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Kevin Fischbeck: I want to thank everyone for joining us. It's my pleasure today to introduce Encompass Health. Encompass is the largest provider of inpatient rehab facilities across the country and also one of the largest providers of home health and hospice services. Presenting today, we have onstage, Doug Coltharp, who is the CFO of the company. We also, in the audience, have Ed Fay, who is the Treasurer, and Travis Wilson, who is the IR manager.

But Doug was nice enough or foolish enough to jump right into Q&A. So I encourage anyone to ask any questions that they might have, but I'll certainly start it off.

When we think about the IRF business, I guess to start off, why is it such an attractive growth area? We've seen other companies get into the business. Select comes to mind, Kindred. What are the dynamics that kind of make that business one of the few inpatient businesses that actually seems to be growing right now?

Doug Coltharp: I think that the primary factor is just the significant demographic tailwind of the patient population that is treated in the IRF setting. So the average age of the patients that we treat in an IRF is 77. The types of conditions that we treat in an IRF are non-discretionary in nature.

In our own patients mix, which skews a little bit towards the higher end of the acuity spectrum for conditions that are permissible for admission to an IRF, we have almost 20% of our patients population comprised of patients who are recovering from a stroke and almost another 20% related to complex neurological disorders. Both of those are conditions that occur with greater frequency in an aging population. And both of those, again, are non-discretionary in nature.

If you look at the age cohort north of 65, age 65, it's growing at a substantially higher rate than the overall U.S. population. If you break it down into five-year growth increments and look at the projected growth rate from 2018 to 2026 in kind of that 70 to 80, which would really put a collar around the age of the patients that we're treating, that growth rate is projected to be between 4% and 4.5%, and that's against a U.S. population growth of roughly 0.7%.

There isn't anything out there, as well, in terms of a medical treatment or change in health and well-being that's likely to change the incidence of those types of conditions within that population. I mean these folks, and it's really the baby boomer generation, the vanguard of which has just turned 72 this year, have already put in 65 or 70 years of their life and they're not going to be able to change that lifestyle in just a couple of years. So unfortunately, there's not going to be anything that decreases the demand for those services and there are a limited number of providers who have both the capital to invest in facilities and the clinical expertise to be able to treat them.

Kevin Fischbeck: And so what do you think that kind of that long-term growth rate, then, is. If the population sweet spot is kind of growing 4%-4.5%, is that the way you think about

volume growth? Or do you think that it's going be a little bit less because there's always people trying to keep people out of the inpatient setting?

Doug Coltharp: You're going to have some of those pressures as well. It's also the case that -- again, the vanguard to the baby boomer generation, so the real front end of that surge in the population growth, as I just mentioned, has just turned 72. So we're seeing some benefit from that right now, but there's really about another five years before we see the full benefit.

About as far as we look out in terms of volume expectations is a three-year time horizon, and the assumptions around that are reflected in the business outlook slides that we include in our investor reference book and then also in materials like our earnings release. And right now we're suggesting that you can kind of pencil in a 3% per annum volume growth, about two-thirds of which we would assume would result from same-store growth and about a third would come from new capacity additions. But certainly, as we get out closer to where the real bulk of that population is approaching our average age, we would assume that there's the potential for a kink-up in the growth curve.

Kevin Fischbeck: Yes. I guess that's one of the things that we've seen, is that you guys have been adding capacity. Can you tell us a little bit about the structure of that? How much you're building kind of on your own and what you're doing in joint ventures and things like that?

Doug Coltharp: Yes. So as Kevin mentioned, we're the largest provider of inpatient rehabilitation services in the country. We have -- and if you're not overly familiar with the industry, the inpatient rehabilitation segment of health care is roughly, if you consider all payers, roughly a $9 billion to $10 billion segment. So it's not a very big segment.

There are two types of certified inpatient rehabilitation facilities in the country. There are freestanding units and there are units that are housed within an acute care hospital. Not surprisingly, the units that are housed in an acute hospital tend to be a lot smaller than the freestanding units. In total, in the U.S., you've got a little bit less than 1,200 total units between freestanding and those within an acute care hospital. Probably 900 to 950 of those are the units within the hospital and the balance of roughly 250-plus are the freestanding units.

