Investor Reference Book

Published: June 25, 2025

Encompass Health

Forward-looking statements

The information contained in this presentation includes certain estimates, projections and other forward-looking information that reflect Encompass Health's current outlook, views and plans with respect to future events, including the business outlook, guidance and growth targets, labor availability and costs, the effect of tariffs on costs, legislative and regulatory developments, strategy, capital expenditures, acquisition and other development activities, such as the de novo pipeline, costs, growth and timelines, operational initiatives, dividend strategies, leverage, repurchases of securities, outstanding shares of common stock, effective tax rates, financial performance, financial assumptions and considerations, balance sheet and cash flow plans, market barriers to entry, and addressable market size. These estimates, projections and other forward-looking information are based on assumptions the Company believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance any estimates, projections or forward-looking information will be realized.

All such estimates, projections and forward-looking information speak only as of the date hereof. The Company undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this Investor Reference Book as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2024, the Form 10-Q for the quarter ended March 31, 2025, and in other documents the Company previously filed with the SEC, many of which are beyond the Company's control, that may cause actual events or results to differ materially from the views, beliefs, and estimates expressed herein.

Note regarding presentation of non-GAAP financial measures
The following Investor Reference Book includes certain "non-GAAP financial measures" as defined in Regulation G under the Securities Exchange Act of 1934, including Adjusted EBITDA, leverage ratios, and adjusted free cash flow. Schedules are attached that reconcile the non-GAAP financial measures included in the Investor Reference Book to the most directly comparable financial measures calculated and presented in accordance with Generally Accepted Accounting Principles in the United States. The Company's Form 8-K, dated June 25, 2025, to which the Investor Reference Book is attached as Exhibit 99.1, provides further explanation and disclosure regarding the Company's use of non-GAAP financial measures and should be read in conjunction with the Investor Reference Book.

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Glossary of terms and abbreviations

Medicare

- Medicare refers to traditional Medicare / Medicare Fee-for-Service (FFS) programs.

Medicare Advantage ("MA")

- Medicare Advantage may also be referred to as Medicare Part C and refers to the private health plans contracted by Medicare as an alternative to traditional Medicare programs.

Return on Invested Capital ("ROIC")

- ROIC is measured using hospital-level EBIT (earnings before interest and taxes) and applying an assumed effective tax rate, i.e., EBIT * (1 - assumed effective tax rate), divided by the hospital's average net assets for the same period.

Abbreviations

- Case Mix Group ("CMG")
- Centers for Medicare and Medicaid Services ("CMS")
- Certificate of Need ("CON")
- Home Health ("HH")
- Inpatient Rehabilitation Facility ("IRF")("hospital")
- Real Estate Investment Trust ("REIT")
- Skilled Nursing Facility ("SNF")

Business Outlook

Business outlook | Strong and sustainable business fundamentals

Attractive healthcare sector

- Large addressable market indicated by low conversion rate of presumptively eligible inpatient rehabilitation patients
- Aging demographic driving increased demand for rehabilitation services
- Supply of licensed IRF beds increased only modestly over the past decade
- High acuity, nondiscretionary conditions treated
- Fragmented sector presents unit consolidation and joint venture opportunities
- Significant barriers to entry

Industry leading position

Encompass Health is uniquely positioned to grow the market and capture incremental share

- Largest provider of inpatient rehabilitation services
- Unparalleled clinical expertise for treating inpatient rehabilitation conditions with consistent delivery of high-quality, cost-effective care
- Enhanced utilization of technology (e.g., clinical, data analytics, and technology-enabled business processes)
- Economies related to scale and market density
- Ability to fund capacity expansions with internally generated funds
- Management experience and depth
- Attractive financial returns on de novo and bed addition investments
- Successful long-standing acute care hospital joint venture strategy

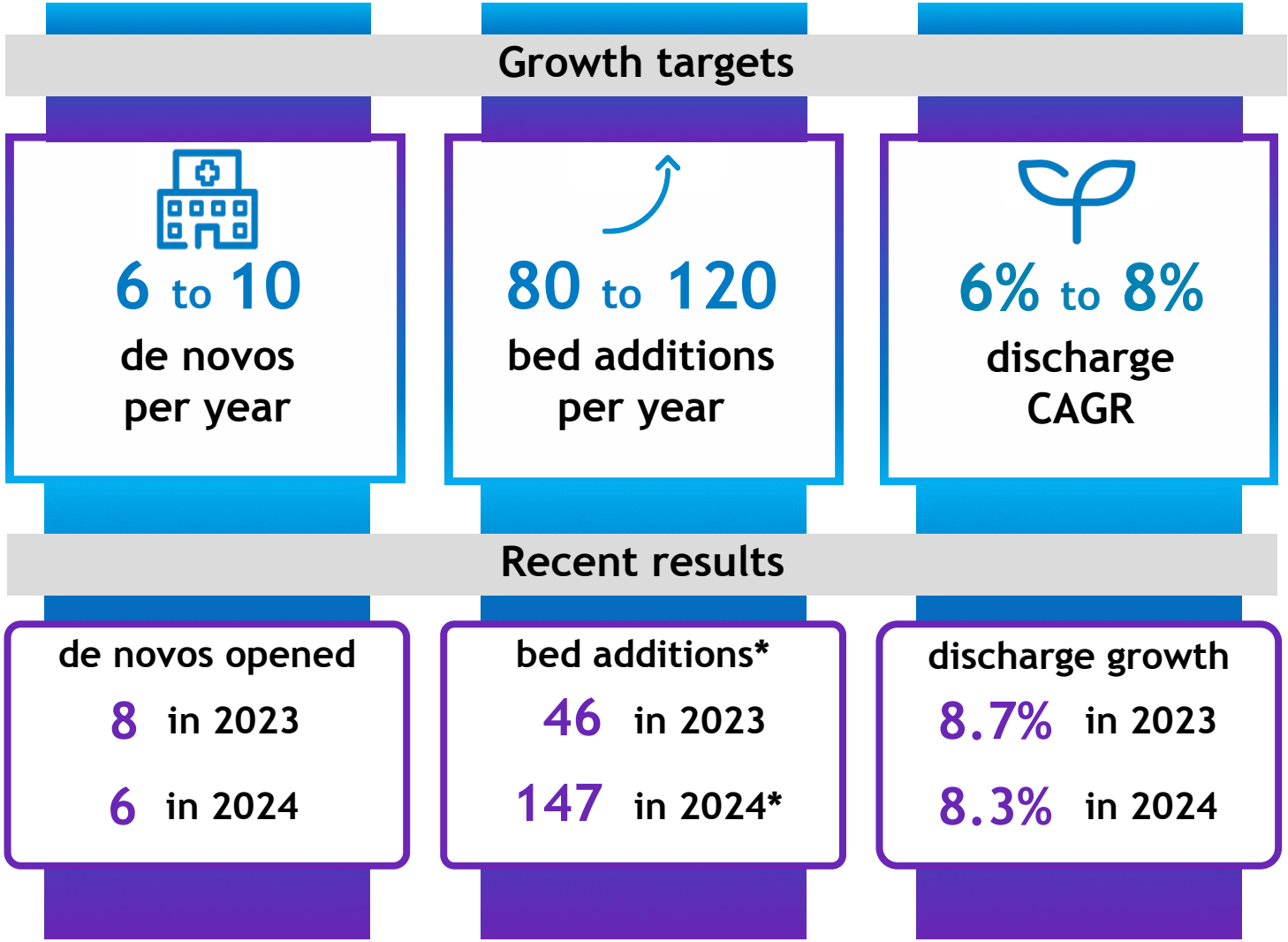
Real estate ownership

- Portfolio of 168 IRFs as of June 13, 2025
  - ✓ 132 owned and 36 leased
  - ✓ Owned real estate is not exposed to annual lease expense increases
  - ✓ Ability to customize building design to EHC specifications; promotes construction and operational efficiencies
  - ✓ Greater flexibility in managing hospital portfolio

Financial strength

- Well-managed balance sheet and liquidity
  - ✓ Manageable near-term maturities (credit agreement matures in 2027; $100 million 2025 bond maturity with other bonds maturing in 2028 and beyond)
  - ✓ $953 million available for borrowing on our $1 billion revolving credit facility (as of March 31, 2025)
- Substantial free cash flow generation
- Return capital in the form of dividends and share repurchases

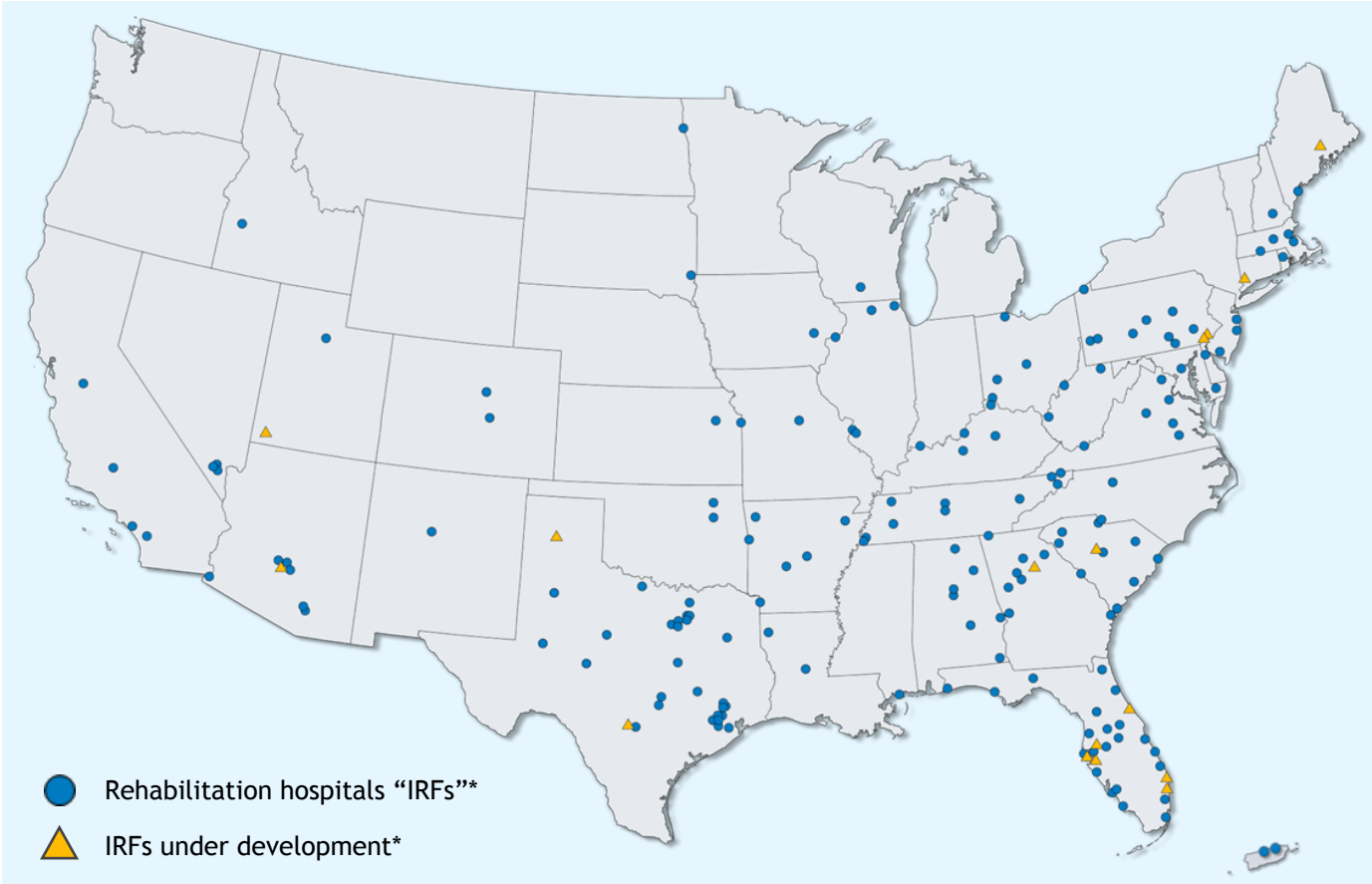
Business outlook | 2023 - 2027



*Bed additions include remote and satellite hospitals.[1]
Refer to pages 60-62 for end notes.

Company Overview

Company overview | Largest owner and operator of IRFs



Company profile as of June 13, 2025

168
Rehabilitation hospitals "IRFs"

67 are joint ventures

17
IRFs under development**

38
States and Puerto Rico

2024 key statistics

~248,500
patient discharges

~$5.4 billion in revenue

8.3% total discharge growth

~40,200 employees

2025 *Fortune* World's Most Admired Companies™
2025 Forbes Most Trusted Companies in America

*IRFs as of June 13, 2025; IRFs under development - previously announced under development as of June 13, 2025
**IRFs under development include de novo and remote and satellite locations.(1)
Refer to pages 60-62 for end notes.

145 Hospitals hold one or more disease-specific certifications[2]

Clinical expertise in Joint Commission specialty accreditations

Number of EHC hospitals with accreditation and EHC's % of all such accreditations

- Stroke rehabilitation accreditations - 144 EHC hospitals (~64%)
- Hip fracture rehabilitation accreditations - 65 EHC hospitals (~96%)
- Brain injury rehabilitation accreditations - 50 EHC hospitals (~74%)
- Amputee rehabilitation accreditations - 41 EHC hospitals (~80%)

Encompass Health provides coordinated therapy and nursing services to patients requiring intensive inpatient rehabilitative care.

Inpatient rehabilitation hospital services include:

- Independent physician oversight of plan of care
- 24/7 nursing care
- Intensive multi-disciplinary therapy
- Extensive clinical support services

Company overview | Primary services

Independent physicians

Independent physicians manage and treat medical conditions as well as oversee the plan of care and medical rehabilitation program. Physician services include:

- Review and approve pre-admission screenings
- Develop an individualized overall plan of care
- At least 3 face-to-face rehabilitation physician visits per week
- Lead Team Conferences
- Manage discharge planning (timing and destination)

Rehabilitation nursing

(CRRN, RN, LPN, LVN, CNA)

Onsite 24/7- assist patients by helping restore, maintain, and promote optimal health. Provide care including:

- Daily/ongoing care
- Medication dispensing
- Wound care
- Infection control
- Patient transfers from bed to wheelchair, bed to restroom, etc.

