PARTICIPANTS

Corporate Participants

Gary P. Taylor – Analyst, JPMorgan Securities LLC
Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.

MANAGEMENT DISCUSSION SECTION

Gary P. Taylor, Analyst, JPMorgan Securities LLC

Good afternoon, no, still morning. Okay, still good morning. Gary Taylor, Healthcare Services Analyst with JPMorgan. It's my pleasure to introduce Encompass Health, formerly known as HealthSouth and probably still best known by that, but now called Encompass Health. One of the nation's largest providers of post-acute health care services offering both facility-based and home-based services in 36 states. The network consists of over 126 IRFs in almost 200 home health locations. And this morning presenting we have a President, CEO Mark Tarr.

Mark J. Tarr, President, Chief Executive Officer & Director, Encompass Health Corp.

Good morning. It's a pleasure to be back here at the conference this year, as indicated we bring a new name with us, Encompass Health. Those of you that have followed our company in the past know that in July of last year, we announced that we would be undergoing a rebranding initiative for the company, up to and including a name change, so as of January 1, we changed our name from HealthSouth to Encompass Health.

Our ticker symbol changed from HLS to EHC and that was all affected on January 1. This gives us an opportunity to go into this year with a common name, a common brand, for both of our two operating segments.

So just as a reminder, this presentation along with other SEC filings along with our Safe Harbor language is on our website. We encourage you to go out and take a look at that. For those of you that may not be familiar with Encompass Health, we are one of the largest owner operators and a leading provider in the post-acute sector. We have a 127 inpatient rehabilitation hospitals, 237 home health and hospice agencies, spanning 36 states and we have two hospitals in the island of Puerto Rico. Our company is committed to delivering high quality, cost-effective care in an integrated manner. And as you can see here, we're very proud of the fact that we're a good employer and consistently ranked among Fortune and Modern Health Care best places to work.

We provide our care in two different operating segments. One is inpatient rehabilitation. Our inpatient rehabilitation segment includes 127 inpatient rehabilitation hospitals or you may see IRFs, I-R-Fs as a designation for that. 42 of these IRFs operate as joint venture offerings with acute care systems. As I mentioned earlier, we're in 31 states with the hospitals and have locations in Puerto Rico as well. This segment accounts for about 80% of the revenues for the company.

In terms of our size, we're the nation's largest owner operator and inpatient rehabilitation hospitals in terms of patients treated, revenues, number of freestanding hospitals, approximately 29% of all Medicare patients receiving care in an IRF last year received them in a HealthSouth or Encompass hospital. So, we're very proud of that fact. Generally our patients who come to our hospitals are significantly debilitated in one way or the other, either physically or cognitive. They had injuries due to some sort of traumatic injuries or other diagnostic categories such as strokes, hip fractures,

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variety of debilitating neurological conditions that are nondiscretionary in nature. So our patients need to be treated in an inpatient setting with an intensive program of care 24-hours a day.

So while approximately 92% of all admissions into our IRFs come directly from an acute care hospital, it's important to note there is not a tight correlation between our volumes and those volumes in the acute care hospitals. In fact, less than 4% of all the patients discharged from acute care hospitals this year will make it into an IRF. So there's not that tight correlation.

The second operating segment is our Home Health and Hospice. This segment comprises the remaining of the 20% of the revenues, provides services through 200 home health agencies, 37 hospice locations, we're spread across 28 states. This makes us the fourth largest Medicare certified skilled home services provider. The services include skilled nursing, physical, occupational and speech therapy, medical social work, home health aide services and hospice services for terminally-ill patients.

Our platform of facility based and home based gives us a strong foothold in each one of these areas. It also allows us to begin to establish integrated provider markets. An area that has been a big focus for ours from a strategic standpoint is to create what we call overlap markets, which we define as a market in which we have both a home health agency and IRF within 30 miles. As you see here, as we ended last year 2017, we had approximately 60% of our markets were identified as being what we call overlap marketplaces.

Healthcare industry is evolving and very much so for an integrated marketplace. We believe that to be successful in this evolving marketplace, it's important for providers to be able to adapt to changes, build strategic relationships across the healthcare continuum and consistently provide high quality, cost effective care. We believe these competencies run throughout our organization.

