accounts Receivable and the Allowance for Doubtful Accounts," to the accompanying consolidated financial statements.

	As of December 31,	
	2013	2012
	(In Millions)	
0 - 30 Days	$ 194.1	$ 178.9
31 - 60 Days	21.7	19.6
61 - 90 Days	10.2	9.4
91 - 120 Days	3.4	4.6
120 + Days	20.0	18.8
Current patients accounts receivable, net	249.4	231.3
Noncurrent patient accounts receivable, net	16.6	—
Other accounts receivable	12.4	18.0
Accounts receivable, net	**$ 278.4**	**$ 249.3**

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers' compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers' compensation risks are insured through a wholly owned insurance subsidiary. See Note 9, *Self-Insured Risks* , to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

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

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

- Historical claims experience
- Trending of loss development factors
- Trends in the frequency and severity of claims
- Coverage limits of third-party insurance
- Demographic information
- Statistical confidence levels
- Medical cost inflation
- Payroll dollars
- Hospital patient census

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

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

Net self-insurance reserves as of December 31, 2013:		
As reported, with 50% statistical confidence level	$	107.7
With 70% statistical confidence level		114.4

Over the past few years, we have experienced volatility in our estimates of prior year claim reserves due primarily to favorable trends in claims and industry-wide loss development trends. We believe our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. With the accumulation of this additional historical data and current favorable trends, when we analyzed our assumptions during our semi-annual review of our self-insurance reserves in the fourth quarter of 2013, we lowered the statistical confidence level used to determine our self-insurance reserves from 70% to 50%. This change, which reflects our current best estimate based on the trends we are experiencing in the resolution of claims, reduced our reserves included in continuing operations by $6.7 million in the fourth quarter of 2013.

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

Goodwill

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

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

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

See Note 1, *Summary of Significant Accounting Policies* , "Goodwill and Other Intangibles," and Note 6, *Goodwill and Other Intangible Assets* , to the accompanying consolidated financial statements for additional information.

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

- Macroeconomic conditions, such as deterioration in general economic conditions, limitations on accessing capital, or other developments in equity and credit markets;
- Industry and market considerations and changes in healthcare regulations, including reimbursement and compliance requirements under the Medicare and Medicaid programs;

- Cost factors, such as an increase in labor, supply, or other costs;
- Overall financial performance, such as negative or declining cash flows or a decline in actual or forecasted revenue or earnings;
- Other relevant company-specific events, such as material changes in management or key personnel or outstanding litigation;
- Material events, such as a change in the composition or carrying amount of our reporting unit's net assets, including acquisitions and dispositions; and
- Consideration of the relationship of our market capitalization to our book value, as well as a sustained decrease in our share price.

In the fourth quarter of 2013, we assessed the qualitative factors described above for our reporting unit and concluded it is more likely than not the fair value of our reporting unit is greater than its carrying amount. As a result of this assessment of qualitative factors, we determined it was not necessary to perform the two-step goodwill impairment test on our reporting unit. If actual results are not consistent with our assumptions and estimates, we may be exposed to goodwill impairment charges. However, at this time, we continue to believe our reporting unit is not at risk for any impairment charges.

Income Taxes

We provide for income taxes using the asset and liability method. We also evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. See Note 1, *Summary of Significant Accounting Policies* , "Income Taxes," and Note 16, *Income Taxes* , to the accompanying consolidated financial statements for a more complete discussion of income taxes and our policies related to income taxes.

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

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

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

During the year ended December 31, 2013 , we decreased our valuation allowance by $9.1 million . As of December 31, 2013 , we had a remaining valuation allowance of $30.7 million which related to state NOLs. At the state jurisdiction level, we determined it was necessary to maintain a valuation allowance due to uncertainties related to our ability to utilize a portion of the deferred tax assets before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence, as described above, including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable.

While management believes the assumptions included in its forecast of future earnings are reasonable and it is more likely than not the net deferred tax asset balance as of December 31, 2013 will be realized, no such assurances can be provided. If management's expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to increase our valuation allowance, or reverse amounts recorded currently in the valuation allowance, for all or a portion of our deferred tax assets. Similarly, future adjustments to our valuation allowance may be necessary if the timing of future tax deductions is

different than currently expected. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. See Note 1, *Summary of Significant Accounting Policies* , "Litigation Reserves," and Note 18, *Contingencies and Other Commitments* , to the accompanying consolidated financial statements for additional information.

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

Recent Accounting Pronouncements

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

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use sensitivity analysis models to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2013, our primary variable rate debt outstanding related to $45.0 million in advances under our revolving credit facility. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $0.4 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $0.1 million over the next 12 months, assuming floating rate indices are floored at 0%.

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

	December 31, 2013		December 31, 2012	
Financial Instrument:	**Book Value**	**Market Value**	**Book Value**	**Market Value**
7.25% Senior Notes due 2018				
Carrying Value	$ 272.4	$ —	$ 302.9	$ —
Unamortized debt premium	(1.0)	—	(1.4)	—
Principal amount	271.4	291.4	301.5	328.6
8.125% Senior Notes due 2020				
Carrying Value	286.6	—	286.2	—
Unamortized debt discount	3.4	—	3.8	—
Principal amount	290.0	319.4	290.0	321.5
7.75% Senior Notes due 2022				
Carrying Value	252.5	—	280.7	—
Unamortized debt premium	(1.4)	—	(1.7)	—
Principal amount	251.1	275.0	279.0	306.5
5.75% Senior Notes due 2024				
Carrying Value	275.0	—	275.0	—
Unamortized debt discount	—	—	—	—
Principal amount	275.0	273.6	275.0	277.1
2.00% Convertible Senior Subordinated Notes due 2043				
Carrying Value	249.5	—	—	—
Unamortized debt discount	70.5	—	—	—
Principal amount	320.0	339.7	—	—

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

Item 8. Financial Statements and Supplementary Data

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

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, an evaluation was carried out by our management, including our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”). Our disclosure controls and procedures are designed to ensure that information required to be disclosed in reports we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2013 , our disclosure controls and procedures were effective.

Management's Report on Internal Control Over Financial Reporting

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

Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2013 . In making this assessment, management used the criteria set forth in *Internal Control-Integrated Framework* (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission, the COSO framework . Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2013 , our internal control over financial reporting was effective.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2013 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears herein.

Changes in Internal Control Over Financial Reporting

There were no changes in the Company's internal controls over financial reporting that occurred during the quarter ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

PART III

We expect to file a definitive proxy statement relating to our 2014 Annual Meeting of Stockholders (the " 2014 Proxy Statement") with the United States Securities and Exchange Commission, pursuant to Regulation 14A, not later than 120 days after the end of our most recent fiscal year. Accordingly, certain information required by Part III has been omitted under General Instruction G(3) to Form 10-K. Only the information from the 2014 Proxy Statement that specifically addresses disclosure requirements of Items 10-14 below is incorporated by reference.

Item 10. Directors and Executive Officers of the Registrant

As previously announced, Mr. Jon F. Hanson, the current chairman of our board of directors, will be retiring effective as of the adjournment of our 2014 annual meeting of stockholders on May 1, 2014. Accordingly, Mr. Hanson will not be included as a nominee in our 2014 Proxy Statement. In connection with Mr. Hanson's retirement, our board unanimously approved on February 14, 2014 a decrease in the number of directors to ten effective as of the adjournment of our 2014 annual meeting.

Mr. Hanson, age 77, is the chairman and founder of The Hampshire Companies and has over 50 years of experience in the real estate industry. Mr. Hanson was named non-executive chairman of the board of HealthSouth, effective October 1, 2005 and has served as a director since September 17, 2002. From 1994 through 2005, Mr. Hanson served as chairman of the National Football Foundation and College Hall of Fame, Inc. He now serves as chairman emeritus. Mr. Hanson served for 20 years as a director, including two years as the lead director, of Prudential Financial, Inc. He also served for 21 years as a director, and now serves as an honorary director, of the Hackensack University Medical Center. Mr. Hanson currently serves as chairman of the board of Pascack Community Bank and as a director of Yankee Global Enterprises.

The other information required by Item 10 is hereby incorporated by reference from our 2014 Proxy Statement under the captions "Items of Business Requiring Your Vote—Proposal 1—Election of Directors," "Corporate Governance and Board Structure—Code of Ethics," "Corporate Governance and Board Structure—Proposals for Director Nominees by Stockholders," "Corporate Governance and Board Structure—Audit Committee," "Section 16(a) Beneficial Ownership Reporting Compliance," and "Executive Officers."

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2014 Proxy Statement under the captions "Corporate Governance and Board Structure—Compensation of Directors," "Compensation Committee Matters," and "Executive Compensation."

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

Equity Compensation Plans

The following table sets forth, as of December 31, 2013 , information concerning compensation plans under which our securities are authorized for issuance. The table does not reflect grants, awards, exercises, terminations, or expirations since that date. All share amounts and exercise prices have been adjusted to reflect stock splits that occurred after the date on which any particular underlying plan was adopted, to the extent applicable.

	Securities to be Issued Upon Exercise		Weighted Average Price [1]	Securities Available for Future Issuance	
Plans approved by stockholders	4,642,531	[2]	$ 20.21	4,206,112	[3]
Plans not approved by stockholders	912,435	[4]	21.98	—	
Total	5,554,966		20.82	4,206,112	

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

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

(3) This amount represents the number of shares available for future equity grants under the Amended and Restated 2008 Equity Incentive Plan approved by our stockholders in May 2011.

(4) This amount includes (a) 805,773 and 7,029 shares issuable upon exercise of stock options outstanding under the 2005 Equity Incentive Plan and the Key Executive Incentive Program, respectively, and (b) 99,633 restr icted stock units issued under the 2004 Amended and Restated Director Incentive Plan.

2004 Amended and Restated Director Incentive Plan

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

2005 Equity Incentive Plan

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

Key Executive Incentive Program

On November 17, 2005, our board of directors adopted the Key Executive Incentive Program, which was a response to unusual employee retention needs we were experiencing at that particular time and served as a means of ensuring management continuity during the Company's strategic repositioning expected to continue through 2008. The associated equity awards, which were made on November 17, 2005, were one-time special equity grants designed to keep key members of our management team intact and to be an effective deterrent to officers leaving the Company during our transition phase. Some option awards remain outstanding and are fully vested. The options vested 25% in January 2007, 25% in January 2008, and the remaining 50% in January 2009. The outstanding options have an exercise price not less than the fair market value of such shares of common stock on the date of grant and an expiration date that is ten years after the grant date. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

Security Ownership of Certain Beneficial Owners and Management

The other information required by Item 12 is hereby incorporated by reference from our 2014 Proxy Statement under the caption "Security Ownership of Certain Beneficial Owners and Management."

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by Item 13 is hereby incorporated by reference from our 2014 Proxy Statement under the captions "Corporate Governance and Board Structure—Director Independence" and "Certain Relationships and Related Transactions."

Item 14. Principal Accountant Fees and Services

The information required by Item 14 is hereby incorporated by reference from our 2014 Proxy Statement under the caption "Items of Business Requiring Your Vote—Proposal 2—Ratification of Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

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

Financial Statement Schedules

None.

Exhibits

See Exhibit Index immediately following page F-69 o f this report.

SIGNATURES

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

HEALTHSOUTH CORPORATION

By: /s/ Jay Grinney

Jay Grinney
President and Chief Executive Officer

Date: February 20, 2014

POWER OF ATTORNEY

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

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

Signature	Capacity	Date
/s/ Jay Grinney **Jay Grinney**	President and Chief Executive Officer and Director	February 20, 2014
/s/ Douglas E. Coltharp **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 20, 2014
/s/ Andrew L. Price **Andrew L. Price**	Chief Accounting Officer	February 20, 2014
/s/ Jon F. Hanson **Jon F. Hanson**	Chairman of the Board of Directors	February 20, 2014
/s/ John W. Chidsey **John W. Chidsey**	Director	February 20, 2014
/s/ Donald L. Correll **Donald L. Correll**	Director	February 20, 2014
/s/ Yvonne M. Curl **Yvonne M. Curl**	Director	February 20, 2014
/s/ Charles M. Elson **Charles M. Elson**	Director	February 20, 2014
/s/ Joan E. Herman **Joan E. Herman**	Director	February 20, 2014
/s/ Leo I. Higdon, Jr. **Leo I. Higdon, Jr.**	Director	February 20, 2014
/s/ Leslye G. Katz **Leslye G. Katz**	Director	February 20, 2014
/s/ John E. Maupin, Jr. **John E. Maupin, Jr.**	Director	February 20, 2014
/s/ L. Edward Shaw, Jr. **L. Edward Shaw, Jr.**	Director	February 20, 2014

Item 15. Financial Statements

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of HealthSouth Corporation:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows present fairly, in all material respects, the financial position of HealthSouth Corporation and its subsidiaries at December 31, 2013 and 2012 , and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013 , based on criteria established in *Internal Control - Integrated Framework* (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

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

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

/s/ PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP
Birmingham, Alabama
February 20 , 2014

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Operations

	For the Year Ended December 31,		
	2013	**2012**	**2011**
	(In Millions, Except Per Share Data)		
Net operating revenues	**$ 2,273.2**	$ 2,161.9	$ 2,026.9
Less: Provision for doubtful accounts	**(26.0)**	(27.0)	(21.0)
Net operating revenues less provision for doubtful accounts	**2,247.2**	2,134.9	2,005.9
Operating expenses:			
Salaries and benefits	**1,089.7**	1,050.2	982.0
Other operating expenses	**323.0**	303.8	288.3
Occupancy costs	**47.0**	48.6	48.4
Supplies	**105.4**	102.4	102.8
General and administrative expenses	**119.1**	117.9	110.5
Depreciation and amortization	**94.7**	82.5	78.8
Government, class action, and related settlements	**(23.5)**	(3.5)	(12.3)
Professional fees—accounting, tax, and legal	**9.5**	16.1	21.0
Total operating expenses	**1,764.9**	1,718.0	1,619.5
Loss on early extinguishment of debt	**2.4**	4.0	38.8
Interest expense and amortization of debt discounts and fees	**100.4**	94.1	119.4
Other income	**(4.5)**	(8.5)	(2.7)
Equity in net income of nonconsolidated affiliates	**(11.2)**	(12.7)	(12.0)
Income from continuing operations before income tax expense	**395.2**	340.0	242.9
Provision for income tax expense	**12.7**	108.6	37.1
Income from continuing operations	**382.5**	231.4	205.8
(Loss) income from discontinued operations, net of tax	**(1.1)**	4.5	48.8
Net income	**381.4**	235.9	254.6
Less: Net income attributable to noncontrolling interests	**(57.8)**	(50.9)	(45.9)
Net income attributable to HealthSouth	**323.6**	185.0	208.7
Less: Convertible perpetual preferred stock dividends	**(21.0)**	(23.9)	(26.0)
Less: Repurchase of convertible perpetual preferred stock	**(71.6)**	(0.8)	—
Net income attributable to HealthSouth common shareholders	**$ 231.0**	$ 160.3	$ 182.7
Weighted average common shares outstanding:			
Basic	**88.1**	94.6	93.3
Diluted	**102.1**	108.1	109.2
Basic and diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	**$ 2.59**	$ 1.62	$ 1.39
Discontinued operations	**(0.01)**	0.05	0.52
Net income	**$ 2.58**	$ 1.67	$ 1.91
Cash dividends per common share	**$ 0.36**	$ —	$ —
Amounts attributable to HealthSouth common shareholders:			
Income from continuing operations	**$ 324.7**	$ 180.5	$ 158.8
(Loss) income from discontinued operations, net of tax	**(1.1)**	4.5	49.9
Net income attributable to HealthSouth	**$ 323.6**	$ 185.0	$ 208.7

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

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2013	**2012**	**2011**
		(In Millions)	
COMPREHENSIVE INCOME			
Net income	**$ 381.4**	$ 235.9	$ 254.6
Other comprehensive (loss) income, net of tax:			
Net change in unrealized (loss) gain on available-for-sale securities:			
Unrealized net holding (loss) gain arising during the period	**(0.7)**	1.6	(0.7)
Reclassifications to net income	**(0.9)**	—	—
Other comprehensive (loss) income before income taxes	**(1.6)**	1.6	(0.7)
Provision for income tax benefit related to other comprehensive (loss) income items	**0.1**	—	—
Other comprehensive (loss) income, net of tax:	**(1.5)**	1.6	(0.7)
Comprehensive income	**379.9**	237.5	253.9
Comprehensive income attributable to noncontrolling interests	**(57.8)**	(50.9)	(45.9)
Comprehensive income attributable to HealthSouth	**$ 322.1**	$ 186.6	$ 208.0

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

HealthSouth Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31,	
	2013	2012
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	**$ 64.5**	$ 132.8
Restricted cash	**52.4**	49.3
Accounts receivable, net of allowance for doubtful accounts of $23.1 in 2013; $28.7 in 2012	**261.8**	249.3
Deferred income tax assets	**139.0**	137.5
Prepaid expenses and other current assets	**62.7**	67.9
Total current assets	**580.4**	636.8
Property and equipment, net	**910.5**	748.0
Goodwill	**456.9**	437.3
Intangible assets, net	**88.2**	73.2
Deferred income tax assets	**354.3**	393.5
Other long-term assets	**144.1**	135.4
Total assets	**$ 2,534.4**	$ 2,424.2
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	**$ 12.3**	$ 13.6
Accounts payable	**61.9**	45.3
Accrued payroll	**90.8**	85.7
Accrued interest payable	**23.8**	25.9
Other current liabilities	**122.8**	130.4
Total current liabilities	**311.6**	300.9
Long-term debt, net of current portion	**1,505.2**	1,239.9
Self-insured risks	**98.2**	106.5
Other long-term liabilities	**44.0**	24.0
	1,959.0	1,671.3
Commitments and contingencies		
Convertible perpetual preferred stock, $.10 par value; 1,500,000 shares authorized; 96,245 shares issued in 2013 and 353,355 shares issued in 2012; liquidation preference of $1,000 per share	**93.2**	342.2
Redeemable noncontrolling interests	**13.5**	7.2
Shareholders' equity:		
HealthSouth shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 102,648,302 in 2013; 100,919,297 in 2012	**1.0**	1.0
Capital in excess of par value	**2,849.4**	2,876.6
Accumulated deficit	**(2,101.1)**	(2,424.7)
Accumulated other comprehensive (loss) income	**(0.1)**	1.4
Treasury stock, at cost (14,654,436 shares in 2013 and 5,233,521 shares in 2012)	**(404.6)**	(163.3)
Total HealthSouth shareholders' equity	**344.6**	291.0
Noncontrolling interests	**124.1**	112.5
Total shareholders' equity	**468.7**	403.5
Total liabilities and shareholders' equity	**$ 2,534.4**	$ 2,424.2

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

HealthSouth Corporation and Subsidiaries
Consolidated Statements of Shareholders' Equity

	HealthSouth Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Noncontrolling Interests	Total
	(In Millions)							
December 31, 2010	93.4	$ 1.0	$ 2,872.9	$ (2,818.4)	$ 0.5	$ (141.8)	$ 83.0	$ (2.8)
Net income	—	—	—	208.7	—	—	42.3	251.0
Dividends declared on convertible perpetual preferred stock	—	—	(26.0)	—	—	—	—	(26.0)
Stock-based compensation	—	—	20.3	—	—	—	—	20.3
Distributions declared	—	—	—	—	—	—	(40.5)	(40.5)
Other	1.8	—	6.9	—	(0.7)	(7.0)	(0.2)	(1.0)
December 31, 2011	95.2	1.0	2,874.1	(2,609.7)	(0.2)	(148.8)	84.6	201.0
Net income	—	—	—	185.0	—	—	47.1	232.1
Receipt of treasury stock	(0.7)	—	—	—	—	(11.9)	—	(11.9)
Dividends declared on convertible perpetual preferred stock	—	—	(23.9)	—	—	—	—	(23.9)
Stock-based compensation	—	—	24.1	—	—	—	—	24.1
Distributions declared	—	—	—	—	—	—	(45.4)	(45.4)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	12.4	12.4
Consolidation of St. Vincent Rehabilitation Hospital	—	—	—	—	—	—	13.9	13.9
Other	1.2	—	2.3	—	1.6	(2.6)	(0.1)	1.2
December 31, 2012	95.7	1.0	2,876.6	(2,424.7)	1.4	(163.3)	112.5	403.5
Net income	—	—	—	**323.6**	—	—	**52.0**	**375.6**
Receipt of treasury stock	**(0.3)**	—	—	—	—	**(5.8)**	—	**(5.8)**
Dividends declared on common stock	—	—	**(32.0)**	—	—	—	—	**(32.0)**
Dividends declared on convertible perpetual preferred stock	—	—	**(21.0)**	—	—	—	—	**(21.0)**
Stock-based compensation	—	—	**24.8**	—	—	—	—	**24.8**
Stock options exercised	**0.3**	—	**8.2**	—	—	—	—	**8.2**
Stock warrants exercised	**0.5**	—	**15.3**	—	—	—	—	**15.3**
Distributions declared	—	—	—	—	—	—	**(40.4)**	**(40.4)**
Repurchases of common stock through tender offer	**(9.1)**	—	—	—	—	**(234.1)**	—	**(234.1)**
Repurchase of preferred stock through convertible exchange	—	—	**(71.6)**	—	—	—	—	**(71.6)**
Equity portion of convertible debt	—	—	**71.0**	—	—	—	—	**71.0**
Tax impact of equity portion of convertible debt	—	—	**(28.0)**	—	—	—	—	**(28.0)**
Other	**0.9**	—	**6.1**	—	**(1.5)**	**(1.4)**	—	**3.2**
December 31, 2013	**88.0**	**$ 1.0**	**$ 2,849.4**	**$ (2,101.1)**	**$ (0.1)**	**$ (404.6)**	**$ 124.1**	**$ 468.7**

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

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2013	2012	2011
		(In Millions)	
Cash flows from operating activities:			
Net income	**$ 381.4**	$ 235.9	$ 254.6
Loss (income) from discontinued operations, net of tax	**1.1**	(4.5)	(48.8)
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for doubtful accounts	**26.0**	27.0	21.0
Provision for government, class action, and related settlements	**(23.5)**	(3.5)	(12.3)
Depreciation and amortization	**94.7**	82.5	78.8
Loss on early extinguishment of debt	**2.4**	4.0	38.8
Equity in net income of nonconsolidated affiliates	**(11.2)**	(12.7)	(12.0)
Distributions from nonconsolidated affiliates	**11.4**	11.0	13.0
Stock-based compensation	**24.8**	24.1	20.3
Deferred tax expense	**6.4**	102.7	36.5
Other	**9.3**	3.0	7.9
(Increase) decrease in assets—			
Accounts receivable	**(55.1)**	(51.3)	(37.1)
Prepaid expenses and other assets	**(4.8)**	0.6	(12.5)
Increase (decrease) in liabilities—			
Accounts payable	**6.4**	(4.4)	0.8
Refunds due patients and other third-party payors	**(0.4)**	2.7	(16.2)
Other liabilities	**5.0**	(5.7)	23.6
Premium received on bond issuance	**—**	—	4.1
Premium paid on redemption of bonds	**(1.7)**	(1.9)	(26.9)
Net cash (used in) provided by operating activities of discontinued operations	**(1.9)**	2.0	9.1
Total adjustments	**87.8**	180.1	136.9
Net cash provided by operating activities	**470.3**	411.5	342.7
Cash flows from investing activities:			
Purchases of property and equipment	**(195.2)**	(140.8)	(100.3)
Capitalized software costs	**(21.3)**	(18.9)	(8.8)
Acquisition of businesses, net of cash acquired	**(28.9)**	(3.1)	(4.9)
Proceeds from sale of restricted investments	**16.9**	0.3	1.2
Proceeds from sale of Digital Hospital	**10.8**	—	—
Purchases of restricted investments	**(9.2)**	(9.1)	(8.4)
Net change in restricted cash	**(3.1)**	(14.0)	1.2
Net settlements on interest rate swaps not designated as hedges	**—**	—	(10.9)
Other	**0.5**	(0.9)	(0.9)
Net cash provided by (used in) investing activities of discontinued operations—			
Proceeds from sale of LTCHs	**—**	—	107.9
Other investing activities of discontinued operations	**3.3**	7.7	(0.7)
Net cash used in investing activities	**(226.2)**	**(178.8)**	**(24.6)**

(Continued)

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2013	**2012**	**2011**
		(In Millions)	
Cash flows from financing activities:			
Principal borrowings on term loan	**—**	—	100.0
Proceeds from bond issuance	**—**	275.0	120.0
Principal payments on debt, including pre-payments	**(62.5)**	(166.2)	(504.9)
Principal borrowings on notes	**15.2**	—	—
Borrowings on revolving credit facility	**197.0**	135.0	338.0
Payments on revolving credit facility	**(152.0)**	(245.0)	(306.0)
Principal payments under capital lease obligations	**(10.1)**	(12.1)	(13.2)
Repurchase of common stock, including fees and expenses	**(234.1)**	—	—
Repurchases of convertible perpetual preferred stock, including fees	**(2.8)**	(46.0)	—
Dividends paid on common stock	**(15.7)**	—	—
Dividends paid on convertible perpetual preferred stock	**(23.0)**	(24.6)	(26.0)
Distributions paid to noncontrolling interests of consolidated affiliates	**(46.3)**	(49.3)	(44.2)
Contributions from consolidated affiliates	**1.6**	10.5	—
Proceeds from exercising stock warrants	**15.3**	—	—
Other	**5.0**	(7.3)	—
Net cash used in financing activities	**(312.4)**	(130.0)	(336.3)
(Decrease) increase in cash and cash equivalents	**(68.3)**	102.7	(18.2)
Cash and cash equivalents at beginning of year	**132.8**	30.1	48.3
Cash and cash equivalents at end of year	**$ 64.5**	$ 132.8	$ 30.1
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	**$ (99.4)**	$ (88.1)	$ (115.4)
Income tax refunds	**4.8**	2.2	9.6
Income tax payments	**(12.5)**	(11.8)	(9.1)
Supplemental schedule of noncash financing activities:			
Convertible debt issued	**$ 320.0**	$ —	$ —
Repurchase of preferred stock	**(320.0)**	—	—

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

1. Summary of Significant Accounting Policies :

Organization and Description of Business—

HealthSouth Corporation, incorporated in Delaware in 1984 , including its subsidiaries, is the largest owner and operator of inpatient rehabilitation hospitals in the United States in terms of patients treated and discharged, revenues, and number of hospitals. We operate inpatient rehabilitation hospitals and provide specialized rehabilitative treatment on both an inpatient and outpatient basis. While our national network of inpatient hospitals stretches across 28 states and Puerto Rico, we 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). We are the sole owner of 72 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 31 jointly owned hospitals. We also had 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.

Reclassifications—

Certain immaterial amounts have been revised to conform to the current year presentation. In our consolidated balance sheet as of December 31, 2012, we reclassified amounts previously reported as *Other long-term liabilities* to a combination of *Capital in excess of par value* , noncurrent *Deferred income tax assets* , and *Redeemable noncontrolling interests* . These amounts relate to a joint venture entity where the partner's noncontrolling interest includes redemption features that are not solely within our control. This adjustment decreased liabilities by $6.2 million , decreased shareholders' equity by $0.6 million , increased assets by $0.4 million , and increased amounts in the mezzanine section of our consolidated balance sheet by $7.2 million . See Note 11, *Redeemable Noncontrolling Interests* .

Out-of-Period Adjustments—

During 2011, we recorded additional income tax expense of approximately $7 million for out-of-period adjustments primarily related to corrections to our 2010 deferred tax assets associated with our net operating losses ("NOLs") and the corresponding valuation allowance. We corrected the errors in our financial statements by increasing our *Provision for income tax expense* , which resulted in a reduction of *Income from continuing operations* and *Net income* for the year ended December 31, 2011. We do not believe the errors or their corrections are material to the consolidated financial statements as of December 31, 2011 or to any prior years' consolidated financial statements. See Note 16, *Income Taxes* .

See also Note 17, *Earnings per Common Share* .

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of HealthSouth and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to HealthSouth* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

We use the cost method to account for our investments in entities we do not control and for which we do not have the ability to exercise significant influence over operating and financial policies. In accordance with the cost method, these investments are recorded at the lower of cost or fair value, as appropriate.

We also consider the guidance for consolidating variable interest entities.

We eliminate all significant intercompany accounts and transactions from our financial results.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) income tax valuation allowances; (8) uncertain tax positions; (9) fair value of stock options and restricted stock containing a market condition; (10) fair value of redeemable noncontrolling interests; (11) reserves for self-insured healthcare plans; (12) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (13) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties—

As a healthcare provider, we are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

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

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements.

If we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues* , it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback

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

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. 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. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions. Because we receive a significant percentage of our revenues from Medicare, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows, if any such changes were to occur.

Pursuant to legislative directives and authorizations from Congress, the United States Centers for Medicare and Medicaid Services (“CMS”) developed and instituted various Medicare audit programs. We undertake significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules. Despite our belief that our coding and assessment of patients is accurate, audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these programs will affect us.

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

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

As discussed in Note 18, *Contingencies and Other Commitments* , we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Net Operating Revenues—

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%

We recognize net patient service revenues in the reporting period in which we perform the service based on our current billing rates (i.e., gross charges), less actual adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid, and managed care and other health plans). We record gross service charges in our accounting records on an accrual basis using our established rates for the type of service provided to the patient. We recognize an estimated contractual allowance and an estimate of potential subsequent adjustments that may arise from post-payment and other reviews to reduce gross patient charges to the amount we estimate we will actually realize for the service rendered based upon previously agreed to rates with a payor. Our patient accounting system calculates contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Other factors that are considered and could further influence the level of our reserves include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors. Payors include federal and state agencies, including Medicare and Medicaid, managed care health plans, commercial insurance companies, employers, and patients.

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

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

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. 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 IRFs, we received requests in 2013 to review certain patient files for discharges occurring from 2010 to 2013. 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.

To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2013, and not all of these patient file requests have resulted in payment denial determinations by the RACs. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of their patients, we currently intend to appeal substantially all RAC denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by Medicare Administrative Contractors ("MACs") (see "Accounts Receivable and Allowance for Doubtful Accounts" below). Due to the delays announced by CMS in the related

adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years. In addition, because we have limited experience with RACS in the context of post-payment reviews of this nature, we cannot provide assurance as to the future success of these disputes. As such, we make provisions for these claims based on our historical experience and success rates in the claim adjudication process. Because these reviews involve post-payment claims, there are no corresponding patient receivables in our consolidated balance sheet. As the ultimate results of these audits impact our estimates of amounts determined to be due to HealthSouth under these reimbursement programs, our provision for claims that are part of this post-payment review process are recorded to *Net operating revenues* . During 2013, we reduced our *Net operating revenues* by approximately $8 million for post-payment claims that are part of this review process.

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

We record all equity securities with readily determinable fair values and for which we do not exercise significant influence as available-for-sale securities. We carry the available-for-sale securities at fair value and report unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive (loss) income* , which is a separate component of shareholders' equity. We recognize realized gains and losses in our consolidated statements of operations using the specific identification method.

Unrealized losses are charged against earnings when a decline in fair value is determined to be other than temporary. Management reviews several factors to determine whether a loss is other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than cost, the financial condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

Accounts Receivable and Allowance for Doubtful Accounts—

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable are geographically dispersed, but a significant portion of our revenues are concentrated by type of payors. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, is as follows:

	As of December 31,	
	2013	**2012**
Medicare	67.4%	62.8%
Medicaid	2.0%	2.1%
Workers' compensation	2.6%	3.0%
Managed care and other discount plans, including Medicare Advantage	22.4%	25.8%
Other third-party payors	4.0%	4.3%
Patients	1.6%	2.0%
Total	100.0%	100.0%

While revenues and accounts receivable from the Medicare program are significant to our operations, we do not believe there are significant credit risks associated with this government agency. Because Medicare traditionally pays claims faster than our other third-party payors, the percentage of our Medicare charges in accounts receivable is less than the percentage of our Medicare revenues. We do not believe there are any other significant concentrations of revenues from any particular payor that would subject us to any significant credit risks in the collection of our accounts receivable.

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

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. While it is our policy to verify insurance prior to a patient being admitted, there are various exceptions that can occur. Such exceptions include instances where we are (1) unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid, and it takes several days, weeks, or months before qualification for such benefits is confirmed or denied, and (3) the patient is transferred to our hospital from an acute care hospital without having access to a credit card, cash, or check to pay the applicable patient responsibility amounts (i.e., deductibles and co-payments). Based on our historical collection trends, our primary collection risks relate to patient accounts for which the patient was the primary payor or the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts remain outstanding. Changes in the economy, such as increased unemployment rates or periods of recession, can further exacerbate our ability to collect patient responsibility amounts.

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine all in-house efforts have been exhausted or it is a more prudent use of resources, accounts may be turned over to a collection agency. Accounts are written off after all collection efforts (internal and external) have been exhausted.

For several years, under programs designated as "widespread probes," certain of our MACs have conducted pre-payment claim reviews of our billings and denied payment for certain diagnosis codes based on medical necessity. We dispute, or "appeal," most of these denials, and we have historically collected approximately 58% of all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 70% success rate. The resolution of these disputes can take in excess of two years, and we cannot provide assurance as to our ongoing and future success of these disputes. As such, we make provisions against these receivables in accordance with our accounting policy that necessarily considers historical collection trends of the receivables in this review process as part of our *Provision for doubtful accounts* . Because we do not write-off receivables until all collection efforts have been exhausted, we do not write-off receivables related to denied claims while they are in this review process. When the amount collected related to denied claims differs from the net amount previously recorded, these collection differences are recorded in the *Provision for doubtful accounts* . As a result, the timing of these denials by MACs and their subsequent collection can create volatility in our *Provision for doubtful accounts* .

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. Changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

Property and Equipment—

We report land, buildings, improvements, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Furniture, fixtures, and equipment	3 to 10
Assets under capital lease obligations:	
Real estate	15 to 20
Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

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

Goodwill and Other Intangible Assets—

We are required to test our goodwill for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform our goodwill impairment testing as of October 1st of each year.

We recognize an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value. We present a goodwill impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the goodwill impairment is associated with a discontinued operation. In that case, we include the goodwill impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our single reporting unit to determine whether it is necessary to perform the first step of the two-step quantitative goodwill impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our reporting unit using generally accepted valuation techniques including the income approach and the market approach. The income approach includes the use of our reporting unit’s discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting unit to our market capitalization. When we dispose of a hospital, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2013 , none of our finite useful lived intangible assets has an estimated residual value. We also review these assets for impairment whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. As of December 31, 2013 , we do not have any intangible assets with indefinite useful lives. The range of estimated useful lives and the amortization basis for our other intangible assets are generally as follows:

	Estimated Useful Life and Amortization Basis
Certificates of need	10 to 30 years using straight-line basis
Licenses	10 to 20 years using straight-line basis
Noncompete agreements	3 to 18 years using straight-line basis
Tradenames	10 to 20 years using straight-line basis
Internal-use software	3 to 7 years using straight-line basis
Market access assets	20 years using accelerated basis

We capitalize the costs of obtaining or developing internal-use software, including external direct costs of material and services and directly related payroll costs. Amortization begins when the internal-use software is ready for its intended use. Costs incurred during the preliminary project and post-implementation stages, as well as maintenance and training costs, are expensed as incurred.

Our market access assets are valued using discounted cash flows under the income approach. The value of the market access assets is attributable to our ability to gain access to and penetrate an acquired facility's historical market patient base. To determine this value, we first develop a debt-free net cash flow forecast under various patient volume scenarios. The debt-free net cash flow is then discounted back to present value using a discount factor, which includes an adjustment for company-specific risk. As noted in the above table, we amortize these assets over 20 years using an accelerated basis that reflects the pattern in which we believe the economic benefits of the market access will be consumed.

Impairment of Long-Lived Assets and Other Intangible Assets—

We assess the recoverability of long-lived assets (excluding goodwill) and identifiable acquired intangible assets with finite useful lives, whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with finite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with finite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised values. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and we cease depreciation.

Investments in and Advances to Nonconsolidated Affiliates—

Investments in entities we do not control but in which we have the ability to exercise significant influence over the operating and financial policies of the investee are accounted for under the equity method. Equity method investments are recorded at original cost and adjusted periodically to recognize our proportionate share of the investees' net income or losses after the date of investment, additional contributions made, dividends or distributions received, and impairment losses resulting from adjustments to net realizable value. We record equity method losses in excess of the carrying amount of an investment when we guarantee obligations or we are otherwise committed to provide further financial support to the affiliate.

We use the cost method to account for equity investments for which the equity securities do not have readily determinable fair values and for which we do not have the ability to exercise significant influence. Under the cost method of

accounting, private equity investments are carried at cost and are adjusted only for other-than-temporary declines in fair value, additional investments, or distributions deemed to be a return of capital.

Management periodically assesses the recoverability of our equity method and cost method investments and equity method goodwill for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate, and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds, and external appraisals, as appropriate. If an investment or equity method goodwill is considered to be impaired and the decline in value is other than temporary, we record an appropriate write-down.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

We accrete discounts and amortize premiums using the effective interest method over the expected life of the related debt, and we report discounts or premiums as a direct deduction from, or addition to, the face amount of the financing. The related income or expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

Fair Value Measurements—

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions market participants would use in pricing an asset or liability.

The basis for these assumptions establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- *Level 1* – Observable inputs such as quoted prices in active markets;
- *Level 2* – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3* – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, restricted marketable securities, accounts receivable, accounts payable, letters of credit, and long-term debt. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, and accounts payable approximate fair value because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt using quoted market prices, when available, or discounted cash flows based on various factors, including maturity schedules, call features, and current market rates.

On a recurring basis, we are required to measure our available-for-sale restricted marketable securities. The fair values of our available-for-sale restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.

On a nonrecurring basis, we are required to measure property and equipment, goodwill, other intangible assets, investments in nonconsolidated affiliates, and assets and liabilities of discontinued operations at fair value. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using quoted prices in private markets, discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the “Redeemable Noncontrolling Interests” section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders’ balance.

Convertible Perpetual Preferred Stock—

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

Because our *Convertible perpetual preferred stock* is indexed to, and potentially settled in, our common stock, we also examined whether the embedded conversion option in our *Convertible perpetual preferred stock* should be bifurcated. Based on our analysis, we determined bifurcation is not necessary.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value* .

