Investor Reference Book

Published: June 21, 2024

Encompass Health®

Forward-looking statements

The information contained in this Investor Reference Book 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, value drivers, labor availability and 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, repurchase of securities, access to capital, financial performance, financial assumptions and considerations, business model, balance sheet and cash flow plans, and market share capture 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, 2023 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 21, 2024, 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.

Table of contents

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 Managed Care or 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 - effective tax rate), divided by the hospital's average net assets for the same period.

Abbreviations

- Accountable Care Organization ("ACO")
- Bundled Payments for Care Improvement ("BPCI")
- Case Mix Group ("CMG")
- Centers for Medicare and Medicaid Services ("CMS")
- Certificate of Need ("CON")
- Comprehensive Care for Joint Replacement ("CJR")
- Home Health ("HH")
- Inpatient Rehabilitation Facility ("IRF")("hospital")
- Public Health Emergency ("PHE")
- Quality Reporting Program ("QRP")
- 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 acquisition 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 primarily 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

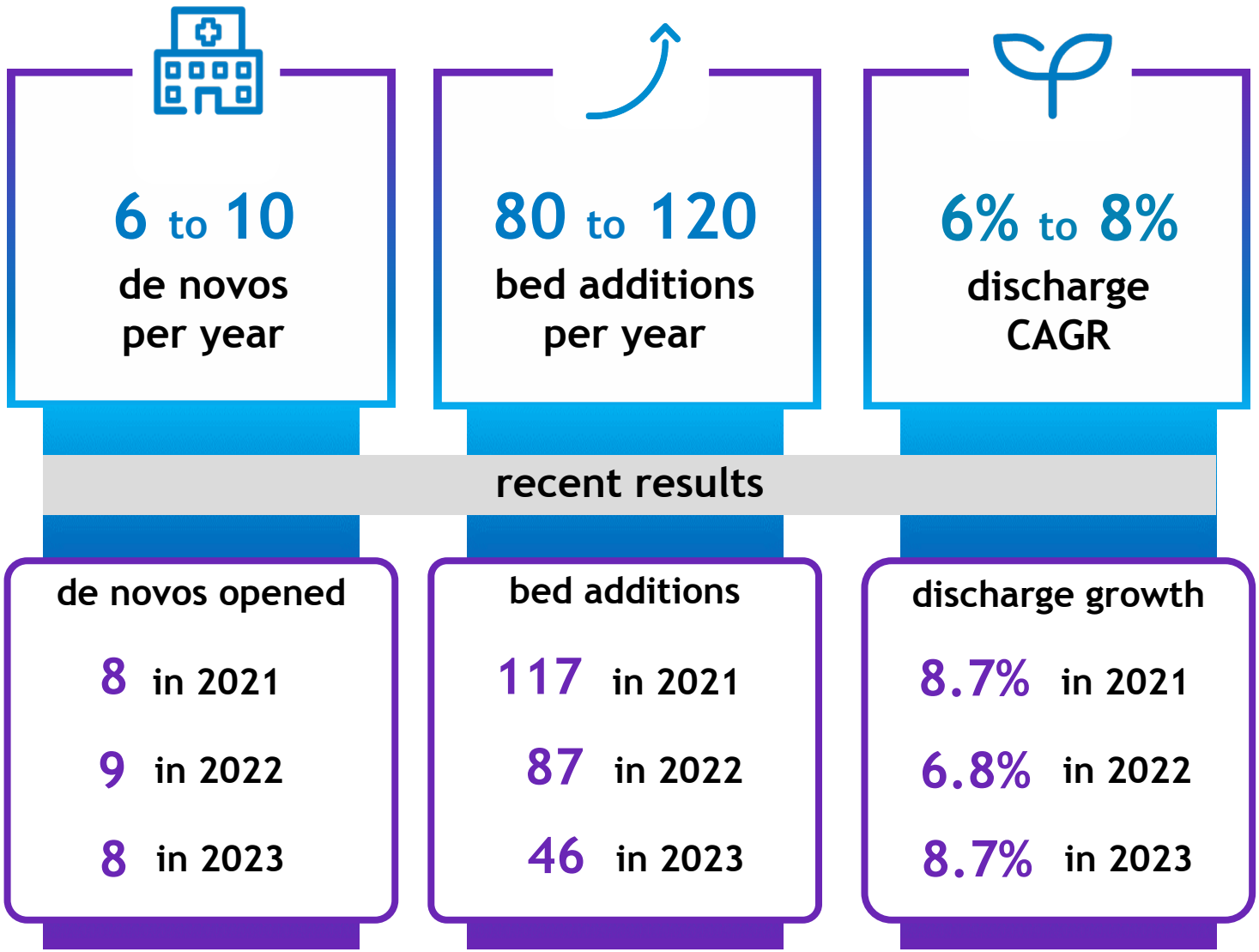
Real estate ownership

- Portfolio of 160 IRFs as of April 24, 2024
  - ✓ 125 owned and 35 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

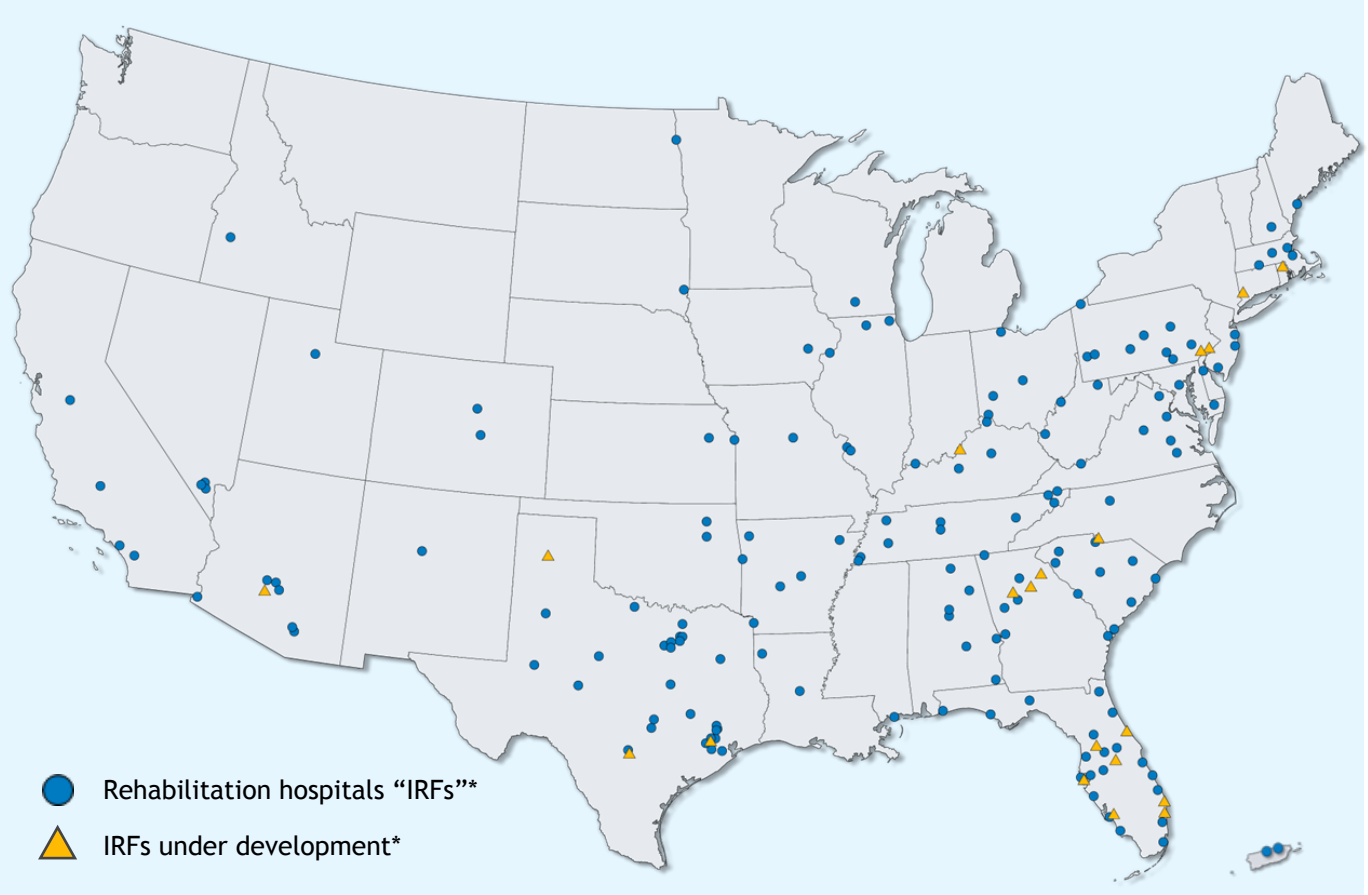
- Well-managed balance sheet and liquidity
  - ✓ Manageable near-term maturities (credit agreement matures in 2027; bonds mature in 2025 and beyond)
  - ✓ $964 million available for borrowing on our $1 billion revolving credit facility (as of March 31, 2024)
- Substantial free cash flow generation
- Cash dividend paid on common stock since 2013

Business outlook | 2023 - 2027 Growth targets



Company Overview

Company overview | Largest owner and operator of IRFs



Recent expansion 2021 - 2023

25	de novo hospitals opened
250	beds added to existing hospitals
1,405	total beds added
13.4% increase in licensed beds	

2023 key statistics

~229,500	patient discharges
~$4.8	billion in revenue
8.7%	total discharge growth

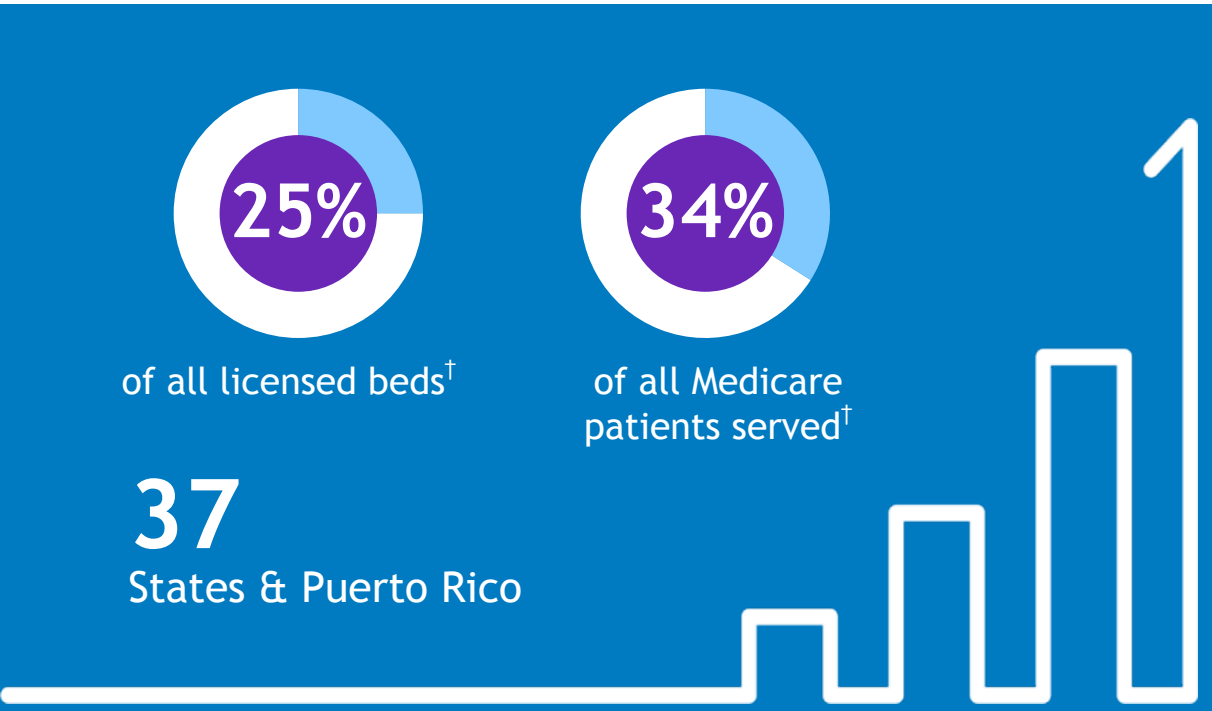
Fortune Magazine
World's Most Admired Companies

~38,500 employees

BECKER'S HEALTHCARE
Top Places to Work in Healthcare

*IRFs as of April 24, 2024; IRFs under development - previously announced under development as of April 24, 2024

Company overview | Largest owner and operator of IRFs



160
Inpatient rehabilitation hospitals

62
Operate as joint ventures with acute care hospitals

142
Hospitals hold one or more disease-specific certifications(1)

Data as of April 24, 2024

Clinical expertise in Joint Commission specialty accreditations*

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

- Stroke rehabilitation accreditations - 141 EHC hospitals (~65%)
- Hip fracture rehabilitation accreditations - 62 EHC hospitals (~95%)
- Brain injury rehabilitation accreditations - 50 EHC hospitals (~75%)
- Amputee rehabilitation accreditations - 39 EHC hospitals (~83%)

† Based on 2022 and 2023 data
Refer to pages 66-68 for end notes.