In terms of change agility, we've demonstrated the ability to adapt across economic cycles in the face of numerous and significant regulatory and legislative changes. We have a proven track record of consistently growing our company during periods of regulatory changes and those changes were whether they are actual or speculative. In fact, we've posted year over year adjusted EBITDA in 35 of the last 36 quarters. That's in spite of sequestration, regulatory changes and the advent of alternative payment models.

We also demonstrated the ability to build strategic partnerships. I mentioned earlier about a third of our hospitals are partnered with acute care systems and this is not a new strategic initiative for us. Our earliest partnership with acute-care hospital dates back to 1991. Like I said, a third of our hospitals are partnered now. We're very proud to say that we've never had a partnership unwind in all of that time.

In addition to these collaborative partnerships with acute-care systems, we've also formed the post-acute innovation center with Cerner Corporation. The post-acute innovation center will develop advanced analytics and predictive models for post-acute management and will work to determine the metrics and methodology for effective, efficient post-acute network. As a provider of care, we think we're in a unique position to work with Cerner in order to develop these analytic capabilities that focus on outcomes and provide that in a most cost effective manner.

Our clinical expertise, combined with Cerner's technology, will allows us to assume a leading position in development and utilization of market specific clinical decision support tools which will position our company to manage post-acute populations across acute-care hospitals and payors.

We're very proud of our quality that's provided in both our hospitals and home settings, our patient outcomes in both segments consistently exceed national industry standards. Our hospitals participate in the Joint Commission Disease-Specific Care Certification progress, and at the end of

2017, accounted for 279 certified programs, a 103 of these programs involving stroke certifications at our various hospitals.

In addition to the joint commission process, we've recently partnered with the American Stroke Association to jointly market to communities the importance of the inpatient hospital care after one suffers from a stroke. Similarly, our home health agencies also exhibit outstanding quality. They've developed programs to create physician-specific custom treatment protocols in order to have the ability to handle the higher acuity patients.

In our clinical collaboration, efforts between our two business segments where we provide for the transition coordinators to care for patients as they transfer from the hospital setting to a home setting. We also had the market leading position in cost effectiveness which we find very important in both of our businesses segments.

Specifically, we can lever our centralized administrative functions, identify the best clinical practices across a broad spectrum. We also have the ability to utilize management systems to maximize staff productivity, take advantage of the supply chain efficiencies. In addition, thorough integration of technology of our operating culture is a key competitive differentiator for us.

Our information systems allow to manage the entire patient workflow, streamline operations, enhance staff recruitment and retention, as well as maintain key focus on our labor productivity. Our strength in these four success factors positions our company as one of the nation's leading providers in post-acute services in this changing environment. And because the average age of our patient we treat is 76, at least, perhaps, one of the major areas from the fact that we will benefit from this Demographic Tailwind that you see exhibited here on this next slide.

The growth rate of Medicare beneficiaries increased in approximate 3% CAGR in [ph] 2011 (00:11:05) when the baby boomers began turning 65. As you think about this demographic trend, it's important to note two key things. First, the 3% CAGR is for persons age 65 through 89. The average age of our Medicare patient is 76. So if you look at the CAGR for our average age patient and the table on the right-hand side of the graph, you'll see it, it increases to a CAGR of approximately 5%. Second, if the baby boomers began turning 65 in [ph] 2011 (00:11:37), the aging population has not yet reached our average age patient. The first of the baby boomers will turn 76 in 2022.

So, as the patient population ages, the likelihood for their need of our services increases. We lay out our strategy here and our efforts to continue to grow both our business segments, both from a home setting and a facility setting, take advantage of the existing relationships that we have with acute care systems and build upon future relationships with provider networks, payers, in order to show that how we can connect the patient care across the various spectrums between in-patient and home in order to produce not only the best outcomes, but do so in a cost effective manner.

We differentiate ourselves from our competitors based on our broad platform, clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, and the application of technology. We've extensive based – facility-based and home-based clinical experience from which we draw upon in terms of best practices and protocols. We've levered our industry leading technology, these clinical best practices and protocols, to help ensure the delivery of consistent high-quality rehabilitative healthcare.