The fair value of our *Redeemable noncontrolling interests* is determined primarily using the income approach. The income approach includes the use of the hospital’s projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable hospitals, or *Level 3* inputs. The projected operating results use management’s best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures.

Share-Based Payments—

HealthSouth has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees, including grants of employee stock options, are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period.

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than $5.0 million , we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of operations, were $5.2 million , $5.0 million , and $4.3 million in each of the years ended December 31, 2013 , 2012 , and 2011 , respectively.

Professional Fees—Accounting, Tax, and Legal—

In 2013 , 2012 , and 2011 , *Professional fees—accounting, tax, and legal* related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments* . These expenses in 2012 also included legal and consulting fees for the pursuit of our remaining income tax benefits, as discussed in Note 16, *Income Taxes* .

Income Taxes—

We provide for income taxes using the asset and liability method . This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly.

We use the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation. Under this method, we recognize these excess tax benefits only after we fully realize the tax benefits of net operating losses.

HealthSouth and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We

include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

Components of an entity that have been disposed of or are classified as held for sale and have operations and cash flows that can be clearly distinguished from the rest of the entity are reported as discontinued operations. In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *(Loss) income from discontinued operations, net of tax* . In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Prepaid expenses and other current assets* , *Other long-term assets* , *Other current liabilities* , and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares, including warrants, that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our nonvested restricted stock awards and restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

We use the if-converted method to include our *Convertible perpetual preferred stock* and convertible senior subordinated notes in our computation of diluted earnings per share. All other potential dilutive shares, including warrants, are included in our weighted-average diluted share count using the treasury stock method.

Treasury Stock—

Shares of common stock repurchased by us are recorded at cost as treasury stock. When shares are reissued, we use an average cost method to determine cost. The difference between the cost of the shares and the reissuance price is added to or deducted from *Capital in excess of par value* . We account for the retirement of treasury stock as a reduction of retained earnings. However, due to our *Accumulated deficit* , the retirement of treasury stock is currently recorded as a reduction of *Capital in excess of par value* .

Comprehensive Income—

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

Recent Accounting Pronouncements —

We do not believe any recently issued, but not yet effective, accounting standards will have a material effect on our consolidated financial position, results of operations, or cash flows.

2. Business Combinations :

In April 2013, we closed the transaction to acquire Walton Rehabilitation Hospital, a 58 -bed inpatient rehabilitation hospital in Augusta, Georgia. The acquisition was not material to our financial position, results of operations, or cash flows. As a result of this transaction, *Goodwill* increased by $13.7 million . The acquisition was funded using availability under our revolving credit facility.

In April 2012, we acquired 12 inpatient rehabilitation beds in Andalusia, Alabama from a subsidiary of LifePoint Hospitals in order to add beds at our existing hospital in Dothan, Alabama. In July 2012, we acquired the 34 -bed inpatient rehabilitation unit of CHRISTUS Santa Rosa Hospital - Medical Center. The operations of this unit have been relocated to and consolidated with our existing hospital in San Antonio, Texas. These transactions, either individually or in the aggregate, were not material to our financial position, results of operations, or cash flows. *Goodwill* did not increase as a result of these transactions. Both acquisitions were funded with available cash.

In November 2011, we completed a transaction to purchase substantially all of the assets of Drake Center's two rehabilitation-focused patient care units located in Cincinnati, Ohio and sublease space for the operation of a 40 -bed inpatient rehabilitation hospital that is fully owned and operated by HealthSouth. HealthSouth Rehabilitation Hospital at Drake remained on Drake's campus and began accepting patients in mid-December 2011. This transaction was not material to our financial position, results of operations, or cash flows. As a result of this transaction, *Goodwill* increased by $1.4 million . The acquisition was funded with available cash.

These acquisitions were made to enhance our position and ability to provide inpatient rehabilitative services to patients in the respective areas. All of the goodwill resulting from these transactions is deductible for federal income tax purposes. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired hospital's historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets.

We accounted for these transactions under the acquisition method of accounting and reported the results of operations of the acquired hospitals from their respective dates of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the acquisition date. The fair values of identifiable intangible assets were based on valuations using the cost and income approaches. The cost approach is based on amounts that would be required to replace the asset (i.e., replacement cost). The income approach is based on management's estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill.

The fair value of the assets acquired and liabilities assumed at the acquisition date for the transaction completed in 2013 was as follows (in millions):

Property and equipment, net	$	11.3
Identifiable intangible assets:		
Noncompete agreement (useful life of 5 years)		0.1
Tradename (useful life of 20 years)		0.9
Certificate of need (useful life of 20 years)		3.3
Goodwill		13.7
Total assets acquired		29.3
Total current liabilities assumed		(0.4)
Net assets acquired	$	28.9

The Company's reported *Net operating revenues* and *Net income* for the year ended December 31, 2013 include operating results for Walton Rehabilitation Hospital from April 1, 2013 through December 31, 2013. The following table summarizes the results of operations of the above mentioned transaction from the date of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisition been January 1, 2012 (in millions):

	Net Operating Revenues	Net Income Attributable to HealthSouth
Acquired entity only: Actual from acquisition date to December 31, 2013	$ 11.8	$ 0.1
Combined entity: Supplemental pro forma from 1/01/2013-12/31/2013 (unaudited)	2,278.1	323.2
Combined entity: Supplemental pro forma from 1/01/2012-12/31/2012 (unaudited)	2,183.6	184.8

Information regarding the net cash paid for all acquisitions during each period presented is as follows (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Fair value of assets acquired	$ 15.6	$ 2.1	$ 0.7
Goodwill	13.7	—	1.4
Fair value of liabilities assumed	(0.4)	—	—
Noncompete agreements	—	1.0	2.8
Net cash paid for acquisitions	$ 28.9	$ 3.1	$ 4.9

See also Note 7, *Investments in and Advances to Nonconsolidated Affiliates* .

3. Cash and Marketable Securities :

The components of our investments as of December 31, 2013 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 64.5	$ 52.4	$ —	$ 116.9
Equity securities	—	—	47.6	47.6
Total	$ 64.5	$ 52.4	$ 47.6	$ 164.5

The components of our investments as of December 31, 2012 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 132.8	$ 49.3	$ —	$ 182.1
Equity securities	—	—	55.8	55.8
Total	$ 132.8	$ 49.3	$ 55.8	$ 237.9

Restricted Cash—

As of December 31, 2013 and 2012 , *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2013	2012
Affiliate cash	$ 13.6	$ 22.5
Self-insured captive funds	37.8	26.0
Paid-loss deposit funds	1.0	0.8
Total restricted cash	$ 52.4	$ 49.3

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 9, *Self-Insured Risks* . These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority. Paid-loss deposit funds represent cash held by third-party administrators to fund expenses and other payments related to claims.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2013 and 2012 , all restricted cash was current.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures HealthSouth's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2013 and 2012 , $42.9 million and $39.4 million , respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets.

A summary of our restricted marketable securities as of December 31, 2013 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities	$ 47.9	$ 0.2	$ (0.5)	$ 47.6

A summary of our restricted marketable securities as of December 31, 2012 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities	$ 54.4	$ 1.5	$ (0.1)	$ 55.8

Cost in the above tables includes adjustments made to the cost basis of our equity securities for other-than-temporary impairments. During the years ended December 31, 2013 , 2012 , and 2011 , we did not record any impairment charges related to our restricted marketable securities.

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

	For the Year Ended December 31,		
	2013	2012	2011
Proceeds from sales of restricted available-for-sale securities	$ 16.6	$ —	$ —
Gross realized gains	$ 1.0	$ —	$ —
Gross realized losses	$ (0.1)	$ —	$ —

Our portfolio of marketable securities is comprised of investments in mutual funds that hold investments in a variety of industries and geographies. As discussed in Note 1, *Summary of Significant Accounting Policies* , "Marketable Securities," when our portfolio includes marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examine the severity and duration of the impairments in relation to the cost of the individual investments. We also consider the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

4. Accounts Receivable :

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2013	2012
Current:		
Patient accounts receivable, net of allowance for doubtful accounts of $23.1 million in 2013; $28.7 million in 2012	$ 249.4	$ 231.3
Other accounts receivable	12.4	18.0
	261.8	**249.3**
Noncurrent patient accounts receivable, net of allowance for doubtful accounts of $10.0 million in 2013	16.6	—
Accounts receivable, net	**$ 278.4**	**$ 249.3**

During 2013, CMS announced additional delays in the adjudication process of claims that are part of Medicare audit programs. Because the resolution of such claims can take in excess of two years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheet.

At December 31, 2013 and 2012 , our allowance for doubtful accounts represented approximately 11.1% and 11.0% , respectively, of the total patient due accounts receivable balance.

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

For the Year Ended December 31,	Balance at Beginning of Period	Additions and Charges to Expense	Deductions and Accounts Written Off	Balance at End of Period
2013	$ 28.7	$ 26.0	$ (21.6)	$ 33.1
2012	$ 21.4	$ 27.0	$ (19.7)	$ 28.7
2011	$ 22.7	$ 21.0	$ (22.3)	$ 21.4

5. Property and Equipment :

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

	As of December 31,	
	2013	2012
Land	$ 96.0	$ 79.6
Buildings	1,085.2	963.7
Leasehold improvements	65.0	62.3
Furniture, fixtures, and equipment	344.4	324.5
	1,590.6	1,430.1
Less: Accumulated depreciation and amortization	(712.6)	(728.1)
	878.0	702.0
Construction in progress	32.5	46.0
Property and equipment, net	$ 910.5	$ 748.0

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* .

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

	As of December 31,	
	2013	2012
Fully depreciated assets	$ 225.0	$ 219.0
Assets under capital lease obligations:		
Buildings	$ 124.4	$ 169.6
Equipment	0.2	0.2
	124.6	169.8
Accumulated amortization	(47.6)	(110.3)
Assets under capital lease obligations, net	$ 77.0	$ 59.5

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

	For the Year Ended December 31,		
	2013	2012	2011
Depreciation expense	$ 67.9	$ 59.0	$ 52.5
Amortization expense	$ 9.5	$ 10.1	$ 11.1
Interest capitalized	$ 1.9	$ 1.0	$ 0.5
Rent expense:			
Minimum rent payments	$ 40.3	$ 41.2	$ 38.5
Contingent and other rents	20.3	20.6	24.2
Other	4.2	4.5	4.2
Total rent expense	$ 64.8	$ 66.3	$ 66.9

Leases—

We lease certain land, buildings, and equipment under noncancelable operating leases generally expiring at various dates through 2025 . We also lease certain buildings and equipment under capital leases generally expiring at various dates through 2034 . Operating leases generally have 3 - to 15 -year terms, with one or more renewal options, with terms to be negotiated at the time of renewal. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Contingent rents are included in rent expense in the year incurred.

Some facilities are subleased to other parties. Rental income from subleases approximated $4.9 million , $4.7 million , and $4.7 million for the years ended December 31, 2013 , 2012 , and 2011 , respectively. Total expected future minimum rentals under these noncancelable subleases approximated $10.4 million as of December 31, 2013 .

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

	As of December 31,	
	2013	2012
Straight-line rental accrual	$ 17.3	$ 7.7

In March 2008, we sold our corporate campus to Daniel Corporation (“Daniel”), a Birmingham, Alabama-based real estate company. The sale included a deferred purchase price component related to an incomplete 13-story building located on the property, often referred to as the Digital Hospital. Under the agreement, Daniel was obligated upon sale of its interest in the building to pay to us 40% of the net profit realized from the sale. In June 2013, Daniel sold the building to Trinity Medical Center. In the third quarter of 2013, we received $10.8 million in cash from Daniel in connection with the sale of the building. The gain associated with this transaction is being deferred and amortized over five years, which is the remaining life of our lease agreement with Daniel for the portion of the property we continue to occupy with our corporate office, as a component of *General and administrative expenses* .

Future minimum lease payments at December 31, 2013 , for those leases having an initial or remaining noncancelable lease term in excess of one year, are as follows (in millions):

Year Ending December 31,	Operating Leases	Capital Lease Obligations	Total
2014	$ 37.9	$ 12.3	$ 50.2
2015	36.0	13.6	49.6
2016	31.0	13.5	44.5
2017	26.3	13.4	39.7
2018	22.0	13.5	35.5
2019 and thereafter	100.7	109.2	209.9
	$ 253.9	175.5	$ 429.4
Less: Interest portion		(86.6)	
Obligations under capital leases		$ 88.9	

In addition to the above, and as discussed in Note 8, *Long-term Debt* , “Other Notes Payable,” we have two sale/leaseback transactions involving real estate accounted for as financings. Future minimum payments, which are accounted for as interest, under these obligations are $2.7 million in each of the next five years and $14.0 million thereafter.

6. Goodwill and Other Intangible Assets :

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2013 , 2012 , and 2011 (in millions):

	Amount
Goodwill as of December 31, 2010	$ 420.3
Acquisition	1.4
Goodwill as of December 31, 2011	421.7
Consolidation of joint venture formerly accounted for under the equity method of accounting	15.6
Goodwill as of December 31, 2012	437.3
Acquisition	13.7
Conversion of 100% owned hospital into a joint venture	6.2
Divestiture of skilled nursing facility beds	(0.3)
Goodwill as of December 31, 2013	$ 456.9

Goodwill increased in 2011 as a result of our acquisition of Drake Center's two rehabilitation-focused patient care units. *Goodwill* increased in 2012 as a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. *Goodwill* increased in 2013 as a result of our acquisition of Walton Rehabilitation Hospital and conversion of our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare offset by the divestiture of 41 skilled nursing facility beds. See Note 2, *Business Combinations* , Note 7, *Investments in and Advances to Nonconsolidated Affiliates* , and Note 11, *Redeemable Noncontrolling Interests* .

We performed impairment reviews as of October 1, 2013 , 2012 , and 2011 and concluded no *Goodwill* impairment existed. As of December 31, 2013 , we had no accumulated impairment losses related to *Goodwill* .

The following table provides information regarding our other intangible assets (in millions):

	Gross Carrying Amount	Accumulated Amortization	Net
Certificates of need:			
2013	$ 14.7	$ (3.0)	$ 11.7
2012	9.9	(2.5)	7.4
Licenses:			
2013	$ 50.5	$ (44.9)	$ 5.6
2012	50.6	(42.9)	7.7
Noncompete agreements:			
2013	$ 40.2	$ (24.8)	$ 15.4
2012	34.3	(20.3)	14.0
Tradenames:			
2013	$ 17.0	$ (9.3)	$ 7.7
2012	16.1	(8.6)	7.5
Internal-use software:			
2013	$ 105.3	$ (63.5)	$ 41.8
2012	84.7	(55.0)	29.7
Market access assets:			
2013	$ 13.2	$ (7.2)	$ 6.0
2012	13.2	(6.3)	6.9
Total intangible assets:			
2013	$ 240.9	$ (152.7)	$ 88.2
2012	208.8	(135.6)	73.2

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

	For the Year Ended December 31,		
	2013	2012	2011
Amortization expense	$ 17.3	$ 13.4	$ 15.2

Total estimated amortization expense for our other intangible assets for the next five years is as follows (in millions):

Year Ending December 31,	Estimated Amortization Expense
2014	$ 17.6
2015	15.8
2016	12.0
2017	8.6
2018	6.2

7. Investments in and Advances to Nonconsolidated Affiliates :

Investments in and advances to nonconsolidated affiliates as of December 31, 2013 represents our investment in 12 partially owned subsidiaries, of which 9 are general or limited partnerships, limited liability companies, or joint ventures in which HealthSouth or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 1% to 51% . We account for these investments using the cost and equity methods of accounting. Our investments, which are included in *Other long-term assets* in our consolidated balance sheets, consist of the following (in millions):

	As of December 31,	
	2013	2012
Equity method investments:		
Capital contributions	$ 2.9	$ 2.8
Cumulative share of income	104.8	93.8
Cumulative share of distributions	(88.8)	(77.4)
	18.9	19.2
Cost method investments:		
Capital contributions, net of distributions and impairments	1.4	1.6
Total investments in and advances to nonconsolidated affiliates	$ 20.3	$ 20.8

The following summarizes the combined assets, liabilities, and equity and the combined results of operations of our equity method affiliates (on a 100% basis, in millions):

	As of December 31,	
	2013	2012
Assets—		
Current	$ 16.6	$ 21.4
Noncurrent	36.2	36.6
Total assets	$ 52.8	$ 58.0
Liabilities and equity—		
Current liabilities	$ 2.4	$ 6.6
Noncurrent liabilities	0.7	1.2
Partners’ capital and shareholders’ equity—		
HealthSouth	18.9	19.2
Outside partners	30.8	31.0
Total liabilities and equity	$ 52.8	$ 58.0

Condensed statements of operations (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Net operating revenues	$ 74.3	$ 83.3	$ 87.0
Operating expenses	(43.6)	(48.1)	(53.1)
Income from continuing operations, net of tax	24.6	28.3	26.5
Net income	24.6	28.3	26.5

During the third quarter of 2012, we negotiated with our partner to amend the joint venture agreement related to St. Vincent Rehabilitation Hospital which resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. The amendment revised certain participatory rights held by our joint venture partner resulting in HealthSouth gaining control of this entity from an accounting perspective. We accounted for this change in control as a business combination and consolidated this entity using the acquisition method. The consolidation of St. Vincent Rehabilitation Hospital did not have a material impact on our financial position, results of operations, or cash flows. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, goodwill increased by $15.6 million , and we recorded a $4.9 million gain as part of *Other income* during the year ended December 31, 2012. See Note 6, *Goodwill and Other Intangible Assets* , and Note 12, *Fair Value Measurements* .

In December 2013, we signed an agreement to acquire an additional 30% equity interest from UMass Memorial Health Care, our joint venture partner in Fairlawn Rehabilitation Hospital in Worcester, Massachusetts. This transaction, which is subject to regulatory approval and is expected to close in 2014, will increase our ownership interest from 50% to 80% and will, when completed, result in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. We expect to account for this change in control as a business combination and will consolidate this entity using the acquisition method. The consolidation of the operating results of Fairlawn Rehabilitation Hospital is not expected to have a material impact on our financial position, results of operations, or cash flows.

8. Long-term Debt :

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

	As of December 31,	
	2013	2012
Credit Agreement—		
Advances under revolving credit facility	$ 45.0	$ —
Bonds payable—		
7.25% Senior Notes due 2018	272.4	302.9
8.125% Senior Notes due 2020	286.6	286.2
7.75% Senior Notes due 2022	252.5	280.7
5.75% Senior Notes due 2024	275.0	275.0
2.00% Convertible Senior Subordinated Notes due 2043	249.5	—
Other notes payable	47.6	36.8
Capital lease obligations	88.9	71.9
	1,517.5	1,253.5
Less: Current portion	(12.3)	(13.6)
Long-term debt, net of current portion	$ 1,505.2	$ 1,239.9

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2014	$ 12.3	$ 12.3
2015	9.0	9.0
2016	9.0	9.0
2017	8.1	8.1
2018	325.0	326.0
Thereafter	1,225.6	1,153.1
Total	$ 1,589.0	$ 1,517.5

In June 2013, we amended our existing credit agreement to, among other things, permit unlimited restricted payments (as defined in the credit agreement) so long as the senior secured leverage ratio remains less than or equal to 1.5 x and extend the maturity date of the revolving credit facility from August 2017 to June 2018. In November 2013, we 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. Pursuant to the terms of these senior notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103% , which resulted in a total cash outlay of approximately $60 million to retire the $58.1 million in principal. We used a combination of cash on hand and availability under our revolving credit facility for this redemption. As a result of this redemption, we recorded a $2.4 million *Loss on early extinguishment of debt* in 2013. Additionally, in November 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 10, *Convertible Perpetual Preferred Stock* .

In August 2012, we amended and restated our credit agreement to increase the size of our revolver from $500 million to $600 million , eliminate the former $100 million term loan ($95 million outstanding), extend the revolver maturity from May 2016 to August 2017, and lower the interest rate spread by 50 basis points to an initial rate of LIBOR plus 1.75% . In addition, in September 2012, we completed a registered public offering of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 at a public offering price of 100% of the principal amount, the proceeds of which were used to repay amounts outstanding under our revolving credit facility and redeem 10% of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022. As a result of these transactions, we recorded a $4.0 million *Loss on early extinguishment of debt* in 2012.

During 2011, we completed refinancing transactions in which we issued an additional $60 million each of our 7.25% Senior Notes due 2018 and 7 .75% Senior Notes due 2022 and amended and restated our credit agreement to create, under a pre-existing accordion feature, a $100 million term loan maturing in 2016. Net proceeds from this senior notes offering were approximately $122 million . We used approximately $45 million of these net proceeds to repay a portion of the amounts outstanding under our revolving credit facili ty. In June 2011, the remainder of the proceeds from this senior notes offering along with the $100 million of proceeds from the new term loan were used to redeem a portion of our 10.75% Senior Notes due 2016, as discussed below. Our 2011 credit agreement amendment also extended the maturity of our revolving credit facility to May 2016 and reduced by 100 basis points the applicable spread on loans. In September 2011, we redeemed the remainder of our 10.75% Senior Notes due 2016, as discussed below. As a resu lt of the redemptions of our 10.75% Senior Notes due 2016, we recorded a $38.8 million *Loss on early extinguishment of debt* in 2011.

Senior Secured Credit Agreement—

2013 Credit Agreement

On June 11, 2013, we amended our existing credit agreement, dated August 10, 2012 (the “Credit Agreement”). The Credit Agreement provides for a $600 million revolving credit facility with a $260 million letter of credit subfacility and a swingline loan subfacility all of which mature in June 2018.

Amounts drawn on the revolving credit facility bear interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays' Bank PLC's ("Barclays") prime rate and (b) the federal funds rate plus 0.5% , in each case, plus an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.375% per annum on the daily amount of the unutilized commitments under the revolving credit facility. The initial interest rate on borrowings under the Credit Agreement is LIBOR plus 1.75% .

The Credit Agreement provides that, subject to the satisfaction of certain conditions, we will have the right to increase the amount of the revolving credit facility prior to its maturity by incurring incremental term loans or by increasing the revolving credit facility, or both, in an aggregate amount not to exceed $300 million .

The Credit Agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio that change over time. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the Credit Agreement and (2) our senior secured leverage ratio, as defined in the Credit Agreement, does not exceed 1.5x. In the event the senior secured leverage ratio exceeds 1.5x, these payments are subject to a limit of $200 million plus an amount equal to a portion of excess cash flows each fiscal year.

The Company's obligations under the Credit Agreement are secured by substantially all of (1) the real property owned by the Company and its subsidiary guarantors as of the date of this amendment and (2) the current and future personal property of the Company and its subsidiary guarantors. The Company's obligations are guaranteed by the subsidiary guarantors pursuant to the amended and restated collateral and guarantee agreement (the "Collateral and Guarantee Agreement"), dated as of October 26, 2010, among the Agent, the Company, and its subsidiaries identified therein (collectively, the "Subsidiary Guarantors"). In addition to the Collateral and Guarantee Agreement, we and the Subsidiary Guarantors entered into mortgages with respect to certain of our material real property that we owned as of the date of this amendment (excluding real property subject to preexisting liens and/or mortgages) to secure our obligations under the Credit Agreement.

As of December 31, 2013, $45.0 million were drawn under the revolving credit facility with an interest rate of 1.9% . Amounts drawn as of December 31, 2013 exclude $36.5 million utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes.

2012 Credit Agreement

On August 10, 2012, we amended and restated our existing credit agreement, dated May 10, 2011 (the "2012 Credit Agreement"). The 2012 Credit Agreement provided for a $600 million revolving credit facility with a $260 million letter of credit subfacility and a swingline loan subfacility all of which would have matured in August 2017.

All other material terms were the same as the Credit Agreement discussed above. Our obligations under the 2012 Credit Agreement also were secured and guaranteed by us and our subsidiaries.

As of December 31, 2012, no amounts were drawn under the revolving credit facility. If amounts had been drawn as of that date, they would have bore interest at a rate of 2.05% . As of December 31, 2012, $39.5 million were being utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes.

2011 Credit Agreement

On May 10, 2011, we amended and restated in its entirety our existing credit agreement, dated October 26, 2010 (the "2011 Credit Agreement"). The 2011 Credit Agreement provided for a $100 million term loan and a $500 million revolving credit facility with a $260 million letter of credit subfacility and a swingline loan subfacility all of which would have matured in May 2016. Quarterly amortization on the term loan began September 30, 2011 at $1.25 million through June 30, 2013, then at $1.875 million through June 30, 2014, and then at $2.5 million through March 31, 2016. In June 2011, the net proceeds from the term loan were used to redeem a portion of the 10.75% Senior Notes due 2016 .

The term loan and amounts drawn on the revolving credit facility under the 2011 Credit Agreement bore interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays' prime rate and (b) the federal funds rate plus

0.5% , in each case, plus an applicable margin that varied depending upon our leverage ratio. We were also subject to a commitment fee of 0.5% per annum on the daily amount of the unutilized commitments under the revolving credit facility.

The initial interest rate on borrowings under the 2011 Credit Agreement was LIBOR plus 2.5% . Under the terms of the 2011 Credit Agreement, the applicable interest rate for a given interest rate period was adjusted based on the leverage ratio (defined in the 2011 Credit Agreement) as of the end of our most recent fiscal quarter. Accordingly, on August 5, 2011, the spread above the applicable base rate (LIBOR) applicable to both our revolving credit facility and term loan decreased from 2.5% to 2.25% as a result of the leverage ratio calculated under the terms of the 2011 Credit Agreement.

The 2011 Credit Agreement provided that, subject to the satisfaction of certain conditions, we had the right to increase the amount of the revolving credit facility prior to its maturity by incurring incremental term loans or by increasing the revolving credit facility, or both, in an aggregate amount not to exceed $200 million .

All other material terms were the same as the Credit Agreement discussed above. Our obligations under the 2011 Credit Agreement also were secured and guaranteed by us and our subsidiaries.

Bonds Payable—

Nonconvertible Notes

The Company's 2018 Notes, 2020 Notes, 2022 Notes, and 2024 Notes (collectively, the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009 between us and The Bank of Nova Scotia Trust Company of New York, as trustee (the "Original Trustee"), as supplemented by the second, third, and fourth supplemental indenture, respectively, relating to the Senior Notes (together with the Base Indenture, the "Indenture"), among us, the Subsidiary Guarantors (as defined in the Indenture), and the Original Trustee. The Original Trustee notified us of its intention to discontinue its corporate trust operations and, accordingly, to resign upon the appointment of a successor trustee. Effective July 29, 2013, Wells Fargo Bank, National Association, was appointed as successor trustee under the Indenture.

Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our Credit Agreement and other capital markets debt (see Note 20, *Condensed Consolidating Financial Information*). The Senior Notes are senior, unsecured obligations of HealthSouth and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

Senior Notes Due 2018 and 2022

On October 7, 2010, we completed a public offering of $525.0 million aggregate principal amount of senior notes, which included $275.0 million of 7.25% Senior Notes due 2018 (the "2018 Notes") at par and $250.0 million of 7.75% Senior Notes due 2022 (the "2022 Notes") at par (collectively, the "2018 and 2022 Senior Notes"). We used the net proceeds from the initial offering of the 2018 and 2022 Senior Notes to repay amounts outstanding under the term loan facility of our former credit agreement dated March 2006.

On March 7, 2011, we completed a public offering of $120 million aggregate principal amount of senior notes, which included an additional $60 million of the 2018 Notes at 103.25% of the principal amount and an additional $60 million of the 2022 Notes at 103.50% of the principal amount. Net proceeds from this offering were approximately $122 million . We used approximately $45 million of the net proceeds to repay a portion of the amounts outstanding under our revolving credit facility. In June 2011, the remainder of the net proceeds were used to redeem a portion of our 10.75% Senior Notes due 2016, as discussed below.

On October 9, 2012, $64.5 million of the net proceeds from our public offering of the 2024 Notes were used to redeem $33.5 million of the outstanding principal amount of our existing 2018 Notes and $31.0 million of the outstanding principal amount of our existing 2022 Notes. The notes were redeemed at a price of 103% , which resulted in an additional cash outlay of $1.9 million from the net proceeds.

On November 29, 2013, we redeemed $30.2 million and $27.9 million of the outstanding principal amount of our existing 2018 Notes and our existing 2022 Notes, respectively. Pursuant to the terms of these senior notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103% , which resulted in a total cash outlay of approximately $60 million to retire the $58.1 million in principal. We used a combination of cash on hand and availability under our revolving credit facility for this redemption.

2018 Notes

The 2018 Notes mature on October 1, 2018 and bear interest at a per annum rate of 7.25% . Due to financing costs, the effective interest rate on the 2018 Notes is 7.5% . Interest is payable semiannually in arrears on April 1 and October 1 of each year.

We may redeem the 2018 Notes, in whole or in part, at any time on or after October 1, 2014, at the redemption prices set forth below:

Period	Redemption Price*
2014	103.625%
2015	101.813%
2016 and thereafter	100.000%

* Expressed in percentage of principal amount

2022 Notes

The 2022 Notes mature on September 15, 2022 and bear interest at a per annum rate of 7.75% . Due to financing costs, the effective interest rate on the 2022 Notes is 7.9% . Interest is payable semiannually in arrears on March 15 and September 15 of each year.

We may redeem the 2022 Notes, in whole or in part, at any time on or after September 15, 2015, at the redemption prices set forth below:

Period	Redemption Price*
2015	103.875%
2016	102.583%
2017	101.292%
2018 and thereafter	100.000%

* Expressed in percentage of principal amount

Prior to September 15, 2015, during any 12-month period, we may redeem up to 10% of the aggregate principal amount of the 2022 Notes at a redemption price equal to 103% of the principal amount, plus accrued and unpaid interest, if any, to the redemption date.

Senior Notes Due 2020

In December 2009, we issued $290.0 million of 8.125% Senior Notes due 2020 (the “2020 Notes”) at 98.327% of par. We used the net proceeds from this transaction along with cash on hand to tender for and redeem all of our former floating rate senior notes due 2014 outstanding at that time. Due to discounts and financing costs, the effective interest rate on the 2020 Notes is 8.7% . Interest is payable semiannually in arrears on February 15 and August 15 of each year.

We may redeem the 2020 Notes, in whole or in part, at any time on or after February 15, 2015, at the redemption prices set forth below:

Period	Redemption Price*
2015	104.063%
2016	102.708%
2017	101.354%
2018 and thereafter	100.000%

* Expressed in percentage of principal amount

Senior Notes Due 2024

On September 11, 2012, we completed a public offering of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 (the “2024 Notes”) at a public offering price of 100% of the principal amount. Net proceeds from this offering were approximately $270 million . We used $195 million of the net proceeds to repay the amounts outstanding under our revolving credit facility. Additionally, in October 2012, $64.5 million of the net proceeds were used to redeem a portion of our 2018 and 2022 Senior Notes.

The 2024 Notes mature on November 1, 2024 and bear interest at a per annum rate of 5.75% . Due to financing costs, the effective interest rate on the 2024 Notes is 6.0% . Interest is payable semiannually in arrears on May 1 and November 1 of each year.

We may redeem the 2024 Notes, in whole or in part, at any time on or after November 1, 2017, at the redemption prices set forth below:

Period	Redemption Price*
2017	102.875%
2018	101.917%
2019	100.958%
2020 and thereafter	100.000%

* Expressed in percentage of principal amount

Senior Notes Due 2016

On June 14, 2006, we completed a private offering of $625.0 million aggregate principal amount of 10.75% senior notes due 2016 (the “2016 Notes”) at 98.505% of par. On June 15, 2011, we completed a call of $335.0 million in principal of the 2016 Notes and on September 1, 2011, we completed the redemption of the remaining $165.6 million in principal of the 2016 Notes. As a result of the above redemptions of our 2016 Notes, we recorded a $38.8 million *Loss on early extinguishment of debt* during 2011. The 2016 Notes bore interest at a per annum rate of 10.75% . Due to discounts and financing costs, the effective interest rate on the 2016 Notes was 11.4% .

Convertible Notes

Convertible Senior Subordinated Notes Due 2043

On November 18, 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 (the "Convertible Notes") for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. The Company's Convertible Notes were issued pursuant to an indenture dated November 18, 2013 (the "Convertible Notes Indenture") between us and Wells Fargo Bank, National Association, as trustee and conversion agent. The Convertible Notes are senior subordinated unsecured obligations of the Company. As such, the Convertible Notes are subordinated to all our existing and future senior unsecured debt and are effectively subordinated to our existing and future secured debt to the extent of the value of the collateral securing such debt. Additionally, the Convertible Notes are structurally subordinated to all existing and future debt and other obligations of our subsidiaries.

The Convertible Notes are senior subordinated unsecured obligations of the Company. They bear regular interest at a rate of 2.0% per year payable semiannually in arrears in cash on June 1 and December 1 of each year , beginning June 1, 2014. Beginning with the six-month period starting December 1, 2018, contingent interest is payable if the trading price of the Convertible Notes for each of the five trading days ending two trading days prior to any six-month contingent interest period is equal to or greater than $1,200. The amount of contingent interest payable per $1,000 principal amount of the Convertible Notes in respect of any contingent interest period is equal to 0.25% of the average trading price of the Convertible Notes during the specified measurement period. Due to discounts and financing costs, the effective interest rate on the Convertible Notes is 6.0% .

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

Prior to December 1, 2018, we may redeem all or any part of the Convertible Notes if the volume weighted average price per share of our common stock is at least 120% of the conversion price of the Convertible Notes for at least 20 trading days during any 30 consecutive trading day period, at a redemption price equal to 100% of the principal amount of Convertible Notes to be redeemed, plus accrued and unpaid interest. On or after December 1, 2018, we may, at our option, redeem all or any part of the Convertible Notes at a redemption price equal to 100% of the principal amount of the Convertible Notes to be redeemed, plus accrued and unpaid interest.

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

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

See also Note 10, *Convertible Perpetual Preferred Stock* .

Other Notes Payable—

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

	As of December 31,		
	2013	2012	Interest Rates
Sale/leaseback transactions involving real estate accounted for as financings	$ 28.0	$ 28.0	8.1% to 11.2%
Acquisition of an inpatient rehabilitation unit	4.3	5.7	7.8%
Construction of a new hospital	13.5	—	LIBOR + 2.5%; 2.7% as of December 31, 2013
Other	1.8	3.1	5.7% to 6.8%
Other notes payable	$ 47.6	$ 36.8	

Capital Lease Obligations—

We engage in a significant number of leasing transactions including real estate and other equipment utilized in operations. Leases meeting certain accounting criteria have been recorded as an asset and liability at the lower of fair value or the net present value of the aggregate future minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally ranged from 6.4% to 10.7% based on our incremental borrowing rate at the inception of the lease. Our leasing transactions include arrangements for equipment with major equipment finance companies and manufacturers who retain ownership in the equipment during the term of the lease and with a variety of both small and large real estate owners.

9. Self-Insured Risks :

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an independent insurance company licensed by the Cayman Island Monetary Authority. We use HCS to fund our first layer of insurance coverage up to $24 million for general and professional liability risks. Workers' compensation exposures are capped on a per claim basis. Risks in excess of specified limits per claim and in excess of our aggregate SIR amount are covered by unrelated commercial carriers.

The following table presents the changes in our self-insurance reserves for the years ended December 31, 2013, 2012, and 2011 (in millions):

	2013	2012	2011
Balance at beginning of period, gross	$ 148.3	$ 153.3	$ 152.9
Less: Reinsurance receivables	(29.4)	(34.4)	(33.6)
Balance at beginning of period, net	118.9	118.9	119.3
Increase for the provision of current year claims	33.7	32.7	32.7
(Decrease) increase for the provision of prior year claims	(5.2)	(5.3)	0.9
Decrease related to change in statistical confidence level	(6.7)	—	(2.8)
Expenses related to discontinued operations	(1.8)	(1.9)	(3.5)
Payments related to current year claims	(3.9)	(4.2)	(4.2)
Payments related to prior year claims	(27.3)	(21.3)	(23.5)
Balance at end of period, net	107.7	118.9	118.9
Add: Reinsurance receivables	32.6	29.4	34.4
Balance at end of period, gross	$ 140.3	$ 148.3	$ 153.3

As of December 31, 2013 and 2012 , $42.1 million and $41.8 million , respectively, of these reserves are included in *Other current liabilities* in our consolidated balance sheets.

Provisions for these risks are based primarily upon actuarially determined estimates. These reserves represent the unpaid portion of the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated ultimate loss amounts are included in current operating results.

Over the past few years, we have experienced volatility in our estimates of prior year claim reserves due primarily to favorable trends in claims and industry-wide loss development trends. Our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. With the accumulation of this additional historical data and current favorable trends, when we analyzed our assumptions during our semi-annual review of our self-insurance reserves in the fourth quarter of 2013, we lowered the statistical confidence level used to determine our self-insurance reserves from 70% to 50% . This change, which reflects our current best estimate based on the trends we are experiencing in the resolution of claims, reduced our reserves included in continuing operations by $6.7 million in the fourth quarter of 2013.

The reserves for these self-insured risks cover approximately 1,150 and 800 individual claims at December 31, 2013 and 2012 , respectively, and estimates for potential unreported claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed management’s estimates.

10. Convertible Perpetual Preferred Stock :

On March 7, 2006 , we completed the sale of 400,000 shares of our 6.50% Series A Convertible Perpetual Preferred Stock. The preferred stock has a liquidation preference of $1,000 per share of preferred stock, which is contingently subject to accretion. Holders of the preferred stock are entitled to receive, when and if declared by our board of directors, cash dividends at the rate of 6.50% per annum on the accreted liquidation preference per share, payable quarterly in arrears. Dividends on the preferred stock are cumulative. Each holder of preferred stock has one vote for each share held by the holder on all matters voted upon by the holders of our common stock.