We have 128 of the freestanding units. The next largest aggregation within any one single company would be within Select and that's 24. We have about 29% of the licensed beds in the U.S., and we serve about 30% of the Medicare beneficiaries who are admitted into the IRF setting. So we've got a very substantial market share.

Out of our 128 hospitals, we have, for a long time, had a belief that we should provide integrated care by partnering with acute care hospitals on a market-by-market basis. So 42 of our existing hospitals are operated as joint ventures with acute care hospitals. It also makes sense because being in the post-acute sector, as the name would suggest, more than 90% of the patients who are admitted into one of our inpatient rehabilitation hospitals come directly from an acute care hospital. We are adding about four to six new hospitals per annum to our portfolio. About 50% of the development pipeline that we have in place are additional joint ventures.

And a typical transaction structure, or a transaction structure that we use frequently, is that we'll identify a market that we believe has good population growth characteristics for the Medicare beneficiary population and that is under-bedded or underserved in terms of rehab beds. Frequently, there is a quality acute care hospital operating in that market, and many times they have an IRF unit within their hospital, but it's not a focus for their business and so it's under-utilized and unproductive, and in many cases, they're not making any money on it.

We can approach that partner, point out with some empirical evidence the fact that they're not managing that facility well and provide them with an opportunity to repurpose that space for general medical and surgical use, something that is the focus of their business, and then we will then offer to build on or proximate to their campus a new freestanding hospital and give them an in-kind equity contribution for exiting the IRF business in their unit. That gives us an immediate relationship with an important referral source. It de-risks our entry into the market. It increases the capacity of IRF beds available to the Medicare patient population in that market. And it's a win-win for everybody. So again, I would assume that, on a go-forward basis, our development activities within the IRF segment, that four to six new units per year, are going to continue to skew 50% or higher towards new joint venture opportunities.

When you look at our joint ventures as well, it's not a new game for us. We have joint ventures that extend back almost 25 years. And that's very telling. And no joint venture -- we have never had a joint venture that we entered into that was subsequently unwound. And if you know the history of our company, we're the company formerly known as HealthSouth, that means that even through the Richard Scrushy perpetrated fraud and the FBI raid and all of that other kind of stuff, our JV partners stuck with us. And that's because that fraud was limited to activities in the corporate office, and in the field we've always delivered very high-quality services, great outcomes for our patients, and those attributes are welcomed and appreciated by acute care hospitals with whom we have partnerships. The list of partnerships that we have includes very notable institutions like the University of Virginia, Vanderbilt. It's a great list of partners.

Kevin Fischbeck: And are these sites largely filled up by your referral source partner? Or how much volume do you get outside of that relationship?

Doug Coltharp: It varies pretty widely from market to market. In some of the smaller, more rural markets, frequently you'll have just one large acute care system that really dominates the market. And in those instances, it wouldn't be unusual for us to have a fairly high percentage of the patients coming into our facility be referrals directly from that acute care hospital. In many other markets, though, even though we have a joint venture, we get a great diversity in terms of the referral population if there are a lot of other acute care hospitals operating in that market. We really think, in many instances, our product speaks for itself.

Kevin Fischbeck: I think one of the things that we always worry about is reimbursement. The IRF reimbursement has been pretty stable probably for the last, I don't know, 10 years or so. Is there anything that you're looking at or worried about prospectively?

Doug Coltharp: About 80% of our payer mix across both business segments is Medicare so a day doesn't go by when we're not worried about reimbursement and what's happening on a regulatory front.

That said, if you look back and, for instance, just take the nine-year period that went from 2009 through 2017, and I pick that period because a lot went on during that timeframe. The Affordable Care Act got introduced. Then you went to the BCA and then you had the president's proposal and sequestration came out. And through that whole time, there was a lot of discussion about; are we going to site-neutral? Is the 75% rule going to come back in? All of those things. And then we got into home health and we had some of the re-basing that took place and the HHGM scare last year.