Intensive multi-dimensional therapy

Patients generally receive at least 3 hours of therapy per day at least 5 days per week; by 2 or more therapy disciplines:

- **Physical therapists -** address physical function, mobility, strength, balance, and safety
- **Occupational therapists** - promote independence through activities of daily living
- **Speech-language therapists -** address speech/voice functions, swallowing, memory/cognition, and language/communication

Clinical support services

- **Case managers -** coordinate the care plan with the physician as well as the interdisciplinary team; serve as facilitators of Team Conferences and work with patients, families and communities to ensure the patient has what is needed when they arrive home
- **Pharmacists** - reconcile medications at admission and discharge, dispense medications during patient stay and assist clinicians with pain management strategies
- **Respiratory therapists -** provide care and cardio-pulmonary medicine to patients with acute critical conditions and cardiac and pulmonary disease enabling them to tolerate intensive multi-disciplinary therapy
- **In-house dialysis** - offered at 110 Encompass Health hospitals as of March 31, 2025 with further roll out to continue; reduces disruption to therapy regimen and leads to increased patient satisfaction
- **Dietetics and nutrition services** - provide nutritional guidance and oversight with respect to each patient's dietary needs

Company overview | Our patients

Admissions

IRF admission criteria	At the time of admission, a patient must meet medical necessity criteria including: • requirement of active and ongoing therapeutic intervention of multiple therapy disciplines • expectation of active participation in, and benefit from, an intensive rehabilitation therapy program • supervision by a physician through face-to-face visits at least 3 days a week
	At least 60% of patients must have at least one CMS-13 medical diagnosis or functional impairment
Average age of EHC patients	72 years old
EHC IRF admission sources	91% of EHC admissions come from acute care hospital discharges, but only ~5.0% of acute care hospital discharges are admitted to an IRF.*

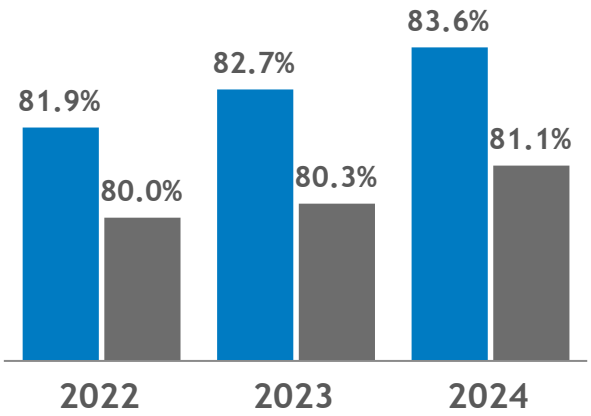
Patient mix

Rehabilitation impairment category ("RIC")		2024
RIC 01	Stroke	18.4 %
RIC 02/03	Brain dysfunction	11.6 %
RIC 04/05	Spinal cord dysfunction	3.9 %
RIC 06	Neurological conditions	20.7 %
RIC 07	Fracture of lower extremity	8.1 %
RIC 08	Replacement of lower extremity joint	3.5 %
RIC 09	Other orthopedic	7.5 %
RIC 10/11	Amputation	2.4 %
RIC 14	Cardiac	3.9 %
RIC 17/18	Major multiple trauma	6.3 %
RIC 20	Other disabling impairments	11.4 %
—	All other RICs	2.3 %

*Source: FORVIS reporting on Q4 2023 - Q3 2024 Medicare claims data

Company overview | High quality clinical results

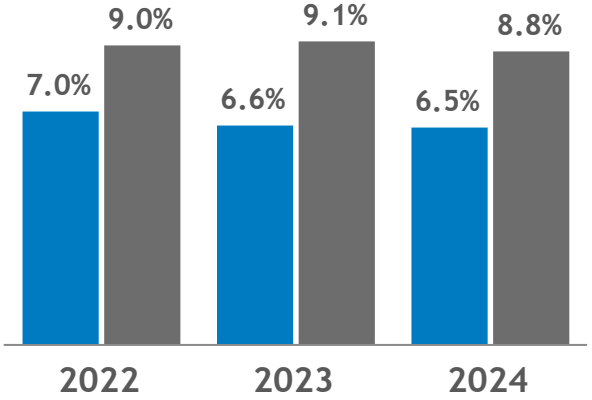
Discharge to Community



Higher is better

Percent of patients discharged to the community, including home or home with home health

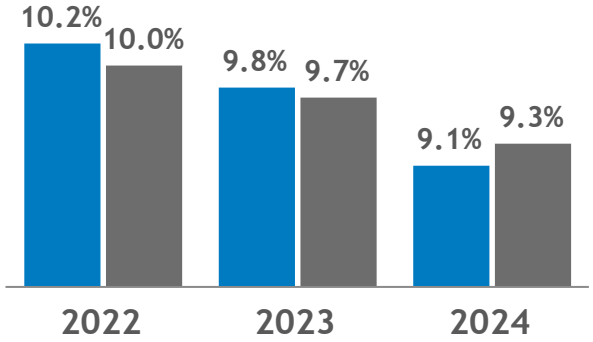
Discharge to SNF



Lower is better

Percent of patients discharged to a skilled nursing facility

Discharge to Acute Care



Lower is better

Percent of patients discharged to an acute care hospital

Encompass Health

UDSMR[3]

The above UDSMR measures include IRF units that are located within acute care hospitals.

Refer to pages 60-62 for end notes.

Company overview | Leading position in cost effectiveness

Encompass Health's clinical expertise and efficiency reduce high cost outlier stipends. As such, Medicare pays Encompass Health less per discharge on average despite comparable acuity, lowering costs for the overall healthcare system.

	# of IRFs	Avg. beds per IRF	Avg. Medicare discharges per IRF[5]	Avg. est. total payment per discharge for FY 2026
Encompass Health[4] =	163	66	926	$25,357
Free-standing = (Non-Encompass Health)	226	55	586	$27,938
Hospital units =	776	25	207	$28,376
Total[6]	1,165	36	381	$27,220

Encompass Health produces high-quality, cost-effective outcomes through:

- *"Best Practices" clinical protocols*
- *Supply chain efficiencies*
- *Sophisticated management information systems*
- *Economies of scale*

- The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration.[7]

Refer to pages 60-62 for end notes.

Company overview | Payors and payment methods

Payor source	Payment methodology	% of 2024 Revenues
Medicare	Prospective Payment System ("PPS") - paid per discharge by Case Mix Group ("CMG")	65.1%
Medicare Advantage	CMG (~90% of MA revenue) - remaining contracts are per diem	16.8%
Managed Care	Predominantly per diem	10.8%
Medicaid	Varies by state	3.3%
Other*	Variety of methodologies	4.0%

*Includes Medicaid supplemental payments[8], other third-party payors, workers' compensation, patients and other income.

Company overview | IRF growth pipeline

Disciplined approach to new store growth

Considerations for entering a new market:

- Market demographics and growth potential
- CON requirements (initial and for expansion)
- Presence of other inpatient rehabilitation services
- Acute care hospital presence and discharge patterns
- Geographic proximity to other Encompass Health hospitals
- Potential joint venture partners
- Major MA and Managed Care plans
- Clinical labor availability and costs
- Capital investment required (e.g., local market land and construction costs)

Typical development pipeline

Project category	Exploratory/ CA executed*	Active development	Annual openings
Number of projects	30 - 50	20 - 30	6 - 10

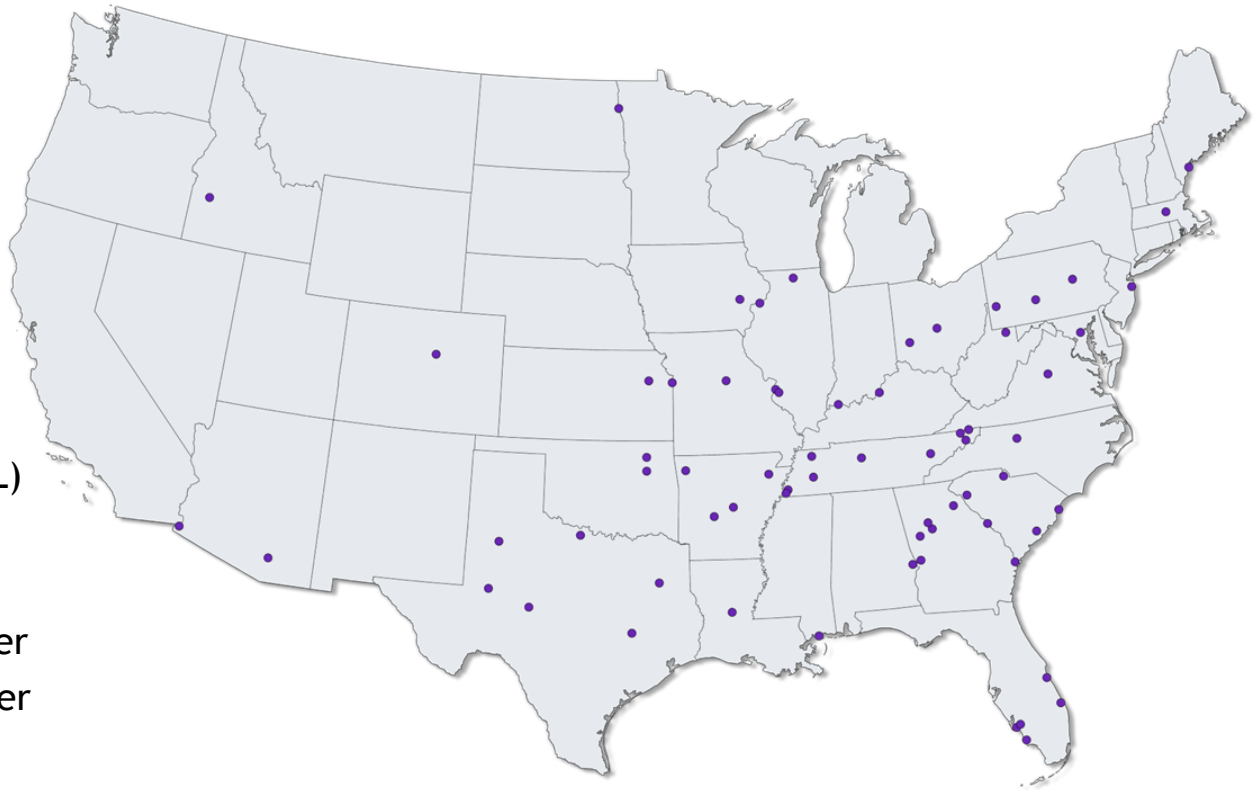
*CA = confidentiality agreement

Company overview | Joint venture partnerships with acute care providers

The Company's joint ventures began in 1991

67 joint venture hospitals* in place with major healthcare systems including:

- Ascension St. John Hospital System
- Ballad Health
- Barnes-Jewish
- Cleveland Clinic Martin Health
- Geisinger Health System
- Lee Health subsidiary
- Monmouth Medical Center (RWJBarnabas Health)
- NCH Healthcare System (Naples, FL)
- Novant Health
- Piedmont
- University of Virginia Medical Center
- Vanderbilt University Medical Center



Joint ventures with acute care hospitals facilitate integrated care delivery

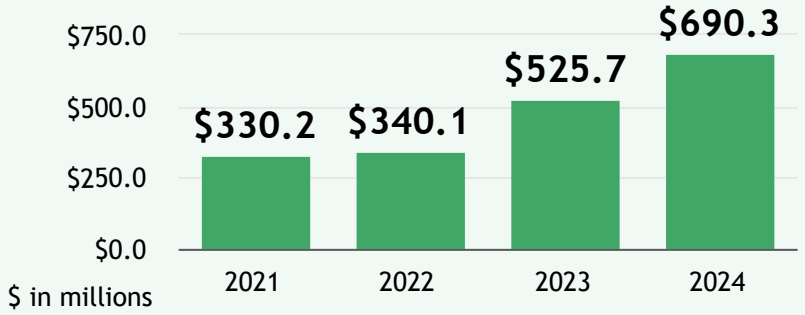
*Data as of June 13, 2025

Company overview | Cash flow and liquidity

Adjusted Free Cash Flow*[9]

Able to fund our growth primarily through free cash flow (FCF)

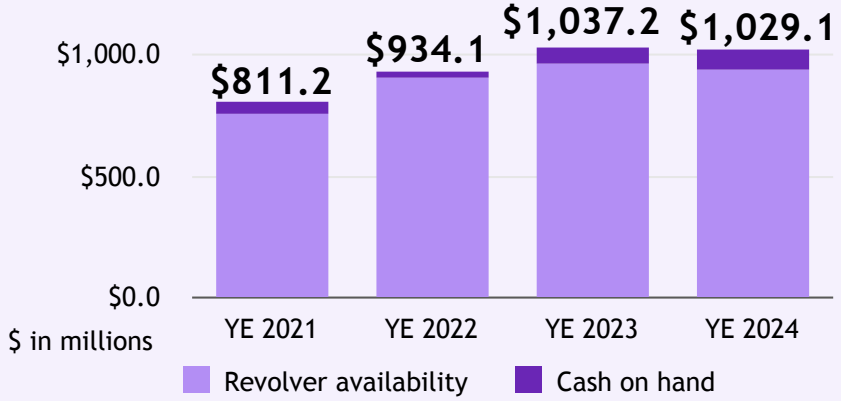
- De novos
- Bed additions including remote and satellite hospitals
- Replacement IRFs
- FCF is after maintenance capex, before discretionary capex



Liquidity*

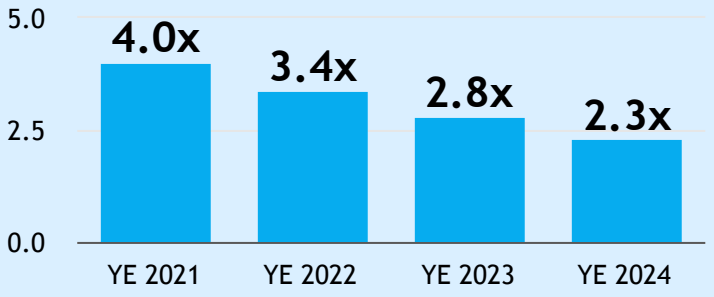
Ensure sufficient liquidity to meet the anticipated operating and strategic needs of the Company

- Liquidity - defined as cash on hand and revolver availability
- Credit facility - a diverse group of well-capitalized lenders in the senior credit facility



Leverage Ratio*

- Leverage ratio = Total Debt / LTM Adjusted EBITDA[10]
- Debt duration - limited near term refinancing risk
- Floating rate debt - very limited exposure



*Historical financial results reflect Enhabit Home Health and Hospice as discontinued operations.
Refer to pages 60-62 for end notes.