The preferred stock is convertible, at the option of the holder, at any time into shares of our common stock. We may at any time cause the shares of preferred stock to be automatically converted into shares of our common stock at the conversion rate then in effect if the closing sale price of our common stock for 20 trading days within a period of 30 consecutive trading days ending on the trading day before the date we give the notice of forced conversion exceeds 150% of the conversion price of the preferred stock. If we are subject to a fundamental change, as defined in the certificate of designation of the preferred stock, each holder of shares of preferred stock has the right, subject to certain limitations, to require us to purchase with cash any or all of its shares of preferred stock at a purchase price equal to 100% of the accreted liquidation preference, plus any accrued and unpaid dividends to the date of purchase. In addition, if holders of the preferred stock elect to convert shares of preferred stock in connection with certain fundamental changes, we will in certain circumstances increase the conversion rate for such shares of preferred stock. As redemption of the preferred stock is contingent upon the occurrence of a fundamental change, and since we do not deem a fundamental change probable of occurring, accretion of our *Convertible perpetual preferred stock* is not necessary.

The agreement underlying the preferred stock includes antidilutive protection that requires adjustments to the number of shares of common stock issuable upon conversion and the exercise price for common stock upon the occurrence of certain events, including payment of cash dividends on our common stock after a *de minimis* threshold. At issuance, the preferred stock had a conversion price of $30.50 per share, which was equal to an initial conversion rate of 32.7869 shares of common stock per share of preferred stock. The payment in January 2014 of an $0.18 per share dividend on our common stock triggered the antidilutive adjustment for the preferred stock. As of January 3, 2014, the resulting exercise price of each share of preferred stock was $30.17 , and the resulting conversion rate was 33.1455 for each preferred share.

During the year ended December 31, 2012, we repurchased 46,645 shares of our preferred stock for total cash consideration of $46.5 million , including fees. In the fourth quarter of 2013, we exchanged $320.0 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding preferred stock. No common stock was issued as part of these exchange transactions. As of December 31, 2013, 96,245 shares of our preferred stock remained outstanding. See Note 8, *Long-term Debt* .

The following is a summary of the activity related to our *Convertible perpetual preferred stock* from December 31, 2011 to December 31, 2013 (in millions, except share data):

	Number of Shares Outstanding	Amount
Balance as of December 31, 2011	400,000	$ 387.4
Repurchase of preferred stock	(46,645)	(45.2)
Balance as of December 31, 2012	353,355	342.2
Repurchase of preferred stock	(257,110)	(249.0)
Balance as of December 31, 2013	96,245	$ 93.2

The allocation of the consideration exchanged for repurchases of preferred stock is as follows (in millions):

	For the Year Ended December 31,	
	2013	2012
Carrying value of shares repurchased	$ 249.0	$ 45.2
Cumulative dividends included as part of repurchase price	2.2	0.5
Excess exchanged in transaction	71.6	0.8
	$ 322.8	$ 46.5

For 2013, the difference between the fair value of the consideration exchanged with the holders of the preferred stock, or $322.8 million (including fees), and the carrying value of the preferred stock in our balance sheet, or $249.0 million , resulted in a charge of $73.8 million to *Capital in excess of par value* that was treated like a dividend and subtracted from *Net income* to

arrive at *Net income attributable to HealthSouth common shareholders* in our consolidated statement of operations. Of this amount, $2.2 million represents cumulative dividends through the date of the exchange transactions.

For 2012, the difference between the fair value of the consideration paid to the holders of the preferred stock, or $46.5 million (including fees), and the carrying value of the preferred stock in our balance sheet, or $45.2 million , resulted in a charge of $1.3 million to *Capital in excess of par value* that was treated like a dividend and subtracted from *Net income* to arrive at *Net income attributable to HealthSouth common shareholders* in our consolidated statement of operations. Of this amount, $0.5 million represents cumulative dividends through the date of the repurchase transactions.

We declared $21.0 million , $23.9 million , and $26.0 million in dividends on our preferred stock in the years ended December 31, 2013, 2012, and 2011, respectively. As of December 31, 2013 and 2012 , accrued dividends of $1.6 million and $5.7 million , respectively, were included in *Other current liabilities* on our consolidated balance sheets. These accrued dividends were paid in January 2014 and 2013 , respectively.

11. Redeemable Noncontrolling Interests

Redeemable noncontrolling interests relate to two joint venture entities:

- In the first quarter of 2013, we entered into an agreement to convert our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare. Following the formation of the joint venture, our ownership percentage was reduced to approximately 56% . As part of this agreement, St. Bernards Healthcare received an option to increase its ownership percentage in the joint venture to 50% . In the fourth quarter of 2013, St. Bernards Healthcare exercised its option which reduced our ownership percentage to 50% . We remain the managing partner of this joint venture and continue to consolidate this entity. See also Note 6, *Goodwill and Other Intangible Assets* .

- In 2009, we entered into an agreement to convert our 100% owned hospital in Altoona, Pennsylvania into a joint venture with Altoona Regional Health System. Following the formation of the joint venture, our ownership percentage was reduced to 55% . Historically, the noncontrolling interest related to this joint venture was included in *Other long-term liabilities* in our consolidated balance sheets. See Note 1, *Summary of Significant Accounting Policies* , “Reclassifications.”

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Balance at beginning of period	$ 7.2	$ 7.3	$ 7.2
Net income attributable to noncontrolling interests	5.8	3.8	3.6
Distributions declared	(4.9)	(3.9)	(3.5)
Contribution to joint venture	7.1	—	—
Change in fair value	(1.7)	—	—
Balance at end of period	$ 13.5	$ 7.2	$ 7.3

The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests* , as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests* , as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented on the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Net income attributable to nonredeemable noncontrolling interests	$ 52.0	$ 47.1	$ 42.3
Net income attributable to redeemable noncontrolling interests	5.8	3.8	3.6
Net income attributable to noncontrolling interests	$ 57.8	$ 50.9	$ 45.9

12. Fair Value Measurements :

Our financial assets and liabilities that are measured at fair value on a recurring basis are as follows (in millions):

		Fair Value Measurements at Reporting Date Using			
As of December 31, 2013	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Valuation Technique [1]
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 4.7	$ —	$ 4.7	$ —	M
Other long-term assets:					
Restricted marketable securities	42.9	—	42.9	—	M
As of December 31, 2012					
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 16.4	$ —	$ 16.4	$ —	M
Other long-term assets:					
Restricted marketable securities	39.4	—	39.4	—	M

[1] The three valuation techniques are: market approach (M), cost approach (C), and income approach (I).

In addition to assets and liabilities recorded at fair value on a recurring basis, we are also required to record assets and liabilities at fair value on a nonrecurring basis. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets.

During the years ended December 31, 2013 and 2011, we did not record any gains or losses related to our nonfinancial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a nonrecurring basis as part of our continuing operations. As a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value, we recorded a $4.9 million gain as part of *Other income* during the year ended December 31, 2012. We determined the fair value of our previously held equity interest using the income approach. The income approach included the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the hospital. The projected operating results used management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. See Note 7, *Investments in and Advances to Nonconsolidated Affiliates* .

During the years ended December 31, 2013 and 2011 , we recorded impairment charges of $1.1 million and $6.8 million , respectively, as part of our results of discontinued operations. See Note 15, *Assets and Liabilities in and Results of Discontinued Operations* .

As discussed in Note 1, *Summary of Significant Accounting Policies* , "Fair Value Measurements," the carrying value equals fair value for our financial instruments that are not included in the table below and are classified as current in our consolidated balance sheets. The carrying amounts and estimated fair values for our other financial instruments are presented in the following table (in millions):

	As of December 31, 2013		As of December 31, 2012	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 45.0	$ 45.0	$ —	$ —
7.25% Senior Notes due 2018	272.4	291.4	302.9	328.6
8.125% Senior Notes due 2020	286.6	319.4	286.2	321.5
7.75% Senior Notes due 2022	252.5	275.0	280.7	306.5
5.75% Senior Notes due 2024	275.0	273.6	275.0	277.1
2.00% Convertible Senior Subordinated Notes due 2043	249.5	339.7	—	—
Other notes payable	47.6	47.6	36.8	36.8
Financial commitments:				
Letters of credit	—	36.5	—	39.5

Fair values for our long-term debt and financial commitments are determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy. See Note 1, *Summary of Significant Accounting Policies* , "Fair Value Measurements."

See also Note 11, *Redeemable Noncontrolling Interests* .

13. Share-Based Payments :

The Company has awarded employee stock-based compensation in the form of stock options and restricted stock awards under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded in 2011 was issued under the 2008 Equity Incentive Plan. The terms of the 2008 Equity Incentive Plan made available up to six million shares of common stock to be granted. In May 2011, our shareholders approved the Amended and Restated 2008 Equity Incentive Plan, which reserves and provides for the grant of up to nine million shares of common stock. All employee stock-based compensation awarded in 2012 and 2013 was issued under this plan. Both incentive plans were approved by our stockholders and provide for the grants of nonqualified stock options, incentive stock options, restricted stock, stock appreciation rights, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of HealthSouth common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which is generally three years.

The fair values of the options granted during the years ended December 31, 2013 , 2012 , and 2011 have been estimated at the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,		
	2013	2012	2011
Expected volatility	41.8%	42.8%	41.5%
Risk-free interest rate	1.4%	1.4%	2.8%
Expected life (years)	7.2	7.0	6.7
Dividend yield	0.0%	0.0%	0.0%

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, option-pricing models require the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected life of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. While our board of directors initiated quarterly dividends of $0.18 per common share in 2013 (see Note 17, *Earnings per Common Share*), we did not include a dividend payment as part of our pricing model because we had not historically paid dividends at the time of our option grants. We estimate forfeitures through an analysis of actual, historical pre-vesting option forfeiture activity. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of employee stock options granted during the years ended December 31, 2013 , 2012 , and 2011 was $10.96 , $9.57 , and $11.27 , respectively.

A summary of our stock option activity and related information is as follows:

	Shares (In Thousands)	Weighted- Average Exercise Price per Share	Weighted- Average Remaining Life (Years)	Aggregate Intrinsic Value (In Millions)
Outstanding, December 31, 2012	2,575	$ 21.12		
Granted	141	24.17		
Exercised	(338)	24.39		
Forfeitures	—	—		
Expirations	(17)	24.47		
Outstanding, December 31, 2013	2,361	20.82	4.5	$ 29.5
Exercisable, December 31, 2013	1,991	20.45	3.8	25.6

We recognized approximately $2.1 million , $2.0 million , and $1.7 million of compensation expense related to our stock options for the years ended December 31, 2013 , 2012 , and 2011 , respectively. As of December 31, 2013 , there was $2.1 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 19 months. The total intrinsic value of options exercised during the years ended December 31, 2013 , 2012 , and 2011 was $1.9 million , $0.1 million , and $0.8 million , respectively.

Restricted Stock—

The restricted stock awards granted in 2013 , 2012 , and 2011 included service-based awards, performance-based awards (that also included a service requirement), and market condition awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For awards with a service and/or performance requirement, the fair value of the award is determined by the closing price of our common stock on the grant date. For awards

with a market condition, the fair value of the awards is determined using a lattice model. Inputs into the model include the historical price volatility of our common stock, the historical volatility of the common stock of the companies in the defined peer group, and the risk free interest rate. Utilizing these inputs and potential future changes in stock prices, multiple trials are run to determine the fair value.

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2012	1,048	$ 19.28
Granted	847	23.55
Vested	(690)	18.25
Forfeited	(43)	22.67
Nonvested shares at December 31, 2013	1,162	22.89

The weighted-average grant date fair value of restricted stock granted during the years ended December 31, 2012 and 2011 was $19.30 and $8.23 per share, respectively. We recognized approximately $21.6 million , $21.2 million , and $17.7 million of compensation expense related to our restricted stock awards for the years ended December 31, 2013 , 2012 , and 2011 , respectively. As of December 31, 2013 , there was $22.0 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 20 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2013 , 2012 , and 2011 was $15.7 million , $34.0 million , and $12.5 million , respectively.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2013 , 2012 , and 2011 , we provided incentives to our nonemployee members of our board of directors through the issuance of RSUs out of our share-based incentive plans. RSUs are fully vested when awarded and receive dividend equivalents in the form of additional RSUs upon the payment of a cash dividend on our common stock. During the years ended December 31, 2013 , 2012 , and 2011 , we issued 53,011 , 42,903 , and 37,332 RSUs, respectively, with a fair value of $22.47 , $20.98 , and $24.11 , respectively, per unit. We recognized approximately $1.2 million , $0.9 million , and $0.9 million , respectively, of compensation expense upon their issuance in 2013 , 2012 , and 2011 . There was no unrecognized compensation related to unvested shares as of December 31, 2013 . As of December 31, 2013 , 357,308 RSUs were outstanding.

14. Employee Benefit Plans :

Substantially all HealthSouth employees are eligible to enroll in HealthSouth-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2013 , 2012 , and 2011 , costs associated with these plans, net of amounts paid by employees, approximated $73.4 million , $67.8 million , and $66.8 million , respectively.

The HealthSouth Retirement Investment Plan is a qualified 401(k) savings plan. The plan allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. HealthSouth’s employer matching contribution is 50% of the first 6% of each participant’s elective deferrals . All contributions to the plan are in the form of cash. Employees who are at least 21 years of age are eligible to participate in the plan. Employer contributions vest 100% after three years of service. Participants are always fully vested in their own contributions.

Employer contributions to the HealthSouth Retirement Investment Plan approximated $13.2 million , $13.2 million , and $12.6 million in 2013 , 2012 , and 2011 , respectively. In 2013 , 2012 , and 2011 , approximately $0.5 million , $0.8 million ,

and $1.7 million , respectively, from the plan's forfeiture account were used to fund the matching contributions in accordance with the terms of the plan.

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals and individual goals. The corporate and regional goals are approved on an annual basis by our board of directors as part of our routine budgeting and financial planning process. The individual goals, which are weighted according to importance, are determined between each participant and his or her immediate supervisor. The program applies to persons who join the Company in, or are promoted to, senior management positions. In 2014 , we expect to pay approximately $12.4 million under the program for the year ended December 31, 2013 . In February 2013 and 2012 , we paid $11.4 million and $12.8 million , respectively, under the program for the years ended December 31, 2012 and 2011 .

15. Assets and Liabilities in and Results of Discontinued Operations :

The operating results of discontinued operations are as follows (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Net operating revenues	$ 0.2	$ 1.0	$ 95.7
Less: Provision for doubtful accounts	0.3	—	(1.5)
Net operating revenues less provision for doubtful accounts	0.5	1.0	94.2
Costs and expenses	0.2	0.2	66.3
Impairments	1.1	—	6.8
(Loss) income from discontinued operations	(0.8)	0.8	21.1
(Loss) gain on disposal of assets/sale of investments of discontinued operations	(0.4)	5.0	65.6
Income tax benefit (expense)	0.1	(1.3)	(37.9)
(Loss) income from discontinued operations, net of tax	$ (1.1)	$ 4.5	$ 48.8

Our results of discontinued operations primarily included the operations of six long-term acute care hospitals ("LTCHs"). In August 2011, we completed a transaction to sell five LTCHs to certain subsidiaries of LifeCare Holdings, Inc. for an aggregate purchase price of $117.5 million . We closed the sixth LTCH in August 2011 and sold the associated real estate in December 2013.

As discussed in Note 18, *Contingencies and Other Commitments* , in April 2011, we entered into a definitive settlement and release agreement with the state of Delaware (the "Delaware Settlement") relating to a previously disclosed audit of unclaimed property conducted on behalf of Delaware and two other states by Kelmar Associates, LLC. During the year ended December 31, 2011, we recorded a $24.8 million gain in connection with this settlement as part of our results of discontinued operations.

The impairment charges presented in the above table for 2013 and 2011 related to the LTCH that was closed in 2011. We determined the fair value of the impaired long-lived assets at this LTCH based on offers from potential buyers of the closed facility's real estate. The impairment charges recorded in 2011 also related to the Dallas Medical Center that was closed in 2008. We determined the fair value of the impaired long-lived assets at this hospital based on the assets' estimated fair value using valuation techniques that included third-party appraisals and offers from potential buyers.

During 2012, we recognized gains associated with the sale of the real estate associated with Dallas Medical Center and an investment we had in a cancer treatment center that was part of our former diagnostic division. As a result of the transaction discussed above to sell five of our LTCHs, we recorded a $65.6 million pre-tax gain as part of our results of discontinued operations in 2011.

Income tax expense recorded as part of our results of discontinued operations in 2011 related primarily to the gain from the sale of five of our LTCHs and the Delaware Settlement.

As discussed in Note 9, *Self-Insured Risks* , we insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program underwritten by HCS. Expenses for retained professional and general liability risks and workers' compensation risks associated with our divested surgery centers, outpatient, and diagnostic divisions and our former LTCHs have been included in our results of discontinued operations.

Assets and liabilities in discontinued operations consist of the following (in millions):

	As of December 31,	
	2013	2012
Total current assets	$ 0.1	$ 0.4
Total long-term assets	$ 0.3	$ 5.0
Total current liabilities	$ 4.6	$ 5.2
Total long-term liabilities	$ 0.6	$ 0.6

As of December 31, 2013 and 2012, assets and liabilities in discontinued operations primarily relate to our former LTCHs. Current assets and long-term assets in the above table are included in *Prepaid expenses and other current assets* and *Other long-term assets* , respectively, in our consolidated balance sheets. Current liabilities and long-term liabilities in the above table are included in *Other current liabilities* and *Other long-term liabilities* , respectively, in our consolidated balance sheets.

In connection with the 2007 sale of our surgery centers division (now known as Surgical Care Affiliates, or "SCA") to ASC Acquisition LLC, an affiliate of TPG Partners V, L.P. ("TPG"), a private investment partnership, we received an option, subject to terms and conditions set forth below, to purchase up to a 5% equity interest in SCA. The price of the option is equal to the original issuance price of the units subscribed for by TPG and certain other co-investors in connection with the acquisition plus a 15% annual premium, compounded annually. The option has a term of ten years and is exercisable upon certain liquidity events, including a public offering of SCA's shares of common stock that results in 30% or more of SCA's common stock being listed or traded on a national securities exchange.

16. Income Taxes :

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Current:			
Federal	$ 0.9	$ 0.7	$ 1.4
State and local	5.4	5.2	(0.8)
Total current expense	6.3	5.9	0.6
Deferred:			
Federal	11.3	104.2	48.2
State and local	(4.9)	(1.5)	(11.7)
Total deferred expense	6.4	102.7	36.5
Total income tax expense related to continuing operations	$ 12.7	$ 108.6	$ 37.1

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, which include federal, state, and other income taxes, is presented below:

	For the Year Ended December 31,		
	2013	2012	2011
Tax expense at statutory rate	35.0 %	35.0 %	35.0 %
Increase (decrease) in tax rate resulting from:			
State income taxes, net of federal tax benefit	4.0 %	3.7 %	3.0 %
Decrease in valuation allowance	(2.3)%	(2.8)%	(11.6)%
Settlement of tax claims	(28.7)%	0.3 %	(7.2)%
Noncontrolling interests	(5.1)%	(5.1)%	(6.5)%
Adjustments to net operating loss carryforwards	— %	— %	2.9 %
Interest, net	(0.1)%	(0.2)%	(1.6)%
Other, net	0.4 %	1.0 %	1.3 %
Income tax expense	3.2 %	31.9 %	15.3 %

In April 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. 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 federal income tax benefit of approximately $115 million in the second quarter of 2013. This federal income tax benefit primarily resulted from an approximate $283 million increase to our federal NOL on a gross basis.

The *Provision for income tax expense* in 2013 is less than the federal statutory rate primarily due to: (1) the IRS settlement discussed above, (2) the impact of noncontrolling interests, and (3) a decrease in our valuation allowance, as discussed below, offset by (4) state income tax expense. See Note 1, *Summary of Significant Accounting Policies* , "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in the above table.

The *Provision for income tax expense* in 2012 is less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests and (2) a decrease in the valuation allowance, as discussed below, offset by (3) state income tax expense.

The *Provision for income tax expense* in 2011 is less than the federal statutory rate primarily due to: (1) an approximate $28 million benefit associated with a current period net reduction in the valuation allowance and (2) an approximate $18 million net benefit associated with settlements with various taxing authorities including the settlement of federal income tax claims with the Internal Revenue Service for tax years 2007 and 2008 offset by (3) approximately $7 million of net expense primarily related to corrections to 2010 deferred tax assets associated with our NOLs and corresponding valuation allowance. See Note 1, *Summary of Significant Accounting Policies* , "Out-of-Period Adjustments."

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of HealthSouth's deferred tax assets and liabilities are presented in the following table (in millions). See also Note 1, *Summary of Significant Accounting Policies* , "Reclassifications."

	As of December 31,	
	2013	2012
Deferred income tax assets:		
Net operating loss	$ 416.5	$ 432.5
Property, net	44.3	40.3
Insurance reserve	28.5	30.7
Stock-based compensation	26.8	26.8
Allowance for doubtful accounts	15.3	14.9
Alternative minimum tax	11.1	11.9
Carrying value of partnerships	19.8	14.7
Other accruals	19.0	18.9
Capital losses	1.2	6.5
Other	2.0	0.4
Total deferred income tax assets	584.5	597.6
Less: Valuation allowance	(30.7)	(39.8)
Net deferred income tax assets	553.8	557.8
Deferred income tax liabilities:		
Intangibles	(29.2)	(26.5)
Convertible debt interest	(28.0)	—
Other	(3.3)	(0.3)
Total deferred income tax liabilities	(60.5)	(26.8)
Net deferred income tax assets	493.3	531.0
Less: Current deferred tax assets	139.0	137.5
Noncurrent deferred tax assets	$ 354.3	$ 393.5

At December 31, 2013 , we had an unused federal NOL of $325.1 million (approximately $929.0 million on a gross basis) and state NOLs of $91.4 million . Such losses expire in various amounts at varying times through 2031 . Our reported federal NOL as of December 31, 2013 excludes $8.6 million related to operating loss carryforwards resulting from excess tax benefits related to share-based awards, the tax benefits of which, when recognized, will be accounted for as a credit to additional paid-in-capital when they reduce taxes payable.

For the years ended December 31, 2013 , 2012 , and 2011 , the net decreases in our valuation allowance were $9.1 million , $10.5 million , and $62.4 million , respectively. The decrease in our valuation allowance in 2013 related primarily to our capital loss carryforwards, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws. During the second quarter of 2013, we determined a valuation allowance related to our capital loss carryforwards was no longer required as sufficient positive evidence existed to substantiate their utilization. This evidence included our partial utilization of these assets as a result of realizing capital gains in 2013 and the identification of sufficient taxable capital gain income within the available capital loss carryforward period. Substantially all of the decrease in the valuation allowance in 2012 and approximately $21 million of the decrease in the valuation allowance during 2011 related primarily to our determination it is more likely than not a substantial portion of our deferred tax assets will be realized in the future. In addition, approximately $34 million of the decrease in the valuation allowance in 2011 was due to the corrections made to the valuation allowance, as discussed above. Approximately $7 million of the decrease in the valuation allowance in 2011 resulted from our settlement with

the IRS for tax year s 2007 and 2008 which enabled us to utilize certain capital losses previously offset by a valuation allowance .

As of December 31, 2013 , we have a remaining valuation allowance of $30.7 million . This valuation allowance remains recorded due to uncertainties regarding 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 including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdictions, or if the timing of future tax deductions differs from our expectations.

Our utilization of NOLs could be subject to limitations under Internal Revenue Code Section 382 ("Section 382") and may be limited in the event of certain cumulative changes in ownership interests of significant stockholders over a three-year period exceed 50%. Section 382 imposes an annual limitation on the use of certain carryforward losses to an amount that approximates the value of a company at the time of an ownership change multiplied by the long-term tax exempt rate. At this time, we do not believe these limitations will restrict our ability to use any NOLs before they expire. However, no such assurances can be provided.

As of January 1, 2011 , total remaining gross unrecognized tax benefits were $12.6 million , all of which would affect our effective tax rate if recognized. Total accrued interest expense related to unrecognized tax benefits was $1.1 million as of January 1, 2011 . The amount of unrecognized tax benefits changed during 2011 primarily due to the settlement of federal income tax claims with the IRS for tax years 2007 and 2008 and the lapse of the applicable statute of limitations for certain federal and state claims. Total remaining gross unrecognized tax benefits were $6.0 million as of December 31, 2011, all of which would affect our effective tax rate if recognized. Total accrued interest expense related to unrecognized tax benefits as of December 31, 2011 was $0.1 million . The amount of unrecognized tax benefits changed during 2012 primarily based on our then ongoing discussions with taxing authorities as part of our continued pursuit of the maximization of our tax benefits, primarily related to our federal NOL. Total remaining gross unrecognized tax benefits were $78.0 million as of December 31, 2012, $76.0 million of which would affect our effective tax rate if recognized. The amount of unrecognized tax benefits changed during 2013 primarily due to the April 2013 IRS settlement discussed above. Total remaining gross unrecognized tax benefits were $1.1 million as of December 31, 2013, $0.4 million of which would affect our effective tax rate if recognized.

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

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
January 1, 2011	$ 12.6	$ 1.1
Gross amount of increases in unrecognized tax benefits related to prior periods	19.8	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(3.0)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(20.2)	—
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(3.2)	(1.0)
December 31, 2011	6.0	0.1
Gross amount of increases in unrecognized tax benefits related to prior periods	75.8	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(2.5)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(0.9)	—
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.4)	(0.1)
December 31, 2012	78.0	—
Gross amount of increases in unrecognized tax benefits related to prior periods	46.7	0.3
Gross amount of decreases in unrecognized tax benefits related to prior periods	(1.9)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(121.7)	—
December 31, 2013	$ 1.1	$ 0.3

Our continuing practice is to recognize interest and penalties related to income tax matters in income tax expense. For the years ended December 31, 2013 , 2012 , and 2011 , we recorded $0.2 million , $0.7 million , and $4.7 million of net interest income, respectively, primarily related to amended state income tax returns, as part of our income tax provision. Total net accrued interest (expense) income was $(0.1) million and $0.2 million as of December 31, 2013 and 2012 , respectively.

HealthSouth and its subsidiaries' federal and state income tax returns are periodically examined by various regulatory taxing authorities. In connection with such examinations, we have settled federal income tax examinations with the IRS for all tax years through 2010. We are currently under audit by two states for tax years ranging from 2007 through 2011.

For the tax years that remain open under the applicable statutes of limitations, amounts related to these unrecognized tax benefits have been considered by management in its estimate of our potential net recovery of prior years' income taxes. We do not expect a material change in our unrecognized tax benefits within the next 12 months due to the closing of the applicable statutes of limitation.

17. Earnings per Common Share :

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. The two-class method should have been used during all prior periods. We assessed the materiality of these revisions and concluded they were not material to any previously issued financial statements. Revisions for the years ended December 31, 2012 and 2011 are presented below.

	Year Ended December 31,	
	2012	2011
Basic earnings per share attributable to HealthSouth common shareholders, as reported:		
Continuing operations	$ 1.65	$ 1.42
Discontinued operations	0.04	0.54
Net income	$ 1.69	$ 1.96
Basic earnings per share attributable to HealthSouth common shareholders as revised using the two-class method:		
Continuing operations	$ 1.62	$ 1.39
Discontinued operations	0.05	0.52
Net income	$ 1.67	$ 1.91

The following table sets forth the computation of basic and diluted earnings per common share (in millions, except per share amounts):

	For the Year Ended December 31,		
	2013	2012	2011
Numerator:			
Income from continuing operations	$ 382.5	$ 231.4	$ 205.8
Less: Net income attributable to noncontrolling interests included in continuing operations	(57.8)	(50.9)	(47.0)
Less: Income allocated to participating securities	(3.4)	(2.2)	(3.2)
Less: Convertible perpetual preferred stock dividends	(21.0)	(23.9)	(26.0)
Less: Repurchase of convertible perpetual preferred stock	(71.6)	(0.8)	—
Income from continuing operations attributable to HealthSouth common shareholders	228.7	153.6	129.6
(Loss) income from discontinued operations, net of tax, attributable to HealthSouth common shareholders	(1.1)	4.5	49.9
Less: Income from discontinued operations allocated to participating securities	—	(0.1)	(1.2)
Net income attributable to HealthSouth common shareholders	$ 227.6	$ 158.0	$ 178.3
Denominator:			
Basic weighted average common shares outstanding	88.1	94.6	93.3
Diluted weighted average common shares outstanding	102.1	108.1	109.2
Basic and diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.59	$ 1.62	$ 1.39
Discontinued operations	(0.01)	0.05	0.52
Net income	$ 2.58	$ 1.67	$ 1.91

The following table sets forth the reconciliation between basic weighted average common shares outstanding and diluted weighted average common shares outstanding (in millions):

	For the Year Ended December 31,		
	2013	2012	2011
Basic weighted average common shares outstanding	88.1	94.6	93.3
Convertible perpetual preferred stock	10.5	12.0	13.1
Convertible senior subordinated notes	1.0	—	—
Restricted stock awards, dilutive stock options, and restricted stock units	2.5	1.5	2.8
Diluted weighted average common shares outstanding	102.1	108.1	109.2

For the year ended December 31, 2013, adding back amounts related to the repurchase of our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. See Note 10, *Convertible Perpetual Preferred Stock* . For the years ended December 31, 2012 and 2011, adding back the dividends on our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings per common share are the same for all years presented.

Options to purchase approximately 0.1 million and 1.8 million shares of common stock were outstanding as of December 31, 2013 and 2012 , respectively, but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

In October 2011, our board of directors authorized the repurchase of up to $125 million of our common stock. No repurchases were made under this original authorization. On February 15, 2013, our board of directors approved an increase in our existing common stock repurchase authorization from $125 million to $350 million . During the first quarter of 2013, we completed a tender offer for our common stock. As a result of the tender offer, we purchased approximately 9.1 million shares at a price of $25.50 per share for a total cost of approximately $234.1 million , including fees and expenses relating to the tender offer. The remaining repurchase authorization expired at the end of the tender offer.

On October 25, 2013, 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.

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 was paid on October 15, 2013 to stockholders of record as of the close of business on October 1, 2013. On October 25, 2013, our board of directors declared a cash dividend of $0.18 per share that was paid on January 15, 2014 to stockholders of record on January 2, 2014. As of December 31, 2013, accrued common stock dividends of $15.8 million were included in *Other current liabilities* in our consolidated balance sheet. Future dividend payments are subject to declaration by our board of directors.

In January 2004, we repaid our then-outstanding 3.25% Convertible Debentures using the net proceeds of a loan arranged by Credit Suisse First Boston. In connection with this transaction, we issued ten million warrants with an expiration date of January 16, 2014 to the lender to purchase shares of our common stock. The agreement underlying these warrants included antidilutive protection that required adjustments to the number of shares of common stock purchasable upon exercise and the exercise price for common stock upon the occurrence of certain events. Following our one-for-five reverse stock split in October 2006, the warrants were exercisable for two million shares of our common stock at an exercise price of $32.50 . This antidilution protection also provided for adjustment upon payment of cash dividends on our common stock after a *de minimis* threshold. 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. The warrants were not assumed exercised for dilutive shares outstanding for the years ended December 31, 2012 or 2011 because they were antidilutive in those periods.

The following table summarizes information relating to these warrants and their activity during 2013 and through their expiration date (number of warrants in millions):

	Number of Warrants	Weighted Average Exercise Price
Common stock warrants outstanding as of December 31, 2012	10.0	$ 32.50
Cashless exercise	(4.8)	32.50
Cash exercise	(2.3)	32.50
Common stock warrants outstanding as of December 31, 2013	2.9	32.50
Cashless exercise	(1.8)	32.16
Cash exercise	(1.0)	32.16
Expired	(0.1)	32.16
Common stock warrants outstanding as of January 16, 2014	—	

The above exercises resulted in the issuance of 0.5 million and 0.2 million shares of common stock in 2013 and 2014, respectively. Cash exercises resulted in gross proceeds of $15.3 million and $6.3 million during 2013 and 2014, respectively.

On September 30, 2009, we issued 5.0 million shares of common stock and 8.2 million common stock warrants in full satisfaction of our obligation to do so under the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. Each warrant has a term of approximately seven years from the date of issuance and an exercise price of $41.40 per share. The warrants were not assumed exercised for dilutive shares outstanding because they were antidilutive in the periods presented.

See also Note 10, *Convertible Perpetual Preferred Stock* .

18. Contingencies and Other Commitments :

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims, or legal and regulatory proceedings could materially and adversely affect our financial position, results of operations, and cash flows in a given period.

Derivative Litigation—

All lawsuits purporting to be derivative complaints on our behalf filed in the Circuit Court of Jefferson County, Alabama since 2002 have been dismissed or consolidated with the first-filed action captioned *Tucker v. Scrushy* and filed August 28, 2002. Derivative lawsuits in other jurisdictions have been stayed as well. The *Tucker* complaint asserted claims on our behalf against, among others, a number of our former officers and directors and Ernst & Young LLP, our former auditor. When originally filed, the primary allegations in the *Tucker* case involved self-dealing by Richard M. Scrushy, our former chairman and chief executive officer, and other insiders through transactions with various entities allegedly controlled by Mr. Scrushy. The complaint was amended four times to add additional defendants and include claims of accounting fraud, improper Medicare billing practices, and additional self-dealing transactions.

The claims against all defendants in the *Tucker* case, except Ernst & Young, have been settled or otherwise resolved. The *Tucker* derivative litigation against Ernst & Young is discussed in more detail below. In 2013, we and the derivative stockholder plaintiffs resolved all claims against the remaining individual defendants. These resolutions included the entry of final judgments against five former officers and resulted in the collection of approximately $5 million during 2013. As a reminder, the 2009 final judgment against Mr. Scrushy found him guilty of fraud and breach of fiduciary duties and ordered him to pay $2.9 billion in damages to us. Our collection efforts against Mr. Scrushy are ongoing.

For the years ended December 31, 2013, 2012, and 2011, we recorded net gains of $9.3 million , $3.5 million , and $12.3 million , respectively, in *Government, class action, and related settlements* in our consolidated statements of operations in connection with our receipt of cash distributions from Mr. Scrushy and the other former officers, after reimbursement of

reasonable out-of-pocket expenses incurred by HealthSouth and the attorneys for the derivative stockholder plaintiffs and after recording a liability for the federal securities plaintiffs' 25% apportionment of the net recovery as required in the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. We are obligated to pay 35% of the recoveries from Mr. Scrushy and the other former officers along with reasonable out-of-pocket expenses to the attorneys for the derivative stockholder plaintiffs. In connection with those obligations, during 2013, 2012, and 2011, $3.3 million , $1.4 million , and $5.2 million , respectively, of the amounts previously collected were distributed to attorneys for the derivative stockholder plaintiffs. We recorded these cash distributions as part of *Professional fees—accounting, tax, and legal* in our consolidated statements of operations for those years.

We had previously recorded an estimated liability for the federal securities plaintiffs' claim for the 25% apportionment of any net recovery from the defendants in the derivative litigation. In September 2013, these plaintiffs filed a request with the federal court overseeing the related settlement to approve an agreement reached on how to calculate this apportionment obligation. As a result of this filing with the court, we recorded a noncash reduction to the liability originally recorded in 2006 for this obligation during 2013 as part of *Government, class action, and related settlements* in our consolidated statements of operations.

Litigation By and Against Former Independent Auditor—

In March 2003, claims on behalf of HealthSouth were brought in the *Tucker* derivative litigation against Ernst & Young, alleging that from 1996 through 2002, when Ernst & Young served as our independent auditor, Ernst & Young acted recklessly and with gross negligence in performing its duties, and specifically that Ernst & Young failed to perform reviews and audits of our financial statements with due professional care as required by law and by its contractual agreements with us. The claims further allege Ernst & Young either knew of or, in the exercise of due care, should have discovered and investigated the fraudulent and improper accounting practices being directed by certain officers and employees, and should have reported them to our board of directors and the audit committee. The claims seek compensatory and punitive damages, disgorgement of fees received from us by Ernst & Young, and attorneys' fees and costs. On March 18, 2005, Ernst & Young filed a lawsuit captioned *Ernst & Young LLP v. HealthSouth Corp.* in the Circuit Court of Jefferson County, Alabama. The complaint alleges we provided Ernst & Young with fraudulent management representation letters, financial statements, invoices, bank reconciliations, and journal entries in an effort to conceal accounting fraud. Ernst & Young claims that as a result of our actions, Ernst & Young's reputation has been injured and it has and will incur damages, expenses, and legal fees. On April 1, 2005, we answered Ernst & Young's claims and asserted counterclaims related or identical to those asserted in the *Tucker* action. Upon Ernst & Young's motion, the Alabama state court referred Ernst & Young's claims and our counterclaims to arbitration pursuant to a clause in the engagement agreements between HealthSouth and Ernst & Young. In August 2006, we and the derivative plaintiffs agreed to jointly prosecute the claims against Ernst & Young in arbitration.

The trial phase of the arbitration process began on July 12, 2010 before a three-person arbitration panel selected under rules of the American Arbitration Association (the "AAA"). On December 18, 2012, the AAA panel granted Ernst & Young's motion to dismiss our claims on the grounds that HealthSouth is not permitted to pursue its claims since certain of its former officers and employees committed fraudulent acts. The panel also denied and dismissed Ernst & Young's claims against us. On December 18, 2012, we, together with the stockholder derivative plaintiffs, filed a notice of appeal of the panel's decision in the Circuit Court of Jefferson County, Alabama. On December 28, 2012, we filed a motion to vacate the decision. We assert that the panel's decision is contrary to the Federal Arbitration Act and the duties of a public accounting firm to its corporate clients, and that the arbitrators exceeded their authority by entering an award contrary to Alabama law. On April 25, 2013, the court denied our motion to vacate. On June 4, 2013, we filed a notice of appeal to the Supreme Court of Alabama seeking review of the Circuit Court's denial of our motion to vacate the arbitration panel's decision, and the parties have since submitted their briefs. At this time, we do not know how long the appellate process will take.

We are vigorously pursuing our claims against Ernst & Young. Based on the ruling of the arbitration panel, we do not believe there is a reasonable possibility of a loss that might result from an adverse judgment or a settlement of this case.

General Medicine Action—

On August 16, 2004, General Medicine, P.C. filed a lawsuit against us captioned *General Medicine, P.C. v. HealthSouth Corp.* seeking the recovery of allegedly fraudulent transfers involving assets of Horizon/CMS Healthcare

Corporation, a former subsidiary of HealthSouth. The lawsuit is pending in the Circuit Court of Jefferson County, Alabama (the “Alabama Action”).