Our hospitals consistently achieve patient outcomes, such as the discharge to community and average functional independence or FIM Measure that exceed industry average while our Home Health segment consistently achieves in acute care readmission rate lower than the industry average, along with an average quality of patient care star rating above the industry average. The clinic collaboration effort between our in-patient and home health services furthers our pursuit of quality in a cost effective setting.

We employ our clinical expertise from a position of financial strength with one of the strongest balance sheets in healthcare. Our leverage into the year at 3.2 times at the end of the third quarter of 2017 and we have substantial liquidity. We own approximately 70% of our hospital real estate, which means our lease adjusted leverage compares even more favorably to other facility-based peers. Our company has historically generated high levels of free cash flow.

We'll deploy these free cash flows to fund high-quality growth opportunities that present themselves in both of our two segments, as well as investment to shareholder distributions, including regularly, quarterly cash dividend in our common stock. We also have devoted substantial effort in resources to developing and leveraging technology to improve patient care and overall outcomes.

We've partnered with Cerner to develop our own inpatient clinical information system that is fully deployed now in our inpatient rehabilitation hospitals, our home health team's knowledge of Homecare Homebase, as well as thorough integration of it into the operating culture allows our team to maximize the system's capability to drive superior clinical, operational and financial outcomes. End of these systems allow us to enhance our clinical and business processes. Our information system allow us to collect, analyze and share information on a timely basis, making us an ideal partner for acute care hospital systems and others in the delivery of care coordination.

As previously mentioned, we benefit from favorable demographic trends and both of our segments are in highly fragmented post-acute sectors that present acquisition and joint venture opportunities. This gives us multiple avenues for sustained growth organically and in new markets. Our clinical best practices and protocols leverage with our industry-leading technology yield a data driven sales process that has allowed both of our segments to consistently achieve market share gains.

In addition, organic growth in our Inpatient Rehabilitation segment can be supplemented by bed additions at our existing hospitals. To complement our organic growth, we target four to six new inpatient hospitals per year, as well as $50 million to $100 million opportunities in Home Health and Hospice acquisitions.

We also believe that we have an opportunity to disintermediate skilled nursing facilities by demonstrating our superiority in terms of quality and cost effectiveness by directing higher acuity patients into our hospitals, lower acuity patients directly into a home and home health services bypassing SNFs altogether.

Finally, we are a leader in post-acute innovation. For example, we've used our ACE-IT, our internal clinical information system to develop predictive modeling for identifying patients for risk of acute care transfer, gives us the opportunity to take clinical intervention earlier in the process, so that we have an opportunity to create an environment where the patient can remain in our hospital and excel from a quality standpoint and not have to be readmitted back to the acute care hospital.

And finally, as I discussed, we're excited about our formation of the Post-Acute Innovation Center, as this center will generate innovative tools to manage post-acute care. As we look back to last year 2017, we're pleased with what we've achieved. We had four new hospitals in terms of growth. We opened four new hospitals including three joint ventures. We have an additional six projects underway, three of which are also joint ventures. We also expanded our existing hospitals by 166 beds to our existing hospitals. We also acquired or opened 15 Home Health Agencies. Operationally, we're focused on clinical collaboration and advancing our technology and predictive modeling skills going forward.

As we discussed throughout 2017, the success of our clinical collaboration effort with our [ph] overall out markets (00:18:09) varies widely. We necessitated the identification and standardization of best practices across our platform. So, we instituted a team works initiative this last year. It's now fully rolled out as of December and we're pleased to announce that we've already seen a nice

increase in our collaboration rate go from a little bit over 28% to now it's north of 31.7%. So, we've seen progress in the collaboration rate already as a result from our team works initiative.

We also continue to devote substantial effort and resources developing and leveraging technology to improve patient care, operating efficiencies. ACE-IT is our clinical information hospital – and our inpatient units are already now rolled out across the entire platform. In regards to our capital structure, we maintained a strong and flexible balance sheet and returned excess cash to shareholders. We reduced leverage, increased liquidity, and for the fourth consecutive year, increased our quarterly cash dividend.