So that's always out there as an undercurrent. And yet, if you look at our own company's performance over that nine-year period that ended in 2017, so that's 36 fiscal quarters, in 35 of those quarters, we posted a year-over-year increase in adjusted EBITDA. And so what I think that suggests is the undercurrents and the concerns about those never turn

out to be as severe as anybody has anticipated, and our ability as a company to adjust to them is well-proven.

And I think as we continue to increase in scale -- and we lead with clinical efficiency, great outcomes for our patients, and being the most cost-effective provider in the business. Because the demand for these services, and this is true for our home health business as well, are only going to increase with the aging population, somebody is going to have to be there to provide them, even as the regulatory landscape shifts. And the highest outcomes at the lowest cost is always going to win, so we feel confident about that.

Having said that, you asked a specific question regarding IRF reimbursement. The proposed rule came out recently. Actually, it came out the day after our earnings call, which was better than having it come out the evening before. And it's -- with regard to the rate update for the next year, it was very much in-line with our expectations.

It did introduce a proposal to change the case mix weightings, the basis on which the IRFs get paid. And the recommended change, as a whole, was very consistent with the direction of the IMPACT Act, which is something that we're in support of. But what it recommended doing was to switch from the FIM score, which has been a central component of determining payment for each of the case mix weightings within the IRF setting, to what is called the CARE tool, which is part of the IRF-PAI that was implemented just in 2017 as part of the progression towards the IMPACT Act. Again, on the surface, that is something that we think could make a lot of sense.

Here's the problem with that. The CARE tool has only been in use for one year, and that was 2017. And it was put in place to run parallel with FIM scoring. FIM scoring is a model that the IRFs have used for a long period of time. And for 2017, the one year that these two overlap -- they are as well in 2018 -- FIM scoring was the basis for payment and CARE tool was just a no-penalty involved, check the box, please just report on this basis as well. Well how much attention do you think anybody really paid to the second tool because it didn't impact anything?

And moreover, the guidelines that were issued by CMS for how the CARE tool ought to be utilized were very vague and required a lot of subjectivity. And so I'll give you a specific example. FIM scoring is a very detailed, very quantitative measurement tool. And there are 18 different activities that you'll measure for a patient, both when they get admitted to our facility and then again upon discharge to measure a patient's progress. And for each one of those 18 measures, there is a point scale that ranges, I think, from 1 to 70. And so you can have a patient come in and one of the things that you'll test is their ability to self-ambulate. And so you'll say, "How many steps can you walk unaided?" That's a very objective measure. It has been replaced with a much more subjective guideline that says, "You should measure that particular patient's ability to ambulate against their usual standard." And usual standard is not defined. So how do you come up with that?

And so our concern with regard to this change being included in the proposed rule is that if we look just as our own database and compare CARE tool scores against FIM scores, in some hospitals -- and we did quite a bit of training around this -- in some hospitals, there's a very high correlation between those two. In other hospitals, there's a great disparity. And that tells us that there wasn't consistent application of that second scoring tool. And I think that's even more prevalent in the broader database for IRFs. So the year on which this change would be based and the case mix weightings would be reassigned is flawed.

And so what we're going to encourage CMS to do through the comment period is really two things. One is wait until more data is available, until providers have had an opportunity to ascend the learning curve and really focus on getting accurate scoring in through the CARE tool. And the second is help us resolve the ambiguities. If you think back to when FIM was adopted, FIM was adopted over a four-year period. So there were four years of data accumulated and that transition was relatively smooth. I think we need a similar trajectory around that.

Kevin Fischbeck: So I mean I guess there's two kind of follow-ups to that then. Because I think the rule indicated a negative shift away from the for-profit providers as a part of this change. When you looked at that analysis, did you agree with that impact to you, I guess on an initial basis, first? And then second, would you expect that delta to narrow over time as you got more experience with the CARE tool and that you wouldn't -- at the end of the day, once everything normalizes, you would expect that same decline?