General Medicine’s underlying claim against Horizon/CMS originates from a services contract entered into in 1995 between General Medicine and Horizon/CMS whereby General Medicine agreed to provide medical director services to skilled nursing facilities owned by Horizon/CMS for a term of three years . Horizon/CMS terminated the agreement for cause six months after it was executed, and General Medicine then initiated a lawsuit against Horizon/CMS in the United States District Court for the Eastern District of Michigan in 1996 (the “Michigan Action”). General Medicine’s complaint in the Michigan Action alleged that Horizon/CMS breached the services contract by wrongfully terminating General Medicine. We acquired Horizon/CMS in 1997 and sold it to Meadowbrook Healthcare, Inc. in 2001 pursuant to a stock purchase agreement. In 2004, Meadowbrook, without the knowledge of HealthSouth, consented to the entry of a final judgment in the Michigan Action in favor of General Medicine against Horizon/CMS for the alleged wrongful termination of the contract with General Medicine in the amount of $376 million , plus interest from the date of the judgment until paid at the rate of 10% per annum (the “Consent Judgment”). The $376 million damages figure was unilaterally selected by General Medicine and was not tested or opposed by Meadowbrook. Additionally, the settlement agreement (the “Settlement”) used as the basis for the Consent Judgment provided that Meadowbrook would pay only $300,000 to General Medicine to settle the Michigan Action and that General Medicine would seek to recover the remaining balance of the Consent Judgment solely from us. We were not a party to the Michigan Action, the Settlement negotiated by Meadowbrook, or the Consent Judgment.

The complaint filed by General Medicine against us in the Alabama Action alleges that while Horizon/CMS was our wholly owned subsidiary, General Medicine was an existing creditor of Horizon/CMS by virtue of the breach of contract claim underlying the Settlement. The complaint also alleges we caused Horizon/CMS to transfer its assets to us for less than a reasonably equivalent value or, in the alternative, with the actual intent to defraud creditors of Horizon/CMS, including General Medicine, in violation of the Alabama Uniform Fraudulent Transfer Act. General Medicine further alleges in its amended complaint that we are liable for the Consent Judgment despite not being a party to it because as Horizon/CMS’s parent we failed to observe corporate formalities in our operation and ownership of Horizon/CMS, misused our control of Horizon/CMS, stripped assets from Horizon/CMS, and engaged in other conduct which amounted to a fraud on Horizon/CMS’s creditors. General Medicine has requested relief including recovery of the unpaid amount of the Consent Judgment, the avoidance of the subject transfers of assets, attachment of the assets transferred to us, appointment of a receiver over the transferred properties, and a monetary judgment for the value of properties transferred.

We have denied liability to General Medicine and asserted counterclaims against General Medicine for fraud, injurious falsehood, tortious interference with business relations, conspiracy, unjust enrichment, abuse of process, and other causes of action. In our counterclaims, we alleged the Consent Judgment is the product of fraud, collusion and bad faith by General Medicine and Meadowbrook and, further, that these parties were guilty of a conspiracy to manufacture a lawsuit against HealthSouth in favor of General Medicine. Consequently, we assert that the Consent Judgment is not evidence of a legitimate debt owed by Horizon/CMS to General Medicine that is collectible from HealthSouth under any theory of liability.

In 2008, after we obtained discovery concerning the circumstances that led to the entry of the Consent Judgment, we filed a motion in the Michigan Action asking the court to set aside the Consent Judgment on grounds that it was the product of fraud on the court and collusion by the parties. On May 21, 2009, the court granted our motion to set aside the Consent Judgment on grounds that it was the product of fraud on the court. On March 9, 2010, General Medicine filed an appeal of the court's decision to the Sixth Circuit Court of Appeals. The parties agreed to a voluntary stay of the Alabama Action pending the outcome of General Medicine's appeal to the Sixth Circuit Court of Appeals. On April 10, 2012, the Sixth Circuit Court of Appeals reversed the lower court's ruling and reinstated the Consent Judgment. Due to the conclusion of the appeal in the Michigan Action, General Medicine requested reactivation of the Alabama Action in the Circuit Court of Jefferson County, Alabama. On January 10, 2013, we filed a motion for partial summary judgment in the Alabama Action seeking a declaration that the Consent Judgment obtained by General Medicine is not enforceable against us because, among other reasons, it was the result of collusion. On February 27, 2013, the court denied our motion. The court also indicated it concurred with the Sixth Circuit Court of Appeals that the Consent Judgment did nothing more than establish Horizon/CMS's liability to General Medicine and did not establish the amount of General Medicine’s damages claim against Horizon/CMS or the merits of General Medicine's separate fraudulent conveyance claims against HealthSouth.

On January 9, 2014 and on February 18, 2014, the court entered rulings which together provided that the $376 million damages figure contained in the Consent Judgment is not admissible at trial and that, accordingly, the issue of collusion with

respect to the amount of the Consent Judgment is now moot. Instead of relying on the Consent Judgment to prove damages against Horizon/CMS, General Medicine will be required to prove the amount of any damages it has against Horizon/CMS. We intend to provide a vigorous defense to those damage claims and to continue to pursue our counterclaims relating to alleged fraud, collusion, and bad faith by General Medicine. The Alabama Action is still in the discovery phase and has been set for trial beginning in September 2014.

Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate the amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case. We intend to vigorously defend ourselves against General Medicine's claims and to vigorously prosecute our counterclaims against General Medicine.

Other Litigation—

We have been named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned *Nichols v. HealthSouth Corp* . The plaintiffs allege that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiffs are seeking compensatory and punitive damages. This case was consolidated with the *Tucker* case for discovery and other pretrial purposes and was stayed in the Circuit Court on August 8, 2005. The plaintiffs filed an amended complaint on November 9, 2010 to which we responded with a motion to dismiss filed on December 22, 2010. During a hearing on February 24, 2012, plaintiffs' counsel indicated his intent to dismiss certain claims against us. Instead, on March 9, 2012, the plaintiffs amended their complaint to include additional securities fraud claims against HealthSouth and add several former officers to the lawsuit. On September 12, 2012, the plaintiffs further amended their complaint to request certification as a class action. One of those named officers has repeatedly attempted to remove the case to federal district court, most recently on December 11, 2012. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. We intend to vigorously defend ourselves in this case. Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate the amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case.

We were named as a defendant in a lawsuit filed March 3, 2009 by an individual in the Court of Common Pleas, Richland County, South Carolina, captioned *Sulton v. HealthSouth Corp, et al.* The plaintiff alleged that certain treatment he received at a HealthSouth facility complicated a pre-existing infectious injury. The plaintiff sought recovery for pain and suffering, medical expenses, punitive damages, and other damages. On July 30, 2010, the jury in this case returned a verdict in favor of the plaintiff for $12.3 million in damages. Given the jury verdict, we had recorded a liability of $12.3 million in *Other current liabilities* in our consolidated balance sheet as of December 31, 2011 with a corresponding receivable of $7.7 million in *Prepaid expenses and other current assets* for the portion of the claim we expected to be covered through our excess insurance coverages. We appealed that verdict, and on November 21, 2012, the Supreme Court of South Carolina reversed the jury verdict in its entirety and remanded the case to the court of common pleas for retrial. Given the reversal, we decreased the liability and corresponding receivable related to the original jury verdict in our consolidated balance sheet and statement of operations as of and for the year ended December 31, 2012. On March 8, 2013, the Court of Common Pleas, Richland County, South Carolina approved our comprehensive settlement agreement with the plaintiff in the *Sulton* case. While the terms of the settlement are confidential, the amount paid to the plaintiff to settle all claims was not material to us and was less than the liability accrued as of December 31, 2012.

Governmental Inquiries and Investigations—

On June 24, 2011, we received a document subpoena addressed to HealthSouth Hospital of Houston, a LTCH we closed in August 2011, and issued from the Dallas, Texas office of the HHS-OIG. The subpoena stated it was in connection with an investigation of possible false or otherwise improper claims submitted to Medicare and Medicaid and requested documents and materials relating to patient admissions, length of stay, and discharge matters at this closed LTCH. We furnished the documents requested and have heard nothing from HHS-OIG since December 2012.

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our wholly owned hospitals. The investigation is being conducted by the United States Department of Justice (the "DOJ"). Each subpoena is in connection with an investigation 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 including, among other things, marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the " 60% rule," an inpatient rehabilitation hospital must treat 60% or more of its patients from at least one of a specified list of medical conditions in order to be reimbursed at the inpatient rehabilitation hospital payment rates, rather than at the lower acute care hospital payment rates. The subpoenas also request complete copies of medical records for 100 patients treated at each of these hospitals between September 2008 and June 2012. We have responded to the subpoenas received, and, 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.

We are cooperating fully with the DOJ in connection with these subpoenas and are currently unable to predict the timing or outcome of the related investigations.

Other Matters—

The False Claims Act, 18 U.S.C. § 287, allows private citizens, called "relators," to institute civil proceedings alleging violations of the False Claims Act. These *qui tam* cases are generally sealed by the court at the time of filing. The only parties privy to the information contained in the complaint are the relator, the federal government, and the presiding court. It is possible that *qui tam* lawsuits have been filed against us and that we are unaware of such filings or have been ordered by the presiding court not to discuss or disclose the filing of such lawsuits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

It is our obligation as a participant in Medicare and other federal healthcare programs to routinely conduct audits and reviews of the accuracy of our billing systems and other regulatory compliance matters. As a result of these reviews, we have made, and will continue to make, disclosures to the HHS-OIG and CMS relating to amounts we suspect represent over-payments from these programs, whether due to inaccurate billing or otherwise. Some of these disclosures have resulted in, or may result in, HealthSouth refunding amounts to Medicare or other federal healthcare programs.

On April 4, 2011, we entered into a definitive settlement and release agreement with the state of Delaware relating to a previously disclosed audit of unclaimed property conducted on behalf of Delaware and two other states by Kelmar Associates, LLC. While the terms of the settlement are confidential, the amount paid to Delaware was less than the amount previously accrued in our consolidated balance sheet as of December 31, 2010. Accordingly, we recorded a $25.3 million pre-tax gain in connection with this settlement in our results of operations for the year ended December 31, 2011. Of this amount, $24.8 million is included in *Income from discontinued operations, net of tax* , as this gain primarily related to our previously divested divisions. The remainder is included in *Net operating revenues* in our consolidated statement of operations for the year ended December 31, 2011.

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are $26.3 million in 2014 , $26.4 million in 2015 , $22.0 million in 2016 , $10.8 million in 2017 , $10.1 million in 2018 , and $25.8 million thereafter. These contracts primarily relate to software licensing and support.

19. Quarterly Data (Unaudited) :

	2013				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 572.6	$ 564.5	$ 564.0	$ 572.1	$ 2,273.2
Operating earnings [a]	108.7	101.1	119.0	106.9	435.7
Provision for income tax expense (benefit)	33.5	(86.5)	35.2	30.5	12.7
Income from continuing operations	66.3	178.9	73.2	64.1	382.5
(Loss) income from discontinued operations, net of tax	(0.4)	0.1	(0.9)	0.1	(1.1)
Net income	65.9	179.0	72.3	64.2	381.4
Less: Net income attributable to noncontrolling interests	(14.6)	(13.8)	(14.1)	(15.3)	(57.8)
Net income attributable to HealthSouth	$ 51.3	$ 165.2	$ 58.2	$ 48.9	$ 323.6
Earnings (loss) per common share:					
Basic earnings (loss) per share attributable to HealthSouth common shareholders: [b][c]					
Continuing operations	$ 0.48	$ 1.82	$ 0.61	$ (0.31)	$ 2.59
Discontinued operations	—	—	(0.01)	—	(0.01)
Net income	$ 0.48	$ 1.82	$ 0.60	$ (0.31)	$ 2.58
Diluted earnings (loss) per share attributable to HealthSouth common shareholders: [b][d]					
Continuing operations	$ 0.48	$ 1.66	$ 0.59	$ (0.31)	$ 2.59
Discontinued operations	—	—	(0.01)	—	(0.01)
Net income	$ 0.48	$ 1.66	$ 0.58	$ (0.31)	$ 2.58

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

[b] Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

(c) 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 for the first and second quarters of 2013.

	2013	
	First Quarter	Second Quarter
Basic earnings per share attributable to HealthSouth common shareholders, as reported:		
Continuing operations	$ 0.49	$ 1.85
Discontinued operations	—	—
Net income	$ 0.49	$ 1.85
Basic earnings per share attributable to HealthSouth common shareholders as revised using the two-class method:		
Continuing operations	$ 0.48	$ 1.82
Discontinued operations	—	—
Net income	$ 0.48	$ 1.82

(d) During the first quarter of 2013, adding back the dividends for the *Convertible perpetual preferred stock* to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. For the fourth quarter of 2013, adding back amounts related to the repurchase of our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings (loss) per common share are the same for these quarters.

	2012				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 538.6	$ 533.4	$ 537.0	$ 552.9	$ 2,161.9
Operating earnings [a]	96.1	92.7	94.4	95.5	378.7
Provision for income tax expense	29.1	26.9	28.1	24.5	108.6
Income from continuing operations	57.2	56.4	60.4	57.4	231.4
(Loss) income from discontinued operations, net of tax	(0.4)	3.5	(0.5)	1.9	4.5
Net income	56.8	59.9	59.9	59.3	235.9
Less: Net income attributable to noncontrolling interests	(12.6)	(13.2)	(12.8)	(12.3)	(50.9)
Net income attributable to HealthSouth	$ 44.2	$ 46.7	$ 47.1	$ 47.0	$ 185.0
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders: [b]					
Continuing operations	$ 0.39	$ 0.38	$ 0.44	$ 0.41	$ 1.62
Discontinued operations	—	0.04	(0.01)	0.02	0.05
Net income	$ 0.39	$ 0.42	$ 0.43	$ 0.43	$ 1.67
Diluted earnings per share attributable to HealthSouth common shareholders: [c]					
Continuing operations	$ 0.39	$ 0.38	$ 0.44	$ 0.41	$ 1.62
Discontinued operations	—	0.04	(0.01)	0.02	0.05
Net income	$ 0.39	$ 0.42	$ 0.43	$ 0.43	$ 1.67

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

[b] 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 for 2012.

	2012				
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year
Basic earnings per share attributable to HealthSouth common shareholders, as reported:					
Continuing operations	$ 0.40	$ 0.39	$ 0.44	$ 0.42	$ 1.65
Discontinued operations	(0.01)	0.04	—	0.02	0.04
Net income	$ 0.39	$ 0.43	$ 0.44	$ 0.44	$ 1.69
Basic earnings per share attributable to HealthSouth common shareholders as revised using the two-class method:					
Continuing operations	$ 0.39	$ 0.38	$ 0.44	$ 0.41	$ 1.62
Discontinued operations	—	0.04	(0.01)	0.02	0.05
Net income	$ 0.39	$ 0.42	$ 0.43	$ 0.43	$ 1.67

[c] During each reporting period of 2012, adding back the dividends for the *Convertible perpetual preferred stock* to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when

calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings per common share are the same.

20. Condensed Consolidating Financial Information :

The accompanying condensed consolidating financial information has been prepared and presented pursuant to SEC Regulation S-X, Rule 3-10, "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered." Each of the subsidiary guarantors is 100% owned by HealthSouth, and all guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. HealthSouth's investments in its consolidated subsidiaries, as well as guarantor subsidiaries' investments in nonguarantor subsidiaries and nonguarantor subsidiaries' investments in guarantor subsidiaries, are presented under the equity method of accounting with the related investment presented within the line items *Intercompany receivable* and *Intercompany payable* in the accompanying condensed consolidating balance sheets.

As described in Note 8, *Long-term Debt* , the terms of our credit agreement restrict us from declaring or paying cash dividends on our common stock unless: (1) we are not in default under our credit agreement and (2) the amount of the dividend, when added to the aggregate amount of certain other defined payments made during the same fiscal year, does not exceed certain maximum thresholds. However, as described in Note 10, *Convertible Perpetual Preferred Stock* , our preferred stock generally provides for the payment of cash dividends, subject to certain limitations.

During 2013, certain wholly owned subsidiaries of HealthSouth made a dividend or distribution of available cash and/or intercompany receivable balances to their parents. In addition, HealthSouth made contributions to certain wholly owned subsidiaries. These dividends, distributions, and contributions impacted the *Intercompany receivable*, *Intercompany payable*, and *HealthSouth shareholders' equity* line items in the accompanying condensed consolidating balance sheet as of December 31, 2013 but had no impact on the consolidated financial statements of HealthSouth Corporation.

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 12.2	$ 1,622.4	$ 709.8	$ (71.2)	$ 2,273.2
Less: Provision for doubtful accounts	—	(18.3)	(7.7)	—	(26.0)
Net operating revenues less provision for doubtful accounts	12.2	1,604.1	702.1	(71.2)	2,247.2
Operating expenses:					
Salaries and benefits	12.1	757.7	334.4	(14.5)	1,089.7
Other operating expenses	10.8	238.5	107.4	(33.7)	323.0
Occupancy costs	4.1	48.3	17.5	(22.9)	47.0
Supplies	—	73.8	31.6	—	105.4
General and administrative expenses	119.1	—	—	—	119.1
Depreciation and amortization	8.8	65.1	20.8	—	94.7
Government, class action, and related settlements	(23.5)	—	—	—	(23.5)
Professional fees—accounting, tax, and legal	9.5	—	—	—	9.5
Total operating expenses	140.9	1,183.4	511.7	(71.1)	1,764.9
Loss on early extinguishment of debt	2.4	—	—	—	2.4
Interest expense and amortization of debt discounts and fees	90.4	8.1	3.1	(1.2)	100.4
Other income	(1.0)	(1.2)	(3.5)	1.2	(4.5)
Equity in net income of nonconsolidated affiliates	(3.6)	(7.5)	(0.1)	—	(11.2)
Equity in net income of consolidated affiliates	(268.0)	(20.6)	—	288.6	—
Management fees	(102.3)	78.6	23.7	—	—
Income from continuing operations before income tax (benefit) expense	153.4	363.3	167.2	(288.7)	395.2
Provision for income tax (benefit) expense	(169.0)	134.4	47.3	—	12.7
Income from continuing operations	322.4	228.9	119.9	(288.7)	382.5
Income (loss) from discontinued operations, net of tax	1.2	(0.8)	(1.5)	—	(1.1)
Net Income	323.6	228.1	118.4	(288.7)	381.4
Less: Net income attributable to noncontrolling interests	—	—	(57.8)	—	(57.8)
Net income attributable to HealthSouth	$ 323.6	$ 228.1	$ 60.6	$ (288.7)	$ 323.6
Comprehensive income	$ 322.1	$ 228.1	$ 118.4	$ (288.7)	$ 379.9
Comprehensive income attributable to HealthSouth	$ 322.1	$ 228.1	$ 60.6	$ (288.7)	$ 322.1

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2012				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 9.0	$ 1,562.8	$ 649.3	$ (59.2)	$ 2,161.9
Less: Provision for doubtful accounts	(0.3)	(18.0)	(8.7)	—	(27.0)
Net operating revenues less provision for doubtful accounts	8.7	1,544.8	640.6	(59.2)	2,134.9
Operating expenses:					
Salaries and benefits	19.8	735.4	308.6	(13.6)	1,050.2
Other operating expenses	10.6	224.8	97.4	(29.0)	303.8
Occupancy costs	4.1	44.5	16.6	(16.6)	48.6
Supplies	0.1	73.3	29.0	—	102.4
General and administrative expenses	117.9	—	—	—	117.9
Depreciation and amortization	8.6	57.1	16.8	—	82.5
Government, class action, and related settlements	(3.5)	—	—	—	(3.5)
Professional fees—accounting, tax, and legal	16.1	—	—	—	16.1
Total operating expenses	173.7	1,135.1	468.4	(59.2)	1,718.0
Loss on early extinguishment of debt	4.0	—	—	—	4.0
Interest expense and amortization of debt discounts and fees	85.1	7.5	2.6	(1.1)	94.1
Other income	(1.2)	(5.0)	(3.4)	1.1	(8.5)
Equity in net income of nonconsolidated affiliates	(4.3)	(8.4)	—	—	(12.7)
Equity in net income of consolidated affiliates	(258.6)	(21.5)	—	280.1	—
Management fees	(97.8)	75.8	22.0	—	—
Income from continuing operations before income tax (benefit) expense	107.8	361.3	151.0	(280.1)	340.0
Provision for income tax (benefit) expense	(75.9)	146.2	38.3	—	108.6
Income from continuing operations	183.7	215.1	112.7	(280.1)	231.4
Income from discontinued operations, net of tax	1.3	1.3	1.9	—	4.5
Net Income	185.0	216.4	114.6	(280.1)	235.9
Less: Net income attributable to noncontrolling interests	—	—	(50.9)	—	(50.9)
Net income attributable to HealthSouth	$ 185.0	$ 216.4	$ 63.7	$ (280.1)	$ 185.0
Comprehensive income	$ 186.6	$ 216.4	$ 114.6	$ (280.1)	$ 237.5
Comprehensive income attributable to HealthSouth	$ 186.6	$ 216.4	$ 63.7	$ (280.1)	$ 186.6

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2011				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 5.8	$ 1,464.9	$ 601.4	$ (45.2)	$ 2,026.9
Less: Provision for doubtful accounts	—	(15.5)	(5.5)	—	(21.0)
Net operating revenues less provision for doubtful accounts	5.8	1,449.4	595.9	(45.2)	2,005.9
Operating expenses:					
Salaries and benefits	18.4	691.6	285.5	(13.5)	982.0
Other operating expenses	10.0	209.7	90.3	(21.7)	288.3
Occupancy costs	3.8	36.9	17.7	(10.0)	48.4
Supplies	—	73.9	28.9	—	102.8
General and administrative expenses	110.5	—	—	—	110.5
Depreciation and amortization	9.5	52.5	16.8	—	78.8
Government, class action, and related settlements	(12.3)	—	—	—	(12.3)
Professional fees—accounting, tax, and legal	21.0	—	—	—	21.0
Total operating expenses	160.9	1,064.6	439.2	(45.2)	1,619.5
Loss on early extinguishment of debt	38.8	—	—	—	38.8
Interest expense and amortization of debt discounts and fees	109.5	8.4	2.6	(1.1)	119.4
Other income	(0.2)	(0.1)	(3.5)	1.1	(2.7)
Equity in net income of nonconsolidated affiliates	(3.1)	(8.9)	—	—	(12.0)
Equity in net income of consolidated affiliates	(234.2)	(13.2)	—	247.4	—
Management fees	(94.5)	73.6	20.9	—	—
Income from continuing operations before income tax (benefit) expense	28.6	325.0	136.7	(247.4)	242.9
Provision for income tax (benefit) expense	(161.1)	157.6	40.6	—	37.1
Income from continuing operations	189.7	167.4	96.1	(247.4)	205.8
Income (loss) from discontinued operations, net of tax	19.0	34.3	(4.5)	—	48.8
Net Income	208.7	201.7	91.6	(247.4)	254.6
Less: Net income attributable to noncontrolling interests	—	—	(45.9)	—	(45.9)
Net income attributable to HealthSouth	$ 208.7	$ 201.7	$ 45.7	$ (247.4)	$ 208.7
Comprehensive income	$ 208.0	$ 201.7	$ 91.6	$ (247.4)	$ 253.9
Comprehensive income attributable to HealthSouth	$ 208.0	$ 201.7	$ 45.7	$ (247.4)	$ 208.0

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 60.5	$ 2.3	$ 1.7	$ —	$ 64.5
Restricted cash	1.0	—	51.4	—	52.4
Accounts receivable, net	—	184.7	77.1	—	261.8
Deferred income tax assets	85.5	34.5	19.0	—	139.0
Prepaid expenses and other current assets	36.0	15.8	29.4	(18.5)	62.7
Total current assets	183.0	237.3	178.6	(18.5)	580.4
Property and equipment, net	16.3	698.5	195.7	—	910.5
Goodwill	—	279.6	177.3	—	456.9
Intangible assets, net	18.1	49.6	20.5	—	88.2
Deferred income tax assets	288.8	24.5	41.0	—	354.3
Other long-term assets	64.6	27.1	52.4	—	144.1
Intercompany receivable	1,438.8	—	—	(1,438.8)	—
Total assets	$ 2,009.6	$ 1,316.6	$ 665.5	$ (1,457.3)	$ 2,534.4
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 19.4	$ 3.8	$ 6.6	$ (17.5)	$ 12.3
Accounts payable	15.1	32.6	14.2	—	61.9
Accrued payroll	23.1	47.8	19.9	—	90.8
Accrued interest payable	22.9	0.8	0.1	—	23.8
Other current liabilities	65.1	18.6	40.1	(1.0)	122.8
Total current liabilities	145.6	103.6	80.9	(18.5)	311.6
Long-term debt, net of current portion	1,381.7	88.1	35.4	—	1,505.2
Self-insured risks	23.2	—	75.0	—	98.2
Other long-term liabilities	21.3	17.4	5.3	—	44.0
Intercompany payable	—	299.2	228.9	(528.1)	—
	1,571.8	508.3	425.5	(546.6)	1,959.0
Commitments and contingencies					
Convertible perpetual preferred stock	93.2	—	—	—	93.2
Redeemable noncontrolling interests	—	—	13.5	—	13.5
Shareholders' equity:					
HealthSouth shareholders' equity	344.6	808.3	102.4	(910.7)	344.6
Noncontrolling interests	—	—	124.1	—	124.1
Total shareholders' equity	344.6	808.3	226.5	(910.7)	468.7
Total liabilities and shareholders' equity	$ 2,009.6	$ 1,316.6	$ 665.5	$ (1,457.3)	$ 2,534.4

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2012				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 131.3	$ 0.3	$ 1.2	$ —	$ 132.8
Restricted cash	0.8	—	48.5	—	49.3
Accounts receivable, net	0.2	178.8	70.3	—	249.3
Deferred income tax assets	106.5	19.7	11.3	—	137.5
Prepaid expenses and other current assets	29.7	15.2	40.5	(17.5)	67.9
Total current assets	268.5	214.0	171.8	(17.5)	636.8
Property and equipment, net	12.7	550.3	185.0	—	748.0
Goodwill	—	266.1	171.2	—	437.3
Intangible assets, net	18.1	41.5	13.6	—	73.2
Deferred income tax assets	340.7	0.9	51.9	—	393.5
Other long-term assets	69.9	21.3	44.2	—	135.4
Intercompany receivable	1,244.4	—	—	(1,244.4)	—
Total assets	$ 1,954.3	$ 1,094.1	$ 637.7	$ (1,261.9)	$ 2,424.2
Liabilities and Shareholders' Equity (Deficit)					
Current liabilities:					
Current portion of long-term debt	$ 19.2	$ 8.4	$ 3.5	$ (17.5)	$ 13.6
Accounts payable	7.4	28.3	9.6	—	45.3
Accrued payroll	20.6	46.8	18.3	—	85.7
Accrued interest payable	25.6	0.1	0.2	—	25.9
Other current liabilities	63.2	18.5	48.7	—	130.4
Total current liabilities	136.0	102.1	80.3	(17.5)	300.9
Long-term debt, net of current portion	1,147.3	64.2	28.4	—	1,239.9
Self-insured risks	28.1	—	78.4	—	106.5
Other long-term liabilities	9.7	11.2	3.1	—	24.0
Intercompany payable	—	515.6	1,021.4	(1,537.0)	—
	1,321.1	693.1	1,211.6	(1,554.5)	1,671.3
Commitments and contingencies					
Convertible perpetual preferred stock	342.2	—	—	—	342.2
Redeemable noncontrolling interests	—	—	7.2	—	7.2
Shareholders' equity (deficit):					
HealthSouth shareholders' equity (deficit)	291.0	401.0	(693.6)	292.6	291.0
Noncontrolling interests	—	—	112.5	—	112.5
Total shareholders' equity (deficit)	291.0	401.0	(581.1)	292.6	403.5
Total liabilities and shareholders' equity (deficit)	$ 1,954.3	$ 1,094.1	$ 637.7	$ (1,261.9)	$ 2,424.2

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 113.2	$ 235.7	$ 121.4	$ —	$ 470.3
Cash flows from investing activities:					
Purchases of property and equipment	(2.8)	(167.9)	(24.5)	—	(195.2)
Capitalized software costs	(6.0)	(11.1)	(4.2)	—	(21.3)
Acquisition of business, net of cash acquired	—	(28.9)	—	—	(28.9)
Proceeds from sale of restricted investments	—	—	16.9	—	16.9
Proceeds from sale of Digital Hospital	10.8	—	—	—	10.8
Purchases of restricted investments	—	—	(9.2)	—	(9.2)
Net change in restricted cash	(0.2)	—	(2.9)	—	(3.1)
Other	—	0.9	(0.4)	—	0.5
Net cash provided by investing activities of discontinued operations	—	3.1	0.2	—	3.3
Net cash provided by (used in) investing activities	1.8	(203.9)	(24.1)	—	(226.2)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(59.5)	(1.3)	(1.7)	—	(62.5)
Principal borrowings on notes	—	—	15.2	—	15.2
Borrowings on revolving credit facility	197.0	—	—	—	197.0
Payments on revolving credit facility	(152.0)	—	—	—	(152.0)
Principal payments under capital lease obligations	(0.3)	(6.3)	(3.5)	—	(10.1)
Repurchase of common stock, including fees and expenses	(234.1)	—	—	—	(234.1)
Repurchases of convertible perpetual preferred stock, including fees	(2.8)	—	—	—	(2.8)
Dividends paid on common stock	(15.7)	—	—	—	(15.7)
Dividends paid on convertible perpetual preferred stock	(23.0)	—	—	—	(23.0)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(46.3)	—	(46.3)
Contributions from consolidated affiliates	—	—	1.6	—	1.6
Proceeds from exercising stock warrants	15.3	—	—	—	15.3
Other	5.0	—	—	—	5.0
Change in intercompany advances	84.3	(22.2)	(62.1)	—	—
Net cash used in financing activities	(185.8)	(29.8)	(96.8)	—	(312.4)
(Decrease) increase in cash and cash equivalents	(70.8)	2.0	0.5	—	(68.3)
Cash and cash equivalents at beginning of year	131.3	0.3	1.2	—	132.8
Cash and cash equivalents at end of year	$ 60.5	$ 2.3	$ 1.7	$ —	$ 64.5

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2012				
	HealthSouth Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 31.3	$ 252.4	$ 127.8	$ —	$ 411.5
Cash flows from investing activities:					
Purchases of property and equipment	(4.8)	(98.4)	(37.6)	—	(140.8)
Capitalized software costs	(8.5)	(7.2)	(3.2)	—	(18.9)
Acquisition of businesses, net of cash acquired	—	(3.1)	—	—	(3.1)
Proceeds from sale of restricted investments	—	—	0.3	—	0.3
Purchases of restricted investments	—	—	(9.1)	—	(9.1)
Net change in restricted cash	(0.1)	—	(13.9)	—	(14.0)
Other	(0.3)	(0.8)	0.2	—	(0.9)
Net cash provided by investing activities of discontinued operations	4.4	3.3	—	—	7.7
Net cash used in investing activities	(9.3)	(106.2)	(63.3)	—	(178.8)
Cash flows from financing activities:					
Proceeds from bond issuance	275.0	—	—	—	275.0
Principal payments on debt, including pre-payments	(164.9)	(1.3)	—	—	(166.2)
Borrowings on revolving credit facility	135.0	—	—	—	135.0
Payments on revolving credit facility	(245.0)	—	—	—	(245.0)
Principal payments under capital lease obligations	(0.3)	(8.9)	(2.9)	—	(12.1)
Repurchases of convertible perpetual preferred stock, including fees	(46.0)	—	—	—	(46.0)
Dividends paid on convertible perpetual preferred stock	(24.6)	—	—	—	(24.6)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(49.3)	—	(49.3)
Contributions from consolidated affiliates	—	—	10.5	—	10.5
Other	0.2	—	(7.5)	—	(7.3)
Change in intercompany advances	153.9	(137.0)	(16.9)	—	—
Net cash provided by (used in) financing activities	83.3	(147.2)	(66.1)	—	(130.0)
Increase (decrease) in cash and cash equivalents	105.3	(1.0)	(1.6)	—	102.7
Cash and cash equivalents at beginning of year	26.0	1.3	2.8	—	30.1
Cash and cash equivalents at end of year	$ 131.3	$ 0.3	$ 1.2	$ —	$ 132.8

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2011				
	HealthSouth Corporation	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash (used in) provided by operating activities	$ (58.3)	$ 273.7	$ 127.3	$ —	$ 342.7
Cash flows from investing activities:					
Purchases of property and equipment	(4.8)	(83.3)	(12.2)	—	(100.3)
Capitalized software costs	(6.6)	(2.0)	(0.2)	—	(8.8)
Acquisition of businesses, net of cash acquired	—	(4.9)	—	—	(4.9)
Proceeds from sale of restricted investments	—	—	1.2	—	1.2
Purchases of restricted investments	—	—	(8.4)	—	(8.4)
Net change in restricted cash	(0.2)	—	1.4	—	1.2
Net settlements on interest rate swaps not designated as hedges	(10.9)	—	—	—	(10.9)
Other	—	(0.9)	—	—	(0.9)
Net cash provided by (used in) investing activities of discontinued operations—					
Proceeds from sale of LTCHs	107.9	—	—	—	107.9
Other investing activities of discontinued operations	—	(0.3)	(0.4)	—	(0.7)
Net cash provided by (used in) investing activities	85.4	(91.4)	(18.6)	—	(24.6)
Cash flows from financing activities:					
Principal borrowings on term loan	100.0	—	—	—	100.0
Proceeds from bond issuance	120.0	—	—	—	120.0
Principal payments on debt, including pre-payments	(507.4)	(1.5)	4.0	—	(504.9)
Borrowings on revolving credit facility	338.0	—	—	—	338.0
Payments on revolving credit facility	(306.0)	—	—	—	(306.0)
Principal payments under capital lease obligations	(0.8)	(10.2)	(2.2)	—	(13.2)
Dividends paid on convertible perpetual preferred stock	(26.0)	—	—	—	(26.0)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(44.2)	—	(44.2)
Change in intercompany advances	235.3	(169.4)	(65.9)	—	—
Net cash used in financing activities	(46.9)	(181.1)	(108.3)	—	(336.3)
(Decrease) increase in cash and cash equivalents	(19.8)	1.2	0.4	—	(18.2)
Cash and cash equivalents at beginning of year	45.8	0.1	2.4	—	48.3
Cash and cash equivalents at end of year	$ 26.0	$ 1.3	$ 2.8	$ —	$ 30.1

EXHIBIT LIST

No.	Description
3.1	Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on May 21, 1998.*
3.2	Certificate of Amendment to the Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on October 25, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on October 31, 2006).
3.3	Amended and Restated Bylaws of HealthSouth Corporation, effective as of October 30, 2009 (incorporated by reference to Exhibit 3.3 to HealthSouth's Quarterly Report on Form 10-Q filed on November 4, 2009).
3.4	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on March 9, 2006).
4.1	Warrant Agreement, dated as of September 30, 2009, among HealthSouth Corporation and Computershare Inc. and Computershare Trust Company, N.A., jointly and severally as warrant agent (incorporated by reference to Exhibit 4.1 to HealthSouth's Registration Statement on Form 8-A filed on October 1, 2009).
4.2.1	Indenture, dated as of December 1, 2009, between HealthSouth Corporation and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 8.125% Senior Notes due 2020, 7.250% Senior Notes due 2018, 7.750% Senior Notes due 2022, and 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.7.1 to HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.2	First Supplemental Indenture, dated December 1, 2009, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 8.125% Senior Notes due 2020 (incorporated by reference to Exhibit 4.7.2 to HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.3	Second Supplemental Indenture, dated October 7, 2010, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 7.250% Senior Notes due 2018 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on October 12, 2010).
4.2.4	Third Supplemental Indenture, dated October 7, 2010, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 7.750% Senior Notes due 2022 (incorporated by reference to Exhibit 4.3 to HealthSouth's Current Report on Form 8-K filed on October 12, 2010).
4.2.5	Fourth Supplemental Indenture, dated September 11, 2012, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on September 11, 2012).
4.3	Indenture, dated November 18, 2013, by and between HealthSouth Corporation and Wells Fargo Bank, National Association, as trustee, relating to HealthSouth's 2.00% Convertible Senior Subordinated Notes due 2043 (incorporated by reference to Exhibit 4.1 to HealthSouth's Current Report on Form 8-K filed on November 19, 2013).
10.1	Stipulation of Partial Settlement, dated as of September 26, 2006, by and among HealthSouth Corporation, the stockholder lead plaintiffs named therein, the bondholder lead plaintiff named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on September 27, 2006).
10.2	Stipulation of Settlement with Certain Individual Defendants dated as of September 25, 2006, by and among HealthSouth

Corporation, plaintiffs named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.3 to HealthSouth's Current Report on Form 8-K filed on September 27, 2006).