*Data as of June 2, 2024

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

Inpatient rehabilitation hospital services primarily 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 three face-to-face rehabilitation physician visits per week
- Lead Team Conference
- 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 personal 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 Conference 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 88 Encompass hospitals as of March 31, 2024; further roll out will continue in 2024, 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: • 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 three 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	All payors = 72 years old
	Medicare FFS = 77 years old
EHC IRF admission sources	91% of EHC admissions come from acute care hospital discharges, but only ~4.5% of acute care hospital discharges in the United States are admitted to an IRF.*

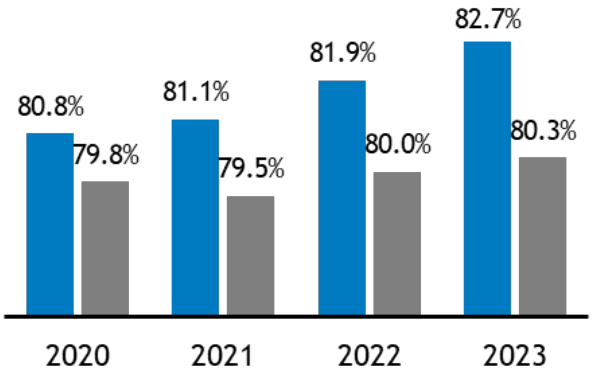
Patient mix

Rehabilitation impairment category ("RIC")		2023
RIC 01	Stroke	17.8 %
RIC 02/03	Brain dysfunction	11.2 %
RIC 04/05	Spinal cord dysfunction	3.9 %
RIC 06	Neurological conditions	20.4 %
RIC 07	Fracture of lower extremity	8.0 %
RIC 08	Replacement of lower extremity joint	3.3 %
RIC 09	Other orthopedic	7.2 %
RIC 10/11	Amputation	2.5 %
RIC 14	Cardiac	4.1 %
RIC 17/18	Major multiple trauma	6.0 %
RIC 20	Other disabling impairments	11.7 %
—	All other RICs	3.9 %

*Source: FORVIS reporting on 2022 Medicare claims data.

Company overview | High quality clinical results

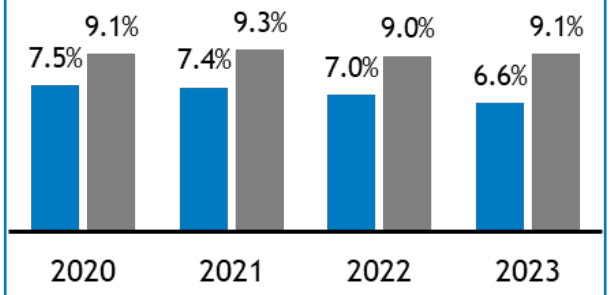
Discharge to Community



Higher is better

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

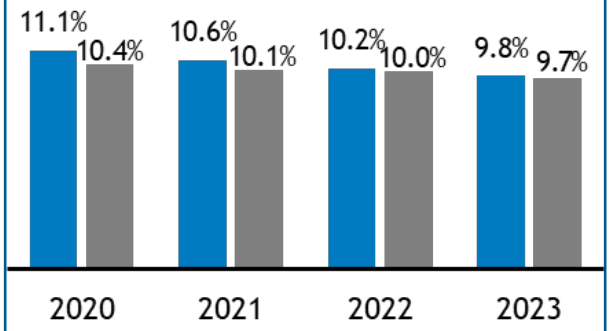
Discharge to SNF



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[2]

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

Company overview | Leading position in cost effectiveness

	# of IRFs	Avg. beds per IRF	Avg. Medicare discharges per IRF[4]	Avg. est. total cost per discharge for FY 2025	Avg. est. total payment per discharge for FY 2025
Encompass Health[3] =	157	66	883	$17,193	$24,836
Free-standing = (Non-Encompass Health)	215	56	536	$22,693	$27,076
Hospital units =	781	25	204	$27,879	$27,687
Total[5]	1,153	36	358	$22,846	$26,560

Medicare FFS pays Encompass Health less per discharge, on average, in spite of comparable acuity

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

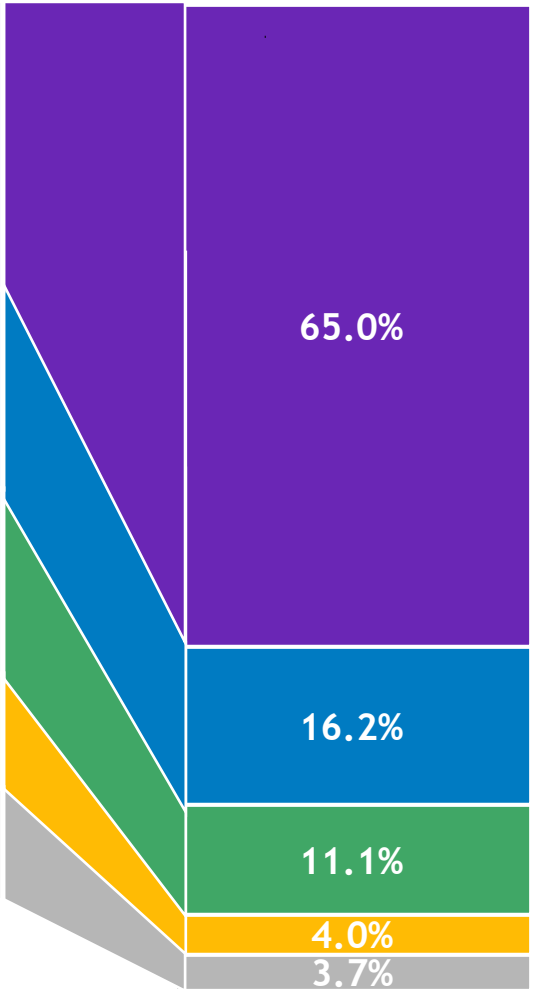
- *"Best Practices" clinical protocols*
- *Supply chain efficiencies*
- *Sophisticated management information systems*
- *Economies of scale*

- The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration[6].

Refer to pages 66-68 for end notes.

Company overview | Payors and payment methods

Payor source	Payment methodology	% of 2023 Revenues
Medicare	**Prospective Payment System ("PPS")** - paid per discharge by Case Mix Group ("CMG")	65.0%
Medicare Advantage	**CMG or per diem** - Negotiated rate - Some are "tiered" for acuity/severity	16.2%
Managed Care	**Per diem or CMG** - Negotiated rate - Some are "tiered" for acuity/severity	11.1%
Medicaid	**Varies by state**	4.0%
Other	**Variety of methodologies**	3.7%



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

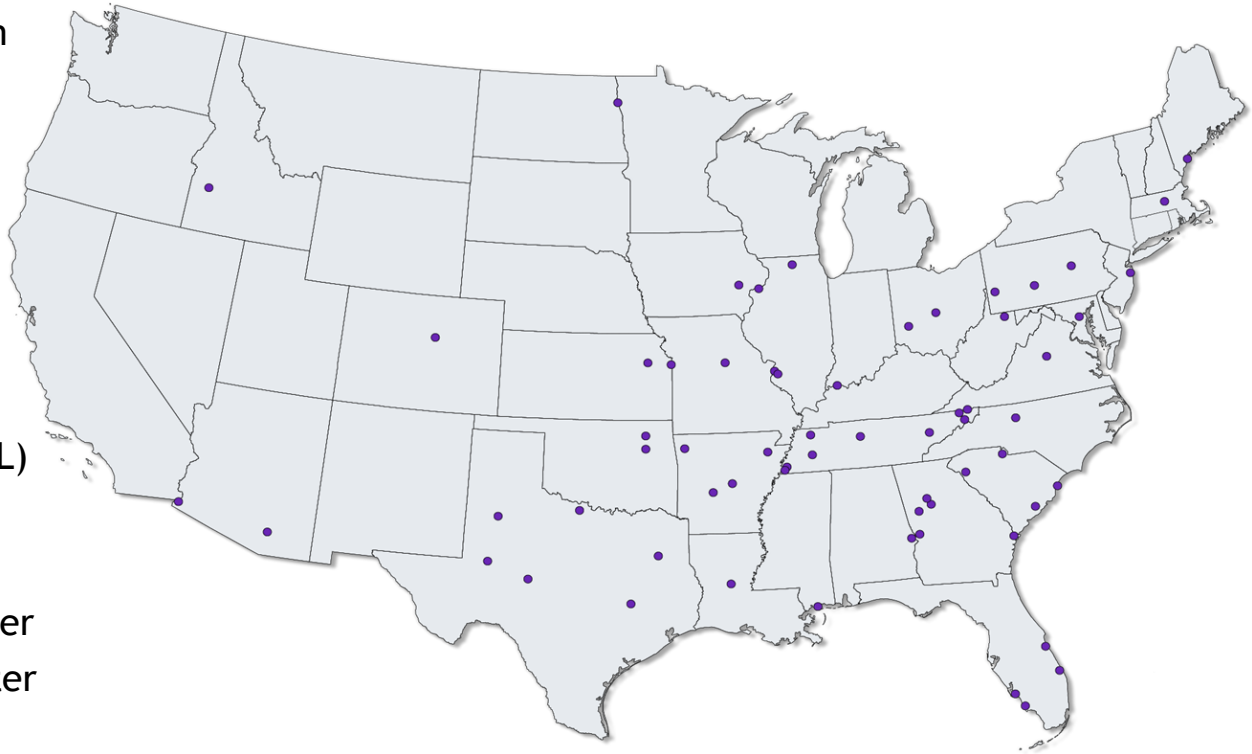
*CA = confidentiality agreement

Company overview | Joint venture partnerships with acute care providers

The Company's joint ventures began in 1991

62 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 Healthcare
- University of Virginia Medical Center
- Vanderbilt University Medical Center



Joint ventures with acute care hospitals facilitate integrated care delivery

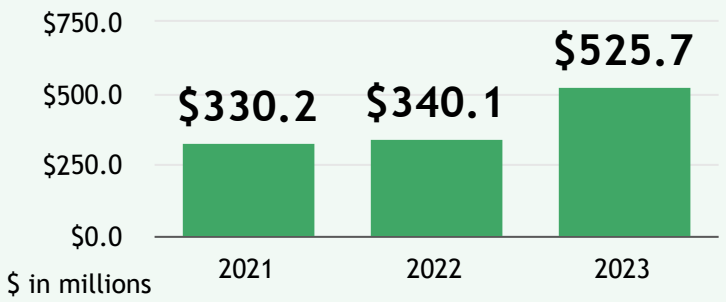
*Data as of April 24, 2024

Company overview | Cash flow and liquidity

Adjusted Free Cash Flow*[7]

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

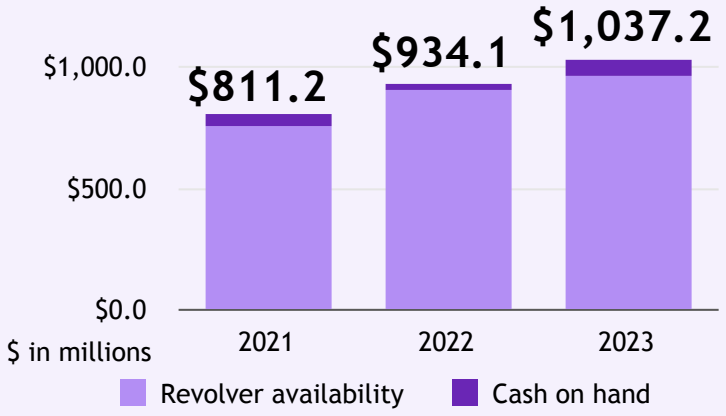
- De novos
- Bed additions
- Replacement IRFs
- FCF is after maintenance capex, before discretionary capex



Liquidity*

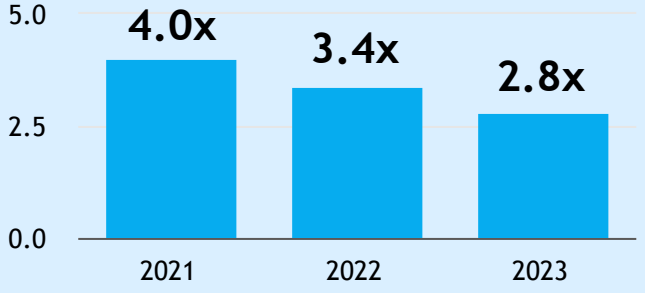
Ensure sufficient liquidity to meet the anticipated operating and strategic needs of the Company

- 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[8]
- 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 66-68 for end notes.