Company overview | Real estate holdings

Own ~79% of IRF real estate

Rationale for real estate ownership

Leases are generally structured as long-term, non-prepayable debt with annual rent escalators

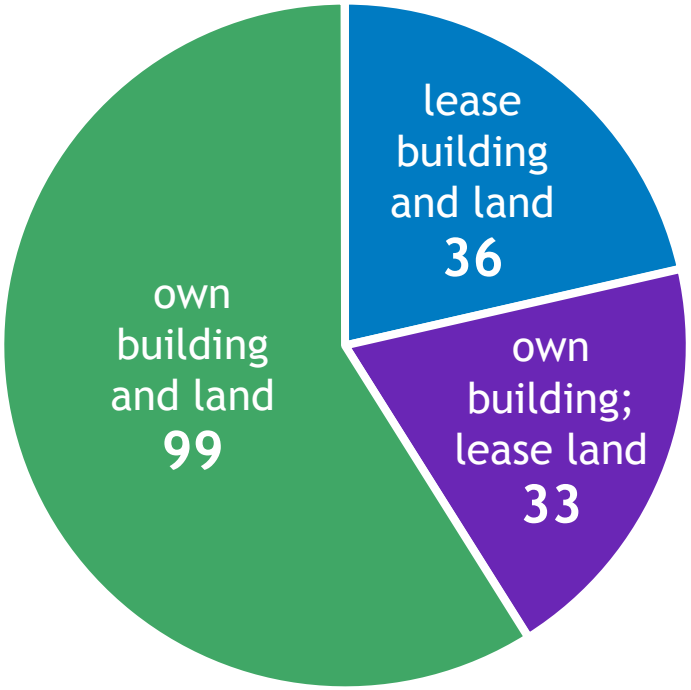
Ownership enhances flexibility in managing real estate portfolio

Presence of real estate on our balance sheet helps to facilitate access to senior debt on attractive terms

Specialty nature of our facilities contributes to relatively high cap rates from REITs

We are better positioned than traditional financing sources to hold the residual risk in our properties

Ownership Profile



Industry Overview

Industry overview | Continuum of healthcare services

Preventive

Routine health care (screenings, check-ups, patient counseling) to prevent illnesses, disease, or other health problems

Ambulatory

Medical care delivered on an outpatient basis (doctor visits, walk-in clinics, blood tests, x-rays, endoscopy, certain biopsies, certain surgical procedures)

Acute

Medical treatment of diseases or injuries for which a patient receives inpatient treatment for a brief but severe episode of illness

Post-acute

Medical care provided after a period of acute care, including: long-term care (LTCH), inpatient rehabilitation (IRF), skilled nursing (SNF), home health (HH)

Medicare acute care patients discharge destination*

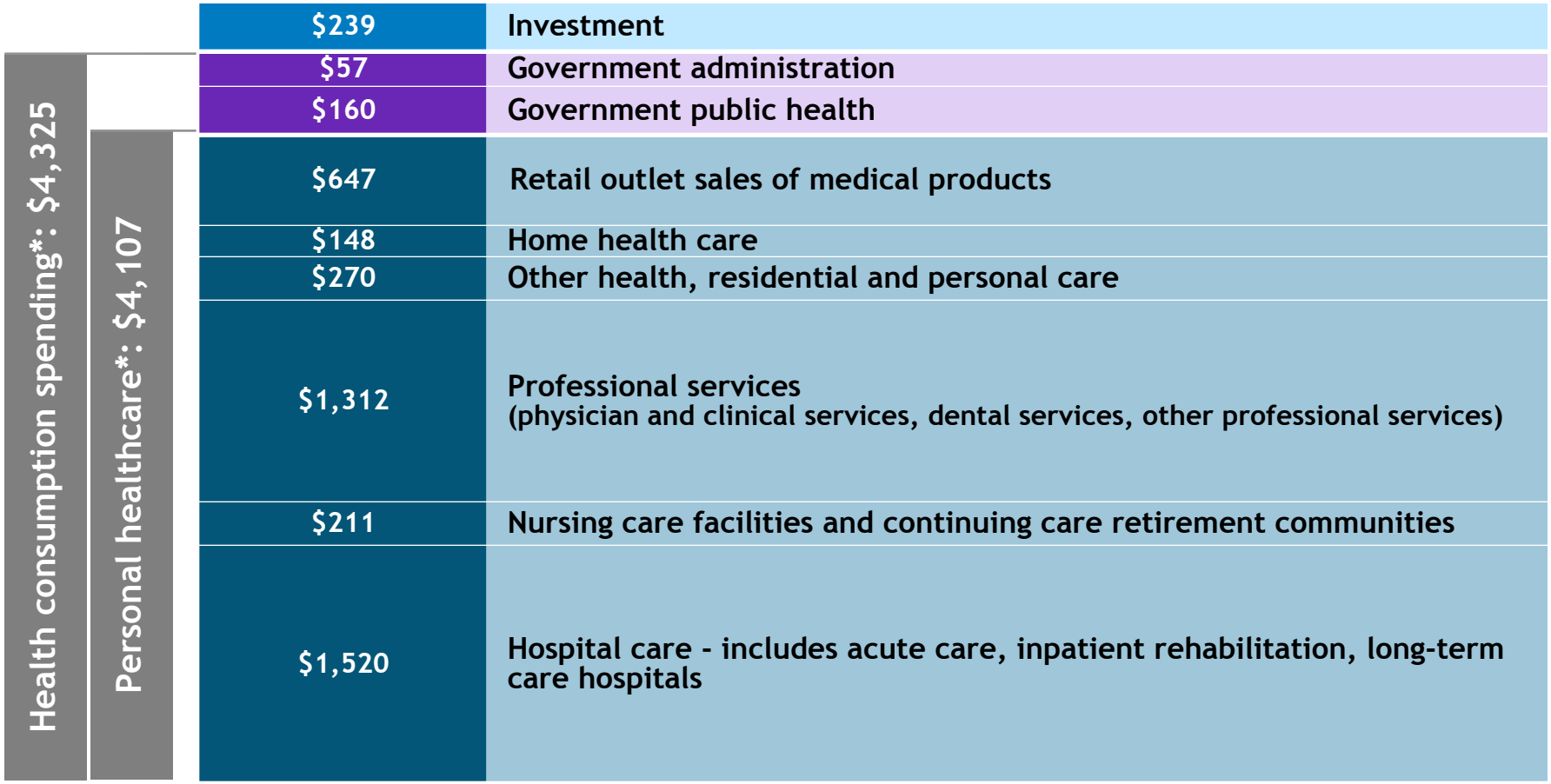
- LTCH ~0.8%
- IRF ~5.0%
- SNF ~19.9%
- HH ~21.3%
- Hospice ~3.7%
- No post-acute care ~44.2%

*Source: FORVIS reporting on Q4 2023 to Q3 2024 Medicare claims data. Other discharge destinations (~5.1%) may include another acute care hospital, specialty hospital, or other destinations.

Industry overview | Total healthcare spending

National healthcare spending: $4.867 trillion in 2023

(in billions)



Healthcare consumption spending includes total spending on healthcare goods and services excluding investments. Investments include non-commercial research and academic investments (including the purchase of buildings and equipment for such research).

Source: Centers for Medicare & Medicaid Services, National Health Expenditure Data (Historical), Table 2 - 2023.
*Excludes net cost of private health insurance of $303 billion.

Industry overview | Medicare 2023 spending

Total Medicare spending	Medicare spending on inpatient rehabilitation
$1,037 billion	$9.6 billion
(inclusive of payments to Medicare Advantage)	*(~1% of all Medicare spending)*

		% of Medicare spend	
$30B	Skilled nursing	3%	Medicare Part A
$144B	Inpatient hospital (includes IRF)	14%	
$71B	Physician payments	7%	Medicare Part B
$67B	Outpatient hospital	6%	
$16B	Home health	2%	Medicare Parts A & B
$26B	Hospice	2%	
$86B	Other services	8%	
$467B	Medicare Advantage* **Medicare Advantage plans also pay for the services listed on this page*	45%	Medicare Part C
$131B	Outpatient Rx	13%	Medicare Part D

Source: Centers for Medicare & Medicaid Services, Medicare Trustees' Report 2024 – page 11; and MedPAC, Medicare Payment Policy, March 2025 - pages 183, 225, 249, 267.

Industry overview | IRF qualifying conditions

60% or more of an IRF's annual admissions must have at least one medical diagnosis or functional impairment from a list of 13 qualifying conditions ("CMS-13").

CMS-13 qualifying conditions	
1	Stroke
2	Brain injury
3	Amputation
4	Spinal cord
5	Fracture of the femur
6	Neurological disorder
7	Multiple trauma
8	Congenital deformity
9	Burns
10	Osteoarthritis (after less intensive setting)
11	Rheumatoid arthritis (after less intensive setting)
12	Joint replacement - Bilateral - Age ≥ 85 - Body mass index > 50
13	Systemic vasculidities (after less intensive setting)

Other IRF qualification requirements at the time of a patient's admission

- ✓ Physician approval of preadmission screen and admission
- ✓ Patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy
- ✓ Patient can reasonably be expected to actively participate in, and benefit from, an intensive interdisciplinary rehabilitation therapy program of 3 hours of therapy a day, 5 days a week
- ✓ Requires supervision by a physician through face-to-face visits at least 3 days per week during the patient's stay to assess the patient both medically and functionally, as well as to modify the course of treatment as needed

Industry overview | Medicare post-acute care services

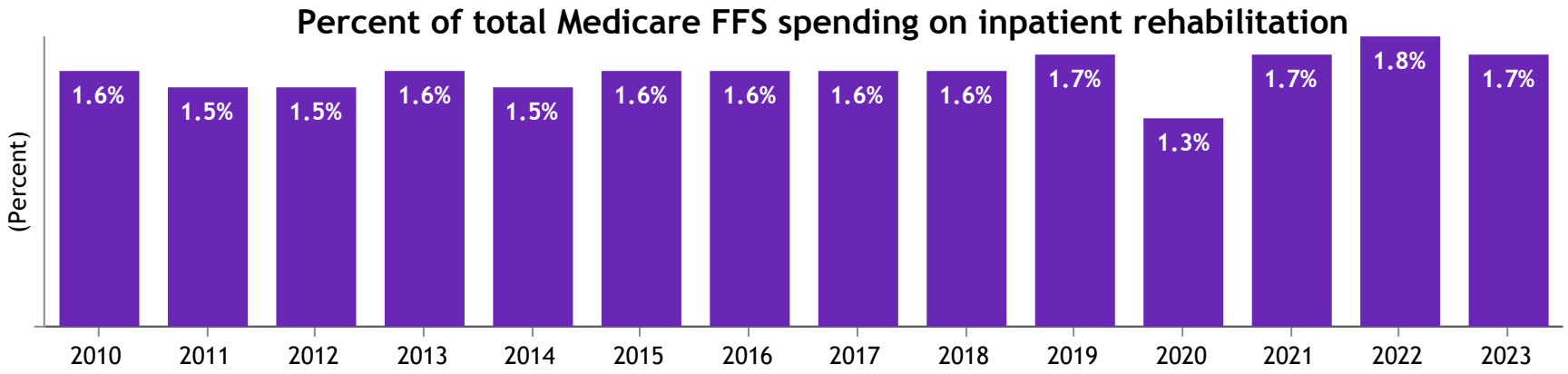
	Inpatient rehabilitation hospital	Skilled nursing facility	Home health
Medicare spending ($ billions)	$9.6	$30.0	$15.7*
# of Discharges/Beneficiaries^	~404,000	~1,600,000	~2,700,000^
Average length of stay	12.5 days	34.5 days	N/A
# of Providers	~1,206	~14,500	~12,057
Facility ownership mix**	For-profit (42%) Non-profit (50%) Gov't (8%)	For-profit (73%) Non-profit (22%) Gov't (5%)	For-profit (93%) Non-profit (7%)
Freestanding vs. hospital based	Freestanding (31%) Hospital based (69%)	Freestanding (97%) Hospital based (3%)	Freestanding (87%) Hospital based (13%)
Rural vs. urban**	Urban (87%) Rural (13%)	Urban (73%) Rural (27%)	Urban (86%) Rural (14%)

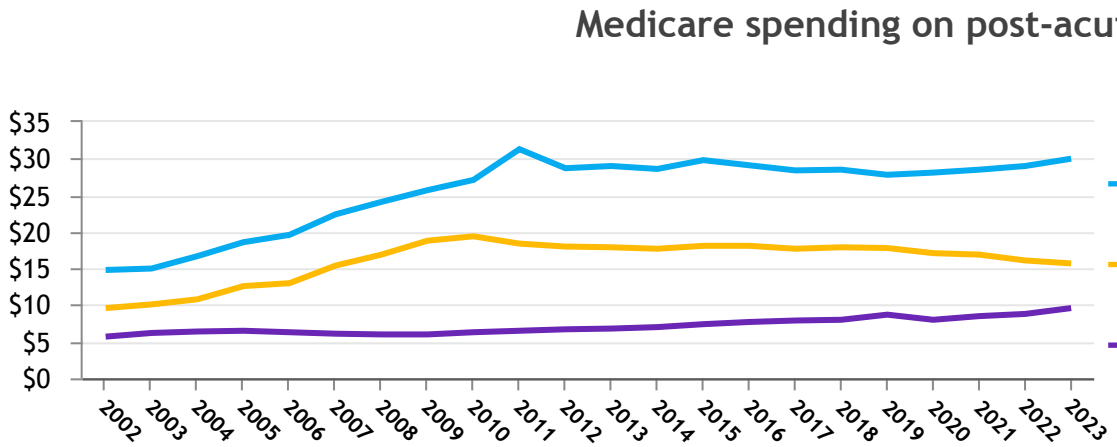
* Not all home health spending occurs as a post-acute service.
**Home health data represents freestanding agencies only.