Doug Coltharp: Yes. Both questions. So first, we haven't been -- as of yet, we haven't been provided enough data by CMS, and we've requested the data, to validate the 2%, whether or not that impacts us directly. On the surface, and this leads very nicely into your second question, it would make sense. It's just kind of logical.

And I say that because if you get back to the breakdown of our industry that I cited before between freestanding hospitals and units within acute care hospitals, most of the freestanding hospitals are for-profit and it's a primary business line. And so there's intense focus on doing detailed coding within the IRF regulations in those hospitals. The not-for-profit sector is highly populated by units within acute care hospitals and frequently you have somebody, who has been an acute care hospital coder, who now moves over into the IRF setting, and the regulations are markedly different.

And as an example, one of the things that CMS guidelines require us to do when a patient is admitted into one of our facilities is to make an assessment of the patient's cognitive impairment because that's one of the things we're supposed to help them with during their stay. Well, that assessment really doesn't factor into acute care hospital coding. And so they tend to overlook that in the acute care units. And as a result, if you think about now moving from this very specific FIM scoring to what is a more general subjective scoring, the entities that heretofore have done more detailed coding are likely to lose points for appropriately coded co-morbidities at a higher rate than the units that were already using more generalized coding. And so you would expect to see that kind of disparity in terms of the initial impact.

Your second point I completely agree with, which is worst case if it comes through and out next year, it may have a larger impact on providers like us. But I would expect the trajectory to return to normal over probably a two- to three-year period as all providers ascend the learning curve on using the CARE tool, as CMS, over that timeframe, works to resolve any ambiguities that are in the guidelines, and then as additional data with -- additional and better data with each subsequent year gets fed into the database that ultimately determines the case mix weightings.

Kevin Fischbeck: Maybe we'll pivot to the home health business, which is the faster growing part of the business now. I guess maybe we'll just stay on the reimbursement side of things because you mentioned the grouping model, I guess it's called the CARE (ph). Does that imply that you feel like it's not over, I mean that it is over? Because I guess we're thinking that in 2020 we may see kind of a new grouping model proposed. What do you think about the timing on that and what the impact might be?

Doug Coltharp: I don't think we'll see HHGM come through as it was proposed previously. I think that, thankfully, CMS listened to the comments from the industry and recognized that there

were flaws in their logic about the impact it might have on beneficiaries' access to care and so forth. I do think, and the Bipartisan Budget Act in February pretty much mandated this, that we're going to see a change in the payment system. And the Bipartisan Budget Act mandated that by 2020 there would be outlined a transition from this 60-day episodic payment to a 30-day payment mechanism.

The substantial flaw that existed, and I think CMS is now aware of this, in the HHGM proposal was that it was trying to move from that 60-day episode to a 30-day episode by simply cutting the length of the episode in half, from 60 to 30 days, but also cutting the payment in half. And what misses is that for virtually all episodes that involve skilled nursing services and therapy services there is a front-end loading of some of those services within the 30-day period. It makes sense. The patient is transitioning onto home health typically from an inpatient post-acute site of care like an IRF and you want to make sure that there are more frequent and more intensive visits in the first couple of weeks extending out through perhaps the first 25 days that that patient has been discharged to ensure that there's not a readmission. And then the patient starts to become more stabilized as you move into the second 30 days, there are less frequent visits that are more of a monitoring nature.

Well, if you just cut the 30-day episode or the 30-day payment in half, the effective smoothing out of the revenue per visit that would occur over a 60-day period is gone and you wind up with just a price cut against the same number of intensive visits in that first 30-day period. And unfortunately, the only way that a provider could really react to that, because margins have already been cut substantially in the business over the last five years, would be to say, "Okay. I'm just going to spread my visits over a longer period of time, and I'm not going to provide the intensity of care in that first 30 days." And if you do that, guess what number is going to go up? Hospital readmissions. And a hospital readmission is a whole lot more expensive than paying for another visit or two within a home health care episode. So I think that factor is being understood.