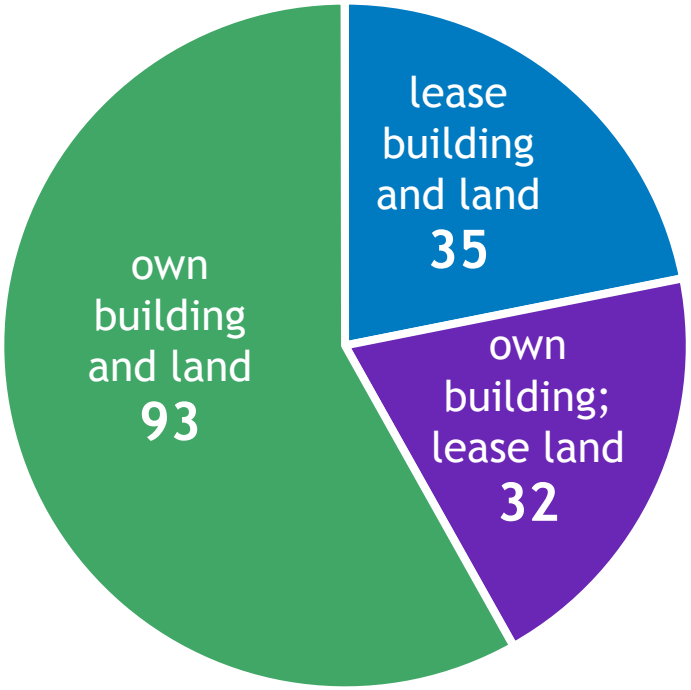
Company overview | Real estate holdings

Own ~78% 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 flexibilty 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 acute care (LTACH), inpatient rehabilitation (IRF), skilled nursing (SNF), home health (HH)

Medicare acute care patients discharge destination*

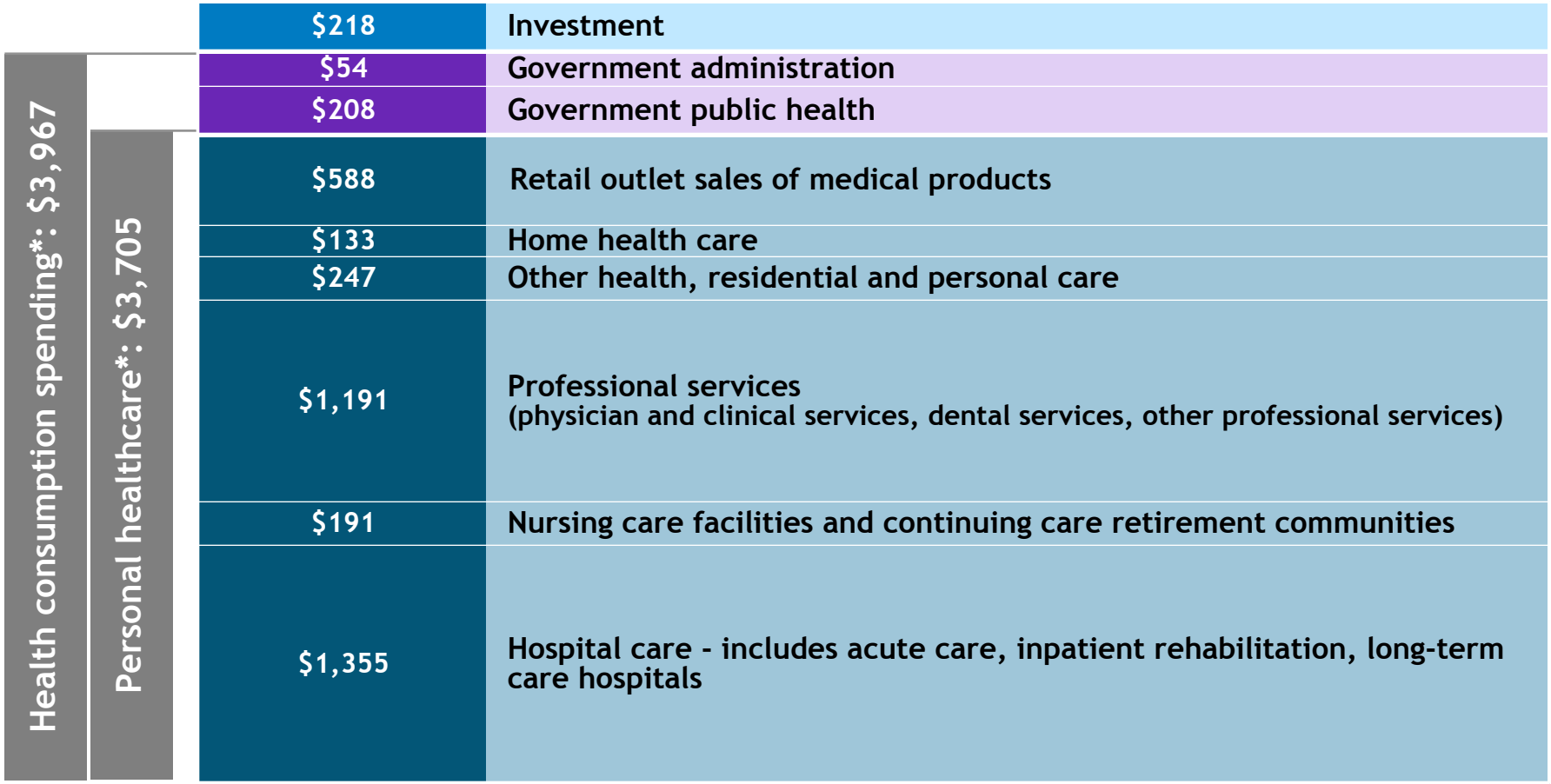
- LTACH ~1.0%
- IRF ~4.5%
- SNF ~19.5%
- HH ~21.5%
- Hospice ~4.0%
- No post-acute care ~44.5%

* Source: FORVIS reporting on 2022 Medicare claims data. Other discharge destinations (~5%) may include another acute care hospital, specialty hospital, or other destinations.

Industry overview | Total healthcare spending

National healthcare spending: $4.465 trillion in 2022

(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 - 2022.
* Excludes net cost of private health insurance of $279 billion.

Industry overview | Medicare 2022 spending

Total Medicare spending $905 billion *(inclusive of payments to Medicare managed care)*	Medicare spending on inpatient rehabilitation $8.8 billion *(~1% of all Medicare spending)*

	% of Medicare spend	
$29B Skilled nursing	3%	Medicare Part A
$143B Inpatient hospital (includes IRF)	16%	
$73B Physician payments	8%	Medicare Part B
$63B Outpatient hospital	7%	
$16B Home health	2%	Medicare Parts A & B
$24B Hospice	3%	
$29B Other services	2%	
$403B Medicare managed care* **Medicare managed care / Medicare Advantage plans also pay for the services listed on this page*	45%	Medicare Part C
$125B Outpatient Rx	14%	Medicare Part D

Source: Centers for Medicare & Medicaid Services, Medicare Trustees' Report 2023 – page 13; and MedPAC, Medicare Payment Policy, March 2024 - pages 163, 201, 225, 261.

Industry overview | Medicare post-acute care services

	Inpatient rehabilitation hospital	Skilled nursing facility	Home health
Medicare spending ($ billions)	$8.8	$29.0	$16.1*
# of Discharges/Beneficiaries^	~383,000	~1,800,000	~2,800,000^
Average length of stay	12.8 days	34.5 days	N/A
# of Providers	~1,181	~14,700	~11,353
Facility ownership mix**	For-profit (39%) Non-profit (51%) Gov't (10%)	For-profit (72%) Non-profit (23%) Gov't (5%)	For-profit (93%) Non-profit (7%)
Freestanding vs. hospital based	Freestanding (29%) Hospital based (71%)	Freestanding (97%) Hospital based (3%)	Freestanding (87%) Hospital based (13%)
Rural vs. urban**	Urban (86%) Rural (14%)	Urban (73%) Rural (27%)	Urban (85%) Rural (15%)

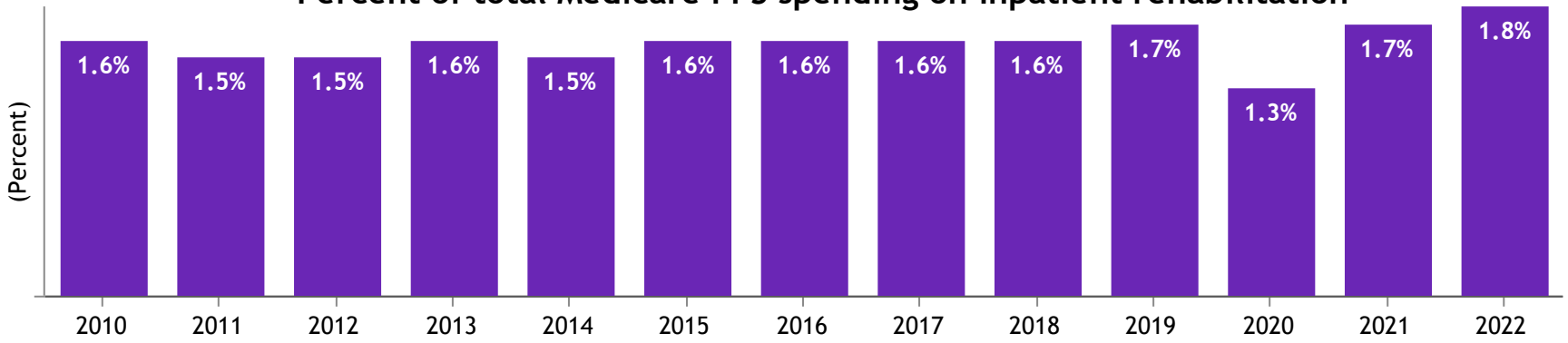
* Not all home health spending occurs as a post-acute service.
**Home health data represents freestanding agencies only.

Source: MedPAC, Medicare Payment Policy, March 2024 - pages 163, 168, 201, 218, 225, 226, and 231; March 2023- page 222 MedPAC, Health Care Spending and the Medicare Program, July 2023 - page 106.

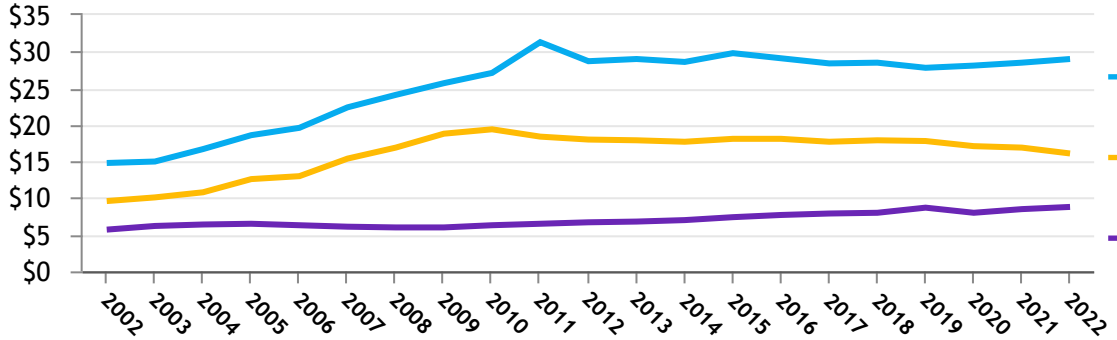
Industry overview | Medicare spending on post-acute services

Medicare spent ~ $54 billion on post-acute services in 2022 (IRF, SNF, HH)

Percent of total Medicare FFS spending on inpatient rehabilitation



Medicare spending on post-acute services



Post-acute setting	2002 Spending	2022 Spending
Skilled nursing facilities	$14.8	$29.0
Home health agencies*	$9.6	$16.1
Inpatient rehabilitation hospitals	$5.7	$8.8

$ in billions

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

Source: MedPAC, Medicare Payment Policy, March 2024 - pages 163, 201 and 225 Centers for Medicare and Medicaid Services, Medicare Trustees' Report 2023 - page 13.

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 compliant 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 three 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 | Regulatory history 2009 - 2023

External factors

IRF-specific regulatory updates

We have demonstrated the ability to adapt in the face of numerous and significant regulatory, legislative and operating environment changes.