Source: MedPAC, Medicare Payment Policy, March 2025 - pages 183, 188, 225, 231, 242, 249, 250, 253; March 2023- page 222; MedPAC, Health Care Spending and the Medicare Program, July 2024 - page 115.

Industry overview | Medicare spending on post-acute services

Medicare spent ~ $55 billion on post-acute services in 2023 (IRF, SNF, HH)





Post-acute setting	2002 Spending	2023 Spending
Skilled nursing facilities	$14.8	$30.0
Home health agencies*	$9.6	$15.7
Inpatient rehabilitation hospitals	$5.7	$9.6

$ in billions

*Not all home health spending occurs as a post-acute service.

Source: MedPAC, Medicare Payment Policy, March 2025 - pages 183, 225, and 249; Centers for Medicare and Medicaid Services, Medicare Trustees' Report 2024 - page 11.

Growth

Growth | Our rationale for continued expansion of IRF capacity

Large, under penetrated and growing market

- ~14.5% estimated conversion rate to IRF[(11)]
- Aging demographic (~4% population growth CAGR for age 75+ population)
- Supply of licensed IRF hospitals has increased only 4.2% since 2010
- SNF disintermediation opportunity
- Non-discretionary conditions

Significant barriers to entry and competitive advantages

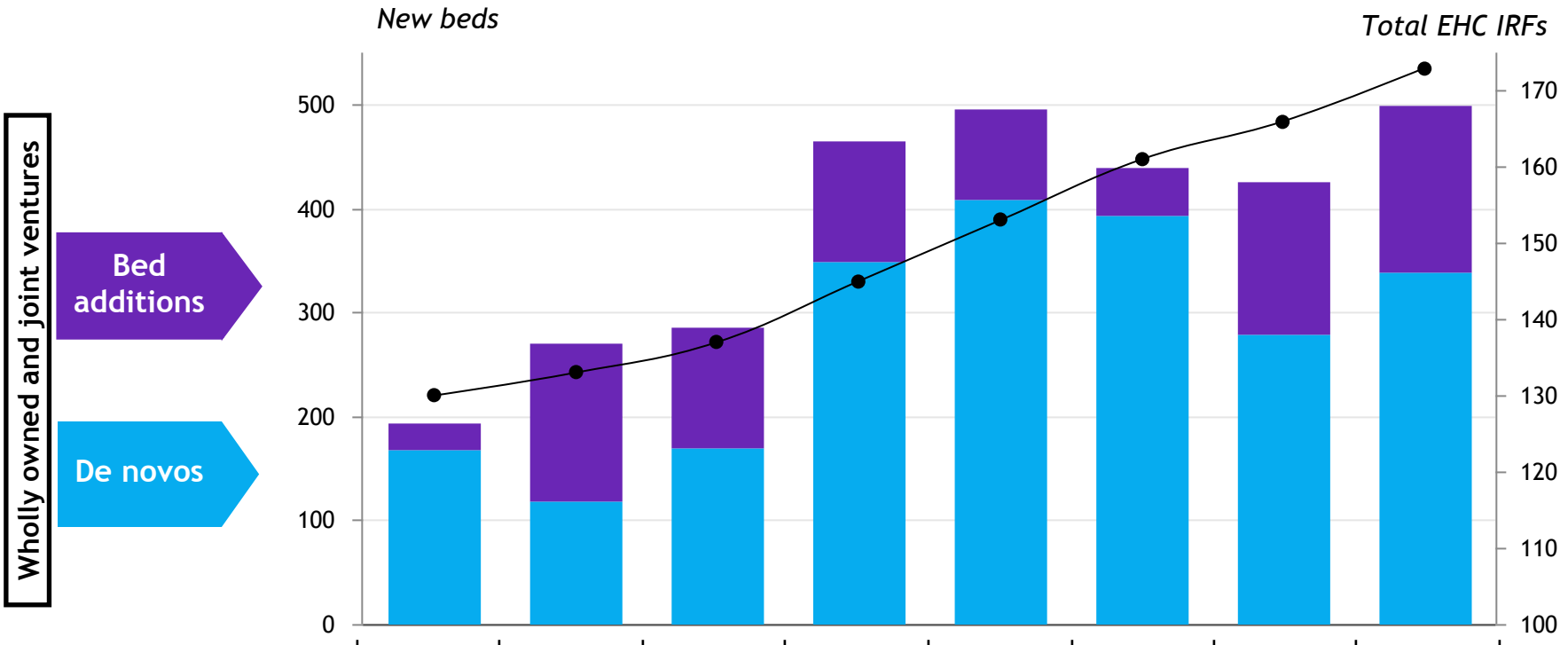
- Clinical expertise
- Access to capital
- Economies of scale
- Regulatory and compliance knowledge and infrastructure
- Long history of successful acute care hospital joint ventures
- Relationships with referral sources and payors
- Nationally known and highly regarded brand

Attractive financial returns on de novos and bed additions

- Fuels revenue and EBITDA growth
- Attractive ROIC
- Significant operating leverage in bed addition strategy
- Future period bed additions can increase de novo returns

Refer to pages 60-62 for end notes.

Growth | IRF growth strategy



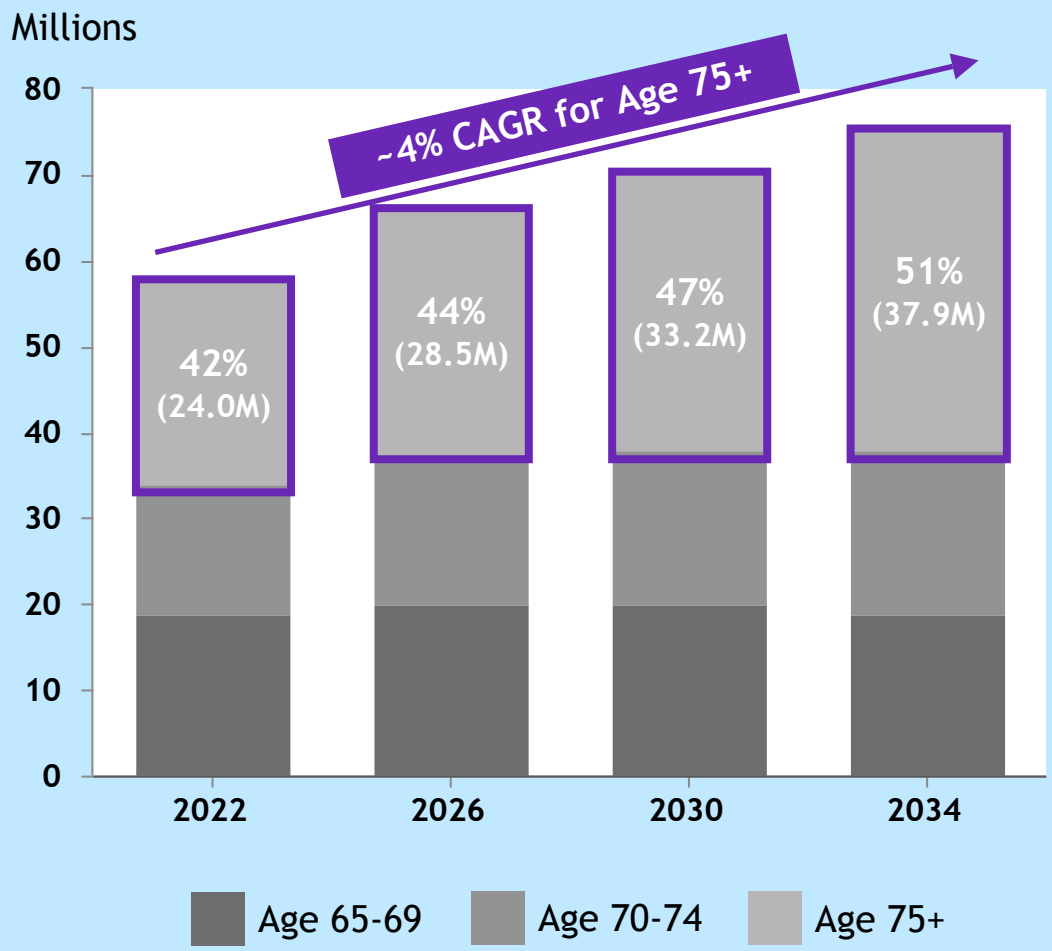
	2018	2019	2020	2021	2022	2023	2024	2025 (P)
Bed additions*	26	152	117	117	87	46	147	160
De novos (bed count)	169	120	170	350	410	395	280	340
De novos (new hospitals)	4	3	4	8	9	8	6	7
Total number of IRFs[12]	130	133	137	145	153	161	166	173
Total number of licensed beds[12]	8,966	9,249	9,505	9,924	10,356	10,778	11,094	11,594

*Bed additions include remote and satellite hospitals.[1]

Growth | Demand for IRF services continues to grow

Demand continues to benefit from a demographic tailwind: growth in the Medicare beneficiary population

Projected population of age 65+



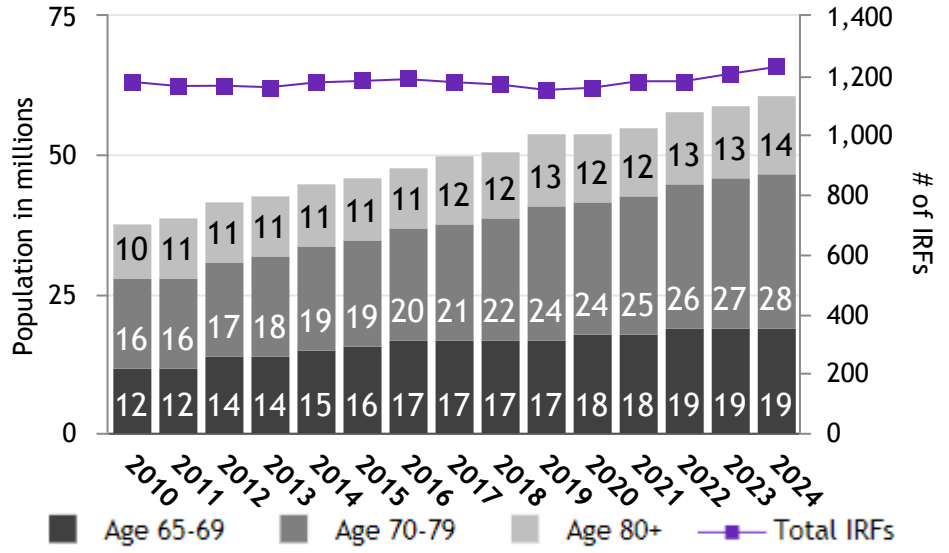
- The growth rate of Medicare beneficiaries increased to an ~3% CAGR in 2011, as "Baby Boomers" started turning age 65.
- **The average age of an Encompass Health Medicare beneficiary patient is ~77 years old.**

CAGR (population growth by age)		
Age	2022 to 2026	2026 to 2030
70-74	2.5%	2.0%
75+	4.4%	3.9%

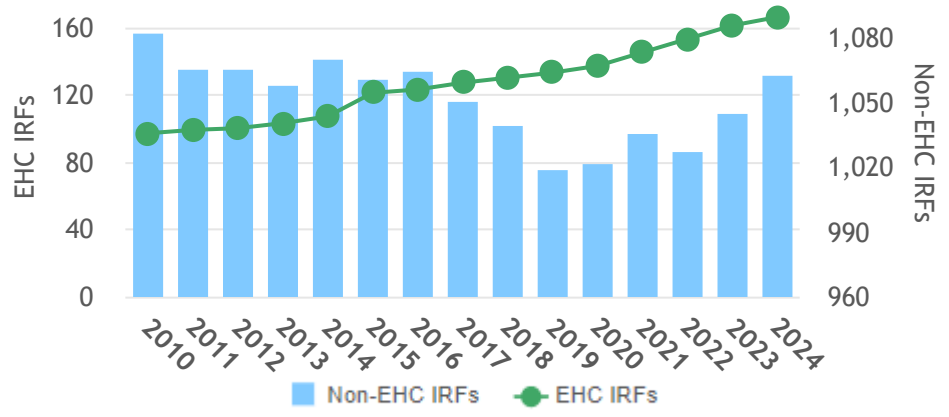
Source: https://www.census.gov/data/datasets/2023/demo/popproj/2023-popproj.html

Growth | IRF supply / demand imbalance continues to widen

IRF supply and demand



Supply of IRFs - EHC vs. Non-EHC



IRF supply has increased only 4.2% since 2010 ...

- 1,179 IRFs in 2010; 1,229 IRFs in 2024

... while the age 65+ population has increased 60.5%

- 38 million in 2010; 61 million in 2024

Challenges to entry include:

- medically complex patients requiring expert clinical services and skilled clinicians
- highly regulated industry
- establishment of referral and payor relationships
- significant capital investment

EHC has the scale, clinical and operational expertise, and access to capital to overcome these challenges. From 2016 to 2024, EHC:

- opened 47 de novo IRFs
- increased total beds from 8,404 to 11,094

Source: MedPAC, Medicare Payment Policy, 2025 – page 253, 2023 - page 263, 2018 – page 277, 2014 – page 247; Provider Data Catalog (cms.gov) inpatient rehabilitation facilities_general information dataset Dec. 2024; U.S. Census Bureau, Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2010 to July 1, 2019 and April 1, 2020 to July 1, 2024; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010-2018.

Growth | IRF conversion rate

IRF admission criteria

- At the time of admission, a patient must meet medical necessity criteria including:
  - ✓ require the active and ongoing therapeutic intervention of multiple therapy disciplines
  - ✓ be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program
  - ✓ receive supervision by a physician through face-to-face visits at least 3 days a week
- At least 60% of patients must have at least one CMS-13 medical diagnosis or functional impairment

IRF conversion rate

- It is estimated that only ~14.5%[11] of acute care patients who are presumptively eligible for IRF services (those with at least one CMS-13 medical diagnosis or condition) are admitted to an IRF

Reasons for low IRF conversion

- Low awareness of IRF vs. SNF care requirements for physician visits, nursing coverage, care team meetings and therapy provision
- Lack of understanding of IRF value proposition
  - ✓ Quality of outcomes
  - ✓ Episodic versus per diem cost comparison
- Restrictive MA prescreening procedures/criteria
- Many markets have low IRF bed availability (sometimes attributable to CON requirements)

☆ EHC strategies are in place to address each of these

Refer to pages 60-62 for end notes.