In addition to paying our quarterly cash dividend of $0.25 per share, we opportunistically repurchased [ph] $38 (00:19:23) million worth of shares in 2017. So, as you think about priorities for 2018, we want to take advantage of the momentum that we had developed in 2017 and rolled into this year. Our growth pipeline is strong. Our goal is four to six new IRFs per year. Currently, we have six IRF projects underway, four of which are scheduled to open in 2018. One of these new hospitals will be in State of North Carolina, it's a state where we've been working now for years. To find an opportunity, we have partnered with Novant, so we're very excited about being in the Tar Heel State this next year. Our home health and hospice side, we plan to deploy $50 million to $100 million for expansion. Typically, these acquisitions are smaller in nature. We'll continue to prioritize market opportunities to create overlap markets with both our IRFs and our home health agencies.

We've also grown increasingly confident in our ability to operate high quality and profitable hospice agencies. We believe demand for hospice services will continue to grow based upon demographic trends that I went over earlier, along with societal acceptance and continued focus on reduction of the end-of-life care cost. Accordingly, we'll seek opportunities to build larger scale hospice businesses.

Our operational initiatives for 2018 are designed to support our strategy, our rebranding and name change, reinforce our strength as one company with the opportunity to brand both of our segments in a common manner. Field operations of both segments will begin transitioning to the Encompass Health name on April 1, with the rollout expected to take about two years, will complete in 2019.

We'll use our clinical expertise to collaborate with Cerner's technology in order to assume a leading position in the development and utilization of market-specific clinical decision support tools, which position our company to manage the entire post-acute spectrum across the marketplace. We're also continuing to enhance the clinical collaboration efforts between our two segments. We remain focused on meeting our longer term goal of increasing our collaboration rate to 35% to 40% within the next two years.

In addition, we'll continue to refine and expand our predictive data analytics to further improve our patient outcomes and patient satisfaction. And we also plan to increase our participation and alternative payment models.

In regards to our capital structure, we'll maintain a leverage and liquidity profile that will allow us to capitalize on any acquisition opportunities that may arise and we'll continue to augment returns from investments in operations with shareholder distributions.

We haven't closed our books yet, but we expect to report a strong end-2017 report in February. We're pleased with the volume that we saw in the fourth quarter, as well as maintaining our guidance for 2017 with adjusted EBITDA between $810 million and $820 million. We currently expect to be at the upper half of this range. For 2018, our preliminary adjusted EBITDA guidance is $830 million to $850 million.

When we look to the guidance for 2018, there are a few things we'd like for you to keep in mind. One is we'll have our work cut out for us as we have an opportunity to grow our volumes, but have

to do so with a Medicare pricing increase that will be less than the salary increase given to all clinical non-management employees and our expected benefit costs increase. We'll need volume productivity, another mitigating strategies to offset this difference.

Our 2018 guidance assumes Medicare claims reviews return to historical levels and our in-patient rehabilitation segment resulting in increased bad debt expense. We also expect to spend between $5 million and $7 million more in 2017 as part of our rebranding and name change.

We also provide preliminary considerations for a diluted share count and tax rate. At this time, we expect our effective tax rate of approximately 28% for 2018, primarily due to the reduction in the federal corporate tax rate, offset by reduced federal benefit of state income tax deductions generated by the recently enacted Tax Cuts and Jobs Act.

As we think about adjusted free cash flow assumptions, we expect to continue to generate a significant amount of free cash flow in 2018 with current free cash flow estimates between $310 million and $405 million. While effective income tax rate is expected to be lower in 2018 due to the Tax Cuts and Jobs Act, our cash taxes are expected to increase over 2017 since we did not pay significant cash taxes in the first quarter of 2017 as we continue to utilize the last of our intervals.

Working capital is expected to increase in 2018 as we assume Medicare prepayment claims denials return to historical levels causing accounts receivables to increase. Free cash flow priorities, we'll continue to prioritize deployment of free cash flow to growth opportunities in both business segments and seek to augment the return generated on operating investments with shareholder distributions.