2009	Global recession	75% Rule permanently changed to 60% Rule with passage of "Medicare, Medicaid & SCHIP Extension Act of 2007" and paid for through a Medicare price rollback & 18-month freeze from 4/1/2008 to 9/30/2009
2010	Medicaid expansion due to the passing of the Patient Protection and Affordable Care Act (ACA) Medicare Advantage enrollment outpaces traditional Medicare enrollment growth	1) Passing of the ACA 2) CMS IRF Rule implemented new requirements for determining whether IRF claim is reasonable and necessary
2011		1) Budget Control Act generates automatic 2% reduction in Medicare payments beginning in 2013 (sequestration) 2) Medicare Shared Savings Program (MSSP) ACO begins
2012 - 2013		IRF Quality Reporting Program (IRF QRP) requires IRFs to report quality data with financial penalties for compliance issues
2014*		1) IMPACT Act directed CMS to create rules requiring the collection and reporting of standard patient assessment data 2) Original BPCI begins
2015*		CMS revised diagnosis codes that count toward 60% Rule
2016*		1) CJR becomes mandatory in certain markets 2) Next Gen ACO begins

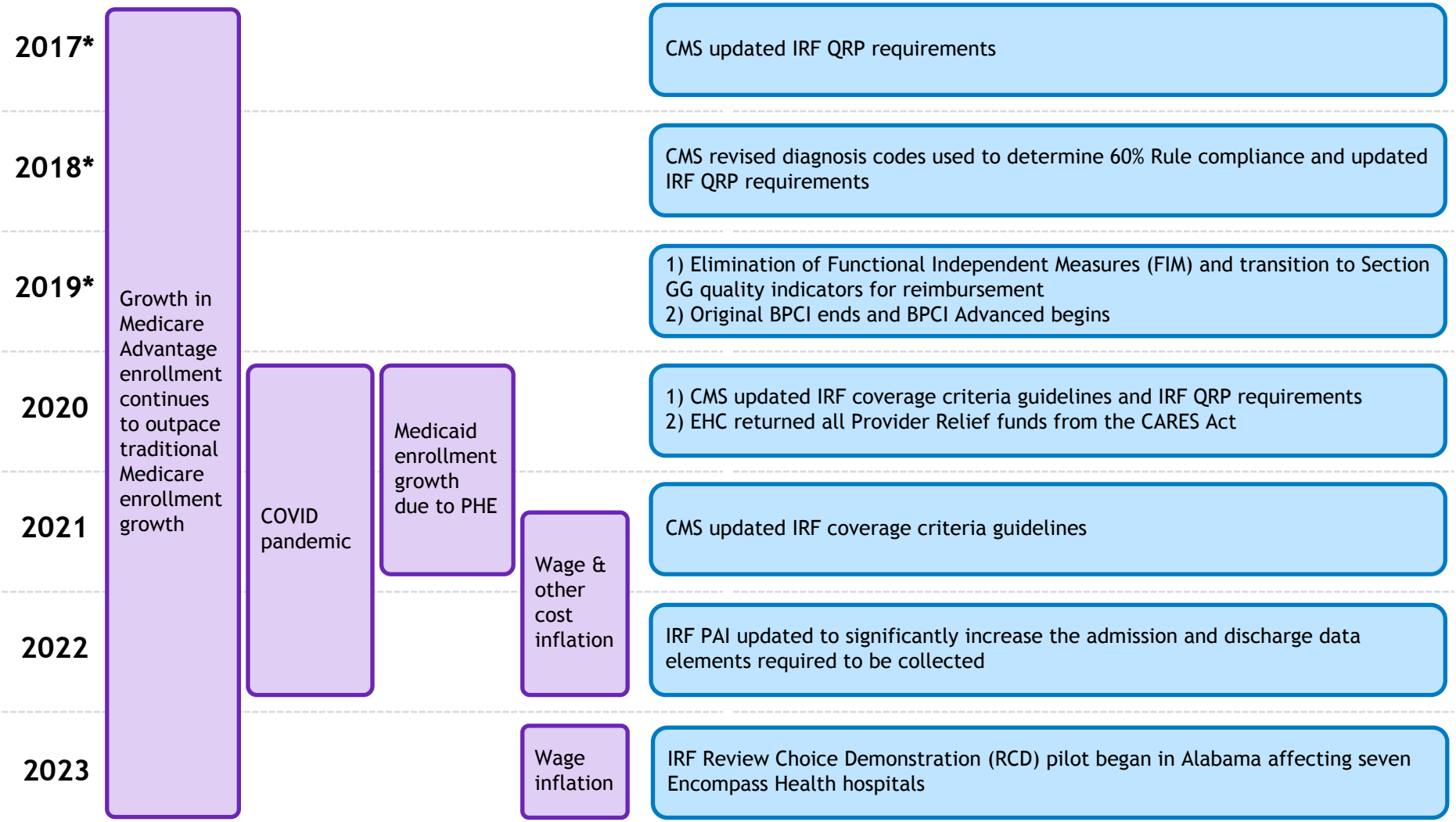
* Between 2014 and 2019, the CMS Innovation Center developed new voluntary and mandatory payment and service delivery models, in accodance with legislation, such as Bundled Payments for Care Improvement (BPCI), Accountable Care Organizations (ACO), and Comprehensive Care for Joint Replacement Model (CJR).

Industry overview | Regulatory history 2009 - 2023 (cont.)

External factors

IRF-specific regulatory updates

We have demonstrated the ability to adapt in the face of numerous and significant regulatory, legislative and operating environment changes.



* Between 2014 and 2019, the CMS Innovation Center developed new voluntary and mandatory payment and service delivery models, in accodance with legislation, such as Bundled Payments for Care Improvement (BPCI), Accountable Care Organizations (ACO), and Comprehensive Care for Joint Replacement Model (CJR).

Growth

Growth | Our rationale for continued expansion of IRF capacity

Large, under penetrated and growing market

- ~14% estimated national conversion rate to IRF[9]
- Aging demographic (~5% population growth CAGR for our average age patient)
- Supply of licensed IRF beds has increased only 2.7% since 2010
- SNF disintermediation opportunity
- Non-discretionary conditions

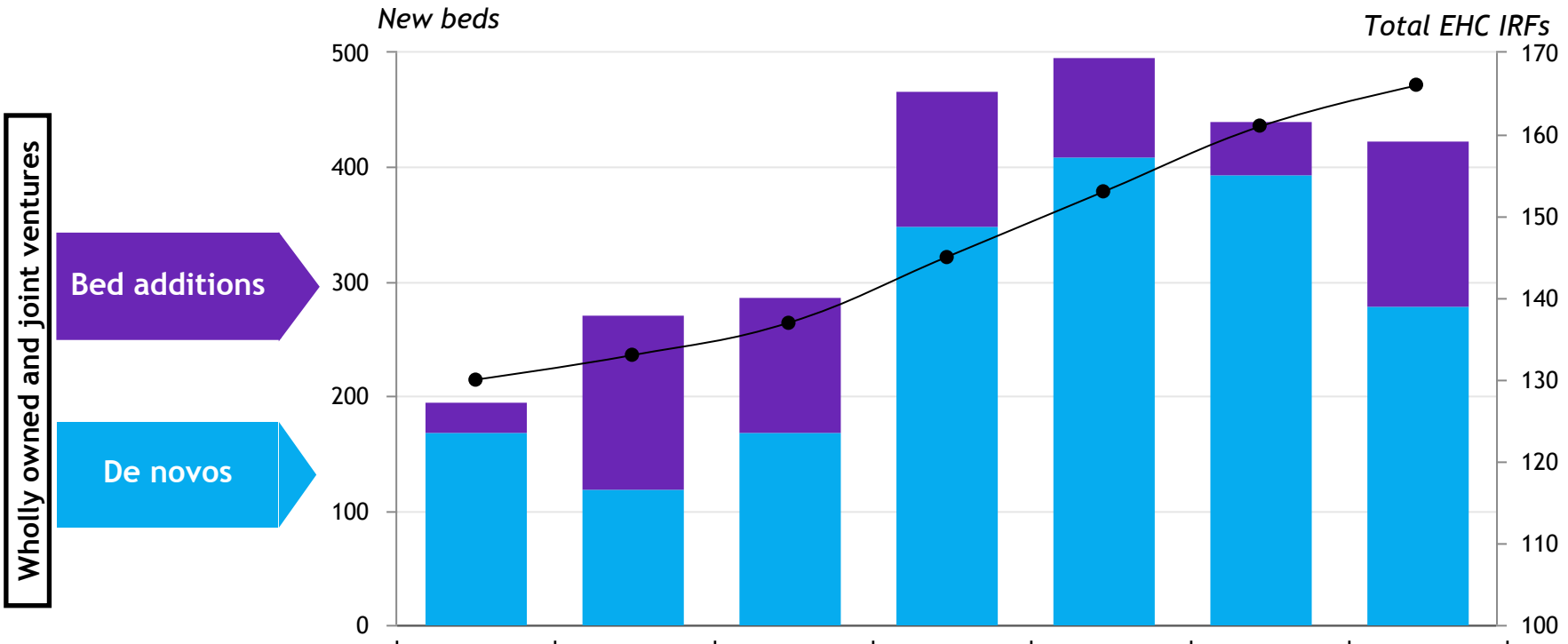
Significant barriers to entry and competitive advantages

- 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

Growth | IRF growth strategy

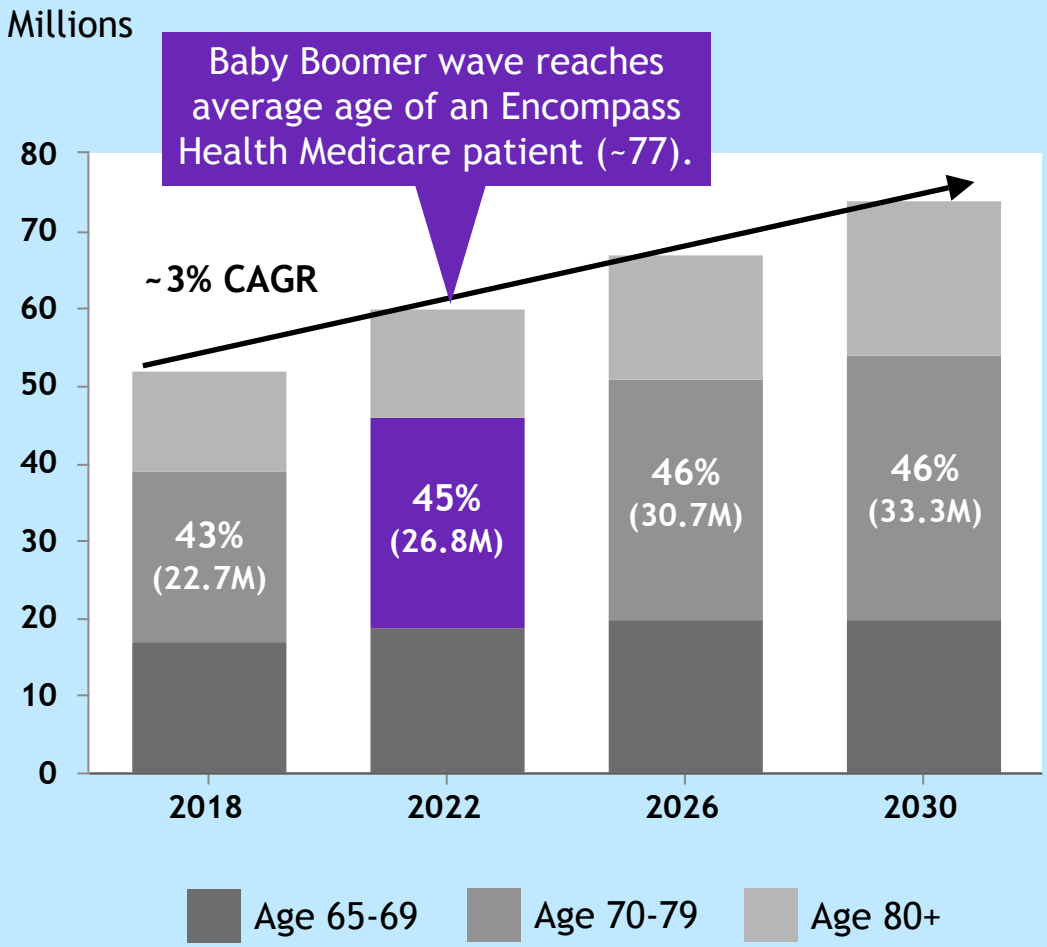


	2018	2019	2020	2021	2022	2023	2024 (P)
Bed additions	26	152	117	117	87	46	144
De novos (bed count)	169	120	170	350	410	395	280
De novos (new hospitals)	4	3	4	8	9	8	6
Total number of IRFs[10]	130	133	137	145	153	161	166
Total number of licensed beds[10]	8,966	9,249	9,505	9,924	10,356	10,778	11,154