Growth | Medicare levels of service required - IRF vs. SNF

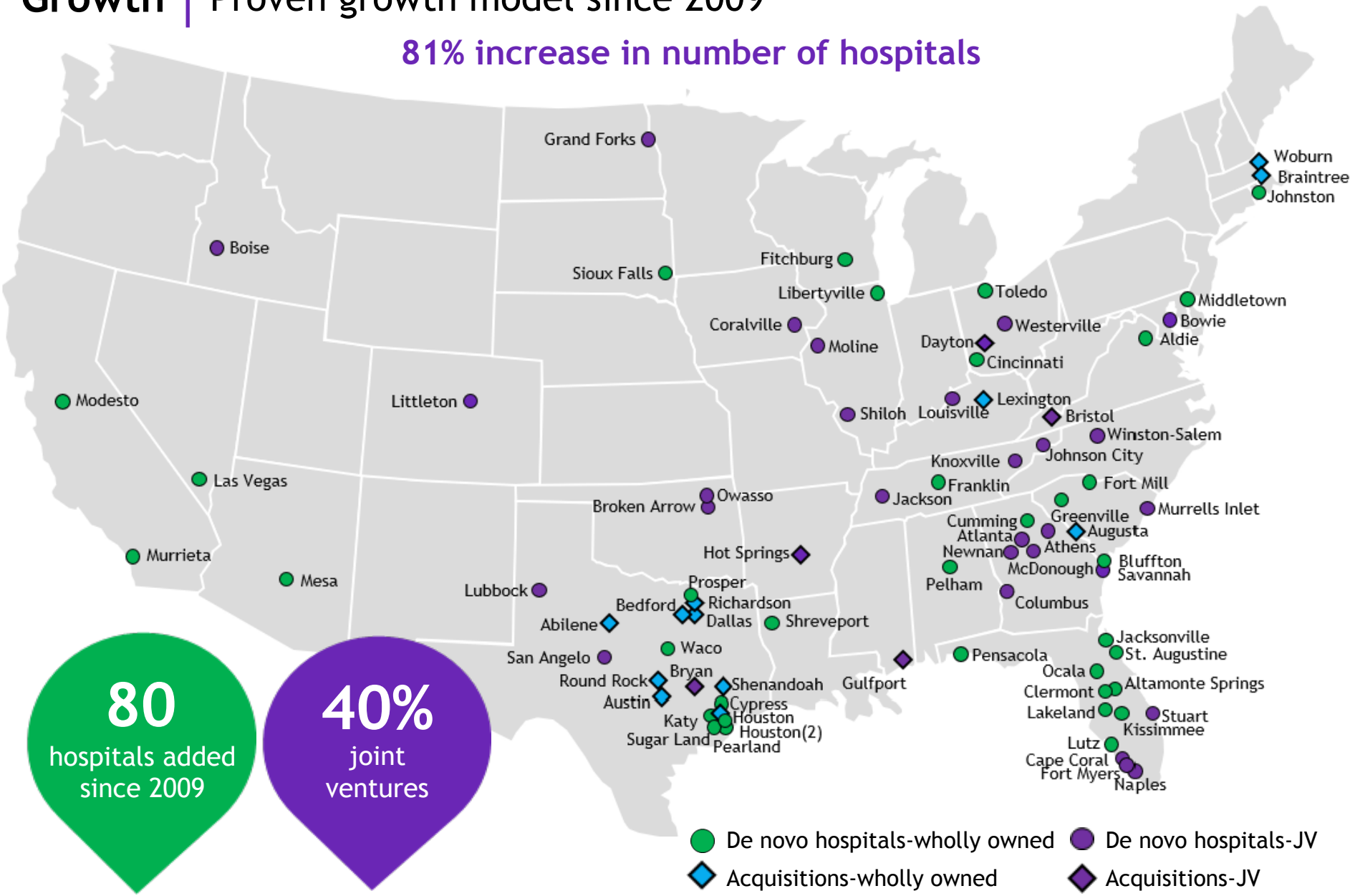
Industry averages			
		IRF	SNF
Quality metrics*	FFS average length of stay	12.5 days	34.5 days
	Discharge to community rate	67.2%	50.9%

CMS requirements for IRFs vs. SNFs			
		IRF	SNF
Regulatory	Facility must satisfy regulatory and policy requirements for hospitals, including Medicare hospital conditions of participation	Yes	No
Patient care	At a minimum, face-to-face rehabilitation physician visits must occur no fewer than 3 times per week during the course of the patient's stay	Yes	No
	All patients must need and generally receive a minimum of 3 hours a day of intensive therapy, 5 days a week	Yes	No
	Nursing care is required 24 hours, 7 days a week by registered nurses	Yes	No
	A weekly team meeting, led by the physician and includes a rehabilitation nurse, a case manager, and a licensed therapist from each therapy discipline	Yes	No
Admission requirements	All patients must be admitted by a physician	Yes	No
	Stringent admission and coverage policies are required and carefully documented for each admission; further restricted in number and type of patients (e.g., 60% Rule)	Yes	No

*Source: MedPAC, Medicare Payment Policy, March 2025 - pages 184 and 250 for IRF data and SNF discharge to community rate; March 2023 – page 222 for SNF average length of stay.

Growth | Proven growth model since 2009

81% increase in number of hospitals



80
hospitals added since 2009

40%
joint ventures

De novo hospitals-wholly owned
De novo hospitals-JV
Acquisitions-wholly owned
Acquisitions-JV

Growth | Robust de novo development pipeline

17 New hospitals announced and underway*

Market considerations

- Demographics and potential growth of local market
- State CON, licensure and other regulatory requirements
- Presence of other inpatient rehabilitation services
- Geographic proximity to other EHC hospitals
- Potential joint venture partners
- Volumes, patient mix, service lines and discharge patterns of acute care hospitals
- Labor supply and costs
- Land and construction costs

Investment considerations

- Key metrics
  - Project NPV, IRR and ROIC
- Sensitivity analysis on key performance assumptions
- Comparison to analog EHC hospitals
- Potential for future expansion

Hospitals opened or under development
2025 to 2027

		Joint venture	Est. Opening Date	# of beds
De novo projects**				
	Athens, GA	✓	opened 1Q25	40
	Fort Myers, FL	✓	opened 2Q25	60
1	Daytona Beach, FL		2Q25	50
2	Danbury, CT		3Q25	40
3	Lake Worth, FL		4Q25	50
4	St. Petersburg, FL		4Q25	50
5	Amarillo, TX		4Q25	50
6	Irmo, SC		2026	50
7	Condordville, PA		2026	50
8	Loganville, GA	✓	2026	40
9	Norristown, PA		2026	50
10	Avondale, AZ		2026	60
11	San Antonio, TX		2026	50
12	Wesley Chapel, FL		2027	50
13	Palm Beach Gardens, FL		2027	50
14	Bangor, ME		2027	50
15	St. George, UT		2027	50
16	Apollo Beach, FL		2027	50
Remote and satellite[(1)]**				
17	Wildwood, FL (in The Villages, FL)		3Q25	50

**All dates are tentative and subject to change

*IRFs under development - previously announced under development as of June 13, 2025
Refer to pages 60-62 for end notes.

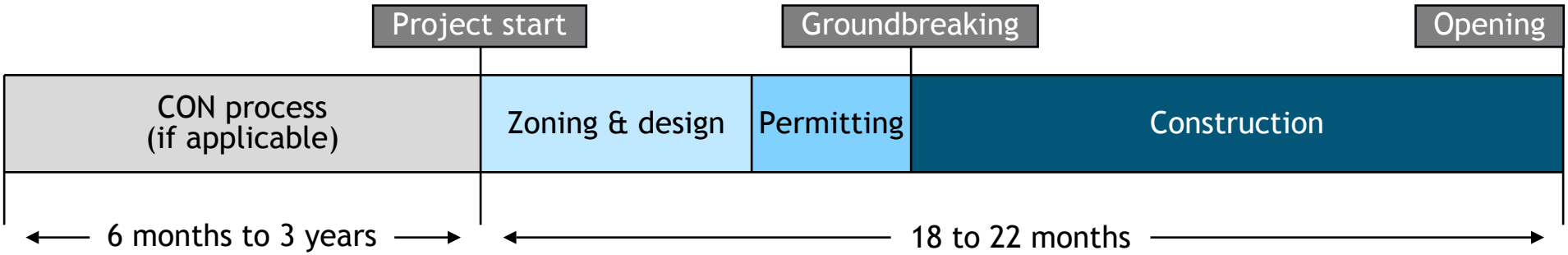
Growth | De novo costs and timeline

- Prototype hospital includes all private rooms
- Core infrastructure of building anticipates future expansion (accretive to financial returns)
- Factors that impact costs/timeline:
  - ✓ CON status
  - ✓ State regulatory requirements
  - ✓ Local planning and zoning approval
  - ✓ Other location- or hospital-specific complexities

Capital cost ($ in millions)	2023-2024	2025-2026
Construction, design, permitting, etc.	$44.0	$47.0
Land	5.0	5.0
Equipment (including CIS)	5.5	6.0
Cost of a typical 50-bed IRF	**$54.5**	**$58.0**
Pre-opening & ramp up costs* ($ in millions)		
Operating	$1.0	$1.0
Salaries, wages, benefits	1.5	1.5
	$2.5	**$2.5**

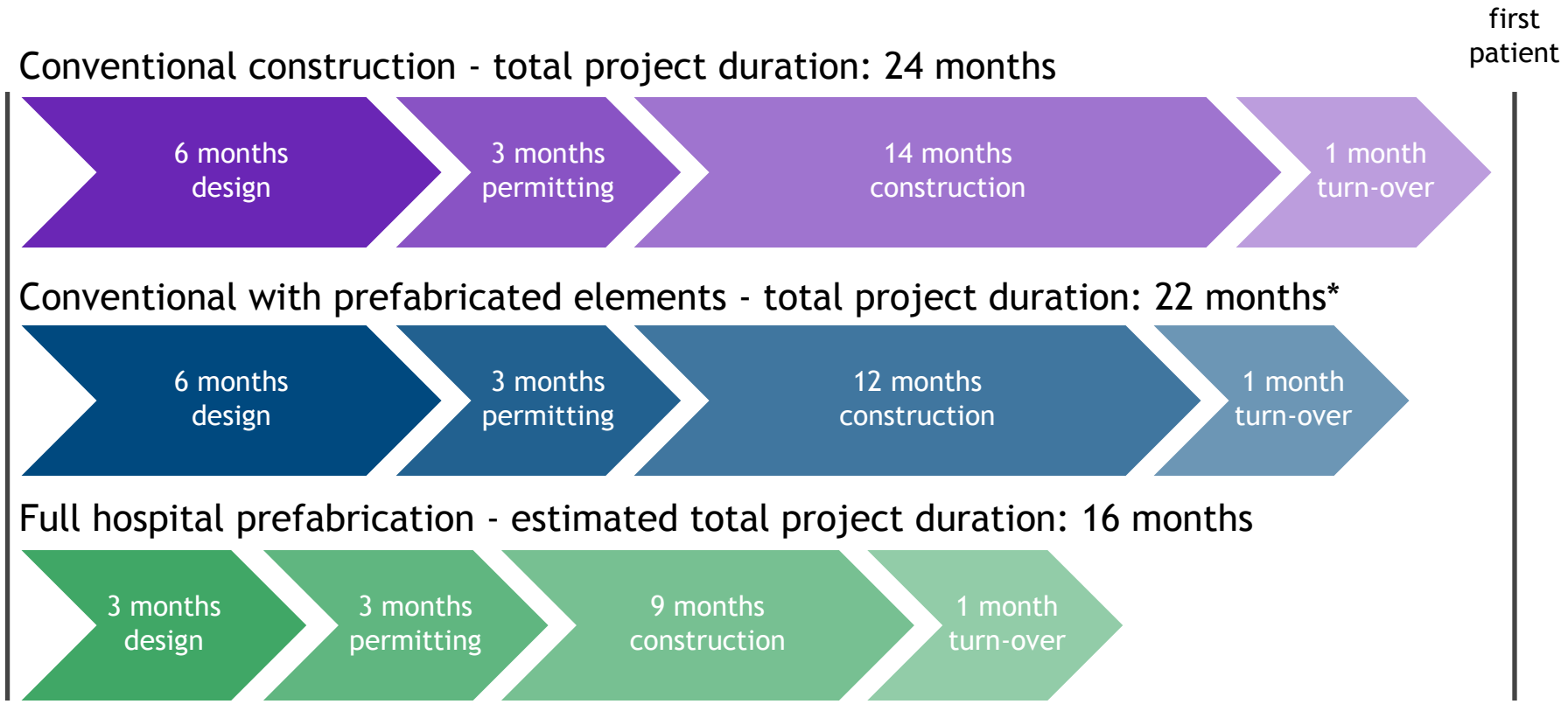
Amounts are the average per hospital capital costs based on actual costs for EHC's 2023 and 2024 50-bed hospitals and the projected costs for EHC's 2025 and 2026 50-bed hospitals. The pricing for these projects is based on contracts established up to two years prior to hospital opening and may not fully represent inflationary pressures in the current market.

Illustrative timeline



*Pre-opening expenses include expenses for pre-opening hires, training and other general operating costs incurred prior to the first patient's admission. The costs for this purpose are not inclusive of any revenues generated during the first month of operation.

Growth | De novo project process



Full prefabrication time to completion benefits:

- 33% reduction (8 months) compared to conventional construction
- 27% reduction (6 months) compared to conventional construction with some elements of prefabrication

*Project duration for conventional construction with prefabricated elements ranges from 18 to 22 months based on the specific project characteristics and site development conditions, and the amount of prefabrication.