As I leave you, I want to leave you with the strong sustainable business fundamentals as we see them. In summary, Encompass Health has a strong business proportion, proposition and sustainable business fundamentals. We're in very attractive sectors of healthcare, sectors that are benefiting from a strong demographic tailwind. We have industry leading positions and both facility-based and home-based services that are cost effective leader in both cost and quality. And we have a strong financial platform and plenty of free cash to deploy growth opportunities in the business.

So that concludes the presentation, I encourage you to join us in the Olympic Room for the Q&A.

PARTICIPANTS

Corporate Participants

Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Chief Financial Officer & Executive Vice President, Encompass Health Corp.
April K. Anthony – Chief Executive Officer, Encompass Home Health

MANAGEMENT DISCUSSION SECTION

Unverified Participant

All right. So welcome to the Encompass Health breakout Q&A session. We have the full Encompass Health board – management team up here. So I'll now open up with a couple questions, and then we'll open to the floor as well.

QUESTION AND ANSWER SECTION

<Q>: So, I guess, first off, one of the questions that we've kind of had is, some of your other peers or competitors have talked about [indiscernible] (00:25) benefit increases in the 2.5%, 3% range. Can you just talk about kind of what [ph] – you had a (00:32) breaking out in your salaries and benefit expense maybe 3% salaries and then 8% to 10% on the benefits, kind of what's different there and any specific type of – which type of labor that would be?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. So, this is Mark Tarr. Let me start – first I'll take from the staffing and the labor side and I'll let Doug talk a little about the health benefit side. But from a staffing standpoint, we have not seen any across the board labor issues from a nursing or clinical perspective. We did factor in the 3% increase this year to accommodate a little bit of what we'd expect to see from all the additional pressure. We look at it market-by-market.

We've put a lot of focus on our ability to retain our existing staff and have successful recruitment opportunities, but we've not experienced any major shortages at this point, don't necessarily expect to. It's something – like I said, we never take that for granted and we put a lot of effort and pride to make sure that we have a very low turnover. When you think about from our staffing standpoint, most critical areas are both nursing and therapy, and we are well below the industry average on turnover and both of those categories in both of our business segments.

<A – Doug Coltharp – Encompass Health Corp.>: With regard to the benefits piece, the majority of our benefits expense is comprised of those expenses related to our group medical program on which we're self-insured. And the – we have been out there recently – if you look at our business outlook slides, which provide an estimate of what we think certain expenses will experience in terms of increases over a three-year period, we've been out there with a rate of increase for benefits of 5% to 10%, which I think is generally indicative of the rate of inflation for healthcare cost.

Yesterday, as part of our guidance for 2018, we cited an estimate at the high end of that range of 8% to 10%, and that is almost purely a function of the fact that we had a very favorable performance group medical expense in 2017. And when you're managing a population the size that we are, absent any material changes to the program design and we have none transitioning from 2017 to 2018, you would generally expect your trends in group medical expense to be mean reverting. So that higher estimate is merely a function of the favorable results that we achieved in group medical for 2017 and in anticipation that we'll see some larger claims come through in 2018 as a result.

<Q>: Great. Coming back to some of the issues with regard to the MAC denials, are these kind of related to the [ph] REC (03:28) or kind of what's driving that going forward for next year? And it was kind of a topic of discussion on your 3Q call, but [ph] want to be more (03:37) clear on that.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. So, generally speaking, with regard to IRF segment bad debt expense, one of the assumptions that we included in our preliminary 2018 guidance is that bad debt expense would be in the 1.6% to 1.9% of net operating revenues and that would represent an increase over the level that we expect to post for 2017. We noted beginning in Q3 that there were a number of positive items that were impacting the 2017 bad debt experience. And both of these could be transitional in nature.

The first is, after many years of requesting CMS to provide more direction to how the various MACs approach pre-claims denials, they issued a policy guidance this summer called TPE, which is an acronym that stands for Targeted Probe and Educate. The specific elements of TPE are described on one of the slides in our IRB, so you can find all of that in there. Basically what it does is it extends the gestation period and extends the process that a MAC has to go through before they can deny a claim. And because we don't reserve for bad debt against a newly denied claim until

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that claim is actually denied, that means that we saw a decrease in bad debt expense as we moved into the second half of 2017 and these new policies were rolled out across the MACs.