One of the other things that came out of the Bipartisan Budget Act was a requirement that CMS put in this payment change in a budget-neutral manner, with a little bit more definition than previously existed because that's always supposed to be a requirement, and also that they engage in a more formal process with the industry on getting feedback and input into the new model. That's through a vehicle called the TEP, a technical expert panel. That panel has met once with CMS. It was comprised of 10 industry experts. And I'm pleased to say that Encompass Health had three representatives on that panel as well. We feel like there's a productive dialogue going.

In terms of when that payment system might be implemented, again the target is to have it identified by 2020. But if you look at 2020, again another part of that Bipartisan Budget Act was that the market basket update for home health got hardwired at 1.5% in 2020 as a tradeoff for the rural add-on extension. And so there are some out there who believe that takes less pressure or that takes pressure off of CMS to say, "We have to implement in 2020." Maybe it's designed and agreed upon by 2020 with an implementation of 2021.

But if you look at both of these, what's happened through HHGM and the progression there on home health and what we just talked about in terms of the progression from FIM to the CARE tool in the IRF sector, it clearly signals that we're going to see a change in the payment system probably for all post-acute sectors. And we completely embrace that. Again, we think all of that is consistent with the IMPACT Act. We think ultimately it will reward the providers who produce the highest-quality outcomes in the most efficient manner. So it's not if; it's a matter of how you get there and just encouraging CMS to be very thoughtful and to engage with industry partners to make sure the system gets done right and in a way that doesn't wind up detracting from the level of care that's being provided to the Medicare beneficiaries.

Kevin Fischbeck: Because the budget-neutrality dynamic was kind of a surprise last time, does CMS still have the authority or the ability to put in a -- I forget what the term is -- but an adjustment to reflect the expectations of how they initially will respond in that budget-neutrality dynamic? Or do you think that it's more limited now and they have to wait to see before they make that adjustment?

Doug Coltharp: Sure. So for those of you who aren't overly familiar with kind of what ability CMS has to set rates for a particular industry and the latitude around that, CMS does set the payment rates where a price-taker, as are all factions within Medicare from CMS and on an annual basis for each of the different sectors, they go through what's called a rule-making process and set the price for the next year. The rule-making process always has two phases for each specific sector. They introduce a proposed rule. Depending on which sector you're in, that falls at one time on the calendar. And then they provide a comment period to various constituencies, including the industry, that allows for several months to take feedback to see if they want to make any further modifications.

The guidelines that CMS has to operate under are they are not allowed to change the overall budget for payments that are allocated to a particular sector. Only Congress has the ability to do that. So if CMS is revising payments within a particular sector, they're required to do so in what is known as a budget-neutral manner. And that means they can take from certain types of cases treated by a particular sector or certain types of providers within a particular sector, but it has to be reallocated to somebody else so that, effectively, no money leaves the system.

When HHGM, which was this change in the payment system that was included in the home health proposed rule last year, came out, CMS said, "We think it's budget-neutral." But it gets to be budget-neutral by assuming a very substantial change in behavior in terms of how the operators all conduct their business. And part of the feedback that we gave individually and through industry groups is that change of behavior is a sea change. It's not just a we'll do something modestly different. And it's incorrect to assume that it will happen to that degree and over that point of time. And if it does not, there's no way that this rule change would be budget-neutral.

And I think CMS came to believe that and I think Congress certainly came to believe that because part of what they did with the Bipartisan Budget Act in terms of not only saying, "Move to the 30-day payment mechanism by 2020," but underscoring that it had to be done in a budget-neutral manner, and that they could only make certain assumptions with regard to behavioral changes. So we felt like that was productive.

Kevin Fischbeck: And can you talk a little bit about the growth expectations for the home health business going forward?

Doug Coltharp: Sure.

Kevin Fischbeck: How do you think about, I guess, volume growth? It seems like there's a lot of shift to low-cost settings so it seems like home health is in a sweet spot right now. So what's the outlook there?

Doug Coltharp: Yes. It really is. So we've been seeing very nice growth in our home health sector for the last three years. On average, we've been posting quarterly total admissions growth that's been between 10% and 15%, sometimes higher than 15%. The overall growth was a little bit lower in Q1. That's largely due to the fact that we were up against a 13.9% same-store admissions growth from last year when we rolled the former CareSouth locations in.