Growth | Prefabrication advantages

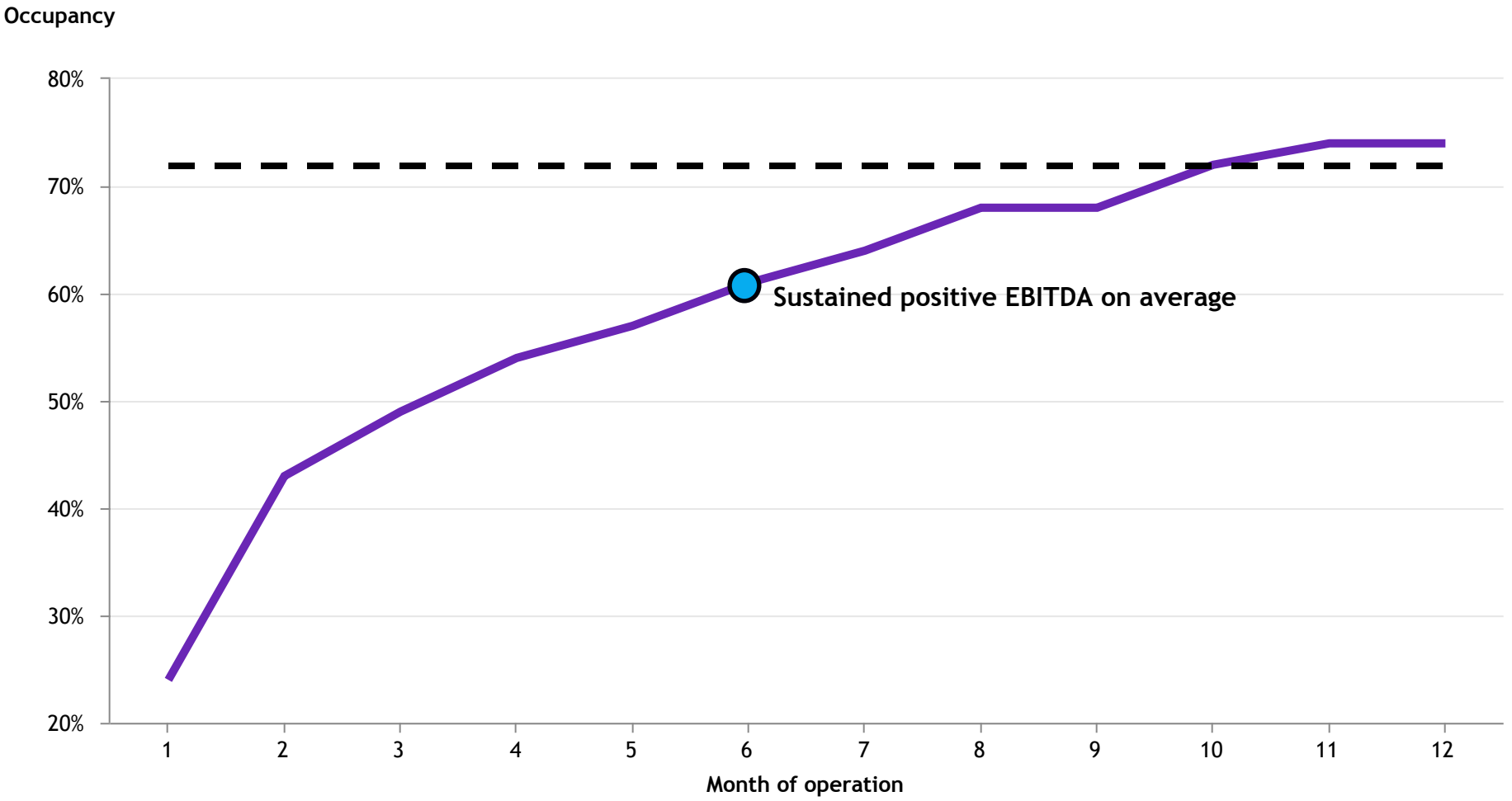
Staffing model for a typical 50-bed de novo hospital at opening

- ~11 FTEs — Hospital management
- ~18 FTEs — Therapy staff
- ~38 FTEs — Nursing staff
- ~33 FTEs — Support staff

Staffing at maturity is ~150 FTEs.

Growth

De novo occupancy and EBITDA* trend - hospitals opened 2021 to 2024



*EBITDA = earnings before interest, taxes, depreciation, and amortization directly attributable to the related hospital

Refer to pages 60-62 for end notes.

Operational Initiatives

Operational initiatives | Summary

Build market share in high acuity, IRF appropriate conditions

- Utilize extensive database on IRF eligible patients to continuously refine clinical protocols and improve patient outcomes

Develop and implement post-acute solutions, clinical initiatives and operational best practices

- Clinical innovation model
- Internally and co-developed solutions
- Incorporate data analytics
- Continuous collaboration across our hospitals

Evaluate and implement therapy and clinical technologies

- Technologies developed in-house or with vendors
- Includes:
  - state-of-the-art therapy technology used by clinicians in the treatment of patients
  - automation and technology used by the patient and the patient's caregivers to improve the patient's non-therapy experience

Operational initiatives | Build market share in high acuity conditions

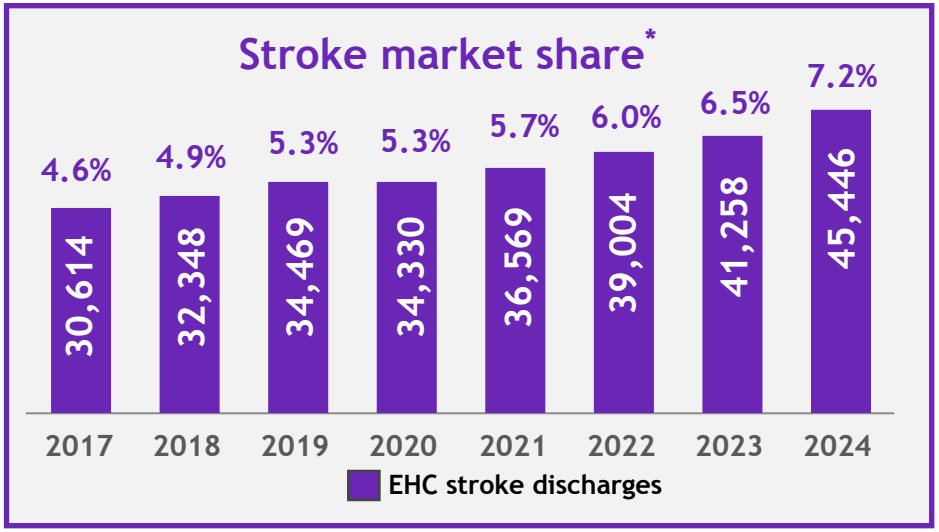
Increase stroke patient market share through education and awareness

American Stroke Association
A division of the American Heart Association.
Together to End Stroke®

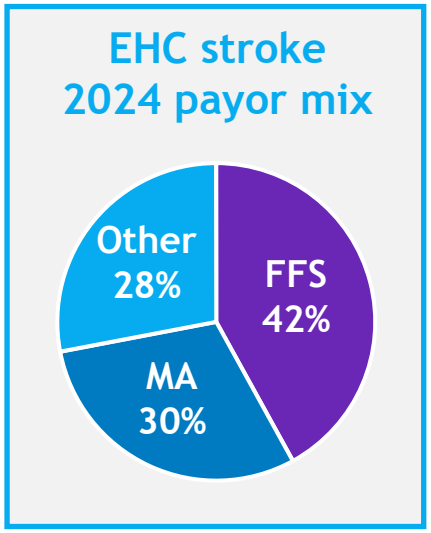
Encompass Health partners with the American Stroke Association and is a proud sponsor of the Together to End Stroke Initiative.

In 2024, Joint Encompass Health and American Stroke Association materials were highlighted for healthcare professionals at the International Stroke Conference, American Association of Neuroscience Nurses Annual Meeting, and World Stroke Congress Conference.

Co-developed materials for 2024 include a lesson module on “Exercising After Stroke” and a how-to video simplifying everyday tasks for stroke survivors. Our online resources continue to outperform our online interaction goals.



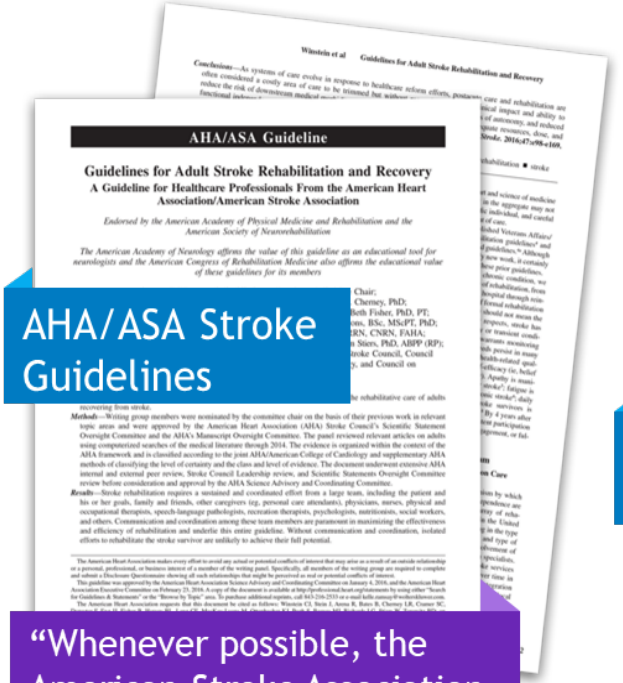
Stroke as a % of payor discharges (2024)	
% of Total discharges	18.3%
% of Medicare FFS discharges	12.6%
% of Medicare Advantage discharges	32.7%



*Stroke market share = EHC stroke discharges / total stroke survivors

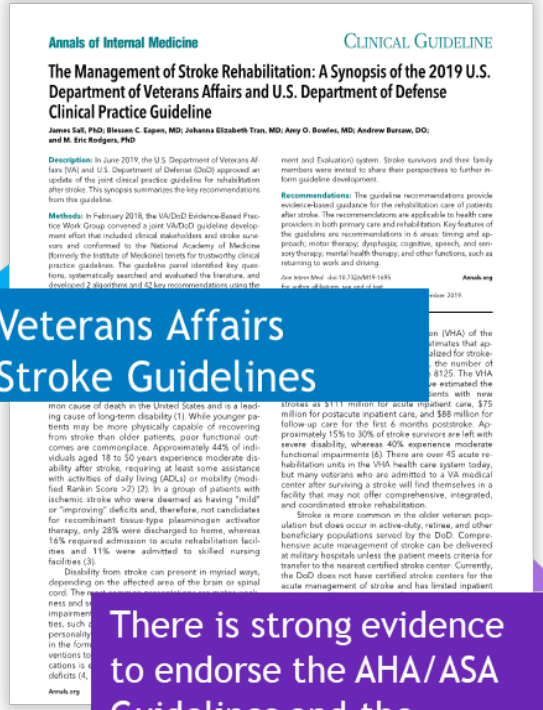
Operational initiatives | Build market share in high acuity conditions

Independent research concludes IRFs are a better rehabilitation option for stroke patients compared to SNFs



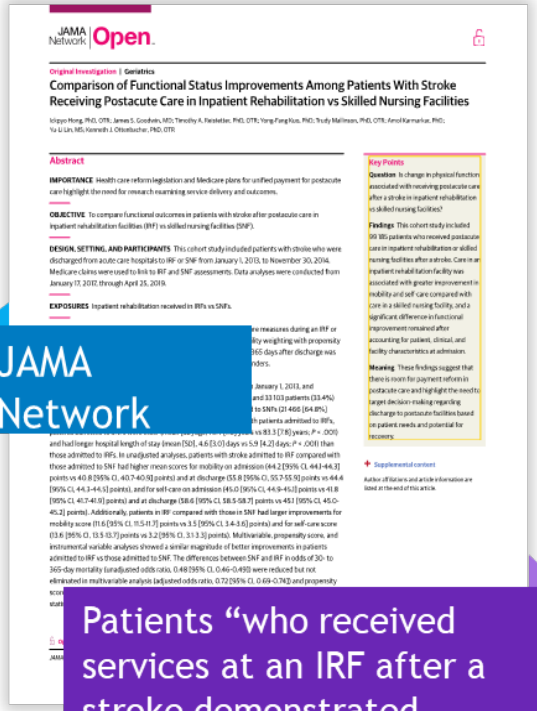
AHA/ASA Stroke Guidelines

"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility."*



Veterans Affairs Stroke Guidelines

There is strong evidence to endorse the AHA/ASA Guidelines and the need for an organized, multidisciplinary approach found at an Inpatient Rehabilitation Facility.



JAMA Network

Patients "who received services at an IRF after a stroke demonstrated greater improvement in mobility and self care compared with patients who received inpatient rehabilitation at a SNF."**

*AHA/ASA press release, "Inpatient rehab recommended over nursing homes for stroke rehab," issued May 4, 2016.
**"The Management of Stroke Rehabilitation" issued December 2019 (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756256?resultClick=1).

Operational initiatives | Build market share in high acuity conditions

Encompass Health's in-house dialysis features a dedicated space and staff on site for ongoing patient and family education. The dialysis team consists of a nephrologist that oversees the program and RN staff with previous dialysis care experience.