10.3.1 HealthSouth Corporation Amended and Restated 2004 Director Incentive Plan.** +

10.3.2 Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan).** +

10.4 HealthSouth Corporation Second Amended and Restated Change in Control Benefits Plan. +

10.5.1 HealthSouth Corporation 1995 Stock Option Plan, as amended.* +

10.5.2 Form of Non-Qualified Stock Option Agreement (1995 Stock Option Plan).* +

10.6.1 HealthSouth Corporation 2002 Non-Executive Stock Option Plan.* +

10.6.2 Form of Non-Qualified Stock Option Agreement (2002 Non-Executive Stock Option Plan).* +

10.7 Description of the HealthSouth Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, “Other Matters,” in HealthSouth’s Quarterly Report on Form 10-Q filed on November 4, 2009).+

10.8 Description of the HealthSouth Corporation Senior Management Bonus and Long-Term Incentive Plans (incorporated by reference to the section captioned “Executive Compensation – Compensation Discussion and Analysis – Elements of Executive Compensation” in HealthSouth’s Definitive Proxy Statement on Schedule 14A filed on April 2, 2013).+

10.9 HealthSouth Corporation Nonqualified 401(k) Plan.+

10.10 HealthSouth Corporation Fourth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.1 to HealthSouth’s Quarterly Report on Form 10-Q filed on October 29, 2013).+

10.11 Letter of Understanding, dated as of December 2, 2010, between HealthSouth Corporation and Jay Grinney (incorporated by reference to Exhibit 10.1 to HealthSouth’s Current Report on Form 8-K filed on December 3, 2010).+

10.12.1 HealthSouth Corporation 2005 Equity Incentive Plan (incorporated by reference to Exhibit 10 to HealthSouth’s Current Report on Form 8-K, filed on November 21, 2005).+

10.12.2 Form of Non-Qualified Stock Option Agreement (2005 Equity Incentive Plan).**+

10.13 Form of Key Executive Incentive Award Agreement.** +

10.14.1 HealthSouth Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to HealthSouth’s Registration Statement on Form S-8 filed on August 2, 2011).+

10.14.2 Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.2 to HealthSouth’s Annual Report on Form 10-K filed on February 24, 2009). +

10.14.3 Form of Restricted Stock Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.3 to HealthSouth’s Annual Report on Form 10-K filed on February 24, 2009).+

10.14.4 Form of Performance Share Unit Award (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.4 to HealthSouth’s Annual Report on Form 10-K filed on February 24, 2009).+

10.14.5 Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.2 to HealthSouth’s Quarterly Report on Form 10-Q filed on August 4, 2011).+

10.14.6 Form of Restricted Stock Agreement (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.3 to HealthSouth’s Quarterly Report on Form 10-Q filed on August 4, 2011).+

10.14.7 Form of Performance Share Unit Award (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to

Exhibit 10.1.4 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011 and the description in Item 5, "Other Items," in HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).+

10.14.8 Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.5 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+

10.15	HealthSouth Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to HealthSouth's Annual Report on Form 10-K filed on February 19, 2013).+
10.16	Written description of the annual compensation arrangement for non-employee directors of HealthSouth Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in HealthSouth's Definitive Proxy Statement on Schedule 14A, filed on April 2, 2013).+
10.17	Form of Indemnity Agreement entered into between HealthSouth Corporation and the directors of HealthSouth.* +
10.18	Lease between LAKD HQ, LLC and HealthSouth Corporation, dated March 31, 2008, for corporate office space (incorporated by reference to Exhibit 10.5 to HealthSouth's Quarterly Report on Form 10-Q filed on May 7, 2008).
10.19	Settlement Agreement and Stipulation regarding Fees, dated as of January 13, 2009 (incorporated by reference to Exhibit 99.3 to HealthSouth's Current Report on Form 8-K filed on January 20, 2009).
10.20.1	Third Amended and Restated Credit Agreement, dated August 10, 2012, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on October 26, 2012).
10.20.2	First Amendment to the Third Amended and Restated Credit Agreement, dated June 11, 2013, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).
10.20.3	Amended and Restated Collateral and Guarantee Agreement, dated as of October 26, 2010, among HealthSouth Corporation, its subsidiaries identified herein, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.3 to HealthSouth's Current Report on Form 8-K/A filed on November 23, 2010).
10.21	Form of Exchange Agreement entered into between HealthSouth Corporation and certain holders of 6.50% Series A Convertible Perpetual Preferred Stock relating to the exchange of such preferred stock for 2.00% Convertible Senior Subordinated Notes due 2043 (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on November 13, 2013).
12	Computation of Ratios.
21	Subsidiaries of HealthSouth Corporation.
23	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.
24	Power of Attorney (included as part of signature page).
31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	Sections of the HealthSouth Corporation Annual Report on Form 10-K for the year ended December 31, 2013, formatted in

XBRL (eXtensible Business Reporting Language), submitted in the following files:

101.INS XBRL Instance Document

Table of Contents

101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule will be furnished supplementally to the Securities and Exchange Commission upon request

* Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on June 27, 2005.

** Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on March 29, 2006.

+ Management contract or compensatory plan or arrangement.

HEALTHSOUTH CORPORATION

SECOND AMENDED AND RESTATED

CHANGE IN CONTROL

BENEFITS PLAN

HealthSouth Corporation, a Delaware corporation (the " *Company* "), has adopted the HealthSouth Corporation Second Amended and Restated Change in Control Benefits Plan (the " *Plan* ") for the benefit of certain Participant employees of the Company and its subsidiaries, on the terms and conditions hereinafter stated. The Plan is intended to help retain qualified employees, maintain a stable work environment and provide financial security to certain Participant employees of the Company in the event of a Change in Control. The Plan is intended to be a plan that "is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees" within the meaning of Sections 201(2), 301(a)(3) and 401(a)(1) of ERISA. Conversely, to the maximum extent permitted by law, the Plan is not intended to provide for any "deferral of compensation," as defined in Section 409A of the Code (" *Section 409A* ") and authoritative Department of Treasury regulations and other interpretive guidance issued thereunder. Instead, payments and benefits under the Plan are intended to fall within the exceptions for "short-term deferrals," as set forth in Treasury Regulations Section 1.409A-1(b)(4), and "separation pay due to involuntary separation from service or participation in a window program," as set forth in Treasury Regulations Section 1.409A-1(b)(9)(iii) and it is further intended that each Participant's benefits shall be payable only upon a Participant's "separation from service" under Treasury Regulations Section 1.409A-1(h). For purposes of Treasury Regulations Section 1.409A-2(b)(2)(iii), the right to each payment under the Plan shall be treated as the right to a separate payment. The Plan shall be administered and interpreted to the extent possible in a manner consistent with these intentions.

ARTICLE I

DEFINITIONS AND INTERPRETATIONS

Section 1.01 Definitions . Capitalized terms used in the Plan shall have the following respective meanings, except as otherwise provided or as the context shall otherwise require:

" *Annual Salary* " shall mean the base salary paid to a Participant immediately prior to his or her Termination Date on an annual basis exclusive of any bonus payments or additional payments under any Benefit Plan.

" *Benefit Plan* " shall mean any "employee benefit plan" (including any employee benefit plan within the meaning of Section 3(3) of ERISA), program, arrangement or practice maintained, sponsored or provided by the Company, including those relating to compensation, bonuses, profit-sharing, stock option, or other stock related rights or other forms of incentive or deferred compensation, paid time-off benefits, insurance coverage (including any self-insured arrangements) health or medical benefits, disability benefits, workers' compensation, supplemental unemployment benefits, severance

benefits and postemployment or retirement benefits (including compensation, pension, health, medical or life insurance or other benefits).

" *Board* " shall mean the Board of Directors of the Company.

" *Cause* " shall have the meaning set forth in any individual employment, severance or similar agreement between the Company and a Participant, or in the event that a Participant is not a party to such an agreement, Cause shall mean:

(i) the Company's procurement of evidence of the Participant's act of fraud, misappropriation, or embezzlement with respect to the Company;

(ii) the Participant's indictment for, conviction of, or plea of guilty or no contest to, any felony (other than a minor traffic violation);

(iii) the suspension or debarment of the Participant or of the Company or any of its affiliated companies or entities as a direct result of any willful or grossly negligent act or omission of the Participant in connection with his or her employment with the Company from participation in any Federal or state health care program. For purposes of this clause (iii), the Participant shall not have acted in a "willful" manner if the Participant acted, or failed to act, in a manner that he or she believed in good faith to be in, or not opposed to the best interests of the Company;

(iv) the Participant's admission of, liability of, or finding by a court or the SEC (or a similar agency of any applicable state) of liability for, the violation of any "Securities Laws" (as hereinafter defined) (excluding any technical violations of the Securities Laws which are not criminal in nature). As used herein, the term "Securities Laws" means any federal or state law, rule or regulation governing the issuance or exchange of securities, including ,without limitation, the Securities Act and the Exchange Act;

(v) a formal indication from any agency or instrumentality of any state or the United States of America, including but not limited to the United States Department of Justice, the SEC or any committee of the United States Congress that the Participant is a target or the subject of any investigation or proceeding into the actions or inactions of the Participant for a violation of any Securities Laws in connection with his or her employment by the Company (excluding any technical violations of the Securities Law which are not criminal in nature);

(vi) the Participant's failure after reasonable prior written notice from the Company to comply with any valid and legal directive of the Chief Executive Officer or the Board that is not remedied within thirty (30) days of the Participant being provided written notice thereof from the Company; or

(vii) other than as provided in clauses (i) through (vi) above, the Participant's breach of any material provision of any employment agreement, if applicable, or the Participant's breach of the material duties of the Participant's job that is not remedied within thirty (30) days or repeated breaches of a similar nature, such as the failure to report to work, perform duties, or follow directions, all as provided herein, which shall not require additional notices as provided in clauses (i) through (vi) above.

Cause shall be determined by the affirmative vote of at least fifty percent (50%) of the members of the Board (excluding the Participant, if a Board member, and excluding any member of the Board involved in events leading to the Board's consideration of terminating the Participant for Cause).

" *Change in Control* " shall mean

(i) the acquisition (other than from the Company) by any person, entity or "group" (within the meaning of Section 13(d)(3) or 14(d)(2) of the Exchange Act, but excluding, for this purpose, the Company or its subsidiaries, or any employee benefit plan of the Company or its subsidiaries which acquires beneficial ownership of voting securities of the Company) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of thirty percent (30%) or more of either the then-outstanding shares of Common Stock or the combined voting power of the Company's then-outstanding voting securities entitled to vote generally in the election of directors; or

(ii) during any period of up to twenty four (24) consecutive months, individuals who at the beginning of such period constituted the Board (together with any new directors whose election by the Board or whose nomination for election by the stockholders of the Company was approved by a vote of a majority of the directors of the Company then still in office who were either directors at the beginning of such period or whose election or nomination for election was previously so approved) cease to constitute at least a majority of the Board; or

(iii) the Company is liquidated or dissolved or adopts a plan of liquidation or dissolution; or

(iv) the merger or consolidation of the Company with or into another person or the merger of another person with or into the Company, or the sale of all or substantially all the assets of the Company (determined on a consolidated basis) to another person, other than a transaction following which (A) in the case of a merger or consolidation transaction, holders of securities that represented one hundred percent (100%) of the combined voting power entitled to vote generally in the election of directors of the Company immediately prior to such transaction (or other securities into which such securities are converted as part of such merger or consolidation transaction) own directly or indirectly at least a majority of the combined voting power entitled to vote generally in the election of directors of the surviving person in such transaction immediately after such transaction and (B) in the case of a sale of assets, each transferee is owned by holders of securities that represented at least a majority of the combined voting power entitled to vote generally in the election of directors of the Company immediately prior to such sale.

" *Code* " shall mean the Internal Revenue Code of 1986, as amended. Reference in the Plan to any section of the Code shall be deemed to include any amendments or successor provisions to such section and any regulations under such section.

" *Common Stock* " shall mean $.01 par value common stock of the Company, and such other securities of the Company as may be substituted for Common Stock.

" *Compensation Committee* " shall mean the Compensation Committee of the Board.

" *Disability* " shall mean a physical or mental condition which is expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months and which renders the Participant incapable of performing the work for which he or she is employed or similar work, as evidenced by eligibility for and actual receipt of benefits payable under a group disability plan or policy maintained by the Company or any of its subsidiaries that is by its terms applicable to the Participant.

" *Effective Date* " shall mean November 4, 2005, the original effective date of the Plan. The amendment and restatement contained herein shall be effective as of October 25, 2013.

" *ERISA* " shall mean the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations promulgated thereunder.

" *Exchange Act* " shall mean the Securities Exchange Act of 1934, as amended and the rules and regulations promulgated thereunder.

" *Good Reason* " shall mean, when used with reference to any Participant, any of the following actions or failures to act, but in each case only if it occurs while such Participant is employed by the Company and then only if it is not consented to by such Participant in writing:

(i) assignment of a position that is of a lesser rank than held by the Participant prior to the assignment and that results in a material adverse change in such Participant's reporting position, duties or responsibilities or title or elected or appointed offices as in effect immediately prior to the effective date of such change, or in the case of a Tier 1 or Tier 2 Participant who was immediately prior to the Change in Control an executive officer of the Company, such Participant ceasing to be an executive officer of a company with securities registered under the Exchange Act;

(ii) a material reduction in such Participant's total compensation from that in effect immediately prior to the Change in Control. For purposes of this clause (ii), "total compensation" shall mean the sum of base salary, target bonus opportunity and the opportunity to receive compensation in the form of equity in the Company. Notwithstanding the foregoing, a reduction will not be deemed to have occurred hereunder on account of (A) any change to a plan term other than ultimate target bonus opportunity or equity opportunity, (B) the actual payout of any bonus amount or equity amount, (C) any reduction resulting from changes in the market value of securities or other instruments paid or payable to the Participant, or (D) any reduction in the total compensation of a group of similarly situated Participants that includes such Participant; or

(iii) any change in a Participant's status as a Tier 1 Participant, Tier 2 Participant or Tier 3 Participant to a status that provides a lower benefit hereunder in the event of a Change in Control if such change in status occurs during the period beginning six (6) months prior to a Change in Control and ending twenty-four (24) months after a Change in Control; or

(iv) any change of more than fifty (50) miles in the location of the principal place of employment of such Participant immediately prior to the effective date of such change.

For purposes of this definition, none of the actions described in clauses (i) through (iv) above shall constitute "Good Reason" if taken for Cause. Additionally, none of the actions described in clauses (i) through (iv) above shall constitute "Good Reason" with respect to any Participant

if remedied by the Company within thirty (30) days after receipt of written notice thereof given by such Participant (or, if the matter is not capable of remedy within thirty (30) days, then within a reasonable period of time following such thirty (30) day period, provided that the Company has commenced such remedy within said thirty (30) day period); provided that "Good Reason" shall cease to exist for any action described in clauses (i) through (iv) above on the sixtieth (60th) day following the later of the occurrence of such action or the Participant's knowledge thereof, unless such Participant has given the Company written notice thereof prior to such date. Furthermore, any benefits under the Plan resulting from the occurrence described in clause (iii) above shall be based on the status of the Participant as set forth on Schedule I hereto as of the date of such occurrence.

" *Participant* " shall mean an employee of the Company who is included on Schedule I hereto, as that schedule may be amended in accordance with Section 2.01.

" *Plan* " shall mean this HealthSouth Corporation Change in Control Benefits Plan, as amended, restated, supplemented or modified from time to time in accordance with its terms.

" *Potential Change in Control* " shall be deemed to have occurred if the event set forth in any one of the following paragraphs shall have occurred:

(i) the Company enters into an agreement, the consummation of which would result in the occurrence of a Change in Control; or

(ii) the Company or any person, entity or "group" (within the meaning of Sections 13(d)(3) or 14(d)(2) of the Exchange Act, but excluding, for this purpose, the Company or its subsidiaries, or any employee benefit plan of the Company or its subsidiaries which acquires beneficial ownership of voting securities of the Company) publicly announces an intention to take or to consider taking actions which, if consummated, would constitute a Change in Control; or

(iii) the acquisition (other than from the Company) by any person, entity or "group" (within the meaning of Sections 13(d)(3) or 14(d)(2) of the Exchange Act, but excluding, for this purpose, the Company or its subsidiaries, or any employee benefit plan of the Company or its subsidiaries which acquires beneficial ownership of voting securities of the Company) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of fifteen (15%) or more of either the then-outstanding shares of Common Stock or the combined voting power of the Company's then-outstanding voting securities entitled to vote generally in the election of Directors; or

(iv) the Board adopts a resolution to the effect that a Potential Change in Control has occurred;

provided, however, that no Potential Change in Control shall be deemed pending for purposes of the Plan if such event or condition is no longer in effect or existence or is otherwise rescinded or terminated (by means of a public filing or announcement in the case of clause (ii) above).

" *Prorated Portion* " shall mean a fraction (i) whose numerator is the number of months elapsed from the beginning of any not yet completed performance period applicable to any cash incentive award or plan through the effective date of termination of a Participant's employment in the circumstances described in Section 3.01 below, and (ii) whose denominator is the total number of

months in such performance period under the applicable cash incentive award or plan. For purposes of this definition, the months elapsed will include the month in which the effective date of termination occurs if such date is the 16th, or a subsequent, day of that month.

" *SEC* " shall mean the United States Securities Exchange Commission.

" *Securities Act* " shall mean the Securities Act of 1933, as amended, and the rules and regulations promulgated thereunder.

" *Successor* " shall mean a successor to all or substantially all of the business, operations or assets of the Company.

" *Termination Date* " shall mean, with respect to any Participant, the termination date specified in the Termination Notice delivered by such Participant to the Company in accordance with Section 2.02 or as set forth in any Termination Notice delivered by the Company, or as applicable, the Participant's date of death.

" *Termination Notice* " shall mean, as appropriate, written notice from (a) a Participant to the Company purporting to terminate such Participant's employment for Good Reason in accordance with Section 2.02 or (b) the Company to any Participant purporting to terminate such Participant's employment for Cause or Disability in accordance with Section 2.03.

" *Tier 1 Participant* " shall mean each Participant designated in Schedule I hereto as a Tier 1 Participant, as that schedule may be amended in accordance with Section 2.01.

" *Tier 2 Participant* " shall mean each Participant designated in Schedule I hereto as a Tier 2 Participant, as that schedule may be amended in accordance with Section 2.01.

" *Tier 3 Participant* " shall mean each Participant designated in Schedule I hereto as a Tier 3 Participant, as that schedule may be amended in accordance with Section 2.01.

Section 1.02 Interpretation . In the Plan, unless a clear contrary intention appears, (a) the words "herein," "hereof" and "hereunder" refer to the Plan as a whole and not to any particular Article, Section or other subdivision, (b) reference to any Article or Section, means such Article or Section hereof; and (c) the words "including" (and with correlative meaning "include") means including, without limiting the generality of any description preceding such term. The Article and Section headings herein are for convenience only and shall not affect the construction hereof.

ARTICLE II

ELIGIBILITY AND BENEFITS

Section 2.01 Eligible Employees .

(a) An employee of the Company shall be a "Participant" in the Plan during each calendar year (or partial calendar year) for which he or she has been designated as a Participant (and in the Tier so designated) by the Chief Executive Officer of the Company and for each succeeding calendar year he or she is employed in such position, unless the Participant is given written notice by December 31 of the preceding year of the determination of the Chief Executive Officer or the Board that such Participant shall cease to be a Participant or shall participate in a different Tier for such succeeding calendar year. Notwithstanding the

foregoing, any Participant may not be removed from the Plan, nor placed in a lower tier (with Tier 1 being the highest Tier and Tier 3 being the lowest Tier), during the pendency of a Potential Change in Control or within two (2) years following a Change in Control.

(b) The Plan is only for the benefit of Participants, and no other employees, personnel, consultants or independent contractors shall be eligible to participate in the Plan or to receive any rights or benefits hereunder.

Section 2.02 Termination Notices from Participants . For purposes of the Plan, in order for any Participant to terminate his or her employment for Good Reason, such Participant must give a Termination Notice to the Company in accordance with the requirements specified under the definition of Good Reason in Section 1.01, which notice shall be signed by such Participant, shall be dated the date it is given to the Company, shall specify the Termination Date and shall state that the termination is for Good Reason and shall set forth in reasonable detail the facts and circumstances claimed to provide a basis for such Good Reason. Any Termination Notice given by a Participant that does not comply in all material respects with the foregoing requirements as well as the "Good Reason" definition provisions set forth in Section 1.01 shall be invalid and ineffective for purposes of the Plan. If the Company receives from any Participant a Termination Notice that states the termination is for Good Reason and which the Company believes is invalid and ineffective as aforesaid, it shall promptly notify such Participant of such belief and the reasons therefor. Any termination of employment by the Participant that either does not constitute Good Reason or fails to meet the Termination Notice requirements set forth above shall be deemed a termination by the Participant without Good Reason.

Section 2.03 Termination Notices from Company . For purposes of the Plan, in order for the Company to terminate any Participant's employment for Cause, the Company must give a Termination Notice to such Participant, which notice shall be dated the date it is given to such Participant, shall specify the Termination Date and shall state that the termination is for Cause and shall set forth in reasonable detail the particulars thereof. For purposes of the Plan, in order for the Company to terminate any Participant's employment for Disability, the Company must give a Termination Notice to such Participant, which notice shall be dated the date it is given to such Participant, shall specify the Termination Date and shall state that the termination is for Disability and shall set forth in reasonable detail the particulars thereof. Any Termination Notice given by the Company that does not comply, in all material respects, with the foregoing requirements shall be invalid and ineffective for purposes of the Plan. Any Termination Notice purported to be given by the Company to any Participant after the death or retirement of such Participant shall be invalid and ineffective.

Section 2.04 Accelerated Vesting of Equity . Upon the occurrence of a Change in Control, notwithstanding the provisions of any Benefit Plan or agreement (except as provided in this Section 2.04):

(a) each outstanding option to purchase Company Common Stock (each, a " *Stock Option* ") shall become automatically vested and exercisable and

(i) in the case of those Stock Options outstanding as of the Effective Date, such Stock Options shall remain exercisable by such Participant until the later of the fifteenth (15th) day of the third (3rd) month following the date at which, or December 31 of the calendar year in which, the Stock Option would have otherwise expired, but in no event beyond the original term of such Stock Option; and

(ii) in the case of all Stock Options granted to a Participant after the Effective Date, such Stock Options shall remain exercisable by such Participant for a period of (x) three (3) years in the case of a Tier 1 Participant, (y) two (2) years in the case of a Tier 2 Participant or (z) one (1) year in the case of

a Tier 3 Participant, beyond the date at which the Stock Option would have otherwise expired, but in no event beyond the original term of such Stock Option;

(b) the vesting restrictions based upon continued employment on all other awards relating to Common Stock (including, but not limited to, restricted stock, restricted stock units and SARs) held by a Participant shall immediately lapse and in the case of restricted stock units and SARs shall become immediately payable, to the extent permitted by Section 409A;

(c) the vesting restrictions based upon achievement of performance criteria on any awards related to Common Stock (including, but not limited to, performance shares or performance share units) held by a Participant shall deemed to have been met to the extent determined by the Compensation Committee as constituted immediately prior to the Change of Control; and

(d) Notwithstanding the foregoing, in the event that the terms of any award under a Benefit Plan shall provide for vesting treatment of equity awards to such Participant that are more favorable than the provisions of paragraphs (a) through (c) above, the provisions of such award shall control the vesting treatment with respect to any equity awards to which such provisions are applicable.

ARTICLE III

SEVERANCE AND RELATED TERMINATION BENEFITS

Section 3.01 Termination of Employment . In the event that a Participant's employment is terminated within twenty-four (24) months following a Change in Control or during the pendency of a Potential Change in Control provided that a related Change in Control occurs, (x) by the Participant for Good Reason (while such Good Reason exists) or (y) by the Company without Cause (other than for Disability), then in each case, such Participant (or his or her beneficiary) shall be entitled to receive, and the Company shall be obligated to pay to the Participant, subject to Sections 3.02 through 3.04 hereof:

(a) In the case of a Tier 1 Participant:

(i) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal to 2.99 times the sum of (A) the Participant's highest Annual Salary in the three (3) years preceding the Termination Date plus (B) the average of the actual bonuses received by such Participant for the three (3) years preceding the Termination Date; plus

(ii) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal the Prorated Portion of the Participant's target cash incentive opportunity for any not yet completed incentive performance period in which the termination occurs; plus

(iii) a lump sum payment as soon as practicable following the Termination Date in an amount equal to (A) all unused paid time off accrued by such Participant as of the Termination Date under the Company's paid time off policy, plus (B) all accrued but unpaid compensation, excluding any nonqualified deferred compensation, earned by such Participant as of the Termination Date to be paid by the Company ((A) and (B) together, the " *Accrued Obligations* "); and

(iv) In addition, for a period of thirty-six (36) months following the Termination Date, such Participant and his or her dependents shall continue to be covered by all medical, dental and vision insurance plans and programs (excluding disability) maintained by the Company under which the Participant was covered immediately prior to the Termination Date (collectively, the " *Continued Benefits* ") at the same cost sharing between the Company and Participant as a similarly situated active employee.

(b) In the case of a Tier 2 Participant

(v) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal to two (2) times the sum of (A) the Participant's highest Annual Salary in the three (3) years preceding the Termination Date plus (B) the average of the actual bonuses received by such Participant for the three (3) years preceding the Termination Date; plus

(vi) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal the Prorated Portion of the Participant's target cash incentive opportunity for any not yet completed incentive performance period in which the termination occurs; plus

(vii) a lump sum payment as soon as practicable following the Termination Date in an amount equal to all Accrued Obligations as soon as practicable following the Termination Date; and

(viii) In addition, for a period of twenty-four (24) months following the Termination Date, such Participant and his or her dependents shall receive Continued Benefits at the same cost sharing between the Company and Participant as a similarly situated active employee.

(c) In the case of a Tier 3 Participant

(i) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal to the sum of (A) the Participant's highest Annual Salary in the three years preceding the Termination Date plus (B) the average of the actual bonuses received by such Participant for the three (3) years preceding the Termination Date; plus

(ii) a lump sum payment within sixty (60) days following the later of such Participant's Termination Date or the date of the Change in Control in an amount equal the Prorated Portion of the Participant's target cash incentive opportunity for any not yet completed incentive performance period in which the termination occurs; plus

(iii) a lump sum payment as soon as practicable following the Termination Date in an amount equal to all Accrued Obligations as soon as practicable following the Termination Date; and

(iv) In addition, for a period of twelve (12) months following the Termination Date, such Participant and his or her dependents shall receive Continued Benefits at the same cost sharing between the Company and Participant as a similarly situated active employee.

(d) Notwithstanding anything herein to the contrary, in the event that a Participant is deemed to be a "specified employee" for purposes of Section 409A(a)(2)(B)(i) of the Code, the lump sum severance payment, together with interest at an annual rate (compounded monthly) equal to the federal short-term rate (as in effect under Section 1274(d) of the Code on the Termination Date) shall be paid, to the extent

required by Section 409A, to such Participant immediately following the six (6)-month anniversary of the Termination Date and no later than thirty (30) days following such anniversary. In any event, all Accrued Obligations shall be paid to the Participant no later than sixty (60) days following the Termination Date.

(e) The cost of the Continued Benefits paid by the Company will be imputed as wage income to the Participant to the extent required to comply with Sections 409A and 105(h) of the Code.

Section 3.02 Golden Parachute Tax .

(a) Anything in the Plan to the contrary notwithstanding, in the event it shall be determined that any payment or distribution to or for the benefit of any Participant or the acceleration thereof (the " *Triggering Payment* ") would be subject to the excise tax imposed by Section 4999 of the Code or any interest or penalties with respect to such excise tax (collectively, such excise tax, together with any such interest or penalties, the " *Excise Tax* ") (all such payments and benefits, including any cash severance payments payable pursuant to any other plan, arrangement or agreement, hereinafter referred to as the " *Total Payments* "), then, after taking into account any reduction in the Total Payments provided by reason of Section 280G of the Code in such other plan, arrangement or agreement, the cash severance payments shall first be reduced, and the noncash severance payments shall thereafter be reduced, to the extent necessary so that no portion of the Total Payments is subject to the Excise Tax but only if (A) the net amount of such Total Payments, as so reduced (and after subtracting the net amount of federal, state and local income taxes on such reduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such reduced Total Payments) is greater than or equal to (B) the net amount of such Total Payments without such reduction (but after subtracting the net amount of federal, state and local income taxes on such Total Payments and the amount of Excise Tax to which the Participant would be subject in respect of such unreduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such unreduced Total Payments). For purposes of determining whether a portion of the Total Payments would be subject to the Excise Tax, the value of the Participant's noncompetition covenant contained in the Release Agreement (defined below in Section 3.03) shall be determined through independent appraisal by the independent accounting firm described in subsection (b), and a corresponding portion of the amount payable pursuant to Section 3.01 shall be allocated as reasonable compensation for the Participant's noncompetition covenant and therefore exempt from the definition of the term "parachute payment" within the meaning of Sections 280G and 4999 of the Code.

(b) All determinations required to be made under this Section 3.02 with respect to a particular Participant shall be made in writing within ten (10) business days of the receipt of notice from the Participant that there has been a Triggering Payment (or at such earlier time as is requested by the Company and the Participant) by the independent accounting firm then retained by the Company in the ordinary course of business (which firm shall provide detailed supporting calculations to the Company and such Participant) and such determinations shall be final and binding on the Company (including the Compensation Committee) and all Participants. Any fees incurred as a result of work performed by any independent accounting firm pursuant to this Section 3.02 shall be paid by the Company.

Section 3.03 Condition to Receipt of Severance Benefits . As a condition to receipt of any payment or benefits under this Article III, such Participant must enter into a restrictive covenant (nonsolicitation, noncompete, nondisclosure, nondisparagement) and release agreement (a " *Release Agreement* ") with the Company and its affiliates substantially in the form attached hereto as Exhibit A . The Participant must execute and deliver a Release Agreement, and such Release Agreement must become effective and irrevocable in accordance with its terms, no later than sixty (60) days following such Participant's Termination Date. If this

requirement is not satisfied, the Participant shall forfeit the right to all benefits, except for the Accrued Obligations and the Continued Benefits as provided, described in this Article III.

Section 3.04 Limitation of Benefits .

(a) Anything in the Plan to the contrary notwithstanding, the Company's obligation to provide the Continued Benefits shall cease if and when the Participant becomes employed by a third party that provides such Participant with substantially comparable health and welfare benefits.

(b) Any amounts payable under the Plan shall be in lieu of and not in addition to any other severance or termination payment under any other plan or agreement with the Company. Without limiting the generality of the foregoing, in the event that a Participant becomes entitled to any payment under the Plan, such Participant shall not be entitled to receive any payment under the Company's Executive Severance Plan. As a condition to receipt of any payment under the Plan, the Participant shall waive any entitlement to any other severance or termination payment by the Company.

Section 3.05 Plan Unfunded; Participant's Rights Unsecured . The Company shall not be required to establish any special or separate fund or make any other segregation of funds or assets to assure the payment of any benefit hereunder. The right of any Participant to receive the benefits provided for herein shall be an unsecured obligation against the general assets of the Company.

ARTICLE IV

DISPUTE RESOLUTION

Section 4.01 Claims Procedure .

(a) It shall not be necessary for a Participant who has become entitled to receive a benefit hereunder to file a claim for such benefit with any person as a condition precedent to receiving a distribution of such benefit. However, any Participant or beneficiary who believes that he or she has become entitled to a benefit hereunder and who has not received, or commenced receiving, a distribution of such benefit, or who believes that he or she is entitled to a benefit hereunder in excess of the benefit which he or she has received, or commenced receiving, may file a written claim for such benefit with the Compensation Committee no later than ninety (90) days following the date on which he or she allegedly became entitled to receive a distribution of such benefit. Such written claim shall set forth the Participant's or beneficiary's name and address and a statement of the facts and a reference to the pertinent provisions of the Plan upon which such claim is based. The Compensation Committee shall, within ninety (90) days after such written claim is filed, provide the claimant with written notice of its decision with respect to such claim. If such claim is denied in whole or in part, the Compensation Committee shall, in such written notice to the claimant, set forth in a manner calculated to be understood by the claimant the specific reason or reasons for denial; specific references to pertinent provisions of the Plan upon which the denial is based; a description of any additional material or information necessary for the claimant to perfect his or her claim and an explanation of why such material or information is necessary; and an explanation of the provisions for review of claims set forth in Section 4.01(b) below.

(b) A Participant or beneficiary who has filed a written claim for benefits with the Compensation Committee which has been denied may appeal such denial to the Compensation Committee and receive a full and fair review of his or her claim by filing with the Compensation Committee a written application for review at any time within sixty (60) days after receipt from the Compensation Committee of the written notice of denial of his or her claim provided for in Section 4.01(a) above. A Participant or beneficiary who submits a timely written application for review shall be entitled to review any and all documents pertinent to his or her claim and may submit issues and comments to the Compensation Committee in writing. Not later than sixty (60) days after receipt of a written application for review, the Compensation Committee shall give the claimant written notice of its decision on review, which written notice shall set forth in a manner calculated to be understood by the claimant specific reasons for its decision and specific references to the pertinent provisions of the Plan upon which the decision is based. In the event the claimant disputes the decision of the Compensation Committee, the claimant may not bring suit in court with respect to such dispute under the Plan later than one hundred eighty (180) days after receiving the Compensation Committee's written notice of its decision.

(c) Any act permitted or required to be taken by a Participant or beneficiary under this Section 4.01 may be taken for and on behalf of such Participant or beneficiary by such Participant's or beneficiary's duly authorized representative. Any claim, notice, application or other writing permitted or required to be filed with or given to a party by this Article shall be deemed to have been filed or given when deposited in the U.S. mail, postage prepaid, and properly addressed to the party to whom it is to be given or with whom it is to be filed. Any such claim, notice, application, or other writing deemed filed or given pursuant to the next foregoing sentence shall in the absence of clear and convincing evidence to the contrary, be deemed to have been received on the fifth (5th) business day following the date upon which it was filed or given. Any such notice, application, or other writing directed to a Participant or beneficiary shall be deemed properly addressed if directed to the address set forth in the written claim filed by such Participant or beneficiary.

ARTICLE V

MISCELLANEOUS PROVISIONS

Section 5.01 Cumulative Benefits . Except as provided in Section 3.04, the rights and benefits provided to any Participant under the Plan are in addition to and shall not be a replacement of, all of the other rights and benefits provided to such Participant under any Benefit Plan or any agreement between such Participant and the Company except for any severance or termination benefits.

Section 5.02 No Mitigation . No Participant shall be required to mitigate the amount of any payment provided for in the Plan by seeking or accepting other employment following a termination of his or her employment with the Company or otherwise. Except as otherwise provided in Section 3.04, the amount of any payment provided for in the Plan shall not be reduced by any compensation or benefit earned by a Participant as the result of employment by another employer or by retirement benefits. The Company's obligations to make payments to any Participant required under the Plan shall not be affected by any set off, counterclaim, recoupment, defense or other claim, right or action that the Company may have against such Participant.

Section 5.03 Amendment or Termination . The Board may amend or terminate the Plan at any time; provided, however, that the Plan may not be amended or terminated during the pendency of a Potential Change in Control or within two (2) years following a Change in Control. Notwithstanding the foregoing, nothing herein shall abridge the authority of the Compensation Committee to designate a new Participant or a new participation Tier for a current Participant or to determine that a Participant shall no longer be entitled to participate in the Plan in accordance with Section 2.01(a) hereof. The Plan shall terminate when all of the obligations to Participants hereunder have been satisfied in full.

To the extent payments and benefits under the Plan remain subject to Section 409A, payments and benefits under the Plan are intended to comply with Section 409A, and all provisions of the Plan and Notice of Participation shall be interpreted in accordance with Section 409A and Department of Treasury regulations and other interpretive guidance issued thereunder, including, without limitation, any such regulations or other guidance that may be issued after the adoption or amendment of the Plan. The Plan shall be interpreted and administered, to the extent possible, in accordance with these intentions. Notwithstanding any provision of the Plan to the contrary, in the event that the Board determines that any payments or benefits may or do not comply with Section 409A, the Board may adopt such amendments to the Plan (without Participant consent) or adopt other policies and procedures (including amendments, policies and procedures with retroactive effect), or take any other actions, that the Board determines are necessary or appropriate to (i) exempt the Plan and any payments or benefits thereunder from the application of Section 409A, or (ii) comply with the requirements of Section 409A.

Section 5.04 Enforceability . The failure of Participants or the Company to insist upon strict adherence to any term of the Plan on any occasion shall not be considered a waiver of such party's rights or deprive such party of the right thereafter to insist upon strict adherence to that term or any other term of the Plan.

Section 5.05 Administration .

(a) The Compensation Committee shall have full and final authority, subject to the express provisions of the Plan, with respect to designation of Participants and administration of the Plan, including, but not limited to, the authority to construe and interpret any provisions of the Plan and to take all other actions deemed necessary or advisable for the proper administration of the Plan.

(b) The Company shall indemnify and hold harmless each member of the Compensation Committee and any other employee of the Company that acts at the direction of the Compensation Committee against any and all expenses and liabilities arising out of his or her administrative functions or fiduciary responsibilities, including any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such member in the performance of such functions or responsibilities, but excluding expenses and liabilities that are caused by or result from such member's or employee's own gross negligence or willful cause. Expenses against which such member or employee shall be indemnified hereunder shall include, without limitation, the amounts of any settlement or judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought or settlement thereof.

Section 5.06 Consolidations, Mergers, Etc . In the event of a merger, consolidation or other transaction, nothing herein shall relieve the Company from any of the obligations set forth in the Plan; provided , however , that nothing in this Section 5.06 shall prevent an acquirer of or Successor to the Company from assuming the obligations, or any portion thereof, of the Company hereunder pursuant to the terms of the Plan provided that such acquirer or Successor provides adequate assurances of its ability to meet this obligation. In the event that an acquirer of or Successor to the Company agrees to perform the Company's

obligations, or any portion thereof, hereunder, the Company shall require any person, firm or entity which becomes its Successor to expressly assume and agree to perform such obligations in writing, in the same manner and to the same extent that the Company would be required to perform hereunder if no such succession had taken place.

Section 5.07 Successors and Assigns . The Plan shall be binding upon and inure to the benefit of the Company and its Successors and assigns. The Plan and all rights of each Participant shall inure to the benefit of and be enforceable by such Participant and his or her personal or legal representatives, executors, administrators, heirs and permitted assigns. If any Participant should die while any amounts are due and payable to such Participant hereunder, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of the Plan to such Participant's devisees, legatees or other designees or, if there be no such devisees, legatees or other designees, to such Participant's estate. In the event of the death of any Participant during the applicable period of eligibility for the Continued Benefits set forth in Section 3.01, dependents of such Participant shall be eligible during such period to continue participation in any Continued Benefits in which the Participant was enrolled at the time of death. No payments, benefits or rights arising under the Plan may be assigned or pledged by any Participant, except under the laws of descent and distribution.

Section 5.08 Notices . All notices and other communications provided for in the Plan shall be in writing and shall be sent, delivered or mailed, addressed as follows: (a) if to the Company, at the Company's principal office address or such other address as the Company may have designated by written notice to all Participants for purposes hereof, directed to the attention of the General Counsel, and (b) if to any Participant, at his or her residence address on the records of the Company or to such other address as he or she may have designated to the Company in writing for purposes hereof. Each such notice or other communication shall be deemed to have been duly given or mailed by United States certified or registered mail, return receipt requested, postage prepaid, except that any change of notice address shall be effective only upon receipt.