The second item is that we have historically had one MAC that was responsible for about 70% of our hospitals. And we've discussed at length previously that that MAC was very difficult to deal with and that we felt that they were unfairly denying claims. Apparently, at least some element of that rang true with CMS, because they fired that MAC called Cahaba in August of this year by re-letting the contract. That contract has been awarded to another MAC called Palmetto. We have limited experience with Palmetto from the IRF side. Only one of our existing IRF's been with Palmetto. But we have a more extensive experience with Palmetto on home health, and that has been generally positive.

The contract will transition. It's in that transition phase right now, and that's expected to be completed by February. What has happened in the interim period is that new claims denial activity by Cahaba for any number of reasons, including the fact that they've lost people as they're unwinding that business have dropped off. In our assumption for 2018, we've assumed that both of these elements are temporary in nature, and then 2018 we'll see a level of bad debt for the IRF segment that is more consistent then with that that was exhibited in years like 2015 and 2016.

<A – Mark Tarr – Encompass Health Corp.>: I will add that there's been some preliminary meetings with our Chief Medical Officer and the Medical Director for Palmetto, along with other operational leadership that had consistently worked with Cahaba that now will be working with Palmetto. And the feedback has been very positive from our side in terms of the ability to work collaboratively with Palmetto and the professionalism that has been exercised and exhibited by Palmetto. So we're very optimistic going forward that a relationship with our [ph] FI (06:58) will be of a positive nature.

<Q>: Any questions on the floor? Okay. Could you guys talk a little bit about your long-term reimbursement outlook and how you guys started evolving?

<A – Mark Tarr – Encompass Health Corp.>: Well, longer term – and I'll let April talk about what they're doing on the home health side. Probably a little bit further ahead of where the hospitals are in terms of developing risk-related models, where the providers are accepting greater risk. We still see that as – where the hospitals will be going too as well. When you think about longer term and you eliminate a fee for service reimbursement structure and you look at reimbursing a provider network, whether that patient is in a facility-based or home-based, but you're taking care of a longer episode, that's what we're developing our company and structuring our strategy for. And to have that footprint in both that facility-based and in home-based to build – put that patient where they are most likely to excel and excel in a cost effective manner. That also ties well to the data analytics and the clinical protocols that I alluded to you earlier and how we will establish those working together with Cerner, and have the ability to put the patient in the best place at the right time for the best outcome.

<A – April Anthony – Encompass Home Health>: I think, in addition to what we're trying to do in the non-Medicare space, continuing to look to our Medicare payer to make sure that our industry is viewed positively by the Medicare system. And so we've been able to work in Washington and be able to have a great deal of impact and influence I think there and getting them to repeal a proposed regulation in 2018 that was to go into effect in 2018. We got them to pull that off the table, give our industry time to speak into that regulation and come up with something that I think could be more productive in the long term and avoid any kind of unintended consequences from a sort of short-sighted reimbursement change.

So we feel good about where we are at the moment. We do have seat at the table with CMS, and I think that's going to help us. We add that stability in the CMS relationship along with all the

alternative payment opportunities that are out there. We see a lot of positive opportunities for the organization.

<Q>: Can you talk a little bit more about the new patient navigation tool and how [indiscernible] (09:32)? And is it something more that gets implemented [indiscernible] (09:35) rather than [indiscernible] (09:38)?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. So, let me talk just briefly. [ph] ACIP (09:40), for those of you that aren't familiar with, that's our internal clinical information system. And we're fully rolled out on that. We've been through five years of the rollout period. So we have a critical mass of data that we can review working with our clinical leadership to better identify areas of opportunities for what we refer to as eliminating the acute care transfer back.

So we've put our toe in the water in terms of developing predictive models and analytics around just our internal data. What the Cerner partnership will allow us to do is, take that [indiscernible] (10:21) going forward in terms of the available data that Cerner brings to this partnership working with what we have internally and our clinical knowledge base and their database. We can create these navigation models that will give us a prediction or the analytics behind what's the best path for that patient given their clinical situation, whether that's in a facility-based or home-based and when that transfer should take place and under what circumstances.