Benefits compared to third-party dialysis include:

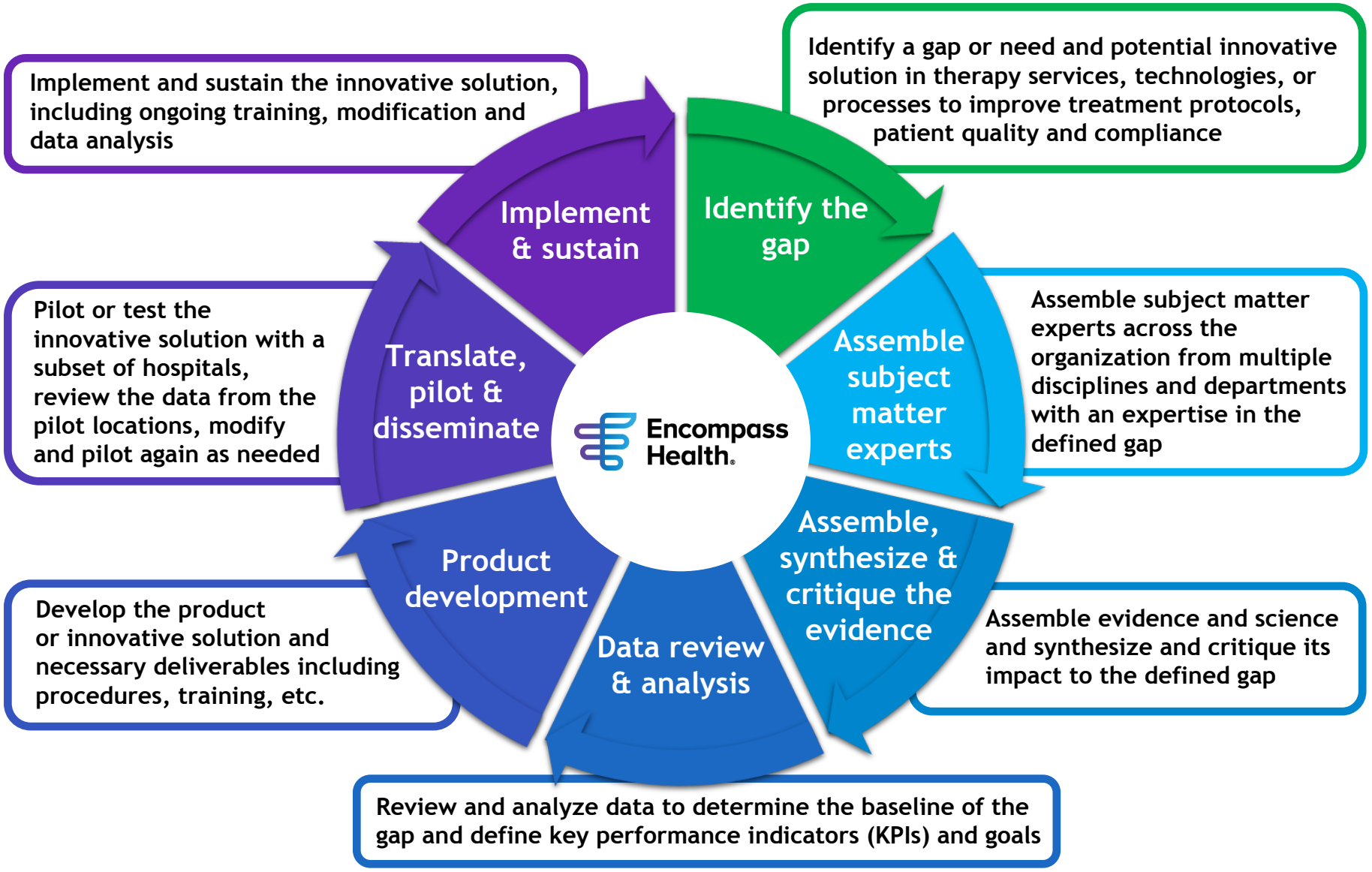
- Better coordination of therapy and dialysis
- Recovery time from dialysis is shorter using Tablo, 2-3 hours versus 24 hours with traditional hemodialysis
- Evidence of a reduction in readmissions
- Hospital's clinical team can take a complete holistic approach to care
- Eliminates patient transport to/from dialysis center allowing for more rest and less therapy interruption

Tablo available in **110** of our hospitals as of March 31, 2025, with additional locations planned in 2025.

Approximately **5%** of Encompass Health patients require dialysis services.

The cost benefit per treatment is **~$300** compared to a third-party dialysis provider.

Operational initiatives | Post-acute clinical innovation model



Operational initiatives | Post-acute solutions

- **Goals are to optimize our predictive tools and to use our extensive clinical database to further improve patient outcomes**
- **Strategy is to regularly update models and incorporate advances in predictive modeling; improve ease of learning and adoption**

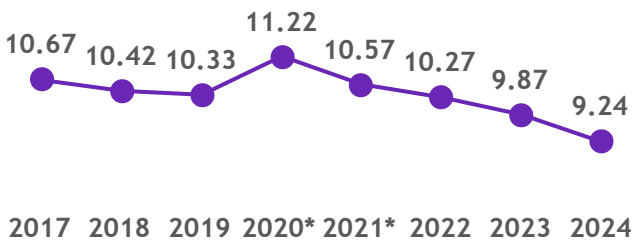
Encompass Health REACT™

Trademarked system developed in 2015 to predict a patient's risk of being transferred back to an acute care hospital.

40 clinical variables are considered in the risk analysis with risk levels assigned to each patient. Higher risk generates action items including clinician intervention as necessary.

The Company's performance since the system was fully implemented in 2017 is shown below.

Acute Care Transfer Rate (%)**



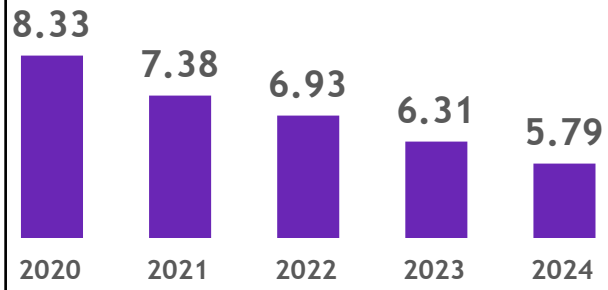
Fall Risk Model

Initiated in November 2021 to provide clinicians a near-real-time evaluation of each patient's fall risk.

50 clinical elements are considered and patients are assigned risk levels. Fall prevention strategies are suggested based on risk assessment.

The Company began implementation in 2021 with an enterprise wide year of utilization in 2022.

Fall Rate***



Readmission Prediction Model

The Readmission Prediction Model was initiated in October 2020. A patient's probability of readmission to an acute care hospital post IRF discharge is assessed based on diagnoses, medications, lab results, vitals and other patient information.

This model is part of the Readmission Prevention Program where the model's assignment of a risk score is paired with the program standards and playbook guide with risk mitigation strategies. Intervention based on risk level may include scheduling follow-up visits, ensuring medication is available, and follow up with caregivers and patients post-discharge.

*Reflects COVID impact **Acute care transfer rate = acute care transfers / total number of discharges
***Fall rate = number of patient falls per 1,000 patient days

Operational initiatives | Evidence-based clinical initiatives

Patient & caregiver education

Enhanced our patient and caregiver education program to include clinician led training, online videos and resources, near real-time caregiver app, personalized home assessments, and support groups.

Wound care

Enhanced our wound care protocol by expanding options of available equipment, increased assessments on admission, and Wound Summits for training of wound care coordinators.

Reduced new or worsening wounds per 1,000 patient days by 41% since 2022.

Infection control

Standardized and improved infection control practices across the Company. These practices and oversight provided clinicians with tools to successfully navigate the COVID-19 pandemic.

Applied evidence-based decision making

Sepsis/SIRS alert

Implemented an evidenced-based predictive model to identify patients at-risk for sepsis or Systemic Inflammatory Response Syndrome (“SIRS”)

Applied intervention strategies as part of the plan of care

Medication reconciliation

Implemented a multidisciplinary reconciliation process using the Company's EMR upon admission and discharge

PEG Talks resources for clinicians

Reduce opioid use

Implemented a multidisciplinary approach to improve pain management, including non-pharmacologic treatment of pain and vigilant opioid stewardship

Required PEG Talks education to all therapists for pain management

PEG TALKS
PRINCIPLES, EXCELLENCE, GUIDELINES

Reduce readmissions & improve outcomes

Operational initiatives | Culture of collaboration and emphasis on best practices

Collaboration among our hospital teams supports continuous learning and deployment of best practices

Standardization across all hospitals

- Care management
- Comfort, Professionalism & Respect (CPR - Heart of the Patient Experience)
- Pre-admission & admission process
- Clinical documentation
- Credentialing
- Career ladders for nursing, therapy and case management
- Contracting
- Therapy practice guidelines
- Medication management & reconciliation
- Clinical education offerings for staff
- Policies & procedures
- Quality reporting program
- Predictive models

Value of collaboration and networking across hospitals

- Strategic development as market dynamics change
- TJC Disease Specific Certification through shared program development tools
- Leadership mentoring among leaders within the same organization
- Lessons learned that impact metrics related to quality, employees and financial measures

Operational initiatives | Therapy and clinical technologies

Therapy Technology

The therapy innovations committee reviews and recommends state of the art technology for our hospitals to ensure our therapy teams have the equipment and the training to provide the best care.

(recent implementations are shown below)

Synchrony 4.0

Integrates surface electromyography with virtual reality to help patients visualize swallow activity

BITS

A multidisciplinary therapy solution used for balance, cognitive and visuo-motor therapy

Vector

Robotic trolleys using dynamic body weight support to promote faster recovery, over-ground gait rehabilitation and activities of daily living

BURT

A highly dexterous robotic arm manipulator for upper-extremity rehabilitation training

To learn more about technologies we offer in our hospitals visit encompasshealth.com/inpatient-rehabilitation/technology

Clinical Technology

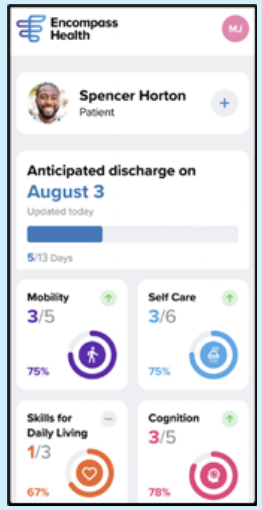
As our employees engage with patients and their families outside of therapy sessions, automation and technology is available for a better patient experience.

(recent implementations are shown below)

MyEncompass Health

The MyEncompass Health caregiver application is a patient experience application designed to promote early, ongoing engagement of the patient and their family or caregivers by communicating real-time progress toward their goals and an overview of their care plan in a secure manner.

The application is integrated with ACE IT (our clinical information system) for real-time updates to the patient's information.



CBORD food service management technology provides the hospital an electronic meal ordering and preparation system with standardized meal plans plus a point-of-sale system for cafeteria operations. The system interfaces with ACE IT to provide accurate and timely diet information, including nutritional data for blood sugar management and malnutrition status.

eMenu eCafé

Information Technology

Information technology | Clinical information system

2010 - Our first hospital went live with the Cerner EMR system

2012 - We began a five year rollout to every hospital

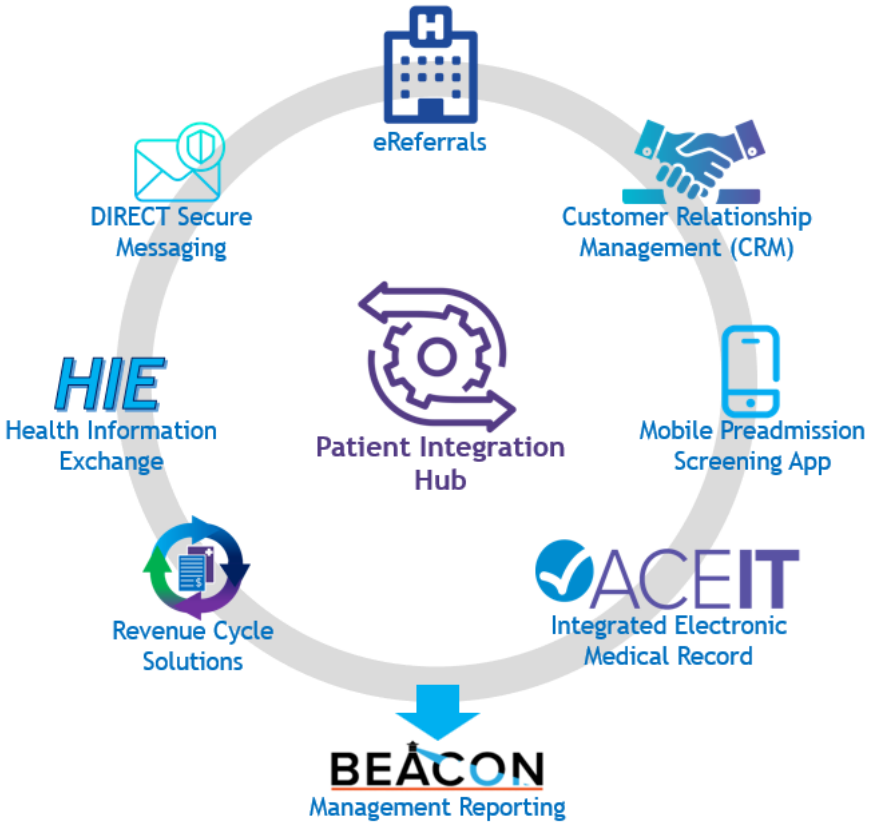
Benefits:

- Patient outcomes and safety
- Operational efficiencies
- Cost effectiveness
- Change agility

Information technology | Beacon management reporting

Standardize the process, then automate it

Enterprise scalability + Proprietary large patient datasets + Clinical and business knowledge = Continuous improvement



BEACON Proprietary Management System

- Proprietary operations management system that provides real-time data
- Benchmarking to promote best practices
- Capabilities include:
  - Physician quality reporting
  - Readmission risk
  - Therapy outcomes analysis
  - Quality and patient satisfaction reporting
  - Workforce and labor productivity
  - Sales and marketing analysis
  - Care management
  - Food and drug spend analysis
  - Ability to run market-by-market analysis and reports
  - Accounts Receivable analysis
  - Dialysis outcomes analysis

MyEncompass Health caregiver application

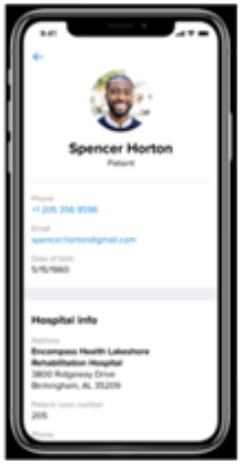
The app shows a patient's real-time progress toward their goals and an overview of their care plan in a secure manner. Information in the app is regularly updated by interfacing with our clinical documentation system specific to the patient's goals and outcomes.