Growth | IRF demand continues to grow

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

Projected population of age 65+



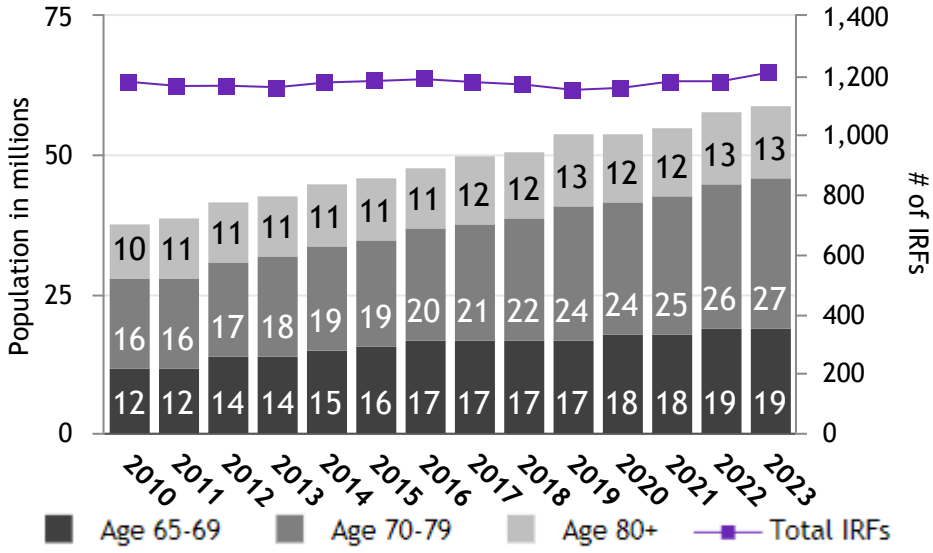
- The growth rate of Medicare beneficiaries increased to an ~3% CAGR in 2011, as "Baby Boomers" started turning age 65.
  - ~10,000 Baby Boomers turn 65 each day
- **The 4-year CAGR for the population in Encompass Health's average Medicare patient age range is ~5%.**

CAGR (population growth by age)		
Age	2018 to 2022	2022 to 2026
65-69	2.6%	1.6%
70-74	3.7%	2.5%
75-79	5.0%	4.9%
80+	2.4%	3.6%
Total	**3.3%**	**2.9%**

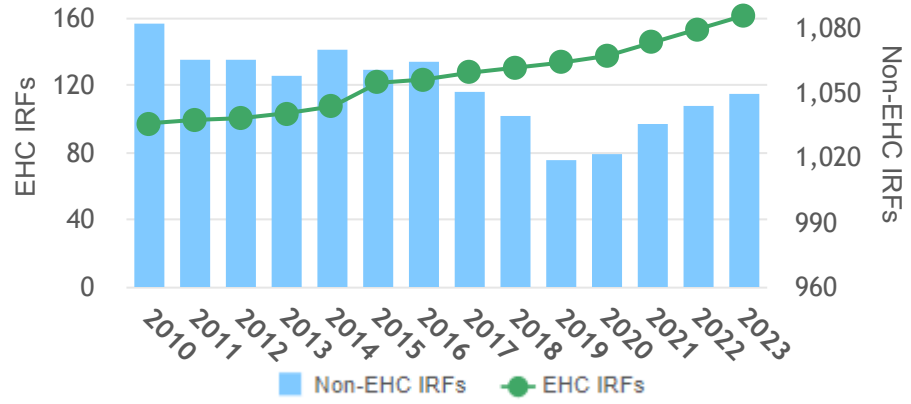
Source: https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html

Growth | IRF supply / demand imbalance continues to widen

IRF supply and demand



Supply of IRFs - EHC vs. Non-EHC



IRF supply has grown slightly since 2010:

- 1,179 IRFs in 2010
- 1,211 IRFs in 2023 (2.7% increase)

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 2023, EHC:

- opened 41 de novo IRFs
- increased total beds from 8,404 to 10,778

Source: MedPAC, Medicare Payment Policy, 2024 - page 231, 2018 - page 277, 2014 - page 247; Provider Data Catalog (cms.gov) inpatient rehabilitation facilities_general information dataset Dec. 2023; 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, 2023; 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:
  - ✓ 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 three 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%[9] of acute care patients who are presumptively eligible for inpatient rehabilitation 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, 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

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

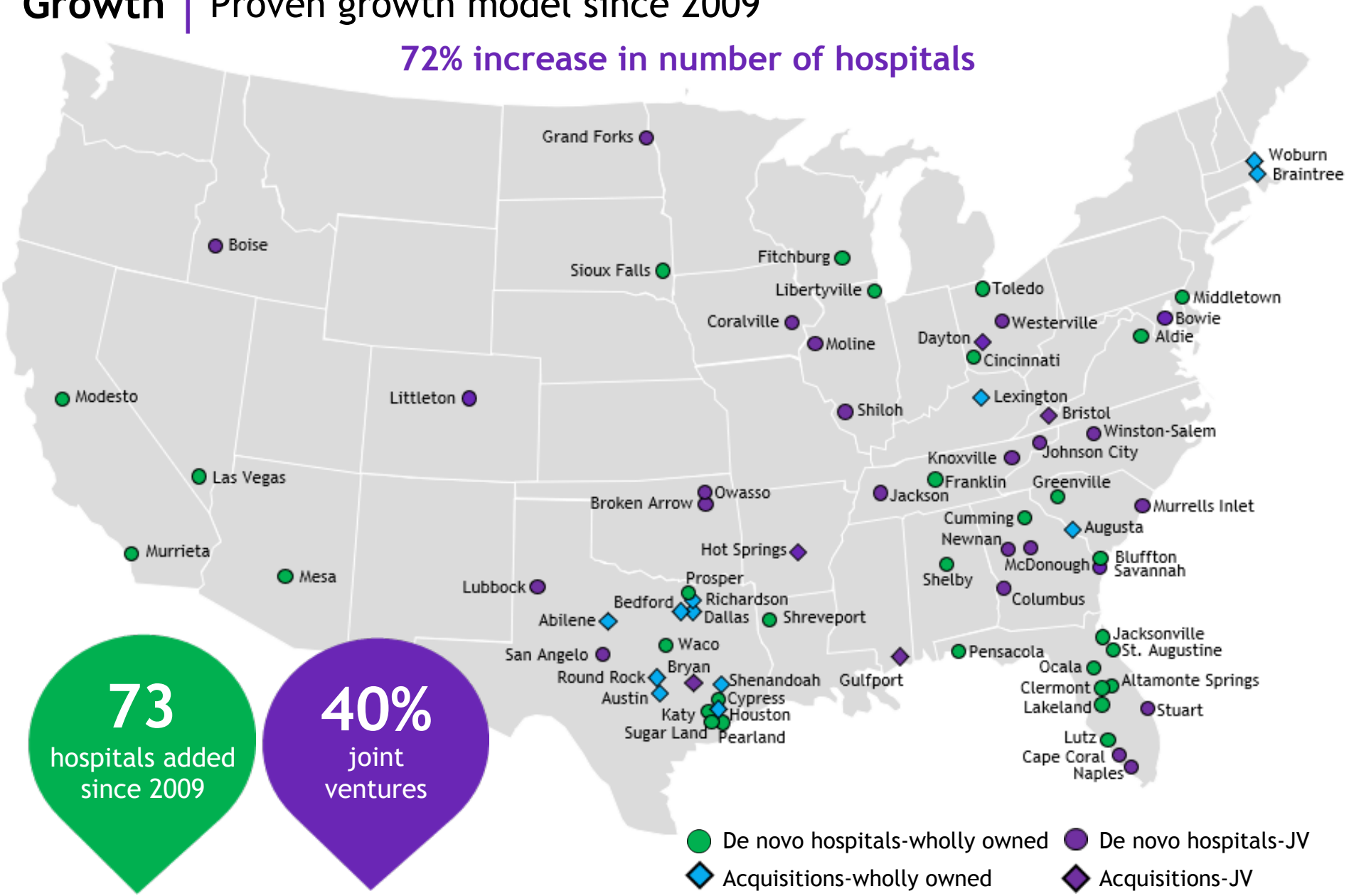
Industry averages			
		IRF	SNF
Quality metrics*	FFS average length of stay	12.8 days	34.5 days
	Discharge to community rate	67.3%	50.7%

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 three hours a day of intensive therapy, five days a week	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 2024 - pages 164 and 226 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

72% increase in number of hospitals



73
hospitals added since 2009

40%
joint ventures

Growth | Robust de novo development pipeline

20 De novos announced and underway*

Market considerations

- Demographics in 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 and service lines 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

		Joint venture	Est. Opening Date	# of beds
De novo projects**				
1	Kissimmee, FL		2024	50
2	Atlanta, GA	✓	2024	40
3	Johnston, RI		2024	50
4	Fort Mill, SC		2024	39
5	Louisville, KY	✓	2024	40
6	Houston, TX		2024	61
7	Daytona Beach, FL		2025	50
8	Fort Myers, FL	✓	2025	60
9	Lake Worth, FL		2025	50
10	Concordville, PA		2025	50
11	Norristown, PA		2025	50
12	Wildwood, FL (in The Villages, FL)		2025	50
13	Athens, GA	✓	2025	40
14	St. Petersburg, FL		2025	50
15	Palm Beach Gardens, FL		2026	50
16	Amarillo, TX		2026	50
17	Danbury, CT		2026	40
18	Avondale, AZ		2026	60
19	Loganville, GA	✓	2026	40
20	San Antonio, TX		2026	50

**All dates are tentative and subject to change

*IRFs under development - previously announced under development as of April 24, 2024

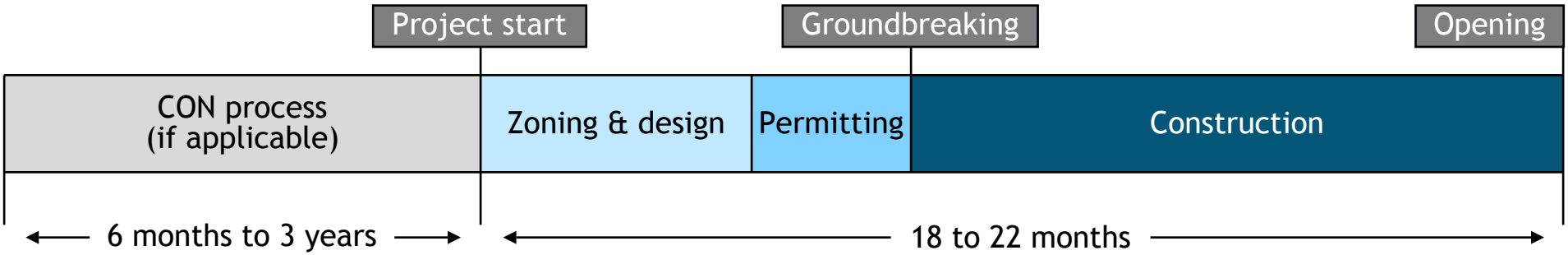
Growth | De novo costs and timeline

- 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 approvals
  - Other location- or hospital-specific complexities

Capital cost ($ in millions)	2022-2023	2023-2024
Construction, design, permitting, etc.	$35.0	$44.0
Land	5.5	5.0
Equipment (including CIS)	5.5	5.5
Cost of a typical 50-bed IRF	**$46.0**	**$54.5**
Pre-opening & ramp up costs* ($ in millions)		
Operating	$1.0	$1.0
Salaries, wages, benefits	1.0	1.5
	$2.0	**$2.5**

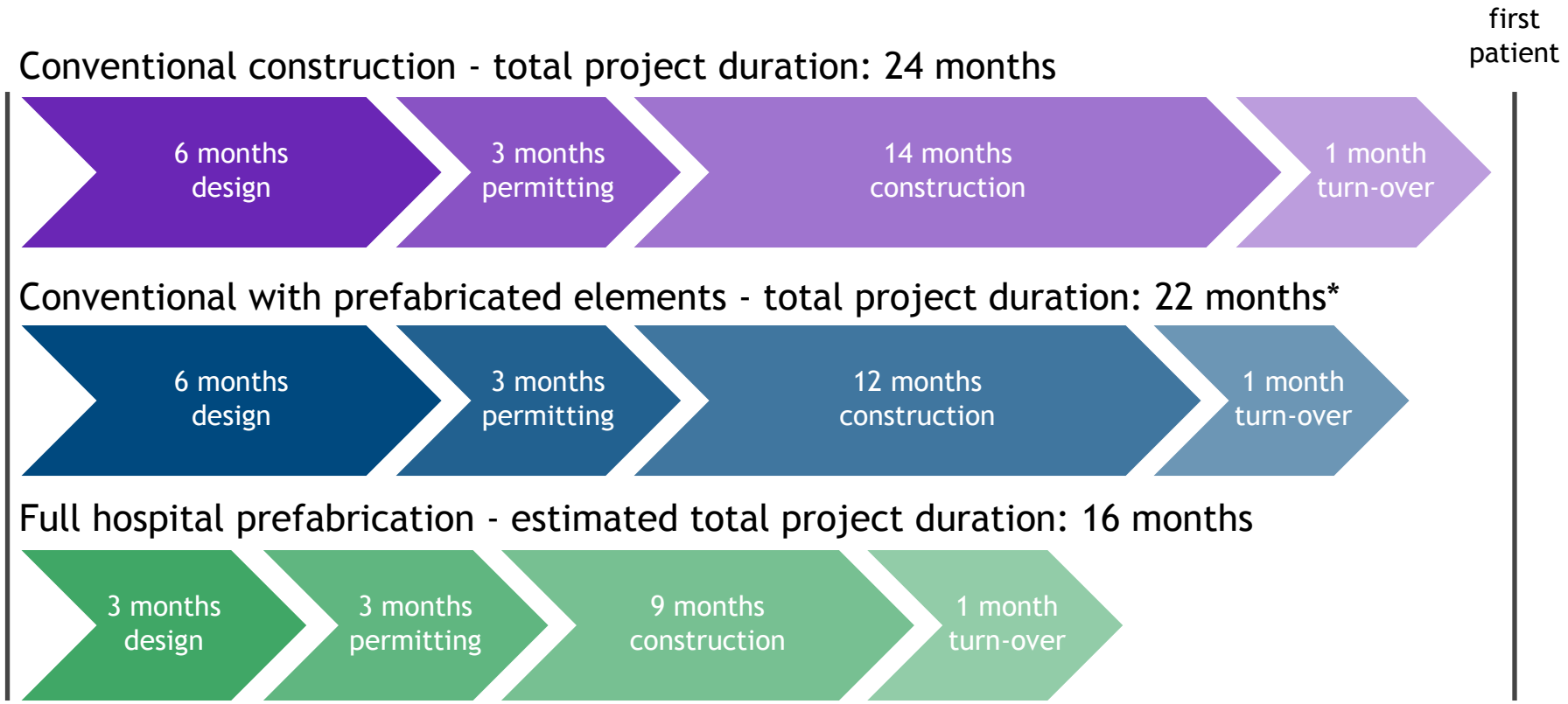
Amounts are the average per hospital capital costs based on actual costs for EHC's 2022 and 2023 50-bed hospitals and the projected costs for EHC's 2024 50-bed hospitals. The pricing for these projects is based on contracts established up to two years prior to hospital opening and may not fully represent 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 is 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