So the wealth of data that we have access to now working with Cerner on this partnership has greatly excelled from what we would have been able to achieve internally just using our own internal data from [ph] ACIP (11:11). Although it's been of a great value, this just takes it to the next level.

<A>: And just to elaborate on that a little bit. If you think about what we're trying to accomplish here, and there are other parties that are out there that are trying to accomplish it as well. Some of them are intermediaries, some of them are payers, and so forth. There are two elements to it. One is, to utilize these enhanced data analytics to actually develop what you believe are going to be and then test to see that they are improved clinical pathways that produce better patient outcomes.

And then the second is to then actually put the patient through those protocols going across multiple provider settings in a specific market, and that's where our position as a provider in developing these networks is far differentiated from any of the other payers or intermediaries that are out there doing that. Because, for those other parties, once they believe they have developed the clinical pathways, in order to put those into effect, they've got to try to influence a change in behavior across multiple providers. And the primary mechanism for influencing that is economic by trying to say we're going to – if you don't adhere to these protocols, we're going to direct patients away from you.

That's going to take a lot of time and it's an indirect way to influence behavior. We're a provider in two important segments. If we believe that we've come up with a clinical protocol that is more effective for the patient, we can change the behavior proactively across our provider set.

<Q>: Just going back to reimbursement, what are your thoughts on how HHGM might kind of come back in some different form in 2018 or 2019? And secondly, how do you think about whether or not Congress might be legislating to – I've heard rumors about home health potentially being a pay for in future years as well.

<A – April Anthony – Encompass Home Health>: Yeah. So the moment we're dealing with some of the extenders bills right now and anticipate that home care will be potentially contributing to some of the costs of those extender packages. Don't know the details yet and I think the next week or two certainly will be pivotal in understanding more about that. Don't tend to anticipate that that's going to be a material change. Think it's more likely to be a market basket adjustment or something

that's pretty consistent with ways we've experienced in the past, and also believe that we'll get a good guide from that, which is the return of the rule add-on, will be part of those extenders. And so the net effect of it, we think, will be relatively minimal for us.

As it relates to the overall HHGM component, I think we have an opportunity really over the next 12 months or so to work alongside CMS to come up with, I think, still some pretty transformational revisions to the home health model, the ones that are done in a more thoughtful manner that really bring to bear the insights of providers along with those of CMS, and really combine and consolidate our view and vision of how our industry could affect the overall Medicare system most positively. So we can come up with really a solution that's a win-win [ph] not only for (14:15) the patient, for the payer in the form of Medicare, as well as for the providers.

And I think it's going to take – it's a major transformation. I think it's going to take a lot of collaboration between the industry partners and the payer partners. But I think that we have an opportunity in the next 12 months to really do that and it will begin as quickly as February 1 when the first Technical Expert Panel is convened and we begin to work through the implications of what some form of payment transformation looks like. But I don't think it will be completely dissimilar to HHGM. I just think it's the fine tuning of what that program was proposing. There were some pretty major flaws that will need to be addressed and we have an opportunity to do that in the next 12 months.

<Q>: [indiscernible] (15:00) consolidation maybe of the home health and hospice market, and then obviously with the Almost Family/LHCG merger, how does that [indiscernible] (15:08) is it opportunistic time to keep expanding and using capital in that space or [indiscernible] (15:16)?

<A – Mark Tarr – Encompass Health Corp.>: We still think it's a good opportunity to go out and continue with our strategy of growing both of our segments. I'll let April to comment on the LHC and Almost Family, but we don't see that is changing or impacting our current strategy of expanding both our business segments moving forward.

<A – April Anthony – Encompass Home Health>: Yeah. We think the LHC and AFAM are both two great companies that represent the home care industry very well. And so I think that has a potential of being positive, a positive reflection on the industry, but I think it really begins to clarify that you've got to be a provider of scale in order to really be effective in the new market. And I think that plays to who we are as a company; it plays to our opportunities to continue to consolidate. There are over 12,000 home care players, and so having AFAM and LHC combine really doesn't limit the field that we can go out and purchase and acquire over the next several years, and so we think we continue to be active.