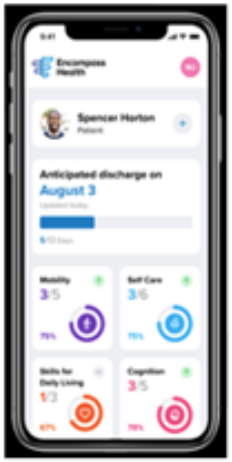
TRACK

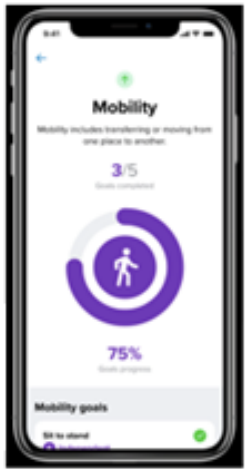
- Follow the patient's stay at our hospital as they make progress toward established goals.
- Track goals established by the patient and the hospital interdisciplinary care team, including mobility, self-care, cognition and behavior, and daily living skills such as meal preparation and medication management.
- See anticipated discharge date / plan for discharge

SHARE

- Invite others to follow along as the patient progresses in their rehabilitation stay
- The patient and those who are granted access to app will have access up to 14 days after discharge







Reconciliations to GAAP

Reconciliation | Net cash provided by operating activities to Adjusted EBITDA[10]

($ in millions)	For the Year Ended December 31, 2024	2023	2022	2021
Net cash provided by operating activities	$ 1,002.8	$ 850.8	$ 705.8	$ 715.8
Interest expense and amortization of debt discounts and fees	137.4	143.5	175.7	164.3
Gain (loss) on sale of investments, excluding impairments	2.7	4.6	(15.5)	3.8
Equity in net income of nonconsolidated affiliates	3.0	3.2	2.9	3.4
Net income attributable to noncontrolling interests in continuing operations	(140.9)	(111.0)	(93.6)	(103.2)
Amortization of debt-related items	(9.7)	(9.5)	(9.7)	(7.8)
Distributions from nonconsolidated affiliates	(4.0)	(1.6)	(4.0)	(2.6)
Current portion of income tax expense	139.5	128.3	72.2	84.5
Change in assets and liabilities	(21.9)	(50.3)	30.4	109.9
Cash used in (provided by) operating activities of discontinued operations	3.1	16.0	(52.3)	(151.1)
Asset impairment impact on noncontrolling interests[13]	(7.3)	—	—	—
State regulatory change impact on noncontrolling interests[14]	—	(2.2)	—	—
Change in fair market value of equity securities	(1.0)	(0.7)	7.4	(0.6)
Adjusted EBITDA	$ 1,103.7	$ 971.1	$ 819.3	$ 816.4

The leverage ratio for 2021 stated in terms of the most comparable GAAP measurement would be Total debt to Net cash provided by operating activities: 4.6x

The leverage ratio for 2022 stated in terms of the most comparable GAAP measurement would be Total debt to Net cash provided by operating activities: 3.9x

The leverage ratio for 2023 stated in terms of the most comparable GAAP measurement would be Total debt to Net cash provided by operating activities: 3.2x

The leverage ratio for 2024 stated in terms of the most comparable GAAP measurement would be Total debt to Net cash provided by operating activities: 2.5x

Information regarding investing and financing categories of the statement of cash flows for the periods presented can be found on Encompass Health's website in the Earnings Releases for those periods.

Refer to pages 60-62 for end notes.

Reconciliation | Net income to Adjusted EBITDA[10]

($ in millions)	For the Year Ended December 31, 2024	2023	2022	2021
Net income	$ 596.6	$ 463.0	$ 365.9	$ 517.2
Loss (income) from discontinued operations, net of tax, attributable to Encompass Health	2.8	12.0	(15.2)	(114.1)
Net income attributable to noncontrolling interests included in continuing operations	(140.9)	(111.0)	(93.6)	(103.2)
Provision for income tax expense	150.2	132.2	100.1	101.9
Interest expense and amortization of debt discounts and fees	137.4	143.5	175.7	164.3
Depreciation and amortization[14]	299.6	273.9	243.6	219.6
Loss on early extinguishment of debt [15][16][17]	0.6	—	1.4	1.0
Loss on disposal or impairment of assets	17.4	9.8	4.8	1.2
Stock-based compensation	48.3	50.6	29.2	29.1
Asset impairment impact on noncontrolling interests[13]	(7.3)	—	—	—
State regulatory change impact on noncontrolling interests[14]	—	(2.2)	—	—
Change in fair market value of equity securities	(1.0)	(0.7)	7.4	(0.6)
Adjusted EBITDA	$ 1,103.7	$ 971.1	$ 819.3	$ 816.4

Refer to pages 60-62 for end notes.

Reconciliation | Net cash provided by operating activities to adjusted free cash flow[9]

($ in millions)	For the Year Ended December 31, 2024	2023	2022	2021
Net cash provided by operating activities	$ 1,002.8	$ 850.8	$ 705.8	$ 715.8
Impact of discontinued operations	3.1	16.0	(52.3)	(151.1)
Net cash provided by operating activities of continuing operations	1,005.9	866.8	653.5	564.7
Capital expenditures for maintenance	(184.6)	(216.9)	(238.4)	(133.4)
Distributions paid to noncontrolling interests of consolidated affiliates	(125.0)	(114.7)	(96.6)	(101.1)
Items not indicative of ongoing operating performance:				
Transaction costs and related liabilities	(6.0)	(9.5)	21.6	—
Adjusted free cash flow	**$ 690.3**	**$ 525.7**	**$ 340.1**	**$ 330.2**

Information regarding investing and financing categories of the statement of cash flows for the periods presented can be found on Encompass Health's website in the Earnings Releases for those periods.

Refer to pages 60-62 for end notes.

End Notes

End notes

(1) Our inpatient rehabilitation hospitals ("IRFs") may operate one or more satellite and/or remote locations. Satellite and remote locations are located proximate to one of our existing IRFs but do not have a separate Medicare provider number. As such, they are considered a bed addition, are included in same store results from the day of opening, and are not included in our count of total open hospitals. As of December 31, 2024, we operated 11 satellite and remote locations.

(2) Under this program, Joint Commission accredited organizations, like the Company's IRFs, 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 the Company's commitment to excellence in providing disease-specific care.

(3) Data compares Encompass Health IRFs to IRFs comprising the Uniform Data System for Medical Rehabilitation ("UDSMR"), part of Netsmart, a data gathering and analysis tool for the rehabilitation industry which represents approximately 80% of the industry, including Encompass Health sites. Data is adjusted by applying Encompass Health IRF case-mix to non-Encompass Health UDS IRFs.

(4) The 163 IRFs shown for Encompass Health excludes Rehabilitation Hospital of Atlanta (opened May 22, 2024); Encompass Health Rehabilitation Hospital of Fort Mill (opened September 24, 2024); Encompass Health Rehabilitation Hospital of Houston at The Medical Center (opened November 11, 2024); Rehabilitation Hospital of Athens (opened March 18, 2025); Encompass Health Rehabilitation Hospital of Fort Myers (opened May 20, 2025); and Rehabilitation Hospital of Western Wisconsin, LLC (closed February 2024).

(5) In 2024, the Company averaged 1,553 total Medicare & Non-Medicare discharges per IRF in its then 160 consolidated IRFs that were open the full year.

(6) Source: FY 2026 CMS Proposed Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2022/2023/2024) or in the case of new IRFs, the Q4 2024 CMS Provider of Service File.

- All data provided was filtered and compiled from the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2026 IRF Proposed Rule Rate Setting File found at: https://www.cms.gov/files/zip/fy-2026-irf-pps-data-files-proposed.zip. The data presented was developed entirely by CMS and is based on its definitions which are different in form and substance from the criteria Encompass Health uses for external reporting purposes. Because CMS does not provide its detailed methodology, Encompass Health is not able to reconstruct the CMS projections or the calculation.
- The CMS file contains data for each of the 1,165 inpatient rehabilitation facilities used to estimate the policy updates for the FY 2026 IRF-PPS Proposed Rule. Most of the data represents historical information from the CMS fiscal year 2023 and 2024 periods and may or may not reflect the same Encompass Health hospitals in operation today. The total was reduced by one to reflect the closure of Rehabilitation Hospital of Western Wisconsin, LLC (closed February 2024).

(7) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation. The CARES Act temporarily suspended the automatic 2% sequestration reduction for the period from May 1 through December 31, 2020. The 2021 Budget Act extended the sequestration suspension through March 31, 2021. An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, signed into law on April 14, 2021, extended the suspension period to December 31, 2021. The Protecting Medicare and American Farmers from Sequester Cuts Act, passed in December 2021, extended the suspension through March 31, 2022, and reduced the sequestration cut to 1% from April 1 to June 30, 2022, followed by the implementation of the full 2% sequestration effective July 1, 2022.

(8) Historically, we have used the term "provider tax revenues" to refer to "Medicaid supplemental payments," both of which represent amounts received in connection with state Medicaid programs that are not included in the specific Medicaid claim reimbursements we receive. These amounts include state directed and supplemental payment programs associated with Medicaid. Provider taxes are amounts paid by us to fund, in part, state Medicaid programs. We have used the term "net provider tax revenues" to represent the difference between provider taxes paid and the Medicaid supplemental payments received.

(9) Definition of adjusted free cash flow, which is a non-GAAP measure, is net cash provided by operating activities of continuing operations minus capital expenditures for maintenance, distributions to noncontrolling interests, and certain other items deemed to be non-indicative of ongoing operating performance. Common stock dividends are not included in the calculation of adjusted free cash flow. Because this measure is not determined in accordance with GAAP and is susceptible to varying calculations, it may not be comparable to other similarly titled measures presented by other companies. Further explanation and disclosure relating to adjusted free cash flow are included in the Company's Form 8-K, dated June 25, 2025, to which this Investor Reference Book is attached as Exhibit 99.1.*

*Reconciliations to GAAP provided on pages 56-59.

End notes, continued

(10) Adjusted EBITDA is a non-GAAP financial measure. The Company's leverage ratio (total consolidated debt to Adjusted EBITDA for the trailing four quarters) is, likewise, a non-GAAP measure. Management and some members of the investment community utilize Adjusted EBITDA as a financial measure and the leverage ratio as a liquidity measure on an ongoing basis. These measures are not recognized in accordance with GAAP and should not be viewed as an alternative to GAAP measures of performance or liquidity. In evaluating Adjusted EBITDA, the reader should be aware that in the future the Company may incur expenses similar to the adjustments set forth. Further explanation and disclosure relating to Adjusted EBITDA are included in the Company's Form 8-K, dated June 25, 2025, to which this Investor Reference Book is attached as Exhibit 99.1.*

(11) The conversion rate of inpatient rehabilitation eligible patients refers to the percent of acute care patients who are presumptively eligible for treatment in an IRF, who are actually discharged from acute care to an IRF. It is based on patients who are discharged from acute-care hospitals within current Encompass Health markets with one or more of 13 specified medical conditions that CMS ties to IRF eligibility based on Medicare fee-for-service data, which is the only publicly available data on the subject.

(12) 2018 total number of licensed beds and total number of IRFs include the consolidation of the Ft. Worth market (decrease of 60 beds) and the de-licensure of 20 SNF beds at a Dallas IRF. 2019 total number of licensed beds includes the de-licensure of 25 SNF beds at Round Rock, TX, the de-licensure of 5 beds at an IRF in Newburgh, IN, the de-licensure of 10 beds in Western Hills, WV, and the consolidation of Yuma (increase of 51 beds). 2020 total number of licensed beds includes the de-licensure of 31 beds at an IRF in Woburn, MA. 2021 total number of licensed beds includes the de-licensure of 48 beds at an IRF in Erie, PA. 2022 total number of IRFs and licensed beds includes the closure of the Wesley hospital (decrease of 65 beds). 2023 total number of IRFs and licensed beds includes a de-licensure of 19 beds at an IRF in York, PA. 2024 total number of IRFs and licensed beds includes the closure of the Eau Claire, WI hospital (decrease of 36 beds), de-licensure of 12 beds at an IRF in Humble, TX, de-licensure of 27 beds at an IRF in Nittany Valley, PA, de-licensure of 6 beds at an IRF in Tallahassee, FL, and de-licensure of 30 beds at an IRF in Florence, SC.

(13) In January 2024, we received notice that our joint venture partner, Hospital Sisters Health System, intended to close its acute-care hospital, Sacred Heart Hospital in Eau Claire, WI, in which our joint venture inpatient rehabilitation hospital is located. We closed that joint venture hospital in February 2024 and incurred a one-time impairment charge of $10.4 million. The impact to net income attributable to Encompass Health during the twelve months ended December 31, 2024 resulting from the impairment was $1.8 million after reductions for net income attributable to noncontrolling interests of $7.3 million and the provision for income tax expense of $1.3 million.

(14) In May of 2023, the governor of South Carolina signed into law S.164, which repealed the requirement of certain healthcare providers to obtain and/or maintain a certificate of need ("CON"). As a result of this repeal, in Q2 2023 the Company accelerated amortization of approximately $6 million in remaining carrying value of our South Carolina CON assets, increasing depreciation and amortization expense by approximately $6 million and reducing noncontrolling interest in continuing operations by approximately $2 million (related to our joint venture partner's share of income at one impacted location). The impact of these adjustments have been excluded from the calculation of adjusted EBITDA and adjusted earnings per share in the second quarter of 2023 given the non-recurring nature of the CON repeal (Florida is the only other state in recent history to repeal its CON law) is not indicative of ongoing operating performance.

(15) In the second quarter of 2021, the Company redeemed a total of $200 million of 5.125% Senior Notes due 2023 ($100 million in April and $100 million in June). The redemptions were completed at 100% of par using cash on hand and drawings under the Company's revolving credit facility. As a result of the redemptions, the Company recorded a $1.0 million loss on early extinguishment of debt in the second quarter of 2021.

(16) In the first quarter of 2022, the Company redeemed the remaining $100 million of its 5.125% Senior Notes due 2023. The redemption was completed at 100% of par using drawings under the Company's revolving credit facility. As a result of the redemption, the Company recorded a $0.3 million loss on early extinguishment of debt in the first quarter of 2022. In the second quarter of 2022, the Company redeemed approximately $236 million of its term loan due 2024 and fully repaid the $250 million outstanding balance on its revolving credit facility. The redemption was completed using proceeds which were dividended from Enhabit. As a result of the redemption, the Company recorded a $1.1 million loss on early extinguishment of debt in the second quarter of 2022.

(17) In the third quarter of 2024, the Company redeemed $150 million of its 5.75% Senior Notes due 2025. The redemption was completed at 100% of par using cash on hand. As a result of the redemption, the Company recorded a $0.4 million loss on early extinguishment of debt in the third quarter of 2024. In the fourth quarter of 2024, the Company redeemed $100 million of its 5.75% Senior Notes due 2025. The redemption was completed at 100% of par using cash on hand. As a result of the redemption, the Company recorded a $0.2 million loss on early extinguishment of debt in the fourth quarter of 2024.

*Reconciliations to GAAP provided on pages 56-59.