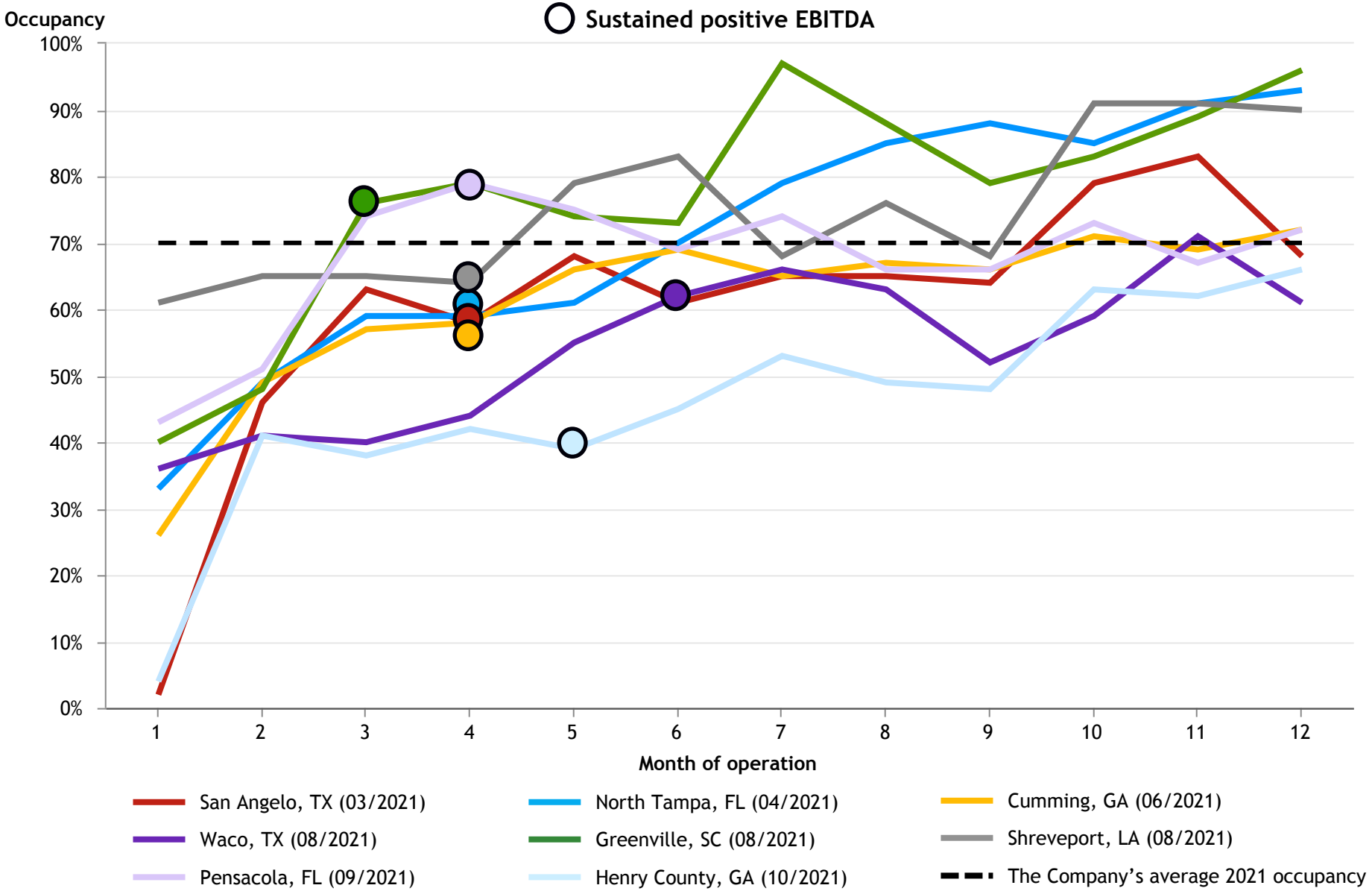
*Project duration for conventional construction with prefabricated elements ranges from 18 to 22 months based on the specific project characteristics and site development conditions, and the amount of prefabrication.

Growth | Prefabrication advantages

Staffing model for a typical 50-bed de novo hospital

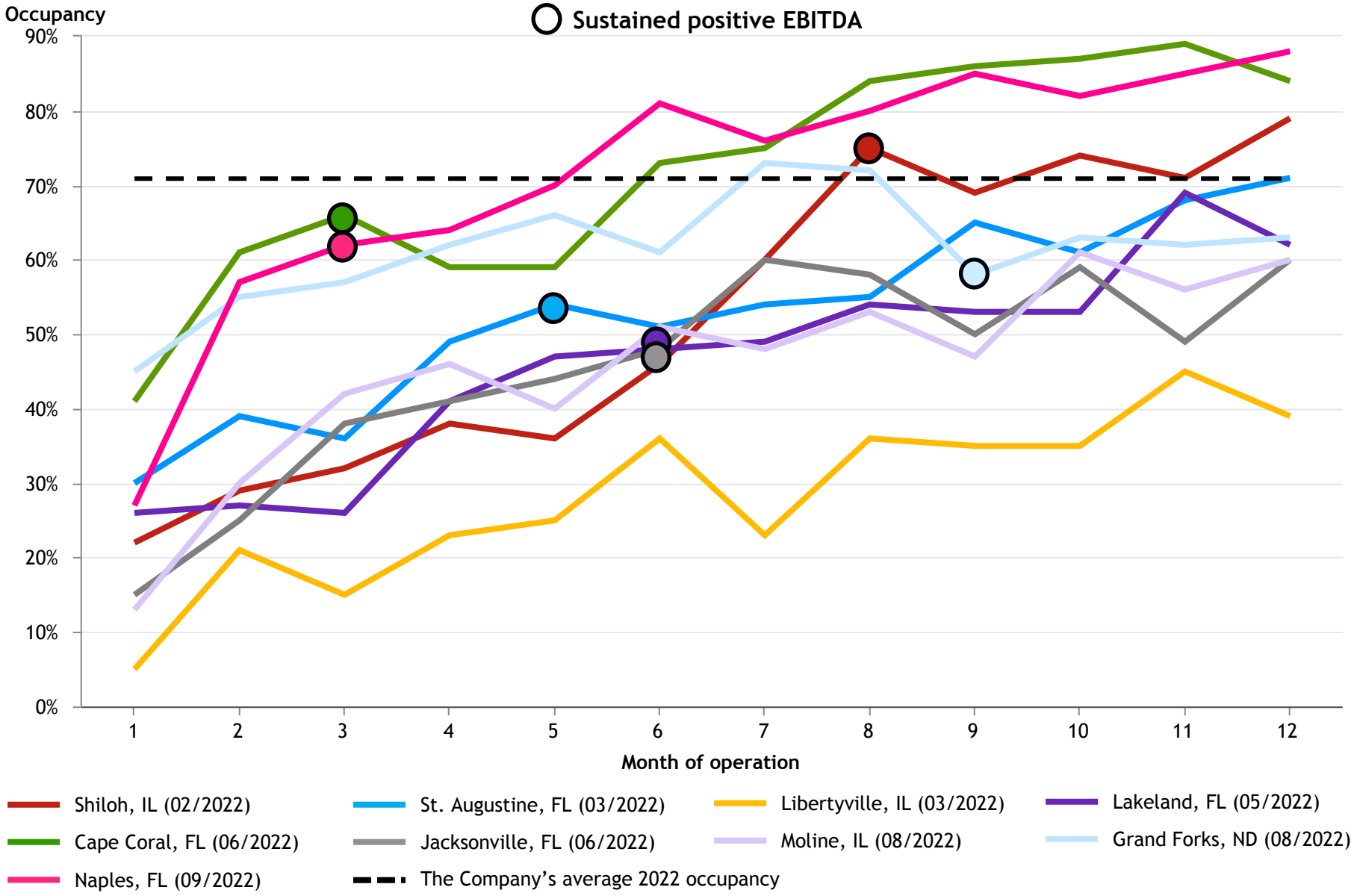
~11 FTEs	Hospital management
~18 FTEs	Therapy staff
~38 FTEs	Nursing staff
~33 FTEs	Support staff

Growth | De novo occupancy and EBITDA* trends - 2021 cohort



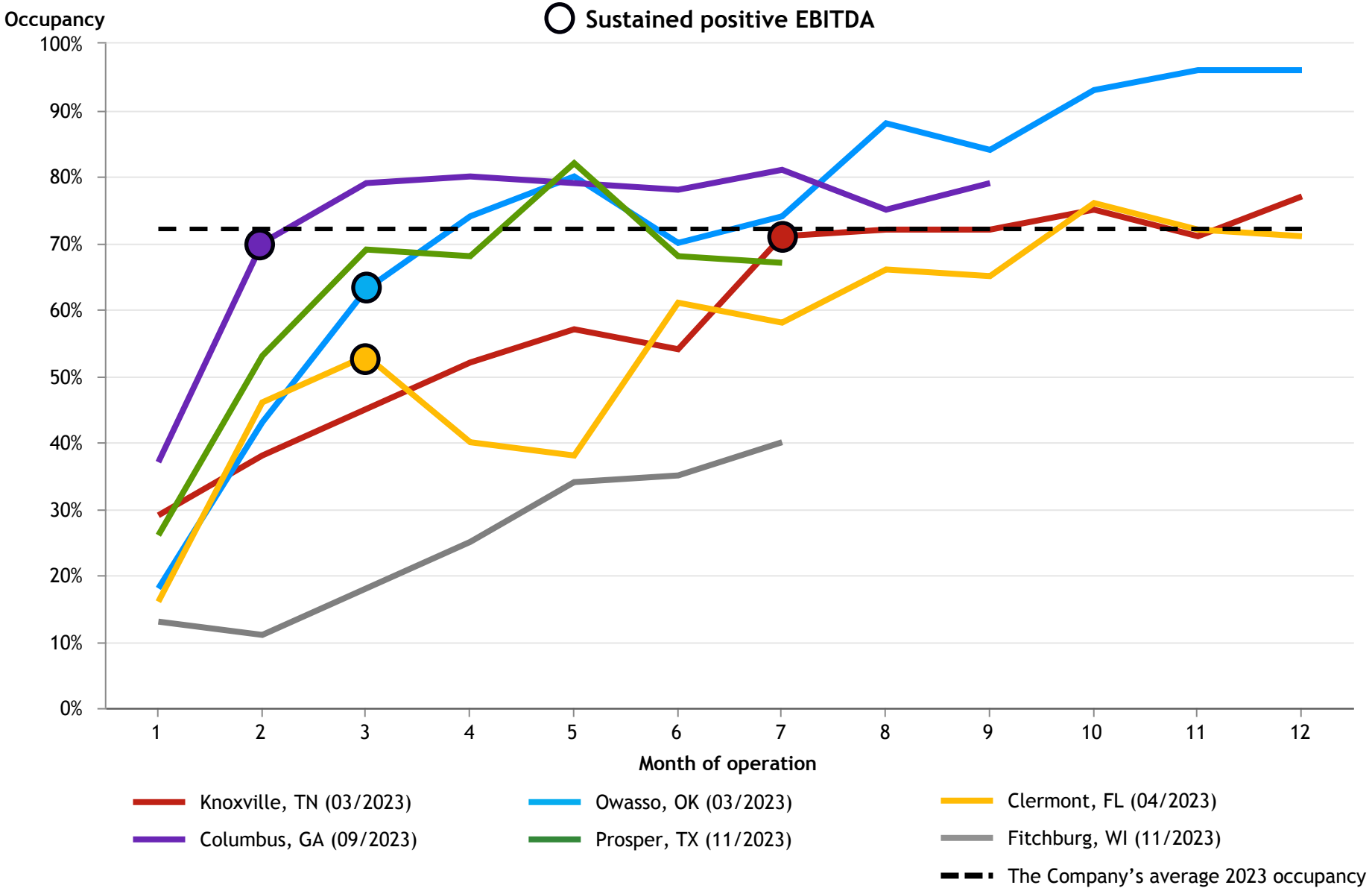
*EBITDA = earnings before interest, taxes, depreciation, and amortization directly attributable to the related hospital