Frankly, if we waited for payment reform clarity, we would have never bought anything in the last 20 years. And so we're going to keep trudging ahead, recognizing that just as we've done over the last nine years of consecutive rate cuts, we continue to find ways to reinvent our approach, our model to further utilize technology to gain efficiency. And those will be things that we'll have to continue to do as the payment systems change and evolve, that we can't pause and wait for clarity, just don't think we're going to have that luxury.

<A – Mark Tarr – Encompass Health Corp.>: Yes.

<Q>: What kind of multiples are you guys paying on home health and hospice acquisitions on a pre and post [indiscernible] (16:47) and has that changed over time?

<A – April Anthony – Encompass Home Health>: We don't really disclose the details of what we're paying and certainly, it evolves in a case by case basis depending on the size and scale of the provider. I would say, we haven't seen material changes. There's perhaps a little bit of an uptick in the last couple of years, but no material changes in the valuations and it's really reflective of the

size. So as you look toward the smaller end of the market, there's been less impact than there is at the higher end of the market as far as larger volume providers.

<Q>: Another one of your competitors has been – there is just some vertical integration in the space right now with the Kindred at Home and Humana acquisition. Do you have any thoughts on how vertical integration could impact your industry and where you see that going?

<A – April Anthony – Encompass Home Health>: So we don't have too much of our business coming from the Humana side, and so as it relates to immediate impacts that might come as the result of the Kindred acquisition by Humana, we don't really anticipate any significant change in the relationship. That's a very small fraction of our total reimbursement. So we don't necessarily have concerns from that perspective. We do think that Humana having a greater interest in home care and a greater recognition in the value that home care can play in maintaining lower cost of care overall is positive for our industry. It is a recognition that home care is a solution that's going to be important to payers.

And so whether it's through direct ownership, relationships, or rather through – whether it's through finding partners in each respective market that helps scale and the density in that local market to make an impact, we think that the recognition that Humana is clearly stating by acquiring Kindred that this is an important segment of how we're going deliver cost-effective care. And that's a 100% positive for our business and certainly for the home care industry at large.

<Q>: [indiscernible] (18:42) SNFs and taking higher [indiscernible] (18:45) volumes during the presentation, is that something that can be done with the skilled nursing staff they you have today or does that require additional investment or hiring different staff?

<A – Mark Tarr – Encompass Health Corp.>: We think that we're doing it today. We think that our quality outcomes – and if you start looking at away from just a per day rate and you look at a longer period of cost of care for a patient and you start factoring in re-admissions back to the acute care hospitals or a longer length of stay, and if you look at the trends for admissions into skilled nursing facilities the last couple of years, so I think you'll see the impacts that already many of these patients are seeing alternative sites of care. And sometimes it's the combination of an IRF being able to treat that patient for two to three weeks, and then working them into a home setting.

But we think that we're already starting to see that significantly, especially among the stroke population is an area, for example, that we've seen a pretty significant change last couple of years, including feedback from some of the payers as we have started to see more and more of their patients referred to us and approved for admission to an IRF versus in the past years, where we may have received that referral, but they would have denied it in lieu of sending that patient to a skilled nursing facility. So we think that this disintermediation is in play now.

<A>: I think one of the questions that you could see us have to add some additional staffing is in the area of, let's call it, post-acute navigation. And so we are – as we are out there both in terms of existing partnerships with our IRFs and as we're exploring new partnerships, we're getting more and more interest and request from acute care hospitals to actually step into the role of being their post-acute navigator and determining what path and to which providers each of their patients requiring post-acute care should travel.

And so this is probably going to mean as we're experimenting right now in a market like Tyler, Texas, for instance, that we're going to add – need to add at least one form of clinician who actually interprets the data and is designing the clinical pathway for that patient and we may require some additional resources who are following up on the patient as they move through each of those particular settings. I think as we add resources in that area, we'll find that we're quickly able to justify those expenses by incremental fee income.

Unverified Participant

If there's no more questions, I think we'll call it there. So I want to thank Encompass Health for coming and have a great day.

Mark J. Tarr, President, Chief Executive Officer & Director, Encompass Health Corp.

Thank you all for being here.