Section 5.09 Tax Withholding . The Company shall have the right to deduct from any payment hereunder all taxes (federal, state or other) which it is required to be withhold therefrom.

Section 5.10 No Employment Rights Conferred . The Plan shall not be deemed to create a contract of employment between any Participant and the Company and/or its affiliates. Nothing contained in the Plan shall (i) confer upon any Participant any right with respect to continuation of employment with the Company or (ii) subject to the rights and benefits of any Participant hereunder, interfere in any way with the right of the Company to terminate such Participant's employment at any time.

Section 5.11 Entire Plan . The Plan contains the entire understanding of the Participants and the Company with respect to Change in Control severance arrangements maintained on behalf of the Participants by the Company. There are no restrictions, agreements, promises, warranties, covenants or undertakings between the Participants and the Company with respect to the subject matter herein other than those expressly set forth herein.

Section 5.12 Prior Agreements . The Plan supersedes all prior agreements, programs and understandings (including verbal agreements and understandings) between the Participants and the Company regarding the terms and conditions of Participant's severance arrangements in the event of a Change in Control.

Section 5.13 Severability . If any provision of the Plan is, becomes or is deemed to be invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions of the Plan shall not be affected thereby.

Section 5.14 Governing Law . The Plan shall be governed by and construed in accordance with the laws of the State of Delaware, without giving effect to its conflict of laws rules, and applicable federal law.

IN WITNESS WHEREOF, the secretary of the Company does hereby certify the adoption of the Plan on October 25, 2013 by the HealthSouth Corporation Board of Directors.

HEALTHSOUTH CORPORATION

By: /s/ John P. Whittington
Name: John P. Whittington
Title: Executive Vice President, General Counsel and Secretary

SCHEDULE I

Tier 1 Participants

President and Chief Executive Officer
EVP and Chief Financial Officer
EVP, General Counsel and Secretary
EVP and Chief Operating Officer

Tier 2 Participants

Regional Presidents
Chief Accounting Officer
Chief Human Resources Officer
Chief Information Officer
Chief Medical Officer
Treasurer

Tier 3 Participants

Chief Development Officer
Chief Investor Relations Officer
Deputy General Counsel
SVP, Operations
SVP, Financial Operations
SVP, Public Policy, Legislation & Regulations
SVP, Reimbursement

Exhibit A

RESTRICTED COVENANT AND RELEASE AGREEMENT

This Release Agreement (this " Agreement ") is entered into between _____ (" Executive ") and HealthSouth Corporation (the " Company "), pursuant to the terms and conditions of the HealthSouth Corporation Second Amended and Restated Change in Control Benefits Plan, which is attached hereto as Exhibit A (the " Plan ").

WITNESSETH

WHEREAS, Executive is employed by the Company as _____ and is a " Participant " in the Plan (as such term is defined in the Plan);

WHEREAS, Executive's last day of employment with the Company will be _____ ___, _____, and such date shall be the " Termination Date " for purposes of this Agreement and the Plan;

WHEREAS, Executive is eligible to receive benefits under Section 3.01 of the Plan, subject to the terms and conditions of the Plan, including, but not limited to, Executive's execution and delivery to the Company of this Agreement and it becoming effective;

WHEREAS, Executive has agreed to comply with, among other things, certain confidentiality, noncompetition and nonsolicitation provisions, which are provided below, and such provisions shall be fully enforceable by the Company; and

WHEREAS, Executive and the Company wish to settle, fully and finally, all matters between them under the terms and conditions exclusively set forth in this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which is mutually acknowledged, the Company and Executive agree as follows:

1. Benefits under the Plan . Provided that this Agreement becomes effective pursuant to Paragraph 4 of this Agreement:

(a) The Company shall pay the amount listed on Line 1 of Exhibit B attached hereto, subject to all applicable federal, state and local withholdings, in accordance with the terms and conditions of the Plan, paid out in a lump sum within sixty (60) days of the Termination Date.

(b) Executive will continue to be eligible to participate in the Company sponsored group healthcare benefits, (excluding disability insurance but specifically including medical, dental and vision plans), under which the Executive was covered immediately prior to the Termination Date, for the number of months listed on Line 2 of Exhibit B attached hereto, after the Termination Date (the " Severance Period "), provided that Executive continues to contribute toward the premiums at the level of an active employee of the Company. Thereafter, Executive's right to continue coverage under the Company sponsored group healthcare plan at Executive's own expense, pursuant to the

statutory scheme commonly known as "COBRA," shall be governed by applicable law and the terms of the plans and programs, and will be explained to Executive in a packet to be sent to Executive under separate cover.

(c) Executive acknowledges and agrees that the severance payments and benefits provided in subsection (a) and (b) of Section 1 are subject to forfeiture and repayment and any awards relating to Common Stock shall be cancellable and/or forfeitable in the event of a material violation by Executive of Sections 6, 7, and/or 8 of this Agreement

2. Release .

(a) Executive, on behalf of Executive, Executive's heirs, executors, administrators, successors and assigns, hereby irrevocably and unconditionally releases the Company and its subsidiaries, divisions and affiliates, together with their respective owners, assigns, agents, directors, partners, officers, trustees, members, managers, employees, insurers, employee benefit programs (including, but not limited to, trustees, administrators, fiduciaries, and insurers of such programs), attorneys and representatives and any of their predecessors and successors and each of their estates, heirs and assigns (collectively, the " Company Releases ") from any and all charges, complaints, claims, liabilities, obligations, promises, agreements, causes of action, rights, costs, losses, debts and expenses of any nature whatsoever, known or unknown, which Executive or Executive's heirs, executors, administrators, successors or assigns ever had, now have or hereafter can, will or may have (either directly, indirectly, derivatively or in any other representative capacity) by reason of any matter, fact or cause whatsoever against the Company or any of the other Company Releases from the beginning of time to the date upon which Executive signs this Agreement, including, but not limited to, any claims arising out of or relating to Executive's employment with the Company and/or termination of employment from the Company. This release includes, without limitation, all claims arising out of, or relating to, Executive's employment with the Company and the termination of Executive's employment with the Company, including all claims for severance or termination benefits under Executive's employment agreement with the Company, if any, and under any plan, policy or agreement (other than those benefits expressly payable hereunder) and all claims arising under any foreign, federal, state and local labor, laws including, without limitation, the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act, the Employee Retirement Income Security Act of 1974, the Americans with Disabilities Act, Title VII of the Civil Rights Act of 1964, the Family and Medical Leave Act, the Civil Rights Act of 1991, the Fair Labor Standards Act, the Equal Pay Act, the Immigration and Reform Control Act, the Uniform Services Employment and Re-Employment Act, the Rehabilitation Act of 1973, Sarbanes-Oxley Act, Executive Order 11246, the Lilly Ledbetter Fair Pay Act, the False Claims Act, the Dodd-Frank Wall Street Reform and Consumer Protection Act, the Alabama Age Discrimination Statute and the Workers' Adjustment and Retraining Notification Act (and any similar state or local law), each as amended.

(b) Nothing in this Paragraph 2 shall be deemed to release (i) Executive's right to enforce the terms of this Agreement; (ii) Executive's rights, if any, to any vested benefits or options under any incentive, bonus, or other benefit plan maintained by the Company; (iii) any right to indemnification under the Company's Restated Certificate of Incorporation or its Amended and Restated By Laws; or (iv) any claim that cannot be waived under applicable law. Nothing in this Agreement prevents Executive from initiating a complaint with or participating in any legally authorized investigation or proceeding conducted by the Equal Employment Opportunity Commission or any federal, state, or local law enforcement agency. Notwithstanding the foregoing, Executive agrees that Executive is waiving all rights to damages and all other forms of recovery arising out of any charge, complaint or lawsuit filed on behalf of Executive or any third party as to all claims waived in this Agreement.

(c) Executive acknowledges and agrees that the Company has fully satisfied any and all obligations owed to Executive arising out of Executive's employment with the Company, and no further sums are owed to Executive by the Company or by any of the other Company Releases at any time. Executive further acknowledges and agrees that the Company has paid Executive for all earned wages and accrued but unused paid time off through the Termination Date. By entering into this Agreement, Executive explicitly waives any rights to severance or other posttermination benefits under any oral or written plan, policy, employment agreement, contract or arrangement with the Company, other than as provided in this Agreement. Executive acknowledges and agrees that, in the absence of this Agreement, the Company has no obligation to provide any of the consideration set forth in Paragraph 1 of this Agreement. Executive further acknowledges and agrees that Executive has no rights to any unvested benefits or options under any incentive, bonus or other benefit plan, except as otherwise provided in the Plan; and that all such vesting shall cease as of the Termination Date. Executive further acknowledges and agrees that any right to continue to contribute to the Company's 401(k) plan for employees ended on the Termination Date. Furthermore, Executive acknowledges and agrees that the payments and benefits provided under Paragraph 1 of this Agreement shall not be included in any computation of earnings under the Company's 401(k) plan or any other plan.

(d) Executive represents that Executive has no lawsuits pending against the Company or any of the other Company Releases. Executive further covenants and agrees that neither Executive nor Executive's heirs, executors, administrators, successors or assigns will be entitled to any personal recovery in any proceeding of any nature whatsoever against the Company or any of the other Company Releases arising out of any of the matters released in Paragraph 2.

3. Consultation with Attorney/Voluntary Agreement . Executive acknowledges that (a) the Company is hereby advising Executive of Executive's right to consult with an attorney of Executive's own choosing prior to executing this Agreement, (b) Executive has carefully read and fully understands all of the provisions of this Agreement, and (c) Executive is entering into this Agreement, including the releases set forth in Paragraph 2 above, knowingly, freely and voluntarily in exchange for good and valuable consideration, including the obligations of the Company under this Agreement.

4. Consideration & Revocation Period .

(a) Executive acknowledges that Executive has been given at least twenty-one (21) calendar days following receipt of this Agreement to consider the terms of this Agreement, although Executive may execute it sooner.

(b) Executive will have seven (7) calendar days from the date on which Executive signs this Agreement to revoke Executive's consent to the terms of this Agreement. Such revocation must be in writing and must be addressed and sent via facsimile as follows: HealthSouth Corporation, Attention: General Counsel, facsimile: (205) 262-3948. Notice of such revocation must be received within the seven (7) calendar days referenced above. In the event of such revocation by Executive, this Agreement shall not become effective and Executive shall not have any rights under this Agreement or the Plan.

(c) Provided that Executive does not revoke this Agreement, this Agreement shall become effective on the eighth calendar day after the date on which Executive signs this Agreement (the " Effective Date ").

5. Acknowledgments.

(a) Executive acknowledges and agrees that: (i) the "Company Business" (as defined in Paragraph 9(a) below) is intensely competitive and that Executive's employment by the Company required Executive to have access to, and knowledge of, "Confidential Information" (as defined in Paragraph 9(b) below); (ii) the use or disclosure of any Confidential Information could place the Company at a serious competitive disadvantage and could do serious damage, financial and otherwise, to the Company; (iii) Executive was given access to, and developed relationships with, employees, clients, patients, physicians and partners of the Company at the time and expense of the Company; and (iv) by Executive's training, experience and expertise, Executive's services to the Company were extraordinary, special and unique, and the Company invested in training and enhancing Executive's skill and experience in the Company Business.

(b) Executive further acknowledges and agrees that (i) Executive's experience and capabilities are such that the provisions contained in Paragraphs 6, 7, and 8 will not prevent Executive from earning a livelihood; (ii) the Company would be seriously and irreparably injured if Executive were to engage in "Competitive Activities" (as defined below), or to otherwise breach the obligations contained in Paragraphs 6, 7 and 8, no adequate remedy at-law would exist and damages would be difficult to determine; (iii) the provisions contained in Paragraphs 6, 7 and 8 are justified by and reasonably necessary to protect the legitimate business interests of the Company, including the Confidential Information and good will of the Company; and (iv) the provisions in Paragraphs 6, 7 and 8 are fair and reasonable in scope, duration and geographical limitations. Accordingly, Executive agrees to be bound fully by the restrictive covenants in this Agreement to the maximum extent permitted by law, it being the intent and spirit of the parties that the restrictive covenants and the other agreements contained herein shall be valid and enforceable in all respects.

6. Confidentiality .

Executive acknowledges and agrees that, from and after the Termination Date, and at all times thereafter, Executive will not communicate, divulge or disclose to any "Person" (as defined in Paragraph 9(c) below) or use for Executive's own benefit or purpose any Confidential Information of the Company, except as required by law or court order or expressly authorized in writing by the Company; provided, however, that Executive shall promptly notify the Company prior to making any disclosure required by law or court order so that the Company may seek a protective order or other appropriate remedy.

7. Covenant Not to Compete .

From the Termination Date through the end of the Severance Period (the " Noncompetition Period "), Executive shall not, directly or indirectly, participate in the management, operation or control of, or have any financial or ownership interest in, or aid or knowingly assist anyone else in the conduct of, any business or entity that (i) engages in the Company Business in any Restricted Territory (as defined in Paragraph 9(d) below), or (ii) is, to Executive's knowledge, making preparations for engaging in the Company Business in any Restricted Territory (collectively, " Competitive Activity "); provided, however, that (x) the "beneficial ownership" by Executive, either individually or as a member of a "group" (as such terms are used in Rule 13d of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended), of not more than one percent (1%) of the voting stock of any publicly held corporation shall not alone constitute a breach of this Paragraph 7 and (y) Executive may enter into, at arm's length, any bona fide joint venture (or partnership or other business arrangement) with any Person who is not directly engaged in the Company Business but which is an affiliate of another Person engaged in the Company Business.

8. Employee Nonsolicitation; Nondisparagement .

(a) Executive shall not, directly or indirectly, within the Noncompetition Period, without the prior written consent of the Company, solicit or direct any other Person to solicit any officer or other employee of the Company to: (i) terminate such officer's or employee's employment with the Company; or (ii) seek or accept employment or other affiliation with Executive or any Person engaged in any Competitive Activity in which Executive is directly or indirectly involved (other than, in each case, any solicitation directed at the public in general in publications available to the public in general or any contact which Executive can demonstrate was initiated by such officer, director or employee or any contact after such officer's or employee's employment with the Company is terminated). Executive's obligations. under this Paragraph 8(a) with respect to new Company employees hired after the Termination Date shall be subject to the condition that Executive shall have been notified of such new employees.

(b) Executive shall not, directly or indirectly, within the Noncompetition Period, without the prior written consent of the Company, solicit or direct any other Person to solicit any Person or entity in a business relationship with the Company (whether an independent contractor, joint venture partner or otherwise) to terminated such Person or entity's business relationship with the Company.

(c) Executive shall not, directly or indirectly, within the Noncompetition Period, make any statements or comments of a defamatory or disparaging nature to third parties regarding the Company or any of their members, principals, officers, managers, directors, personnel, employees, agents, services or products; provided, however, that nothing contained in this Paragraph 8(b) shall preclude Executive from providing truthful testimony in response to a valid subpoena, court order, regulatory request or as may be required by law.

9. Definitions .

(a) For the purposes of this Agreement, the " Company Business " shall mean the business of owning, operating or managing inpatient rehabilitation facilities offering a range of rehabilitative health care services, and services directly ancillary thereto for which the Company receives compensation.

(b) For purposes of this Agreement, " Confidential Information " includes, but is not limited to, certain or all of the Company's and its patients', physicians' and third-party managed care providers' supply agreement arrangements, regulatory packages, registration packages, data compensation packages, methods, information, systems, plans for acquisition or disposition of products, expansion plans, financial status and plans, customer lists, client data, personnel information, consulting reports, investigative reports, Personal Health Information (PHI), strategic plans and trade secrets.

(c) For the purposes of this Agreement, " Person " shall mean an individual, corporation, joint venture, partnership, limited liability company, association, joint stock or other company, business trust, trust or other entity or organization, including any national, federal, state, territorial agency, local or foreign judicial, legislative, executive, regulatory or administrative authority, commission, court, tribunal, any political or other subdivision, department or branch of any of the foregoing, and any self regulatory organization or arbitrator.

(d) For the purposes of this Agreement, the " Restricted Territory " means the area within seventy-five (75) miles of any location where an inpatient rehabilitation facility, which is owned or operated by the Company, is located as of the Termination Date.

10. Notice to the Company . In the event that Executive accepts employment with another party at any time during the Severance Period, Executive shall inform the Company in writing on or before the commencement date of such employment and provide the Company with such other information relating to available health and welfare benefits as a result of said employment as required by Section 3.03(a) of the Plan.

11. Duty to Inform . Executive shall inform in writing any Person, who seeks to employ or engage Executive in any capacity, of Executive's obligations under Paragraphs 6, 7 and 8 of this Agreement, prior to accepting such employment or engagement.

12. Company Property . Executive represents that Executive has returned to the Company all property of the Company. Such property includes, but is not limited to, laptop computers, BlackBerry, printers, other computer equipment (including computers, printers and equipment paid for by the Company for use at Executive's residence), cellular phones and pagers, keys, security passes, passwords, work files, records, credit cards, building ID's and all other Company property in Executive's possession on the last day of Executive's employment with the Company. Following the Termination Date, the Company shall also have no obligation to continue to make payments under any car loan or corporate membership provided to Executive as an employee of the Company.

13. No Admission of Wrongdoing . Nothing herein is to be deemed to constitute an admission of wrongdoing by the Company or any of the other Company Releases.

14. Assignment . This Agreement is binding on, and will inure to the benefit of, the Company and the other Company Releases. All rights of Executive under this Agreement shall inure to the benefit of, and be enforceable by, Executive's personal or legal representatives, executors, administrators, successors, heirs, distributes, devisees and legatees.

15. Injunctive Relief . Executive agrees that the Company would suffer irreparable harm if Executive were to breach, or threaten to breach, any provision of this Agreement and that the Company would by reason of such breach, or threatened breach, be entitled to injunctive relief in a court of appropriate jurisdiction, without the need to post any bond, and Executive further consents and stipulates to the entry of such injunctive relief in such a court prohibiting Executive from breaching this Agreement. This Paragraph 15 shall not, however, diminish the right of the Company to claim and recover damages and other appropriate relief, including, but not limited to, repayment of any severance payments or benefits provided to Executive, in addition to injunctive relief.

16. Severability . In the event that any one or more of the provisions of this Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. Moreover, if any one or more of the provisions contained in this Agreement shall be held to be excessively broad as to duration, activity or subject, such provisions shall be construed by limiting and reducing them so as to be enforceable to the maximum extent allowed by applicable law. Furthermore, a determination in any jurisdiction that this Agreement, in whole or in part, is invalid, illegal or unenforceable shall not in any way affect or impair the validity, legality or enforceability of this Agreement in any other jurisdiction.

17. Waiver . The failure of either party to this Agreement to enforce any of its terms, provisions or covenants shall not be construed as a waiver of the same or of the right of such party to enforce the same. Waiver by either party hereto of any breach or default by the other party of any term or provision of this Agreement shall not operate as a waiver of any other breach or default.

18. No Oral Modifications . This Agreement may not be changed orally, but may be changed only in a writing signed by Executive and a duly authorized representative of the Company.

19. Governing Law; Venue . This Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware, without regard to the application of any choice-of-law rules that would result in the application of another state's laws. With respect to any action, suit or proceeding, each party irrevocably (i) submits to the jurisdiction of the courts of the State of Delaware and the United States District Court of the District of Delaware, and (ii) waives any objection which it may have at any time to the laying of venue of any proceeding brought in any such court, waives any claim that such proceedings have been brought in an inconvenient forum and further waives the right to object, with respect to such proceedings, that such court does not have jurisdiction over such party.

20. Entire Agreement. This Agreement sets forth the entire understanding between Executive and the Company, and supersedes all prior agreements, representations, discussions, and understandings concerning their subject matter. Executive represents that, in executing this Agreement, Executive has not relied upon any representation or statement made by the Company or any other Company Releases, other than those set forth herein, with regard to the subject matter, basis or effect of this Agreement or otherwise.

21. Descriptive Headings . The paragraph headings contained herein are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

22. Counterparts . This Agreement may be executed simultaneously in counterparts, each of which shall be an original, but all of which shall constitute but one and the same agreement.

IN WITNESS WHEREOF, Executive and the Company have executed this Agreement on the date indicated below.

HEALTHSOUTH CORPORATION

By: _____

Date: _____

EXECUTIVE

By: _____

Date: _____

EXHIBIT A

[INSERT PLAN]

EXHIBIT B

Name: _____

1. Amount Payable: $_____

2. Months: _____

Exhibit 10.9

HEALTHSOUTH CORPORATION

NONQUALIFIED 401(k) plan

As Amended and Restated March 1, 2013

HEALTHSOUTH CORPORATION NON-QUALIFIED 401(K) PLAN

PREAMBLE

HealthSouth Corporation (the "Company") adopted the HealthSouth Corporation Nonqualified 401(k) Plan (the "Plan") effective March 1, 2008, to benefit certain senior executives of the Company. The Plan is intended to operate both in connection with and independent from the Company's qualified section 401(k) plan and will be administered accordingly. However, although participation in the two plans may be coordinated, an election

to participate or not participate in the qualified 401(k) plan will satisfy the requirements of section 409A of the Code and the regulations issued thereunder since such a decision will not result in the increase or decrease in elective deferrals to this Plan in excess of the limitations set forth by section 402(g) of the Code and will not create a corresponding increase or reduction in employer matching contributions in excess of such limitation or in excess of the amount of employer matching contributions the participant would have received under the qualified 401(k) plan determined without regard to the limits on such contributions under the Internal Revenue Code.

The Benefits Committee amended and restated the Plan, generally effective December 31, 2008, except as otherwise provided therein, to (i) make certain clarifying amendments to reflect current administrative practices with respect to the benefit election and distribution provisions of the Plan and any changes required to ensure compliance with section 409A of the Code and (ii) expand the Plan's eligibility provisions to include Chief Executive Officers and Chief Financial Officers of each of the Company's hospitals, provided that such officers earn more than the compensation limit set forth in section 414(q) of the Code, effective January 1, 2009. The provisions of this amended and restated Plan were effective December 31, 2008, except as specifically provided therein, in order to comply with applicable law or prior design decisions adopted by the Company.

By this instrument, the Benefits Committee desires to amend and restate the Plan, generally effective March 1, 2013, except as otherwise stated below, to (i) amend the Plan to add a definition of “Spouse” to conform to the recent Supreme Court decision on the constitutionality of the Defense of Marriage Act and (ii) make additional clarifying amendments to reflect current plan provisions set forth in the terms of the Plan’s election forms and administrative practices with respect to the benefit election and distribution provisions of the Plan.

The Company may adopt one or more domestic trusts to serve as a possible source of funds for the payment of benefits under this Plan.

End of Preamble

ARTICLE I
PURPOSE AND NATURE OF PLAN

1.1 Purpose of Plan

The objective and purpose of this Plan is to attract and retain competent officers and key executives by providing flexible compensation opportunities to officers and key executives of the Company and its affiliates to offer them an opportunity to build an estate or supplement income for use after retirement. In addition to this Plan, the Company sponsors certain broad-based employee benefit plans covering its employees.

1.2 Nature of Plan

Through this Plan, the Company intends to permit the deferral of compensation and to provide additional benefits to a select group of management or highly compensated employees. Accordingly, it is intended that this Plan will not constitute a "qualified plan" subject to the limitations of section 401(a) of the Internal Revenue Code of 1986, as amended (the "Code"), nor will it constitute a "funded plan", for purposes of such requirements. It is also intended that this Plan will be exempt from the participation and vesting requirements of Part 2 of Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the funding requirements of Part 3 of Title I of ERISA, and the fiduciary requirements of Part 4 of Title I of ERISA by reason of the exclusions afforded plans which are unfunded and maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

End of Article I

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.1 Definitions

When a word or phrase will appear in this Plan with the initial letter capitalized, and the word or phrase does not commence a sentence, the word or phrase will generally be a term defined in this Section 2.1. The following words and phrases with the initial letter capitalized will have the meaning set forth in this Section 2.1, unless a different meaning is required by the context in which the word or phrase is used.

(a) " **Account** " means one or more of the bookkeeping accounts maintained by the Company or its agent on behalf of a Participant, as described in more detail in Section 4.5.

(b) " **Affiliate** " means a corporation that is (i) a member of a controlled group of corporations (as defined in section 414(b) of the Code) which includes the Company, (ii) any trade or business (whether or not incorporated) which is in common control (as defined in section 414(c) of the Code) with the Company, or (iii) any entity that is a member of the same affiliated service group (as defined in section 414(m) of the Code) as the Company. In addition, the term Affiliate will also include any related entity (regardless of whether in the Company's controlled group of corporations, as defined above) that the Company has designated for participation in the Plan.

(c)" **Beneficiary** " means the person designated by the Participant to receive a distribution of his benefits under the Plan upon the death of the Participant. In the event that a Participant fails to designate a Beneficiary, or if the Participant's Beneficiary does not survive the Participant, the Participant's Beneficiary will be his surviving Spouse, if any, or if the Participant does not have a surviving Spouse, his estate. The term "Beneficiary" also will mean a Participant's Spouse or former Spouse who is entitled to all or a portion of a Participant's benefit pursuant to Section 6.2. Solely for purposes of identifying a Participant’s beneficiary, the term "Spouse" as used in this definition will include a same or opposite sex domestic partner of the Participant, provided the domestic partner satisfies the requirements for domestic partner benefits under the Employer's Domestic Partner Guidelines set forth in Appendix B. Appendix B may be revised from time-to-time by the Daily Administrator without the need for a formal amendment to the Plan.

(d) " **Benefits Committee** " means the administrative committee responsible for the administration of the Plan in accordance with Article VIII.

(e) " **Board** " means the Board of Directors of the Company.

(f)" **Claimant** " means a Participant or Beneficiary who files a claim for benefits pursuant to Section 8.5.

(g) " **Code** " means the Internal Revenue Code of 1986, as amended from time to time and any regulations or rulings issued thereunder.

(h) " **Company** " means HealthSouth Corporation or any successor thereto.

(i) " **Compensation** " means the total of all amounts paid by the Employer to or for the benefit of an Employee for services rendered or labor performed for the Employer while a Participant and while an Employee, which are required to be reported on the Employee's Federal Wage and Tax Statement, Form W-2 or its successor; provided, however, that Compensation will not include: (i) mileage reimbursements; (ii) severance pay; (iii) termination vacation payouts; (iv) termination paid time-off payouts; (v) relocation reimbursements; (vi) income from the exercise or award of any stock options or stock grants; (vii) imputed income from life insurance; (viii) car allowances; (ix) club dues; (x) housing allowances; and (A) any stock purchase plan match monies. Further, Compensation excludes:

(i) elective contributions made on the Employee's behalf by the Employer that are not includible in income under sections 125, 132(f)(4), 402(e)(3), 402(h), or 403(b) of the Code;

(ii) compensation deferred under an eligible deferred compensation plan within the meaning of section 457(b) of the Code; and

(iii) employee contributions described in section 414(h) of the Code that are picked up by the employing unit and treated as employer contributions.

Compensation will include all of the Employee's Form W-2 earnings defined in the preceding sentences accrued and paid by the last day of the Plan Year.

(j) " **Compensation Committee** " means the Compensation Committee of the Board of Directors of the Company.

(k) " **Compensation Deferral** " means the deferral described in Section 4.1 made by a Participant who has elected to defer all or a portion of his Compensation under the Plan including a deferral of Compensation classified as a bonus that is subject to a separate and distinct deferral election.

(l) " **Daily Administrator** " means the individuals, entity or department designated by the Compensation Committee or the Benefits Committee to handle the day to day administration of the Plan and to make initial claim determinations pursuant to Section 8.5. In the event the Compensation Committee or the Benefits Committee fails to appoint a Daily Administrator, the Benefits Committee will be the Daily Administrator.

(m)" **Disability** " means that due to a physical or mental condition, the Participant has been determined to be totally and permanently disabled by the Social Security Administration and is eligible to receive Social Security disability benefits.

(n) " **Effective Date** " means March 1, 2013, except as expressly provided otherwise herein.

(o) " **Election Process** " means the written forms or on-line processes provided by the Daily Administrator, or delegate thereof, pursuant to which the Participant consents to participation in the Plan, elects to defer Compensation

as a Compensation Deferral and specifies the time and form in which such Compensation Deferrals, Employer Matching Contributions attributable to such Compensation Deferrals and any Employer Discretionary Contributions will be paid as provided in Article V. Such Participant consent and elections may be done either in writing or on-line through an electronic signature as determine by the Daily Administrator.

(p) " **Eligible Employee** " means each Employee who holds the position of an Executive Officer, Senior Vice President, Vice President or Director or is the Chief Executive Officer or Chief Financial Officer of one of the Company's hospitals; provided, however, that each such individual must earn more than the compensation limit set forth in section 414(q) of the Code (*i.e.* , one hundred fifteen thousand dollars ($115,000) for 2013 (as adjusted under section 414(q)(1) of the Code)).

(q) " **Employee** " means any person employed by the Employer in the capacity of a common law employee and not in the capacity of an Leased Employee or independent contractor, even if such Leased Employee or independent contractor is subsequently determined by the Employer, the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of the Employer. Each such Employee who is currently employed by the Employer or an Affiliate will be referred to herein as an "Active Employee" and each such Employee who is no longer employed by the Employer or an Affiliate but has an Account balance under the Plan will be referred to herein as an "Inactive Employee."

(r) " **Employer** " means the Company and any other Affiliate which adopts the Plan. An Affiliate may evidence its adoption of the Plan either by a formal action of its governing body or by commencing deferrals and taking other administrative actions with respect to this Plan on behalf of its employees.

(s) " **Employer Discretionary Contribution** " means discretionary profit sharing contributions made to the Plan on behalf of a Participant.

(t) " **Employer Matching Contribution** " means the matching contributions made to the Plan on behalf of a Participant.

(u) " **ERISA** " means the Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulations or rulings issued thereunder.

(v) " **Hour of Service** " means each hour for which an Employee is directly or indirectly paid, or is entitled to payment, by the Employer (including any predecessor business of an Employer conducted as a corporation, partnership or proprietorship) or Affiliate for the performance of duties or reasons other than the performance of duties, including but not limited to vacation, holidays, sickness, disability, paid layoff, jury duty, military duty, leave of absence and similar paid periods of nonworking time. An Hour of Service also includes each hour, not credited above, for which back pay, irrespective of mitigation of damages, has been either awarded or agreed to by the Employer or an Affiliate. For all purposes of the Plan, Hours of Service will be credited for any individual considered to be a Leased Employee and for any individual considered an Employee under section 414(o) of the Code and the final regulations thereunder.

(i) **Acquired Entities** . Service or employment completed by an Employee of an acquired facility or an acquired employee group before such facility became an Affiliate or before the employees of such employee group become Employees will not be credited except to the extent provided in the acquisition agreement, a resolution by the Board of Directors or other governing body of the Employer. Any such prior vesting service credit will be described in Appendix A attached hereto. Appendix A may be revised from time-to-time by the Daily Administrator without the need for a formal amendment to the Plan.

(ii) **Licensed Professionals** . Service or employment completed by licensed professionals on behalf of professional corporations for which the Company provides payroll services who become Employees will be taken into account for purposes of determining Hours of Service under this Plan.

(w) " **Investment Options** " means the investment options used under the Plan to measure the investment returns attributable to each Participant's Account. As of the Effective Date, any investment fund offered through the Charles Schwab Trust Company may be selected as an Investment Option under the Plan. The Benefits Committee may revise the Investment Options provided under the Plan from time to time without the need for a formal Plan amendment, in which case the new Investment Options will be communicated to Participants.

(x)" **Key Employee** " means a key employee within the meaning of section 41(i) of the Code. Specifically, an individual who is:

(i) an officer of the Company or an Affiliate having compensation of greater than one hundred thirty thousand dollars ($130,000) (as adjusted under section 416(i)(1) of the Code) (*i.e.* , one hundred sixty-five thousand dollars ($165,000) for 2013);

(ii) a five percent (5%) owner of the Company or an Affiliate as defined in section 416 of the Code; or

(iii) a one percent (1%) owner of the Company or an Affiliate as defined in section 416 of the Code having compensation of more than one hundred fifty thousand dollars ($150,000).

For purposes of the preceding paragraphs, the Company has elected to determine the compensation of an officer or one percent owner in accordance with section 1.415(c)-2(d)(4) of the Treasury Regulations (*i.e.* , W-2 wages plus amounts that would be includible in wages except for an election under section 125(a) of the Code (regarding cafeteria plan elections), section 132(f) of the Code (regarding qualified transportation fringe benefits), or section 402(e)(3) of the Code (regarding section 401(k) plan deferrals)) without regard to the special timing rules and special rules set forth, respectively, in sections 1.415(c)-2 (e) and 2(g) of the Treasury Regulations.

The determination of Key Employees will be based upon a twelve (12) month period ending on December 31 of each year (*i.e.* , the identification date). Employees who are Key Employees during such twelve (12) month period will

be treated as Key Employees for the twelve (12) month period beginning on the first day of the fourth month following the end of the twelve (12) month period (*i.e.* , since the identification date is December 31, then the twelve (12) month period to which it applies begins on the next following April 1).

The determination of who is a Key Employee will be made in accordance with section 416(i)(1) of the Code and other guidance of general applicability issued thereunder. For purposes of determining whether an employee or former employee is an officer, a five percent owner or a one percent owner, the Company and each Affiliate will be treated as a separate employer (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will not apply). Conversely, for purposes of determining whether the one hundred thirty thousand dollar ($130,000) adjusted limit on compensation is met under the officer test described in Section 2.1(x)(i), compensation from the Company and all Affiliates will be taken into account (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply). Further, in determining who is an officer under the officer test described in Section 2.1(x)(1), no more than fifty (50) employees of the Company or its Affiliates (*i.e.* , the controlled group rules of sections 414(b), (c), (m) and (o) of the Code will apply) will be treated as officers. If the number of officers exceeds fifty (50), the determination of which employees or former employees are officers will be determined based on who had the largest annual compensation from the Company and Affiliates for the Plan Year.

(y) " **Leased Employee** " means each person who is not an employee of the Employer or an Affiliate but who performs services for the Employer or an Affiliate pursuant to an agreement (oral or written) between the Employer or an Affiliate and any leasing organization, provided that such person has performed such services for the Employer or an Affiliate or for related persons (within the meaning of section 144(a)(3) of the Code) on a substantially full-time basis for a period of at least one (1) year and such services are performed under primary direction or control by the Employer or an Affiliate. In the case of any person who is a Leased Employee before or after a Period of Service as an Employee, the entire period during which he has performed services as a Leased Employee will be counted as Service as an Employee for all purposes of the Plan, except that he will not, by reason of that status, become a Member of the Plan.

(z) " **Normal Retirement Age** " means the date the Participant reaches age sixty-five (65).

(aa) " **Participant** " means each Eligible Employee who has elected to participate in the Plan by timely completing the Election Process and whose participation in this Plan has not terminated. Each such Participant who is currently employed by the Employer will be referred to herein as an "Active Participant" and each such Employee who is no longer employed by the Employer or is employed by an Affiliate who has not adopted the Plan but has an Account balance under the Plan will be referred to herein as an "Inactive Participant."

(bb) " **Plan** " means the HealthSouth Corporation Nonqualified 401(k) Plan, as described in this document, and as it may hereafter be amended.

(cc)" **Plan Year** " means the fiscal year of this Plan, which will commence on January 1 each year and end on December 31 of such year, except that the initial Plan Year will commence on March 1 and end on December 31.

(dd) " **Rabbi Trust** " means the grantor trust established by the Company to assist with the payment of benefits under the Plan. The Rabbi Trust will be unfunded within the meaning of ERISA and its assets will be subject to the claims of the Employer's and Affiliate's general creditors. Such Rabbi Trust and its assets will conform to the terms of the model trust, as described in Revenue Procedure 92- 64.

(ee) " **Scheduled In-Service Withdrawal** " means a distribution elected by the Participant pursuant to Section 5.1 for an in-service withdrawal of amounts of Compensation Deferrals, Employer Matching Contributions attributable to such Compensation Deferrals and any Employer Discretionary Contributions made in a given Plan Year, and earnings or losses attributable thereto, as set forth in the Election Process for such Plan Year.

(ff) " **Scheduled In-Service Withdrawal Date** " means the distribution date elected by the Participant for a Scheduled In-Service Withdrawal.

(gg) “ **Spouse** ” means the legal spouse (as defined by applicable state law) of an Eligible Employee (including, effective September 23, 2013, a same sex spouse recognized as such under state law where the marriage was performed), except that such term will not include a common law spouse unless all documentation of the common law marriage required by the Plan Administrator has been received by the Plan Administrator.

(hh) " **Termination of Employment** " means the date that such Employee ceases performing services for the Employer and its Affiliates in the capacity of an Employee. For this purpose an Employee who is on a leave of absence that exceeds six (6) months and who does not have statutory or contractual reemployment rights with respect to such leave, will be deemed to have incurred a Termination of Employment on the first day of the seventh (7th) month of such leave, An Employee who transfers employment from an Employer to an Affiliate, regardless of whether such Affiliate has adopted the Plan as a participating employer, will not incur a Termination of Employment.

(ii) " **Trustee** " means the individual or entity appointed to serve as trustee of any trust established as a possible source of funds for the payment of benefits under the Plan as provided in Section 7.1.

(jj) " **Unforeseeable Emergency** " means a severe financial hardship to the Participant resulting from (i) an illness or accident of the Participant, his Spouse, his beneficiary, or his dependent (as defined under section 152(a) of the Code), (ii) a loss of the Participant's property due to casualty, or (iii) any other similar extraordinary and unforeseeable loss arising from events beyond the control of the Participant, as determined by the Daily Administrator in its sole and absolute discretion in accordance with the requirements of section 409A of the Code.

A distribution on account of Unforeseeable Emergency may only be made to the extent that the Participant's need cannot be relieved through reimbursement or compensation from insurance or otherwise, by liquidation of the Participant's assets, to the extent that liquidation of such assets would not cause a severe financial hardship or by cessation of Compensation Deferrals under the Plan. The amount of the distribution cannot exceed the amount necessary to meet the need (plus any taxes resulting from the distribution).

(kk) " **Year of Vesting Service** " means a Plan year in which an Employee is credited with no less than one thousand (1,000) Hours of Service.