Growth | De novo occupancy and EBITDA* trends - 2022 cohort



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

Growth | De novo occupancy and EBITDA* trends - 2023 cohort



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

Growth | Bed additions

Proven ability to enter new markets and boost returns with subsequent bed additions

56 Hospitals built since 2009

Of the newly constructed hospitals built 2009 to 2020:

- 52% have added beds
- 23% have had beds added more than once

Location	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024(P)
Mesa, AZ	40	40	60	60	60	60	60	60	60	60	70	70	70	70	70	70
Aldie, VA		40	40	40	40	55	55	60	60	60	60	60	60	60	60	60
Houston, TX			40	40	40	60	60	60	60	60	60	60	60	60	60	60
Ocala, FL				40	40	50	50	60	60	60	70	80	80	80	80	80
Littleton, CO					40	40	40	40	40	40	40	60	60	60	60	60
Stuart, FL					34	34	44	44	54	54	64	80	80	80	80	80
Altamonte Springs, FL						50	50	50	50	60	60	70	70	70	70	70
Newnan, GA						50	50	50	50	50	50	60	60	60	60	60
Middletown, DE						34	34	34	37	37	37	40	40	40	40	50
Pearland, TX									40	40	40	60	60	60	60	60
Murrells Inlet, SC										29	75	75	75	75	75	75
Lubbock, TX											40	40	66	66	66	66
Katy, TX											40	40	40	60	60	60
North Tampa, FL													50	50	50	71
Bowie, MD															60	70

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

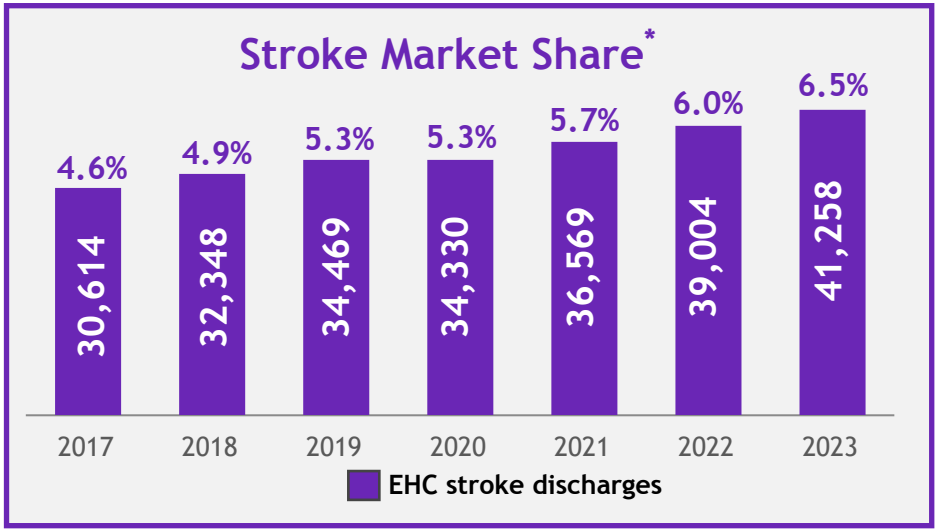
Increase stroke patient market share through education and awareness

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.

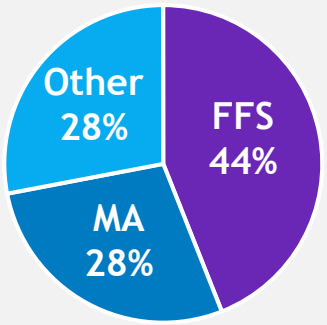
In 2023, we developed and launched an additional stroke support group lesson module, "Self-Care for Caregivers." The resources aim to address caregiver burnout.

Other sponsored modules include "Post-Stroke Depression," "Personality Changes After Stroke," and "Post-Stroke Pain."



Stroke as a % of Payor Discharges (2023)

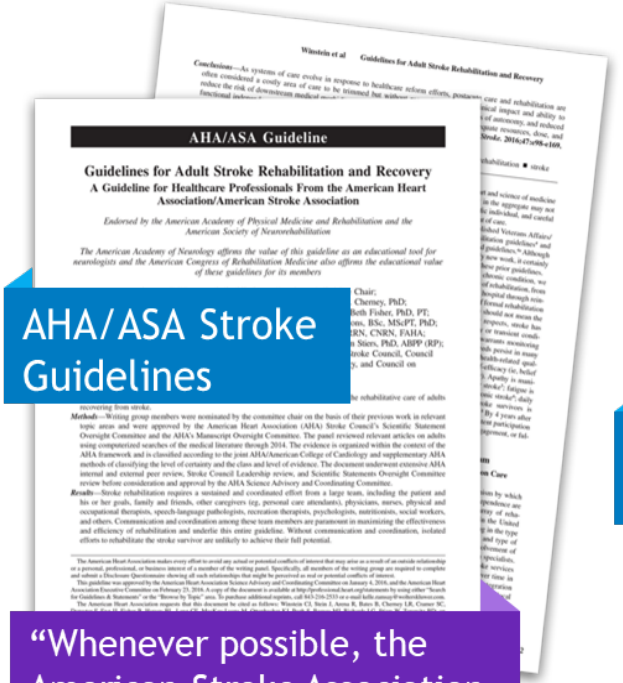
% of Total Discharges	18.0%
% of Medicare FFS Discharges	12.9%
% of Medicare Advantage Discharges	30.6%



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

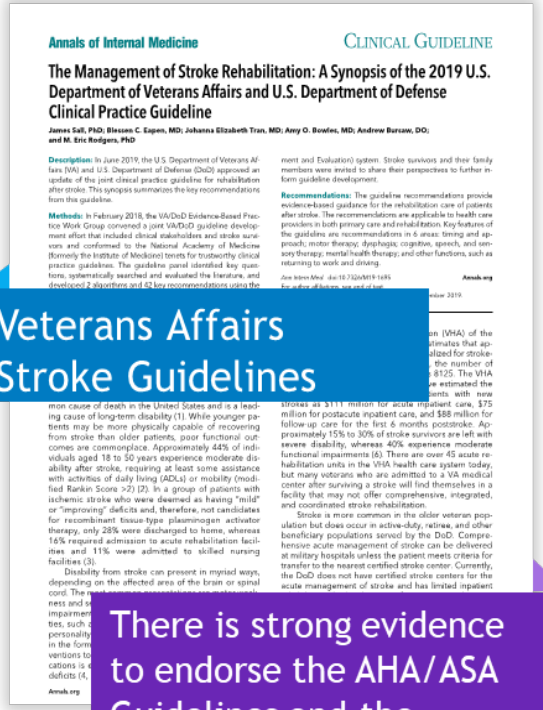
Operational initiatives | Build market share in high acuity conditions

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



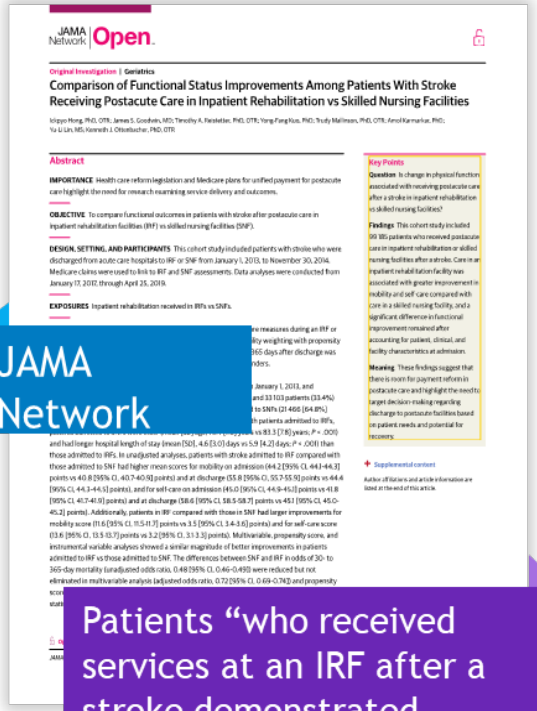
AHA/ASA Stroke Guidelines

"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:

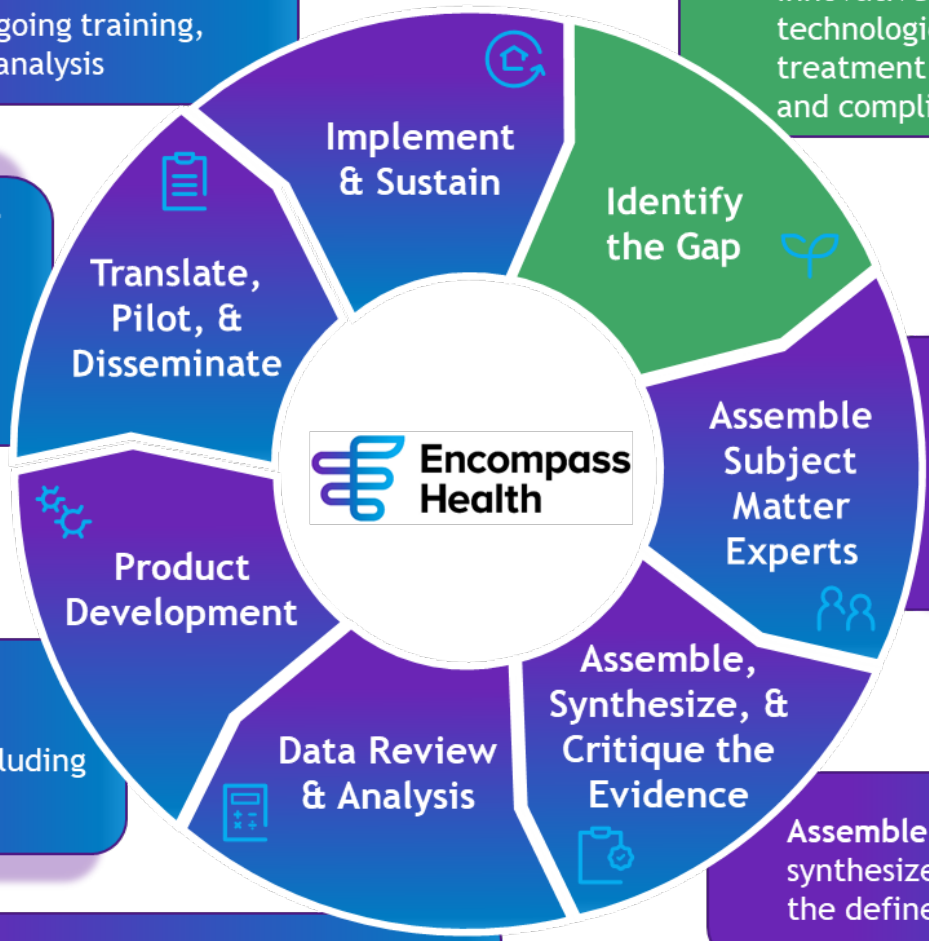
- Better coordination of therapy and dialysis
- Recovery time from dialysis is shorter using Tablo, 2-3 hours versus 24 hours with traditional hemodialysis
- Evidence of a reduction in readmissions and an increase in therapy intensity
- Hospital's clinical team can take a complete holistic approach to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

Tablo available in **88** of our hospitals as of March 31, 2024, with additional locations planned in 2024.

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



Implement & sustain the innovative solution, including ongoing training, modification, & data analysis

Identify a gap or need and potential innovative solution in therapy services, technologies or processes to improve treatment protocols, patient quality and compliance

Pilot or test the innovative solution with a subset of hospitals, review the data from the pilot locations, modify and pilot again as needed

Assemble subject matter experts across the organization from multiple disciplines & departments with an expertise in the defined gap

Develop the product or innovative solution and necessary deliverables including procedures, training, etc.