2.2 Construction

If any provision of this Plan is determined to be for any reason invalid or unenforceable, the remaining provisions of this Plan will continue in full force and effect. All of the provisions of this Plan will be construed and enforced in accordance with the laws of the State of Alabama and will be administered according to the laws of such state, except as otherwise required by ERISA, the Code or other applicable federal law. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of the Plan. The masculine gender, where appearing in this Plan, will include the feminine gender, the singular may include the plural; and vice versa, unless the context clearly indicates to the contrary.

2.3 409A Compliance

The provisions of the Plan will be construed and administered in a manner that enables the Plan to comply with the provisions of section 409A of the Code.

End of Article II

ARTICLE III
PARTICIPATION AND VESTING

3.1 Eligibility and Participation

An Employee who is a Participant as of March 1, 2013, will continue as an Active Participant as of such date if such Eligible Employee has timely completed the required Election Process pursuant to Section 4.1. An Employee who becomes an Eligible Employee during a Plan Year, or an Employee hired during a Plan Year who is an Eligible Employee as of his hire date, will become a Participant as of the January 1st of the Plan Year following his initial eligibility to participate in the Plan if such Eligible Employee has timely completed the required Election Process prior to the beginning of such Plan Year. Prior to the beginning of each subsequent Plan Year, each Eligible Employee may elect to defer portions of his Compensation by completing the required Election Process prior to the beginning of the Plan Year.

3.2 Continued Eligibility and Participation

Any Eligible Employee who does not elect to make Compensation Deferrals when he is first eligible, may elect to do so in a subsequent Plan Year by completing the required Election Process prior to the beginning of the Plan Year. Such Eligible Employee will become a Participant as of January 1st of the Plan Year for which he first elects to make Compensation Deferrals. Eligibility to become a Participant for any Plan Year will not entitle an Eligible Person to continue as an Active Participant for any subsequent Plan Year.

3.3 Cessation of Participation

A Participant will cease to be a Participant as of the earlier of:

(a) the date on which the Plan terminates, or

(b) the date on which he receives a distribution of all amounts credited to his Account.

A Participant under this Plan who incurs a Termination of Employment or who continues employment with the Employer but ceases to be eligible to participate in the Plan, will continue as an Inactive Participant under this Plan until the Participant has received a distribution of all amounts credited to his Plan Account; provided, however, that if a Participant ceases active participation in the Plan because he ceases to be an Eligible Employee, his Compensation Deferrals will continue for the remainder of the Plan Year in which such loss of eligibility occurs, but such Participant will not be eligible to make future Compensation Deferrals until he again qualifies as an Eligible Employee.

End of Article III

ARTICLE IV
CONTRIBUTIONS AND ACCOUNTING

4.1 Deferral Elections

An Eligible Employee may become a Participant by electing to defer Compensation pursuant to the required Election Process. Such Election Process will be completed prior to the first day of the Plan Year for which the election is effective. A Participant's deferral election will only be effective with respect to a single Plan Year and will be irrevocable for the duration of such Plan Year, except as provided in Article V regarding Unforeseeable Emergency distributions. Deferral elections for each subsequent Plan Year of participation will be made pursuant to a new election for such Plan Year.

An Eligible Employee who is an Active Employee may elect to have a sum equal to at least one percent (1%) but not more than one hundred percent (100%) of his Compensation which otherwise would have been paid to him by the Employer deferred under the Plan as a Compensation Deferral. The Daily Administrator may allow such Employee to make a separate and distinct deferral election with regard to any amounts of Compensation classified by the Employer as a bonus if such election is completed prior to the first day of the Plan Year during which the services are performed that give rise to the bonus, regardless of when the bonus would otherwise be paid but for such deferral election. An Eligible Employee's deferral election (including his separate and distinct deferral election with respect to his bonus, if any) must specify, in the format adopted by the Company as part of its Election Process, the time and manner in which his Compensation Deferral for each Plan Year will be paid, in accordance with the benefit distribution options set forth in Article V. An Eligible Employee may make a separate and distinct distribution election with respect to each Plan Year in which he elects to make a Compensation Deferral to the Plan. The Eligible Employee may not modify his election as to the manner in which a Compensation Deferral will be paid.

Compensation Deferrals will be made pursuant to administrative procedures established by the Plan Administrator. Such procedures will provide that Compensation Deferrals will be subject to a "withholding hierarchy" for purposes of determining the amount of such contributions that may be contributed on behalf of a Participant. The Plan Administrator (or its delegates) will determine the order of withholdings taken from a Participant's Compensation (*e.g.* , for federal, state and local taxes, social security, wage garnishments, welfare plan contributions, 401(k) deferrals, and similar withholdings) and Compensation Deferrals will be subject to such withholding hierarchy. As a result, Compensation Deferrals may be effectively limited to Compensation available after the application of such withholding hierarchy (*i.e.* , the Participant may not be able to defer one hundred percent (100% of his Compensation).

4.2 Company Contributions

(a) **Employer Matching Contribution** . Each Plan Year, the Employer will make an Employer Matching Contribution to the Plan for each Participant who makes Compensation Deferrals pursuant to Section 4.1 above. Such Employer Matching Contribution will equal fifty percent (50%) of the first six percent (6%) of the Participant's Compensation contributed to the Plan as a Compensation Deferral offset by any Employer Matching Contributions made to the HealthSouth Corporation Retirement Investment Plan (the

"Retirement Plan") on behalf of such Participant (*i.e.* , the total of Employer Matching Contributions that a Participant may receive between this Plan and the Retirement Plan will equal fifty percent (50%) of the first six percent (6%) of the Participant's Compensation contributed to both this Plan as Compensation Deferrals and the Retirement Plan as Salary Deferral Contributions (as defined in the Retirement Plan).

(b) **Employer Discretionary Contribution** . The Employer may elect to make an Employer Discretionary Contribution to the Plan at such time and in such amount as may be determined by the Compensation Committee.

4.3 Vesting

(a) **Participant Deferrals** . A Participant will be one hundred percent (100%) vested in the Compensation Deferrals credited to his Account, including the earnings and losses thereon.

(b) **Employer Matching Contributions** . A Participant will become vested in Employer Matching Contributions made on his behalf to the Plan in accordance with the following schedule:

Years of Vesting Service	Percentage Vested
2 or fewer years	0%
3 or more years	100%

Notwithstanding the foregoing, a Participant will become fully vested in his Employer Matching Contributions when he reaches his Normal Retirement Age, dies or incurs a Disability (in each such case while an Employee), without regard to his Years of Vesting Service. Any portion of a Participant's Account that has not become vested, as herein provided, will be forfeited.

(c) **Employer Discretionary Contributions** . Each Employer Discretionary Contribution may be subject to a vesting schedule, as determined by the Compensation Committee, in its sole discretion, at the time such Employer Discretionary Compensation is elected to be made to the Plan.

Notwithstanding the foregoing, as provided in Section 7.2, each Participant will be only a general creditor of the Company and/or Employer with respect to the payment of any benefit under this Plan.

4.4 **Plan Benefits**

The benefits to which a Participant and, if applicable, his Beneficiary are entitled under the Plan will consist of the Compensation Deferrals, Employer Matching Contributions and any Employer Discretionary Contributions credited to such Participant's Account, plus earnings thereon and less losses allocable thereto, if any, attributable to the investment of such amounts pursuant to Section 4.5(c) hereof. Distribution of benefits

attributable to a Participant's Account(s) will be made pursuant to the provisions of Article V.

4.5 **Accounting for Deferred Compensation**

(a) **Establishment of Accounts** . The Daily Administrator will establish and maintain an individual Account under the name of each Participant under the Plan. Further, in the sole discretion of the Daily Administrator, additional Accounts may be established for each Participant to facilitate record keeping convenience and accuracy. Each such Account will be credited and adjusted as provided in this Plan. Such Account will be maintained until all amounts credited to such Account have been distributed in accordance with the terms and provisions of this Plan. The establishment and maintenance of a separate Account or Accounts for each Participant will not be construed as giving any person any interest in assets of the Company or an Affiliate, or a right to payment other than as provided hereunder. Amounts credited to such Accounts will be held with the general assets of the Employer.

(b) **Crediting Accounts** . All amounts deferred under the Plan as Compensation Deferrals will be credited to the Participant's Account at the end of the pay period during which such Compensation would have otherwise been paid to the Participant. The amount of Employer Matching Contributions to be contributed to the Plan on the Participant's behalf will be computed on the last day of each month and will be contributed as soon as administratively practicable after such computation. Any Employer Discretionary Contributions made to the Plan will be credited to the Participant's Account at the time such contributions are made.

(c) **Adjustment of Accounts** . Each Account will be adjusted on each business day that the New York Stock Exchange is open to reflect the Compensation Deferrals, Employer Matching Contributions and any Employer Discretionary Contributions made to the Plan, any earnings credited on such Compensation Deferrals, Employer Matching Contributions and Employer Discretionary Contributions pursuant to this Section 4.5(c), and any payment of such Compensation Deferrals, Employer Matching Contributions and Employer Discretionary Contributions under the Plan.

(i) **Participant Investment Recommendations** . For purposes of measuring the investment returns of the Participant's Account(s), the Participant may select the Investment Options in which all or part of his Account(s) will be deemed to be invested. The Participant will make his initial investment designation in the Enrollment Process and such an investment designation will remain effective until it is subsequently changed by the Participant pursuant to this Section 4.5(c). The Participant may change his investment designation each Plan Year at the time and manner specified by the Daily Administrator. The Participant may change the investment allocation of his existing Account(s) at the time and manner specified by the Daily Administrator. During the Plan Year, a Participant may elect to make transfers of his Account(s) among the Investment Options by written, telephonic or electronic means at the time and manner specified by the Daily Administrator.

(ii) **Benefits Committee Investment Designation** . Notwithstanding the foregoing, the Benefits Committee in its sole and absolute discretion may direct the Daily Administrator to disregard the Participant's investment designation and determine that all interests in the Account(s) will be deemed to be invested in one particular or a mixture of the Investment Options. Likewise, if a Participant fails to make any investment recommendations, the Daily Administrator will invest the Participant's Account(s) in any default investment fund established under the Plan by the Benefits Committee or in such other manner as the Benefits Committee deems appropriate in its sole and absolute discretion.

End of Article IV

ARTICLE V
DISTRIBUTION OF BENEFITS

5.1 General Rule Regarding Payment of Account

Subject to Section 5.6, Compensation Deferrals made in accordance with Section 4.1 and Employer Matching Contributions and Employer Discretionary Contributions made in accordance with Section 4.2 will be distributed to a Participant (i) upon the Participant's Termination of Employment or (ii) in a future year in which the Participant is still employed by the Employer and that is at least three (3) calendar years after the end of the Plan Year in which the Compensation would have otherwise been paid, but within forty (40) calendar years of the first day of the Plan Year in which such Compensation would have otherwise been paid (*i.e.* , as a Scheduled In-Service Withdrawal, subject to the provisions of Section 5.2). Amounts paid by reason of a Termination of Employment will be subject to the six (6) month delay applicable to Key Employees under Section 5.6.

Prior to the Plan Year commencing in 2014, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment before his Scheduled In-Service Withdrawal date, his Scheduled In-Service Withdrawal election will be cancelled and of no effect and such amounts will be paid according to the Participant’s distribution election with respect to his Employer Matching Contributions and Employer Discretionary Contributions, if any, for the Plan Year in which his related Compensation Deferrals were made (*i.e.* , in accordance with the Participant's Termination of Employment distribution election with respect to such Employer Matching Contributions or Employer Discretionary Contributions), subject to the six (6) month delay applicable to Key Employees under Section 5.6. If a Participant does not have a Termination of Employment distribution election on file with respect to the Plan Year in which Employer Matching Contributions and any Employer Discretionary Contributions were made, such amounts will be paid in a single lump sum distribution upon his Termination of Employment (subject to the six (6) month delay applicable to Key Employees under Section 5.6).

Commencing for the 2014 Plan Year and thereafter, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment before his Scheduled In-Service Withdrawal date, his Scheduled In-Service Withdrawal election will be cancelled and of no effect and such amounts will be paid in a single lump sum distribution upon his Termination of Employment (subject to the six (6) month delay applicable to Key Employees under Section 5.6).

5.2 Subsequent Deferral of Scheduled In-Service Withdrawals

A Participant who elects a Scheduled In-Service Withdrawal pursuant to Section 5.1 may subsequently elect to delay such distribution beyond the date specified in his initial deferral election, provided that:

(a) such distribution is deferred for a period of at least five (5) years from the date such amounts would otherwise be paid,

(b) such distribution election does not defer such distribution more than forty (40) calendar years from the first day of the Plan Year in which such Compensation would have otherwise been paid, and

(c) the Participant makes such subsequent deferral election at least twelve (12) months before the date such amounts would otherwise be paid (*i.e.* , before the date certain and not more than thirty-five (35) years after the first day of the Plan Year in which such Compensation would have otherwise been paid).

A Participant may elect to postpone his Scheduled in-Service Withdrawal date up to two (2) times pursuant to this Section 5.2. A Participant may not elect pursuant to this Section 5.2 to delay a distribution that will be made upon his Termination of Employment.

If a Participant makes a subsequent deferral election within twelve (12) months from the date such amounts would otherwise be paid (*i.e.* , within twelve (12) months of the date certain on which such distribution would otherwise be made), such subsequent deferral election will be of no effect and the Participant's Compensation Deferrals subject to such election will be paid according to the Participant's initial deferral election.

5.3 Distributions on Death

In the event of a Participant's death prior to the distribution of all amounts credited to his Account, the Participant's Account balance will be paid in a single lump sum to his Beneficiary within ninety (90) days following the date of the Participant's death. If the Participant had been receiving annual installments from amounts credited to his Account under the Plan, the remainder of such annual installments will continue to be paid to the Participant's Beneficiary. This six (6) month restriction applicable to Key Employees under Section 5.6 will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

5.4 Distributions on Disability

In the event of the Participant's Disability prior to the receipt of his entire Account, he will receive amounts credited to such Account in accordance with the terms of Section 5.1 (*i.e.* , at Termination of Employment or as a Scheduled In-Service Withdrawal). Alternatively, if the Participant elects, he may apply to the Daily Administrator for an Unforeseeable Emergency distribution pursuant to Section 5.5 of the Plan.

5.5 Unforeseeable Emergency

A Participant who is an Active Employee or who has incurred a Disability may submit a written application to the Daily Administrator for an earlier distribution of amounts credited to his Account on account of an Unforeseeable Emergency. The existence

of an Unforeseeable Emergency will be determined by the Daily Administrator in its sole and absolute discretion. In the event that the Daily Administrator determines an Unforeseeable Emergency exists, it may permit the Participant to receive a distribution of all or a portion of his Account as necessary to satisfy such Unforeseeable Emergency as provided under the final regulations issued under section 409A. Specifically, the amount distributable on account of an Unforeseeable Emergency must be limited to the amount reasonably necessary to satisfy the emergency need (which may include amounts necessary to pay any Federal, state or local income taxes or penalties reasonably anticipated to result from the distribution). The determination of an Unforeseeable Emergency must take into account any additional compensation that is available by reason of the cessation of the Participant's Compensation Deferrals to the Plan pursuant to this Section 5.5. However, such determination is not required to take into account additional compensation that could be paid to the Participant, but which has not actually been paid, under any other nonqualified deferred compensation plan in which the Participant is a member or pursuant to the provisions of Article V of this Plan. An Unforeseeable Emergency distribution to an Active Employee will result in the suspension of his Compensation Deferrals to the Plan for the remainder of the Plan Year in which the Unforeseeable Emergency distribution occurs.

5.6 Time and Form of Payment

Prior to the Plan Year commencing in 2014, any Scheduled In-Service Withdrawal distribution will be paid in the form of a single lump sum in March of the year specified by the Participant in accordance with Section 5.1. Effective for the 2014 Plan Year and thereafter, such Scheduled In-Service Withdrawal distribution will be paid in the form of a single lump sum in January of the year specified by the Participant in accordance with Section 5.1

Upon Termination of Employment, the Participant's entire Account balance will be distributed in the form of either (i) a single lump sum or (ii) in a series of between two (2) and fifteen (15) equal annual installments with the final payment being a distribution of one hundred percent (100%) of the Account balance, as elected by the Participant in accordance with Section 4.1 and Section 5.1. The Participant may not modify his election as to the form of distribution upon Termination of Employment.

To the extent that a Participant has elected to receive installment distributions upon his Termination of Employment, such installment distributions will only be paid if the value of the Participant's Accounts upon Termination of Employment exceeds Ten Thousand Dollars ($10,000). If such Accounts equal Ten Thousand Dollars ($10,000) or less, such Accounts will be paid in the form of a lump sum payment. Further, in the event that the Participant elects a Scheduled In-Service Withdrawal and incurs a Termination of Employment prior to the Scheduled In-Service Withdrawal Date, the Participant's Scheduled In-Service Withdrawal election will be cancelled and payable in accordance with the provisions of Section 5.1 of this Plan.

A lump sum payment of amounts credited to a Participant's Account will be made as soon as administratively possible following the date the Participant is entitled to a distribution under this Article V but in no event more than sixty (60) days following the date entitling the Participant to such distribution. The first annual installment payment of amounts credited to a Participant's Account will be made as soon as administratively possible following the date the Participant is entitled to a distribution under this Article V but in no event more than (60) days following the date entitling the Participant to such distribution. Subsequent installment payments of the Participant's Account will be made in March or, effective January 1, 2014, January of each year thereafter.

As provided in Section 4.1, if the Participant does not specify the time and form of payment with respect to his Account under the Plan, such Account balance will be distributed to the Participant upon his Termination of Employment in a single lump sum.

Notwithstanding the foregoing, distributions under this Plan that are payable to a Key Employee on account of a Termination of Employment will be delayed for a period of six (6) months and one (1) day following such Participant's Termination of Employment. This six (6) month restriction will not apply, or will cease to apply, with respect to a distribution to a Participant's Beneficiary by reason of the death of the Participant.

End of Article V

ARTICLE VI
PAYMENT LIMITATIONS

6.1 Payment Due an Incompetent

If a person entitled to any payment under this Plan is, in the sole judgment of the Daily Administrator, under a legal disability, or is otherwise unable to apply such payment to his own interest and advantage, the Daily Administrator, in the exercise of its discretion, may direct the Employer or payor of the benefit to make any such payment in any one (1) or more of the following ways:

(a) Directly to such person;

(b) To his legal guardian or conservator; or

(c) To his Spouse or to any person charged with the duty of his support, to be expended for his benefit and/or that of his dependents.

The decision of the Daily Administrator will in each case be final and binding upon all persons in interest.

6.2 Nonalienation of Benefits

To the extent permitted by law, benefits payable under this Plan will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary except that the Plan will recognize the division of benefits between the Participant and his Spouse in connection with a divorce. However, no benefit awarded to the Spouse pursuant to such divorce will be payable to such Spouse until the time the Participant is entitled to receive a distribution of benefits from the Plan. The benefit payable to the Spouse will be paid in the form of a lump sum cash payment as soon as practicable following the event entitling the Participant to a distribution but in no event more than ninety (90) days after such distribution event.

Any unauthorized attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder will be void. No part of the assets of the Employer will be subject to seizure by legal process resulting from any attempt by creditors of or claimants against any Participant (or beneficiary), or any person claiming under or through the foregoing, to attach his interest under the Plan.

End of Article VI

ARTICLE VII
FUNDING

7.1 Funding

Benefits under the Plan will constitute general unfunded obligations of the Employer in accordance with the terms of the Plan. No amounts in respect of such benefits will be set aside or held in trust, and no recipient of any benefit under this Plan will have any right to have the benefit paid out of any particular assets of the Employer; provided, however, that the Company may establish a Rabbi Trust to assist with the payment of benefits under the Plan. The assets of any such Rabbi Trust will be subject to the claims of the Employer's and the Affiliate's general creditors. Such Rabbi Trust and its assets will conform to the terms of the model trust, as described in Revenue Procedure 92-64.

7.2 Creditor Status

Participants have the status of general unsecured creditors of the Employer and this Plan constitutes the Employer's promise to make benefit payments as described herein. It is the intention of the parties to this Plan and any companion Rabbi Trust that benefits under this Plan be unfunded for tax purposes and for purposes of Title I of ERISA.

End of Article VII

ARTICLE VIII
ADMINISTRATION

8.1 Appointment of Benefits Committee

Responsibility for administration of this Plan will be with the Benefits Committee who will be the named Plan Administrator. The Benefits Committee will be appointed by the Compensation Committee. If the Compensation Committee fails to appoint a Benefits Committee, it will serve as the Benefits Committee. The members of the Benefits Committee will not receive compensation with respect to their services for the Benefits Committee. The members of the Benefits Committee will serve without bond or security for the performance of their duties under the Plan unless the applicable law makes the furnishing of such bond or security mandatory or unless required by the Compensation Committee.

8.2 Committee Powers and Duties

The Benefits Committee will have sole and absolute discretion regarding the exercise of its powers and duties under this Plan. Such powers and duties will include, but not be limited to, the following powers and duties as may be necessary to discharge its responsibilities under the Plan:

(a) to appoint a Daily Administrator to handle the day-to-day administration of the Plan pursuant to Section 8.3, and, if applicable, to appoint the Trustee of the Rabbi Trust;

(b) to construe and interpret the Plan, decide all questions of eligibility, determine the amount, manner and time of payment of any benefits under the Plan and make final determinations regarding all benefit claims;

(c) to prescribe rules for the operation of the Plan;

(d) to receive from the Employer and from Employees such information as will be necessary for the proper administration of the Plan;

(e) to make any necessary filings with the appropriate government agency;

(f) to furnish any Employee or Beneficiary, who requests in writing, statements indicating such Employee's or Beneficiary's total Account balances;

(g) to maintain all records necessary for the administration of the Plan;

(h) to select the Investment Options under the Plan;

(i) to report to the Trustee of the Rabbi Trust all available information regarding the amount of benefits payable to each Employee, the computations with respect to the allocation of assets, and any other information which the Trustee may require;

(j) to delegate to one or more of the members of the Benefits Committee the right to act in its behalf in all matters connected with the administration of the Plan and Rabbi Trust;

(k) to delegate to any individual such of the powers and duties as the Benefits Committee deems appropriate; and

(l) to appoint or employ for the Plan any agents it deems advisable, including, but not limited to, legal counsel.

Except as provided in Section 10.1, the Benefits Committee will have no power to add to, subtract from or modify any of the terms of the Plan, nor to change or add to any benefits provided by the Plan, nor to waive or fail to apply any requirements of eligibility for benefits under the Plan. All rules and decisions of the Benefits Committee will be uniformly and consistently applied to all Employees in similar circumstances.

A majority of the members of the Benefits Committee will constitute a quorum for the transaction of business. No action will be taken except upon a majority vote of the Benefits Committee members. An individual will not vote or decide upon any matter relating solely to himself or vote in any case in which his individual right or claim to any benefit under the Plan is particularly involved.

8.3 Appointment of Daily Administrator

The Compensation Committee or the Benefits Committee will appoint the Daily Administrator who will have the responsibility and duty to administer the Plan on a daily basis in a nondiscretionary manner. The Compensation Committee or the Benefits Committee may remove the Daily Administrator with or without cause at any time. The Daily Administrator may resign upon written notice to the Benefits Committee.

8.4 Daily Administrator Powers and Duties

The Daily Administrator will have the following duties:

(a) to direct the administration of the Plan in accordance with its terms;

(b) to adopt rules of procedure and regulations necessary for the administration of thePlan, provided such rules are not inconsistent with the terms of the Plan;

(c) to determine all questions with regard to rights of Employees, Participants, and Beneficiaries under the Plan including, but not limited to, questions involving eligibility of an Employee to participate in the Plan and the value of the Participant's vested Account;

(d) to enforce the terms of the Plan and any rules and regulations adopted by the Benefits Committee;

(e) to review and render decisions respecting an initial claim for a benefit under the Plan;

(f) to furnish the Employer with information which the Employer may require for tax or other purposes;

(g) to engage the service of counsel (who may, if appropriate, be counsel for the Employer), actuaries, and agents whom it may deem advisable to assist it with the performance of its duties;

(h) to prescribe procedures to be followed by distributees in obtaining benefits;

(i) to receive from the Employer and from Employees such information as is necessary for the proper administration of the Plan;

(j) to receive and review reports from the Trustee of the financial condition and receipts of disbursements from the Rabbi Trust;

(k) to establish and maintain, or cause to be maintained, the individual Account(s) described in Section 2.1 (a);

(l) to create and maintain such records and forms as are required for the efficient administration of the Plan;

(m) to make all determinations and computations concerning the benefits, credits and debits to which any Participant, or other Beneficiary, is entitled under the Plan;

(n) to give the Trustee specific directions in writing with respect to:

(i)the making of distribution payments, giving the names of the payees, the amounts to be paid and the time or times when payments will be made; and

(ii) the making of any other payments which the Trustee is not by the terms of the Trustee Agreement authorized to make without

a direction in writing by the Daily Administrator;

(o) to prepare, or cause to be prepared, an annual report for the Employer, as of the last day of each Plan Year, in such form as may be required by the Employer;

(p) to determine and maintain records of the age and amount of Compensation, Hours of Service, and Service of each Employee;

(q) to comply (or transfer responsibility for compliance to the Trustee) with all applicable Federal income tax withholding requirements for benefit distributions; and

(r) to construe the Plan, in its sole and absolute discretion, and make equitable adjustments for any mistakes and errors made in the administration of the Plan.

The foregoing list of express duties is not intended to be either complete or conclusive, and the Daily Administrator will, in addition, exercise such other powers and perform such other duties as it may deem necessary, desirable, advisable or proper for the supervision and administration of the Plan.

8 .5 Claim Procedures

(a)**Initial Claim** . In the event that an Employee, Eligible Employee, Participant or his Beneficiary claims to be eligible for benefits, or claims any rights under this Plan, such Claimant must complete and submit such claim forms and supporting documentation as will be required by the Daily Administrator, in its sole and absolute discretion. Likewise, any Participant or Beneficiary who feels unfairly treated as a result of the administration of the Plan must file a written claim, setting forth the basis of the claim, with the Daily Administrator. In connection with the determination of a claim, or in connection with review of a denied claim, the Claimant may examine this Plan, and any other pertinent documents generally available to Participants that are specifically related to the claim.

A written or electronic notice of the disposition of any such claim will be furnished to the Claimant within ninety (90) days after the claim is filed with the Daily Administrator. Such notice will refer, if appropriate, to pertinent provisions of this Plan, will set forth in writing the reasons for denial of the claim if a claim is denied (including references to any pertinent provisions of this Plan) and, where appropriate, will describe any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary. If the claim is denied, in whole or in part, the Claimant will also be notified of the Plan's claim review procedure, including the Claimant's right to file an action under section 502(a) of ERISA, and the time limits applicable to such procedures following an adverse decision regarding his claim on review as provided below. All benefits provided in this Plan as a result of the disposition of a claim will be paid as soon as practicable following receipt of proof of entitlement, if requested.

(b) **Request for Review** . Within ninety (90) days after receiving the notice of the Daily Administrator's disposition of the claim, the Claimant may file with the

Benefits Committee a written request for review of his claim. In connection with the request for review, the Claimant will be entitled to be represented by counsel and will be given, upon request and free of charge, reasonable access to all pertinent documents for the preparation of his claim. If the Claimant does not file a written request for review within ninety (90) days after receiving notice of the Daily Administrator's disposition of the claim, the Claimant will be deemed to have accepted the Daily Administrator's written or electronic disposition, unless the Claimant was physically or mentally incapacitated so as to be unable to request review within the ninety (90) day period.

(c) **Decision on Review** . After receipt by the Benefits Committee of a written application for review of his claim, the Benefits Committee will review the claim taking into account all comments, documents, records and other information submitted by the Claimant regarding the claim without regard to whether such information was considered in the initial benefit determination. The Benefits Committee will notify the Claimant of its decision by delivery or by certified or registered mail to his last known address. A decision on review of the claim will be made by the Benefits Committee within sixty (60) days following receipt of the written application for review. If special circumstances require an extension of the sixty (60) day period, the Benefits Committee will so notify the Claimant and a decision will be rendered within one hundred-twenty (120) days of receipt of the request for review. In any event, if a claim is not determined by the Benefits Committee within one hundred-twenty (120) days of receipt of written submission for review, it will be deemed to be denied.

The decision of the Benefits Committee will be provided to the Claimant as soon as possible but no later than five (5) days after the benefit determination is made. The decision will be in writing or electronic and will include the specific reasons for the decision presented in a manner calculated to be understood by the Claimant and will contain references to all relevant Plan provisions on which the decision was based. Such decision will also advise the Claimant that he may receive upon request, and free of charge, reasonable access to and copies of all documents, records and other information relevant to his claim and that he may file an action under section 502(a) of ERISA in the case of an adverse decision regarding his claim on review. The decision of the Benefits Committee will be final and conclusive.

8.6 Benefits Committee Procedures

The Benefits Committee may adopt such bylaws as it deems desirable. The Benefits Committee will elect one of its members as chairman and will elect a secretary who may, but need not, be a member of the Benefits Committee.

End of Article VIII

ARTICLE IX

OTHER BENEFIT PLANS OF THE COMPANY

9.1 Other Plans

Nothing contained in this Plan will prevent a Participant prior to his death, or his Spouse or other Beneficiary after his death, from receiving, in addition to any payments provided for under this Plan, any payments provided for under any other plan or benefit program of the Company or an Affiliate, or which would otherwise be payable or distributable to him, his surviving Spouse or Beneficiary under any plan or policy of the Company or an Affiliate or otherwise. Nothing in this Plan will be construed as preventing the Company or any of its Affiliates from establishing any other or different plans providing for current or deferred compensation for employees. Unless specifically provided otherwise in any plan of the Company intended to "qualify" under section 401 of the Code, Compensation deferrals made under this Plan will not constitute earnings or compensation for purposes of determining contributions or benefits under such qualified plan.

End of Article IX

ARTICLE X
MISCELLANEOUS

10.1 Amendment

The Compensation Committee may, by resolution, in its absolute discretion, from time to time, amend, any or all of the provisions of the Plan. In addition, the Benefits Committee may amend the Plan to comply with changes in the law or to implement administrative or design changes that will not materially increase the cost of the Plan to the Company. No such amendment may adversely impact the amount of benefits a Participant has accrued under the Plan at such time except to the extent required by applicable law.

10.2 Termination

The Compensation Committee may, by resolution, in its absolute discretion, terminate the Plan in whole or part at any time; provided, that no such termination may adversely impact the amount of benefits a Participant has accrued under the Plan at such time except to the extent required by applicable law. Any termination of the Plan will comply with the provisions of section 409A of the Code as set forth in this Section 10.2.

The Plan may be terminated and liquidated under the following circumstances:

(a) **Corporate Dissolution or Bankruptcy** . The Compensation Committee may terminate and liquidate the Plan within twelve (12) months of a corporate dissolution taxed under section 331 of the Code or with the approval of a bankruptcy court pursuant to 11 U.S.C. § 503(b)(1)(A), provided that the amounts deferred under the Plan are included in Participants; gross incomes in the latest of the following years (or if earlier, the taxable year in which the amount is actually or constructively received):

(i) The calendar year in which the Plan termination and liquidation occurs.

(ii) The first calendar year in which the amount is no longer subject to a substantial risk of forfeiture.

(iii) The first calendar year in which the payment is administratively practicable.

(b) **Change in Control** . The Compensation Committee may terminate and liquidate the Plan within the thirty (30) days preceding or the twelve (12) months following a change in control event, as defined in Treasury Regulation section 1.409A-3(i)(5)), provided that all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated with respect to each Participant that experienced the change in control event so that under the terms of the Plan and all such arrangements the Participant is required to receive all amounts of compensation deferred under such arrangements within twelve (12) months of the termination of the Plan or arrangement, as applicable. In the case of a change of control event which constitutes a sale of assets, the termination of the Plan pursuant to this Section 10.2(b) may be made with respect to the Employer that is primarily liable immediately after the change of control transaction for the payment of benefits under the Plan.

(c) **Termination of Plan** . The Compensation Committee may terminate and liquidate the Plan provided that (i) the termination and liquidation does not occur by reason of a downturn of the financial health of the Company or an Employer, (ii) all plans or arrangements that would be aggregated with the Plan under section 409A of the Code are also terminated and liquidated, (iii) no payments in liquidation of the Plan are made within twelve (12) months of the date of termination of the Plan other than payments that would be made in the ordinary course operation of the Plan, (iv) all payments are made within twenty-four (24) months of the date the Plan is terminated and (v) the Company or the Employer, as applicable depending on whether the Plan is terminated with respect to such entity, do not adopt a new plan that would be aggregated with the Plan within three (3) years of the date of the termination of the Plan.

10.3 Nonguarantee of Employment

Nothing contained in this Plan will be construed as a contract of employment between the Employer and any Employee, or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

10.4 Indemnification

The Company will indemnify each of its Compensation Committee members and Benefits Committee members against any and all claims, loss, damages, expense (including reasonable counsel fees), and liability arising from any action, failure to act, or other conduct in the member's official capacity, except when due to such Compensation Committee or Benefits Committee's member's own gross negligence or willful misconduct.

10.5 Withholding

The Employer or its designee will withhold from any benefit payments made under this Plan, the required amounts of federal, state or local income or other applicable taxes.

10.6 Expenses

The Employer will pay all costs and expenses incurred in operating and administering the Plan. Such costs and expenses will be paid by the Employer from its general assets or the Rabbi Trust.

End of Article X

APPENDIX A

SERVICE CREDITING

Participant Vesting for Certain Acquisitions or Business Transactions

An individual who becomes an Employee of the Employer or an Affiliate and a Participant in the Plan in connection with an acquisition (either stock, partnership interest or assets) or a similar business transaction (such as an outsourcing or employee leasing arrangement) will be given credit for his prior service with the seller, outsourcing entity or leasing company, as applicable, for vesting purposes under the Plan if the terms of the acquisition agreement, business transaction documents or an action of the Employer or an Affiliate so provides. This prior vesting service credit applies with respect to the following acquisitions and business transactions:

Acquisition or Transaction	Effective Date

No further action except amending this schedule under Appendix A by the Daily Administrator will be necessary to reflect prior service granted to employees of acquired entities or groups by the Company.

This Appendix A may be updated from time to time without the need for formal amendment to the Plan in which case an updated appendix A will be attached hereto.

APPENDIX B

DOMESTIC PARTNER GUIDELINES FOR THE HEALTHSOUTH CORPORATION GROUP LIFE, AD&D, DISABILITY AND MEDICAL PLAN AND THE HEALTHSOUTH CORPORATION RETIREMENT INVESTMENT PLAN

HealthSouth Corporation (" **HealthSouth"**) adopts this Domestic Partner Guidelines (the " **Guidelines** ") to extend group health, dental and vision coverage under the HealthSouth Corporation Group Life, AD&D, Disability and Medical Plan (the " **Group Health Plan" or "GHP** ") to the " **Domestic Partner** " (as defined below) of an eligible employee of HealthSouth (" **Employee** ") and to the children of a Domestic Partner up to age 26.

The Guidelines also provide that a participant's Domestic Partner will be the default beneficiary for purposes of the HealthSouth Corporation Retirement Investment Plan (the " **401(k) Plan** ") and the HealthSouth Corporation Nonqualified 401(k) Plan (the " **Nonqualified 401(k) Plan** ") in situations where the participant dies without designating a beneficiary in accordance with the requirements of the 401(k) Plan and the Nonqualified 401(k) Plan.

The applicable requirements of the Guidelines are outlined below. Together, the GHP, the 401(k) Plan and the Nonqualified 401(k) Plan are referred to herein as the " **Plans** ".

PART A - DOMESTIC PARTNERSHIP DEFINED

A Domestic Partnership is defined as follows:

For purposes of the Plans, a domestic partner consists of an eligible Employee and one other person of the same or opposite sex (a " **Domestic Partner** ").

A Domestic Partnership must satisfy the following requirements:

Each partner must be the other's sole domestic partner and must intend to remain so indefinitely. The partners must have an exclusive mutual commitment similar to that of marriage and:

(a) Each partner must be at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;

(b) The partners must share the same permanent residence and have done so for at least 12 months;

(c) The partners cannot be related by blood to a degree that would prohibit marriage;

(d) The partners cannot be legally married to each other or anyone else or in a domestic partnership with another individual nor have had another domestic partner within the prior six months;

(e) The partners must share the same permanent address and must be able to provide their driver's licenses listing the common address;

(f) The partners must share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;

(g) The partners must each be mentally competent to consent to contract; and

(h) The partners must be financially interdependent, demonstrated by at least two of the following:

i. Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;

ii. Common ownership of a motor vehicle;

iii. Joint ownership of a residence; or evidence of a joint mortgage or lease;

iv. Evidence of common household expenses, *e.g.* utility, phone;

v. Execution of wills naming each other as executor and/or beneficiary;

vi. Granting each other durable powers of attorney; or

vii. Designation of each other as beneficiary under a retirement benefit account.

Notwithstanding the foregoing, the Plans will recognize an individual as a Domestic Partner of an Employee if the Domestic Partnership has been registered with any state or local government registry recognizing domestic partnerships and the Domestic Partnership meets the requirements of such registry or if the domestic partners have entered into a legal civil union in any state recognizing such civil union.

Dependent Children of Domestic Partners include the following individuals:

For purposes of the GHP, children of a Domestic Partner (" **Dependent Children** ") are eligible for coverage under any GHP that provides dependent coverage when they are:

(a) A "child" as defined in the GHP (*e.g.* , a natural child of the Domestic Partner, step child of the Domestic Partner or adopted child of the Domestic Partner);

(b) Unmarried; and

(c) Under the age of 26.

Obtaining Domestic Partner Coverage:

In order to obtain Domestic Partner status for purposes of the Plans, the Employee and Domestic Partner must complete and file with Human Resources, the **Affidavit Declaring Domestic Partnership** (the " **Affidavit** "), attached hereto. *For purposes of the GHP* , such Affidavit must be filed at annual enrollment. *For purposes of the 401(k) Plan and the Nonqualified 401(k) Plan* , such Affidavit may be filed at any time. However, if the Affidavit is not filed during an annual enrollment period, GHP coverage for the Domestic Partner will not begin until after the next annual enrollment period, unless the Domestic Partner loses other group health coverage during the plan year and is entitled to a mid-year entry under the plan's HIPAA special enrollment provisions that apply in the case of a loss of other group health coverage. Note, due to federal law, a same sex Domestic Partner may not be enrolled in a GHP mid-year under the HIPAA special enrollment provisions that apply in the case of acquisition of dependent. Likewise, mid-year enrollment of a same sex Domestic Partner as a "change in status" (as defined in the GHP) is also not permitted by federal law. In the case of an opposite sex Domestic Partner, mid-year enrollment on account of an acquisition of dependent or as a "change in status" is only possible if the Domestic Partner qualifies as the Employee's Spouse under state law.

To the extent that the Domestic Partner has Dependent Children, such children may be enrolled pursuant to the terms of the GHP at the same time the Domestic Partner is enrolled; provided, the children satisfy the definition of Dependent Children above. Dependent Children may also be entitled to mid-year enrollment under the plan's HIPAA special enrollment provisions that apply in the case of acquisition of a child or a loss of other group health coverage. Dependent Children may also be entitled to mid-year enrollment on account of a "change in status."

Termination of a Domestic Partnership:

(a) Each Employee with a Domestic Partner has an obligation to notify "change in status", by filing the **Declaration of Termination of Domestic Partnership** (attached hereto), if there is any change in

the Domestic Partnership status as attested to in the Affidavit that would terminate such partnership (such as the death of a Domestic Partner, a change in residence of one partner, termination of the relationship, etc.). **The Employee must notify Human Resources within thirty-one (31) days of such change in the Domestic Partnership for purposes of the GHP.**

(b) Upon termination of the Domestic Partnership, the GHP coverage of the Domestic Partner who is not an employee as well as coverage of any Dependent Children of such Domestic Partner will cease, unless the Dependent Children continue to satisfy the definition of Dependent Children under the GHP (*i.e.* , are unmarried and under the age of 26). Termination of such coverage (obtained as a result of completion of the **Declaration of Termination of Domestic Partnership**) will be effective on the date the relationship ends as indicated on such form.

(c) In the event a Domestic Partnership is terminated for reasons other than death of a Domestic Partner, an Employee cannot re-enroll for Domestic Partnership coverage under the GHP until six months from the date the Domestic Partnership ended.

(d) A Domestic Partner will no longer be the Participant's default beneficiary under the 401(k) Plan and the Nonqualified 401(k) Plan following the filing of a Declaration of Termination of Domestic Partnership.

COBRA coverage upon termination of Domestic Partnership:

(a) **Domestic Partner** . Under federal law, COBRA is only available to qualifying employees and their qualifying spouses and dependent children. Thus, under the law a Domestic Partner may not elect COBRA in his or her own right. However, an Employee on COBRA may add a Domestic Partner to the GHP in the same manner as is permitted for active employees. In the event an Employee who is a COBRA beneficiary dies or becomes Medicare entitled, or the Domestic Partnership is terminated, the Employee's Domestic Partner (or former Domestic Partner) may not make an election under the GHP pursuant to COBRA as a second qualifying event.

(b) **Dependent Children** . If dependent coverage of the Dependent Child of the Domestic Partner ends under the GHP because such a child or children cease to satisfy the definition of Dependent Children under such plan, such children will be eligible to elect COBRA.

PART B - TAX CONSEQUENCES OF GHP COVERAGE

Possible Tax Implications of Domestic Partner:

There may be federal income tax implications associated with providing coverage under the GHP to Domestic Partners (*i.e.* , if the Domestic Partner does not qualify as your dependent under section 152 of the Internal Revenue Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)), the fair market value of the Domestic Partner coverage will be includible in your income as wages for federal income tax purposes). Similar tax implications apply for state income tax purposes. However, GHP coverage provided to your Domestic Partner may qualify for exclusion from income for state income tax purposes based on state law. Exemption from state income tax is often conditioned on the relationship being registered or the parties having entered into a civil union or marriage. It is your responsibility to determine the requirements of your state. The Employee and Domestic Partner should consult with their tax advisor prior to making a declaration of Domestic Partnership.

In addition, an Employee may not obtain reimbursement for medical expenses incurred by the Domestic Partner under the Health Care Flexible Spending Account Program unless the Domestic Partner qualifies as the Employee's federal tax dependent as described above. The same rules regarding the after-tax treatment of the cost of coverage and premiums under the Plan and the reimbursement of medical expenses under the health care flexible spending account will also apply to the Domestic Partner's Dependent Child(ren) unless such Dependent Child(ren) are adopted by the Employee. The Employee and Domestic Partner should consult with their tax advisor prior to making a declaration of Domestic Partnership.

Proof of Tax-Qualified Status of Domestic Partnership:

Domestic Partner coverage under the GHP (including coverage of the Domestic Partner's Child(ren)) will be provided on an after-tax basis for both federal and state income tax purposes **unless** the Employee certifies on the Affidavit Declaring Domestic Partnership Status that such coverage may be provided on a pre-tax basis for federal or state (or both) income tax purposes. The Employee will be required to provide proof of dependent status by submitting a copy of his or her redacted tax return or similar documentation.

PART C- CONSEQUENCES OF COVERAGE ON 401(k) PLAN AND NONQUALIFIED 401(k) PLAN DEFAULT BENEFICIARY

For purposes of the 401(k) Plan and the Nonqualified 401(k) Plan, a Domestic Partner will be the default death beneficiary for an Employee's account balances under the 401(k) Plan and the Nonqualified 401(k) Plan if the Employee has not completed a beneficiary designation in accordance with the policies and procedures under such plan at the time of the Employee's death. Any beneficiary designation made by the Employee under the 401(k) Plan and the Nonqualified 401(k) Plan is revoked upon the execution of the Affidavit. A Domestic Partner will cease to be such default beneficiary upon the filing of a Declaration of Termination of Domestic Partnership with HealthSouth.

HEALTHSOUTH CORPORATION

Return this Form to Human Resources

AFFIDAVIT DECLARING DOMESTIC PARTNER STATUS

We, _____, (the " **Employee** ") and _____, (the " **Domestic Partner** "), are " **Domestic Partners** " within the meaning of the HealthSouth Corporation Domestic Partner Benefit Guidelines (the " **Guidelines** "). Capitalized terms not defined in this Affidavit Declaring Domestic Partner Status (this " **Affidavit** ") will have the meaning set forth in the Guidelines. We execute this Affidavit as of the date set forth below as part of the requirements for (i) coverage of the Domestic Partner under the medical, dental and vision coverages under the HealthSouth Corporation Group Life, AD&D, Disability and Medical Plan (the " **GHP** ") provided by HealthSouth or one of its affiliates (" **HealthSouth** ") and (ii) recognition of the Domestic Partner as the default beneficiary for the Employee's accounts under the HealthSouth Corporation Retirement Income Plan (the " **401(k) Plan** ") and the HealthSouth Corporation Nonqualified 401(k) Plan (the " **Nonqualified 401(k) Plan** "), in accordance with the terms set forth in the Guidelines. We hereby certify as follows:

1. We acknowledge that we have read and understand the Guidelines, which summarize the eligibility criteria, termination provisions, available benefits, employee responsibilities, taxation, and notification requirements pertaining to Domestic Partner status.

2. We declare that we meet the eligibility requirements for Domestic Partner status as set forth below: [Check a., b. and c. below as applicable]

____ a. We are currently registered as domestic partners with a state or local government (and we meet the requirements of such registry);

____ b. We have entered into a legally binding civil union; or

____ c. We meet the alternative criteria for establishing Domestic Partner status as set forth below:

i. We are both at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;

ii. We have lived together for at least the last 12 consecutive months prior to the date of this Affidavit;

iii. The Employee has not had another person enrolled as a Domestic Partner or as a Spouse in any benefit program offered by HealthSouth in the six months prior to the date on this Affidavit;

iv. Neither of us is legally married to another person;

v. We are not related by blood or adoption to a degree that would prohibit marriage in our state of residence;

vi. The Domestic Partner is not eligible for GHP coverage as an employee or as a retiree in any benefit program offered by HealthSouth.

vii. We share the same permanent address and each has a driver's license listing the common address;

viii. We share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;

ix. We each are mentally competent to consent to contract; and

x. We are financially interdependent, demonstrated by at least two of the following: [Check at least two items below as applicable]

____ A. Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;

____ B. Common ownership of a motor vehicle;

____ C. Joint ownership of a residence; or evidence of a joint mortgage or lease;

____ D. Evidence of common household expenses, *e.g.* utility, phone;

____ E. Execution of wills naming each other as executor and/or beneficiary;

____ F. Granting each other durable powers of attorney; or

____ G. Designation of each other as beneficiary under a retirement benefit account.

3.We acknowledge that the Plan Administrator reserves the right, at its discretion, to require that we supply copies of appropriate documentation supporting any of the certifications made in this Affidavit, including certification of Domestic Partner status, Dependent Children status or federal tax dependent status.

4. We understand that obtaining Domestic Partner recognition and coverage and the execution of this Affidavit may affect our liability to each other, to taxing authorities, and to third parties. We understand that we should consult with our respective tax and/or legal advisors regarding these and other potential consequences, and we acknowledge that we have been advised to do so.

5. We understand that HealthSouth may take disciplinary action against us if we misrepresent or falsify any of the information in this Affidavit. Disciplinary action may include termination of employment by HealthSouth and appropriate legal action, such as reimbursement of HealthSouth for the contributions and benefits that were improperly obtained and costs incurred related to such misrepresentation or falsification.

6. We acknowledge that we have read and understand this Affidavit and that all information set forth in this Affidavit is true and correct. We further acknowledge that HealthSouth will rely on this Affidavit and that HealthSouth will not be liable for a false or inaccurate Affidavit.

(Declarations Relating Solely to GHP)

7. We seek to obtain Domestic Partner coverage in the following GHP plans or programs offered by HealthSouth: [Check below as applicable]

__ Medical Benefit Program

__ Dental Benefit Program

__ Vision Benefit Program

We understand that HealthSouth is not legally required to offer the GHP to Domestic Partners and that due to insurer or other constraints, Domestic Partner coverage may not be available under all health programs offered by HealthSouth.

8. We seek to obtain coverage for the Dependent Children of the Domestic Partner in the following GHP plans or programs offered by HealthSouth: [Check below as applicable]

__ Medical Benefit Program

__ Dental Benefit Program

__ Vision Benefit Program

We understand that HealthSouth is not legally required to offer the GHP to Dependent Children of Domestic Partners and that due to insurer or other constraints, Dependent Children of Domestic Partner coverage may not be available under all health programs offered by HealthSouth.

9. We understand the GHP coverage for the Domestic Partner and the Dependent Children of Domestic Partners (as applicable) will not take effect until the dates set forth in the Guidelines.

10. We further understand that the benefits under the GHP will be provided to the Domestic Partner on an after-tax basis for federal income tax purposes **unless** the Domestic Partner qualifies as a dependent (within the meaning of section 152 (without regard to sections 152(b)(1), (b)(2), or (d)(1)(B)) of the Internal Revenue Code such that benefits under the GHP may be provided on a pre-tax basis for purposes of federal law. We hereby certify that the Domestic Partner ___ is ___ is not (***select one***) the Employee's federal tax dependent within the meaning of Code section 152 (determined without regard to Code sections 152(b)(1), (b)(2), and (d)(1)(B)).

11. We further understand that the benefits under the GHP will be provided on an after-tax basis for state income tax purposes, unless such benefits qualify for pre-tax payment or an income tax exclusion under state tax law. We hereby certify that we ___ are___ are not (***select one***) eligible to pay for Domestic Partner health benefits on a pre-tax basis for state tax purposes.

12. We, understand that the benefits under the GHP for the Domestic Partner's Child(ren) who do not qualify as the Employee's Child(ren) as defined under the Plan will be provided on an after-tax basis for federal and state law purposes. I certify that we ___ are ___ are not (***select one***) eligible to pay for the Domestic Partner's children's health benefits on a pre-tax basis for __ federal and/or __ state tax (***select as appropriate***) purposes.

13. We agree that each year during the annual open enrollment period, or at such time as there is a material change in GHP benefits (or at other times, at the discretion of the Plan Administrator), we will certify to the status of the Domestic Partner (and any enrolled Dependent Children of the Domestic Partner).

14. We agree to notify HealthSouth within 31 days after the termination of the Domestic Partner relationship for any reason, including death. We understand that, except in cases of death, the Employee will not be eligible to cover another Domestic Partner under the GHP or recognize until six months after notification to HealthSouth of termination of this Domestic Partner relationship.

(Declaration Relating to 401(k) Plan and Nonqualified 401(k) Plan)

15. We acknowledge that solely for purposes of the 401(k) Plan and the Nonqualified 401(k) Plan, pursuant to this Affidavit, the Domestic Partner will be the default death beneficiary for the Employee's

account balances under the 401(k) Plan and the Nonqualified 401(k) Plan if the Employee has not completed a beneficiary designation in accordance with the policies and procedures under the 401(k) Plan at the time of the Employee's death. We further acknowledge that this Affidavit revokes any beneficiary designation made by the Employee under the 401(k) Plan before this Affidavit is signed. We further acknowledge that the Domestic Partner will cease to be such default beneficiary upon the filing of a Declaration of Termination of Domestic Partnership with HealthSouth.

EMPLOYEE: **DOMESTIC PARTNER:**

Signed: _____ Signed: _____

Printed Name: _____ Printed Name: _____

Date: Date:

Subscribed and sworn to me this _____day of _____, 20____.

Witness my hand and official seal.

_____
[Seal]

My Commission expires:
Notary Public:

Subscribed and sworn to me this _____day of _____, 20____.

Witness my hand and official seal.

_____
[Seal]

My Commission expires:
Notary Public:

Return this Form to Human Resources

HEALTHSOUTH CORPORATION

Return this Form to Human Resources

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP FORM

I, _____ (the " **Employee** "), certify and declare that _____ (the " **Former Domestic Partner** ") and I are no longer domestic partners as of __/__/__ (the " **Termination Date** ").

I understand that medical, dental and vision coverage under the HealthSouth Corporation Group Life, AD&D, Disability and Medical Plan (the " **GHP** ") for the Former Domestic Partner (and Dependent Children of the Former Domestic Partner) will terminate effective as of the Termination Date.

I further understand that the Former Domestic Partner Domestic Partner will cease to be my default beneficiary under the under the HealthSouth Retirement Income Plan (the " **401(k) Plan** ") and the HealthSouth Nonqualified 401(k) Plan (the " **Nonqualified 401(k) Plan** ") as of the Termination Date.

1. I make and file this Declaration of Termination of Domestic Partnership in order to cancel the Affidavit Declaring Domestic Partnership filed with HealthSouth on __/__/__.

2. Termination of the Affidavit Declaring Domestic Partnership is due to: [Check below as applicable]

   __ Termination of domestic partnership

   __ No longer jointly responsible for each other's common welfare and living expenses

   __ Death of domestic partner

I understand that with respect to the GHP another **Affidavit Declaring Domestic Partnership** cannot be filed until **six months** from the date the relationship ends (as indicated above) except with respect to death of my Former Domestic Partner.

In the event that termination of this relationship is not due to the death of my Former Domestic Partner, I will mail my Former Domestic Partner a copy of this notice to the following address:

_____

_____

_____

(Former Domestic Partner new address)

I affirm, under penalty of perjury, that the above statements are true and correct.

_____ ___/__/_____ __/__/__

Signature of Employee Date of Birth Date

_____

Printed name **Return this Form to Human Resources**

Exhibit 12

HealthSouth Corporation and Subsidiaries

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES

AND RATIO OF EARNINGS TO COMBINED FIXED CHARGES AND PREFERRED STOCK DIVIDENDS

In computing the ratio of earnings to fixed charges: (1) earnings have been based on income from continuing operations before income taxes, fixed charges (exclusive of interest capitalized), and distributed income of equity investees and (2) fixed charges consist of interest and amortization of debt discounts and fees expense (including amounts capitalized), the estimated interest portion of rents, and dividends on our convertible perpetual preferred stock.

	For the Year Ended December 31,				
	2013	**2012**	**2011**	**2010**	**2009**
COMPUTATION OF FIXED CHARGES:					
Interest expensed and capitalized in continuing operations, including amortization of debt discounts and fees	$ 102.3	$ 95.1	$ 119.9	$ 126.0	$ 125.7
Interest expensed and capitalized in discontinued operations, including amortization of debt discounts and fees	—	0.1	0.7	1.0	1.4
Interest element of rentals [1]	21.6	22.1	22.3	21.1	20.7
Total fixed charges	123.9	117.3	142.9	148.1	147.8
Dividend requirements on convertible perpetual preferred stock [2]	34.4	39.2	42.6	42.6	42.6
Total combined fixed charges and preferred stock dividends	$ 158.3	$ 156.5	$ 185.5	$ 190.7	$ 190.4
COMPUTATION OF EARNINGS:					
Pre-tax income from continuing operations before equity in net income of nonconsolidated affiliates	$ 384.0	$ 327.3	$ 230.9	$ 179.8	$ 102.9
Fixed charges	123.9	117.3	142.9	148.1	147.8
Distributed income of equity investees	11.4	11.0	13.0	8.1	8.6
Interest capitalized	1.9	1.0	0.5	0.4	—
Total earnings	$ 521.2	$ 456.6	$ 387.3	$ 336.4	$ 259.3
RATIO OF EARNINGS TO FIXED CHARGES	4.2	3.9	2.7	2.3	1.8
RATIO OF EARNINGS TO COMBINED FIXED CHARGES AND PREFERRED STOCK DIVIDENDS	3.3	2.9	2.1	1.8	1.4

[1] Management has determined the interest component of rent expense to be 33%.

[2] Grossed up to pre-tax based on an approximate 39% blended federal and state statutory tax rate. Excludes $71.6 million and $0.8 million in 2013 and 2012, respectively, for excess amounts exchanged in preferred stock repurchase transactions.

Exhibit 21

HEALTHSOUTH CORPORATION
SUBSIDIARY LIST

Subsidiary Name	Jurisdiction of Incorporation	DBA
Advantage Health, LLC	DE	
AnMed Enterprises, Inc./HealthSouth, L.L.C.	SC	AnMed Health Rehabilitation Hospital, an affiliate entity of AnMed Health and HealthSouth Corporation
BJC/HealthSouth Rehabilitation Center, L.L.C.	MO	The Rehabilitation Institute of St. Louis The Orthopedic Center The Milliken Hand Center
Central Arkansas Rehabilitation Associates, L.P.	DE	St. Vincent Rehabilitation Hospital
Central Louisiana Rehab Associates, L.P.	DE	HealthSouth Rehabilitation Hospital of Alexandria
CMS Alexandria Rehabilitation, LLC	DE	
CMS Development and Management Company, Inc.	DE	
CMS Fayetteville Rehabilitation, Inc.	DE	
CMS Jonesboro Rehabilitation, Inc.	DE	
CMS Kansas City Rehabilitation, Inc.	DE	
CMS Rehab of WF, L.P.	DE	HealthSouth Rehabilitation Hospital of Wichita Falls HealthSouth Home Health Agency of Wichita Falls
CMS Sherwood Rehabilitation, Inc.	DE	
CMSI Systems of Texas, Inc.	TX	
Continental Medical of Arizona, Inc.	DE	
Continental Medical of Colorado, Inc.	DE	
Continental Medical Systems, Inc.	DE	
Continental Rehab of W.F., Inc.	TX	
Continental Rehabilitation Hospital of Arizona, Inc.	DE	
HCA Wesley Rehabilitation Hospital, Inc.	DE	Wesley Rehabilitation Hospital, An Affiliate of HealthSouth Wesley Home Health
HCS Limited	Cayman Islands, B.W.I.	
HealthSouth Arizona Real Estate, LLC	DE	
HealthSouth Aviation, LLC	DE	
HealthSouth Bakersfield Rehabilitation Hospital, LLC	DE	HealthSouth Bakersfield Rehabilitation Hospital
HealthSouth California Real Estate, LLC	DE	
HealthSouth Clinical Technologies, LLC	DE	
HealthSouth Colorado Real Estate, LLC	DE	
HealthSouth Deaconess Holdings, LLC	DE	

HealthSouth Harmarville Rehabilitation Hospital, LLC	DE	HealthSouth Harmarville Rehabilitation Hospital Harmarville Home Health Agency Harmarville Transitional Rehabilitation Unit
HealthSouth Joint Ventures Holdings, LLC	DE	
HealthSouth Kansas Real Estate, LLC	DE	
HealthSouth Kentucky Real Estate, LLC	DE	
HealthSouth Littleton Rehabilitation, LLC	DE	HealthSouth Rehabilitation Hospital of Denver
HealthSouth Martin County Holdings, LLC	DE	
HealthSouth Mesa Rehabilitation Hospital, LLC	DE	HealthSouth East Valley Rehabilitation Hospital
HealthSouth Middletown Rehabilitation Hospital, LLC	DE	
HealthSouth Nevada Real Estate, LLC	DE	
HealthSouth New Mexico Real Estate, LLC	DE	
HealthSouth Northern Kentucky Rehabilitation Hospital, LLC	DE	HealthSouth Northern Kentucky Rehabilitation Hospital
HealthSouth of Altoona, LLC	DE	
HealthSouth of Dothan, Inc.	AL	HealthSouth Rehabilitation Hospital
HealthSouth of East Tennessee, LLC	DE	HealthSouth Rehabilitation Hospital
HealthSouth of Erie, LLC	DE	HealthSouth Rehabilitation Hospital of Erie
HealthSouth of Fort Smith, LLC	DE	HealthSouth Rehabilitation Hospital of Fort Smith HealthSouth Outpatient Rehabilitation HealthSouth Sleep Disorder Center
HealthSouth of Montgomery, Inc.	AL	HealthSouth Rehabilitation Hospital of Montgomery
HealthSouth of Nittany Valley, Inc.	DE	HealthSouth Nittany Valley Rehabilitation Hospital HealthSouth Rehabilitation Center of Lewistown HealthSouth Rehabilitation Center of Mifflintown
HealthSouth of Phenix City, Inc.	DE	
HealthSouth of Reading, LLC	DE	HealthSouth Reading Rehabilitation Hospital HealthSouth Reading Rehab at Home HealthSouth Reading Rehabilitation Hospital-Pottstown
HealthSouth of San Antonio, Inc.	DE	HealthSouth Rehabilitation Institute of San Antonio (RIOSA) HealthSouth RIOSA Home Health Agency
HealthSouth of Sea Pines Limited Partnership	AL	HealthSouth Sea Pines Rehabilitation Hospital Sea Pines Home Health Services
HealthSouth of South Carolina, Inc.	DE	HealthSouth Rehabilitation Hospital of Columbia

HealthSouth of Spring Hill, Inc.	DE	HealthSouth Rehabilitation Hospital of Spring Hill HealthSouth Home Health of Spring Hill
HealthSouth of Toms River, LLC	DE	HealthSouth Rehabilitation Hospital of Toms River
HealthSouth of Treasure Coast, Inc.	DE	HealthSouth Treasure Coast Rehabilitation Hospital
HealthSouth of York, LLC	DE	HealthSouth Rehabilitation Hospital of York HealthSouth Rehabilitation Center of Industrial Highway HealthSouth Rehabilitation Center - Red Lion HealthSouth Therapy at Home HealthSouth-Normandie Drive
HealthSouth of Yuma, Inc.	DE	
HealthSouth Ohio Real Estate, LLC	DE	
HealthSouth Owned Hospitals Holdings, LLC	DE	
HealthSouth Pennsylvania Real Estate, LLC	DE	
HealthSouth Plano Rehabilitation Hospital, LLC	DE	HealthSouth Plano Rehabilitation Hospital HealthSouth Home Health of Plano HealthSouth Rehabilitation Specialists-Plano
HealthSouth Press, LLC	DE	
HealthSouth Real Estate, LLC	DE	
HealthSouth Rehabilitation Center of New Hampshire, Inc.	DE	HealthSouth Rehabilitation Hospital
HealthSouth Rehabilitation Center, Inc.	SC	HealthSouth Rehabilitation Hospital of Florence
HealthSouth Rehabilitation Hospital at Drake, LLC	DE	HealthSouth Rehabilitation Hospital at Drake
HealthSouth Rehabilitation Hospital of Altoona, LLC	DE	HealthSouth Rehabilitation Hospital Of Altoona HealthSouth Rehabilitation Center - Regency Square HealthSouth Rehabilitation Center - Tyrone HealthSouth Rehabilitation Center - Meadowbrook Plaza HealthSouth Rehabilitation Center - Bedford
HealthSouth Rehabilitation Hospital of Arlington, LLC	DE	HealthSouth Rehabilitation Hospital of Arlington
HealthSouth Rehabilitation Hospital of Austin, Inc.	DE	HealthSouth Rehabilitation Hospital of Austin HealthSouth At Home HealthSouth Wound Care and Hyperbaric Center

HealthSouth Rehabilitation Hospital of Beaumont, LLC	DE	HealthSouth Rehabilitation Hospital of Beaumont HealthSouth Home Health Agency of Beaumont HealthSouth Rehabilitation Center - Beaumont
HealthSouth Rehabilitation Hospital of Charleston, LLC	SC	HealthSouth Rehabilitation Hospital of Charleston
HealthSouth Rehabilitation Hospital of Cypress, LLC	DE	HealthSouth Rehabilitation Hospital of Cypress
HealthSouth Rehabilitation Hospital of Desert Canyon, LLC	DE	HealthSouth Desert Canyon Rehabilitation Hospital
HealthSouth Rehabilitation Hospital of Fort Worth, LLC	DE	HealthSouth Rehabilitation Hospital of Fort Worth
HealthSouth Rehabilitation Hospital of Fredericksburg, LLC	DE	HealthSouth Rehabilitation Hospital of Fredericksburg
HealthSouth Rehabilitation Hospital of Gadsden, LLC	DE	HealthSouth Rehabilitation Hospital of Gadsden
HealthSouth Rehabilitation Hospital of Henderson, LLC	DE	HealthSouth Rehabilitation Hospital of Henderson HealthSouth Home Health of Henderson
HealthSouth Rehabilitation Hospital of Humble, LLC	DE	HealthSouth Rehabilitation Hospital of Humble
HealthSouth Rehabilitation Hospital of Jonesboro, LLC	AR	HealthSouth Rehabilitation Hospital of Jonesboro
HealthSouth Rehabilitation Hospital of Largo, LLC	DE	HealthSouth Rehabilitation Hospital of Largo
HealthSouth Rehabilitation Hospital of Las Vegas, LLC	DE	HealthSouth Rehabilitation Hospital of Las Vegas
HealthSouth Rehabilitation Hospital of Manati, Inc.	DE	HealthSouth Rehabilitation Hospital of Manati
HealthSouth Rehabilitation Hospital of Marion County, LLC	DE	HealthSouth Rehabilitation Hospital of Ocala
HealthSouth Rehabilitation Hospital of Martin County, LLC	DE	HealthSouth Rehabilitation Hospital at Martin Health
HealthSouth Rehabilitation Hospital of Mechanicsburg, LLC	DE	HealthSouth Rehabilitation Hospital of Mechanicsburg
HealthSouth Rehabilitation Hospital of Miami, LLC	DE	HealthSouth Rehabilitation Hospital of Miami
HealthSouth Rehabilitation Hospital of Midland/Odessa, LLC	DE	HealthSouth Rehabilitation Hospital of Midland/Odessa HealthSouth Home Care of Midland-Odessa
HealthSouth Rehabilitation Hospital of New Mexico, LLC	DE	HealthSouth Rehabilitation Hospital HealthSouth Home Health of Albuquerque
HealthSouth Rehabilitation Hospital of Newnan, LLC	DE	
HealthSouth Rehabilitation Hospital of Northern Virginia, LLC	DE	HealthSouth Rehabilitation Hospital of Northern Virginia
HealthSouth Rehabilitation Hospital of Petersburg, LLC	DE	HealthSouth Rehabilitation Hospital of Petersburg

HealthSouth Rehabilitation Hospital of San Juan, Inc.	DE	HealthSouth Rehabilitation Hospital of San Juan HealthSouth Outpatient Therapy of San Juan
HealthSouth Rehabilitation Hospital of Sarasota, LLC	DE	HealthSouth Rehabilitation Hospital of Sarasota
HealthSouth Rehabilitation Hospital of Seminole County, LLC	DE	HealthSouth Rehabilitation Hospital of Altamonte Springs
HealthSouth Rehabilitation Hospital of Sewickley, LLC	DE	HealthSouth Rehabilitation Hospital of Sewickley
HealthSouth Rehabilitation Hospital of South Jersey, LLC	DE	HealthSouth Rehabilitation Hospital of Vineland
HealthSouth Rehabilitation Hospital of Sugar Land, LLC	DE	HealthSouth Sugar Land Rehabilitation Hospital
HealthSouth Rehabilitation Hospital of Tallahassee, LLC	DE	HealthSouth Rehabilitation Hospital of Tallahassee
HealthSouth Rehabilitation Hospital of Texarkana, Inc.	DE	HealthSouth Rehabilitation Hospital of Texarkana HealthSouth of Texarkana Home Care Agency
HealthSouth Rehabilitation Hospital of Utah, LLC	DE	HealthSouth Rehabilitation Hospital of Utah HealthSouth Home Care
HealthSouth Rehabilitation Hospital of Williamson County, LLC	TN	
HealthSouth Rehabilitation Hospital The Woodlands, Inc.	DE	HealthSouth Rehabilitation Hospital The Woodlands HealthSouth Home Health Agency of Houston
HealthSouth Rehabilitation Institute of Tucson, LLC	AL	HealthSouth Rehabilitation Institute of Tucson HealthSouth Home Health of Tucson
HealthSouth Scottsdale Rehabilitation Hospital, LLC	DE	HealthSouth Scottsdale Rehabilitation Hospital
HealthSouth Sea Pines Holdings, LLC	DE	
HealthSouth South Carolina Real Estate, LLC	DE	
HealthSouth Sunrise Rehabilitation Hospital, LLC	DE	HealthSouth Sunrise Rehabilitation Hospital HealthSouth Sunrise Comprehensive Pain Care Center HealthSouth Sunrise Home Health Services Outpatient Therapy and Day Rehab
HealthSouth Support Companies, LLC	DE	
HealthSouth Texas Real Estate, LLC	DE	
HealthSouth Tucson Holdings, LLC	DE	
HealthSouth Utah Real Estate, LLC	DE	
HealthSouth Valley of the Sun Rehabilitation Hospital, LLC	DE	HealthSouth Valley of The Sun Rehabilitation Hospital HealthSouth Home Health of Phoenix
HealthSouth Walton Rehabilitation Hospital, LLC	DE	HealthSouth Walton Rehabilitation Hospital

HealthSouth West Virginia Real Estate, LLC	DE	
HealthSouth Williamson County Real Estate, LLC	DE	
HealthSouth/Deaconess L.L.C.	IN	HealthSouth Deaconess Rehabilitation Hospital
HealthSouth/GHS Limited Liability Company	PA	Geisinger HealthSouth Rehabilitation Hospital Geisinger HealthSouth Rehabilitation Center of Berwick Geisinger HealthSouth Rehabilitation Center of Bloomsburg Geisinger HealthSouth Rehabilitation Center of Bucknell Geisinger HealthSouth Rehabilitation Center of Danville Geisinger HealthSouth Rehabilitation Center of Milton Geisinger HealthSouth Rehabilitation Center of Selinsgrove Geisinger HealthSouth Rehabilitation - Hospital Outpatient Center
HealthSouth/Maine Medical Center Limited Liability Company	ME	New England Rehabilitation Hospital of Portland, a Joint Venture of Maine Medical Center and HealthSouth
HealthSouth/Methodist Rehabilitation Hospital Limited Partnership	TN	HealthSouth Rehabilitation Hospital of Memphis HealthSouth Rehabilitation Hospital-North
K.C. Rehabilitation Hospital, Inc.	DE	Mid America Rehabilitation Hospital
Kansas Rehabilitation Hospital, Inc.	DE	Kansas Rehabilitation Hospital KRH Home Health Care
Lakeshore System Services of Florida, Inc.	FL	HealthSouth Emerald Coast Rehabilitation Hospital
Lakeview Rehabilitation Group Partners	KY	HealthSouth Lakeview Rehabilitation Hospital of Central Kentucky HealthSouth Lakeview Outpatient
New England Rehabilitation Management Co., LLC	NH	
New England Rehabilitation Services of Central Massachusetts, Inc.	MA	Fairlawn Rehabilitation Hospital
Northwest Arkansas Rehabilitation Associates	AR	HealthSouth Rehabilitation Hospital, a Partner with Washington Regional
Piedmont HealthSouth Rehabilitation, LLC	SC	HealthSouth Rehabilitation Hospital of Rock Hill
Plano Health Associates Limited Partnership	DE	
Print Promotions Group, LLC	DE	

Rebound, LLC	DE	HealthSouth Cane Creek Rehabilitation Hospital HealthSouth Chattanooga Rehabilitation Hospital HealthSouth Lakeshore Outpatient HealthSouth Lakeshore Rehabilitation Hospital HealthSouth Rehabilitation Hospital of Huntington HealthSouth Rehabilitation Hospital of North Alabama
Rehab Concepts Corp.	DE	
Rehabilitation Hospital Corporation of America, LLC	DE	HealthSouth Chesapeake Rehabilitation Hospital HealthSouth Chesapeake Rehab Home Health Agency HealthSouth Rehabilitation Hospital of Virginia HealthSouth Inpatient Rehabilitation Unit at Camden-Clark Memorial Hospital HealthSouth Outpatient Therapy Services HealthSouth Southern Hills Rehabilitation Hospital HealthSouth Western Hills Regional Rehabilitation Hospital HealthSouth Western Hills Outpatient
Rehabilitation Hospital of Colorado Springs, Inc.	DE	HealthSouth Rehabilitation Hospital of Colorado Springs HealthSouth Home Health of Colorado Springs
Rehabilitation Hospital of Phenix City, L.L.C.	AL	Regional Rehabilitation Hospital
Rehabilitation Hospital of Plano, LLC	DE	
Rehabilitation Institute Of Western Massachusetts, LLC	MA	HealthSouth Rehabilitation Hospital of Western Massachusetts
Rusk Rehabilitation Center, L.L.C.	MO	Rusk Rehabilitation Center, a Joint Venture of HealthSouth and the University of Missouri - Columbia
Saint Barnabas/HealthSouth Rehabilitation Center L.L.C.	NJ	HealthSouth Rehabilitation Hospital of Tinton Falls
Sherwood Rehabilitation Hospital, Inc.	DE	
Southern Arizona Regional Rehabilitation Hospital, L.P.	DE	HealthSouth Rehabilitation Hospital of Southern Arizona
Tarrant County Rehabilitation Hospital, Inc.	TX	HealthSouth City View Rehabilitation Hospital HealthSouth Tarrant County Home Health
Tyler Rehab Associates, L.P.	DE	Trinity Mother Frances Rehabilitation Hospital, Affiliated with HealthSouth Trinity Mother Frances Home Health Services
Tyler Rehabilitation Hospital, Inc.	TX	

University of Virginia/HealthSouth L.L.C.	VA	UVA-HealthSouth Rehabilitation Hospital UVa-HealthSouth Sports Medicine & Rehabilitation Center
Van Matre Rehabilitation Center LLC	IL	Van Matre HealthSouth Rehabilitation Hospital
Vanderbilt Stallworth Rehabilitation Hospital, L.P.	TN	Vanderbilt Stallworth Rehabilitation Hospital
Wellmont/HealthSouth IRF, LLC	DE	The Rehabilitation Hospital of Southwest Virginia
West Virginia Rehabilitation Hospital, Inc.	WV	HealthSouth Mountain View Regional Rehabilitation Hospital HealthSouth Mountainview at Bridgeport
Western Medical Rehab Associates, L.P.	DE	HealthSouth Tustin Rehabilitation Hospital
Western Neuro Care, Inc.	DE	
Yuma Rehabilitation Hospital, LLC	AZ	Yuma Rehabilitation Hospital, a Partnership of HealthSouth & YRMC

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-3 (Nos. 333-183740 and 333-192510) and Form S-8 (Nos. 333-157445 and 333-175981) of HealthSouth Corporation of our report dated February 20, 2014 relating to the financial statements and the effectiveness of internal control over financial reporting, which appears in this Form 10−K.

/s/ PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP
Birmingham, Alabama
February 20, 2014

Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Jay Grinney, certify that:

1. I have reviewed this Annual Report on Form 10-K of HealthSouth Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2014

By: /s/ Jay Grinney

Name: Jay Grinney

Title: President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Douglas E. Coltharp, certify that:

1. I have reviewed this Annual Report on Form 10-K of HealthSouth Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2014

By: /s/ Douglas E. Coltharp

Name: Douglas E. Coltharp

Title: Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATE OF CHIEF EXECUTIVE OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED
PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of HealthSouth Corporation on Form 10-K for the period ended December 31, 2013 , as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Jay Grinney, President and Chief Executive Officer of HealthSouth Corporation, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (the "2002 Act"), that to the best of my knowledge and belief:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of HealthSouth Corporation.

Date: February 20, 2014

By: /s/ Jay Grinney

Name: Jay Grinney

Title: President and Chief Executive Officer

A signed original of this written statement has been provided to HealthSouth Corporation and will be retained by HealthSouth Corporation and furnished to the Securities and Exchange Commission or its staff upon request. This written statement shall not, except to the extent required by the 2002 Act, be deemed filed by HealthSouth Corporation for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and will not be deemed to be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act, except to the extent that HealthSouth Corporation specifically incorporates it by reference.

Exhibit 32.2

CERTIFICATE OF CHIEF FINANCIAL OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED
PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of HealthSouth Corporation on Form 10-K for the period ended December 31, 2013 , as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Douglas E. Coltharp, Executive Vice President and Chief Financial Officer of HealthSouth Corporation, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (the "2002 Act"), that to the best of my knowledge and belief:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of HealthSouth Corporation.

Date: February 20, 2014

By: /s/ Douglas E. Coltharp

Name: Douglas E. Coltharp

Title: Executive Vice President and Chief Financial Officer

A signed original of this written statement has been provided to HealthSouth Corporation and will be retained by HealthSouth Corporation and furnished to the Securities and Exchange Commission or its staff upon request. This written statement shall not, except to the extent required by the 2002 Act, be deemed filed by HealthSouth Corporation for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and will not be deemed to be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act, except to the extent that HealthSouth Corporation specifically incorporates it by reference.