Assemble evidence and science, and synthesize and critique its impact to the defined gap

Review and analyze data to determine the baseline of the gap and define key performance indicators (KPIs) and goals

Operational initiatives | Post-acute solutions

Our goals are to optimize our predictive tools and to use our extensive clinical database to further improve patient outcomes

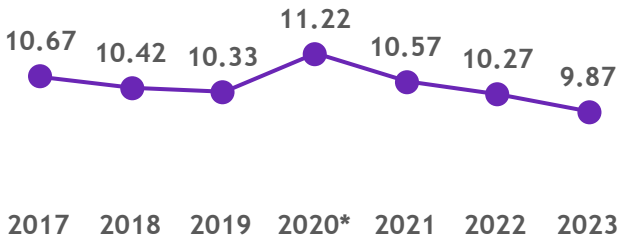
Encompass Health REACT™

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. High risk levels generate action items for the clinical staff to intervene and evaluate the patient.

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

Acute Care Transfer Rate (%)**



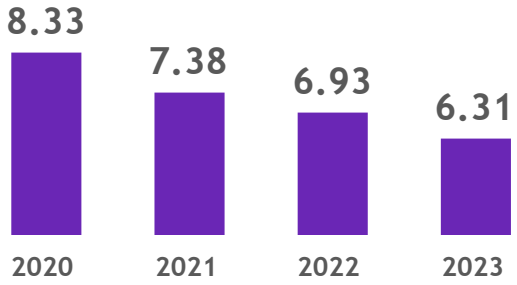
Fall Risk Model

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 and workflows are created and assigned based on risk assessment.

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

Fall Rate***



Innovation Center

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.

The Innovation Center's ongoing strategy includes:

- Regular updating of models to stay ahead of model degradation and to incorporate advances in AI
- Improve ease of learning and adoption by standardizing categories for all models and optimizing training resources for onboarding and continuing education

*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

Wound care

- Enhanced our wound protocol by expanding options of available equipment, increased assessments on admission, and Wound Summits for in-person and virtual training of wound care coordinators.
- Reduced new or worsening wounds per 1,000 patient days by 29%.

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 160+ 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)

Ambu aScope

Swallowing study technology that is portable with a disposable scope eliminating the labor intensive cleaning process with previous technologies

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

Clinical Technology

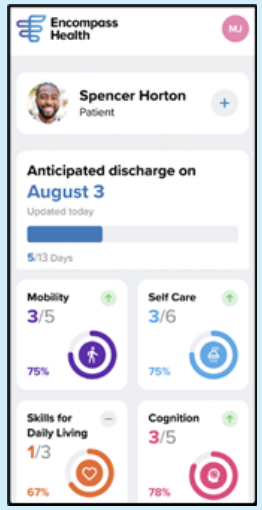
As our employees engage with patients and their families outside of therapy sessions, automation and technology is available for a better patient experience.

(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

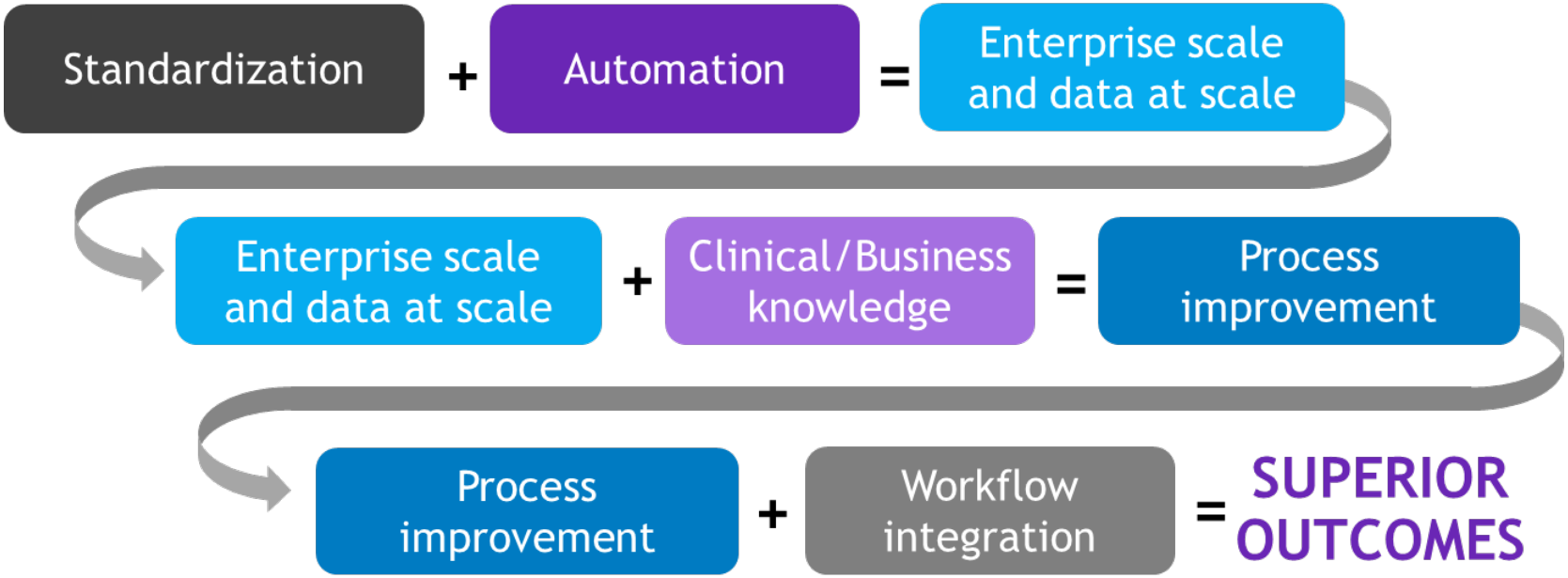
Information Technology

Information technology | Investment thesis and strategy

Our digital health strategy is based on leveraging our:

- clinical expertise
- exceptionally large post-acute datasets
- business and technology partners (e.g., Oracle Cerner)
- and our proven capabilities in
  - enterprise EMR technologies
  - data integration
  - data analytics and predictive analytics

to drive value-based performance across the continuum for our patients, our partners and our payors.



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

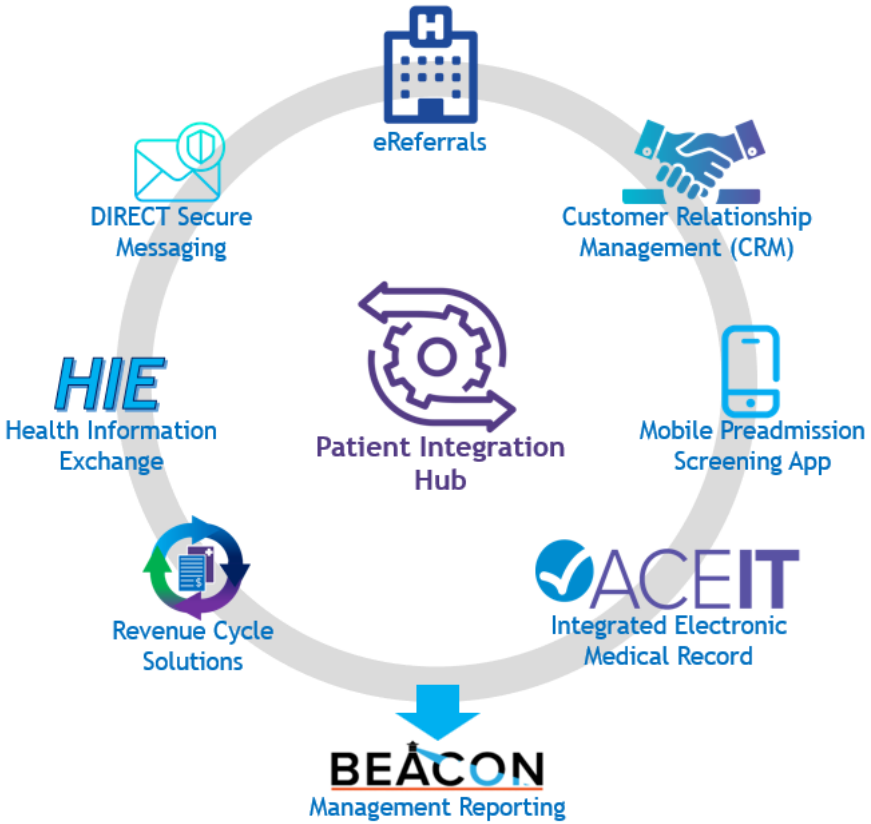
Benefits:

- 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

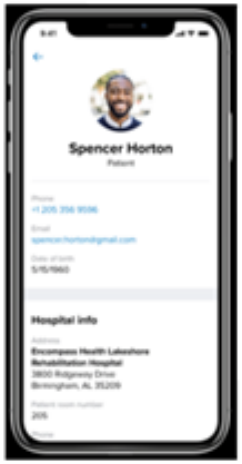
The app shows a patient's real-time progress toward their goals and an overview of their care plan in a secure manner. Information in the app is regularly updated by interfacing with our clinical documentation system specific to the patient's goals and outcomes.

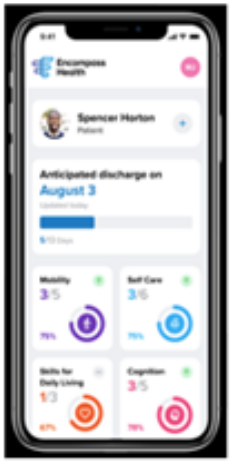
TRACK

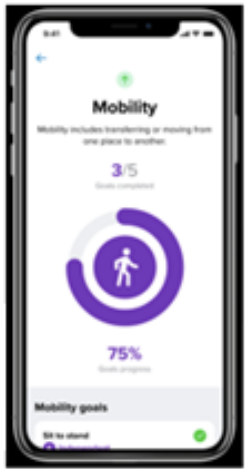
- Follow the patient's stay at our hospital as they make progress toward established goals.
- Track goals established by the patient and the hospital interdisciplinary care team, including mobility, self-care, cognition and behavior, and daily living skills such as meal preparation and medication management.
- 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[8]

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

The leverage ratio for 2021 stated in terms of the most comparable GAAP measurement would be 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 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 Debt to Net cash provided by operating activities: 3.2x

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.

Reconciliation | Net income to Adjusted EBITDA[8]

($ in millions)	For the Year Ended December 31, 2023	2022	2021
Net income	$ 463.0	$ 365.9	$ 517.2
Loss (income) from discontinued operations, net of tax, attributable to Encompass Health	12.0	(15.2)	(114.1)
Net income attributable to noncontrolling interests included in continuing operations	(111.0)	(93.6)	(103.2)
Provision for income tax expense	132.2	100.1	101.9
Interest expense and amortization of debt discounts and fees	143.5	175.7	164.3
Depreciation and amortization[13]	273.9	243.6	219.6
Loss on early extinguishment of debt [11][12]	—	1.4	1.0
Loss on disposal or impairment of assets	9.8	4.8	1.2
Stock-based compensation	50.6	29.2	29.1
State regulatory change impact on noncontrolling interests[13]	(2.2)	—	—
Change in fair market value of equity securities	(0.7)	7.4	(0.6)
Adjusted EBITDA	$ 971.1	$ 819.3	$ 816.4

Reconciliation

Net cash provided by operating activities to adjusted free cash flow[7]

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

End Notes

End notes

(1) 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.

(2) 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.

(3) The 157 IRFs shown for Encompass excludes Rehabilitation Hospital of Columbus (opened September 12, 2023); Encompass Health Rehabilitation Hospital of Prosper (opened November 14, 2023); Encompass Health Rehabilitation Hospital of Fitchburg (opened November 14, 2023); and Rehabilitation Hospital of Western Wisconsin, LLC (closed February 2024).

(4) In 2023, the Company averaged 1,477 total Medicare & Non-Medicare discharges per IRF in its then 153 consolidated IRFs that were open the full year.

(5) Source: FY 2025 CMS Proposed Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2021/2022/2023) or in the case of new IRFs, the Q1 2024 CMS Provider of Service File.

- All data provided was filtered and compiled from the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2025 IRF Proposed Rule Rate Setting File found at: https://www.cms.gov/files/zip/fy-2025-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 1,153 inpatient rehabilitation facilities used to estimate the policy updates for the FY 2025 IRF-PPS Proposed Rule. Most of the data represents historical information from the CMS fiscal year 2022 and 2023 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).

(6) 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 impacts payments for all Medicare Fee-for-Service (FFS) claims extending the suspension through March 31, 2022, a payment adjustment of 1% from April 1 to June 30, 2022, and full 2% sequestration beginning July 1, 2022.

(7) 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 21, 2024, to which this Investor Reference Book is attached as Exhibit 99.1.*

(8) 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 21, 2024, to which this Investor Reference Book is attached as Exhibit 99.1.*

(9) The conversion rate of inpatient rehabilitation eligible patients is based on patients who are discharged from acute-care hospitals 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.

End notes, continued

(10) 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. Projected 2024 total number of IRFs and licensed beds includes the closure of the Eau Claire, WI hospital (decrease of 36 beds) and de-licensure of 12 beds at an IRF in Humble, TX.

(11) 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.

(12) 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.

(13) 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 results 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.