We've penciled into that same business outlook slide that I referenced previously that gives a three-year look forward that we should expect to see about 10% per annum admissions growth. That's a number we feel comfortable that we can deliver on. I would expect that probably 60% to 70% of that will come predominantly from same store, and within that same store, probably 100 to 150 basis points will be related to the clinical collaboration between our home health business and our IRFs, and the balance will be based on capacity additions.

We had a very nice capacity addition that we closed on here, most recently, in early May with the acquisition of Camellia. That was $135 million transaction in terms of the purchase price. I'll note that that carries with it a $20 million to $25 million present value of the tax benefits, so an effective reduction in purchase price there. In 2017, that business did approximately $80 billion in revenue. And what's also interesting about that business is it's roughly equally split between home health and hospice.

But we feel like there are great growth characteristics that still exist for us within home health. It remains a highly fragmented business even today. You've got approximately 12,200 licensed home health agencies in the U.S. That's a big number. It's down from about 12,500 a couple of years ago, largely due to some of the pressures that are coming to bear, particularly on the small players, related to the multi years of rate cuts and also some of the increased quality reporting measures and so forth. We think that's a good thing. We think CMS is pushing for further industry consolidation.

We think there are other opportunities like Camellia out there. We're also interested in some of the smaller transactions where they give us the opportunity to either add market density to a market in which we're already operating or to add additional IRF overlap in markets.

Kevin Fischbeck: Can you talk a little bit about labor costs? Because that seems to be the one pressure that we've definitely seen increase in the last couple of years. What are you seeing from a rate growth perspective? And it feels like that number is going to be higher than your rate updates on both the IRF and the home health side. So how do you think about being able to maintain margin in that rate environment?

Doug Coltharp: Sure. We've been battling that, particularly on the home health side now for, again, I forget whether we're into our fifth or sixth year of rate cuts. It's just gotten to be an environment we're accustomed to. And over the last several years, our assumption in both segments about the level of increase in our SW has risen from 2.25% to 2.5% to right now at 3%. It feels like it's kind of stabilizing around 3%. Rough numbers, about 50% of all of our revenue dollars are consumed by the SWB line. And within that SWB line, about 85% is SW. So that's with the 3% inflation factor. And another 15% is benefits, which is predominantly group healthcare, and that's been rising a little bit faster.

In the IRF sector, probably with the next year because of macro notwithstanding, if we can get north of a 1.5% rate increase, you're effectively even on the SWB component, and then you can get leverage in terms of your margin against some of the other expense categories, absent a year when we're making investments in things like rebranding. And I feel pretty confident, with the exception of maybe an off year here or there, that we're probably going to see IRF price increases from CMS and from our managed care providers that will get us into that 1.5% or north. So the margin pressure on the IRF sector is likely to be less.

It's hard to say when pricing stabilizes on the home health side. We witnessed over that five- to six-year period some pretty significant margin deterioration in our home health business. We reversed that last year and into the first quarter of this year. I think we've demonstrated, frankly, that we're better than anybody else in the industry in terms of

labor productivity measures. It helps that April Anthony, who is the CEO of our home health and hospice segment, was the founder of Homecare Homebase, which is the most widely used software program by home health and hospice providers. And she is a super user and our business is a super user of that product.

So one of the ways that you can help offset some of those pricing pressures in SWB, I'll just give one example, and that is to make sure that you're appropriately matching the license of the caregiver to the needs of the patient. And so don't send an RN to do a visit that could be done by a nurse practitioner. And really making sure that you drive the efficiency that way. That requires market density and it requires a lot of attention to how you manage the logistics of your caregivers.

But there is going to continue to be margin pressure on the home health side. Although, I do feel like what's happened in the rate environment over the last five to six years has helped CMS accomplish a lot of what they wanted to in terms of starting to weed out some of the smaller players and bending the growth curve in home health even as you see increased pressures to move more patients into home health more quickly and out of some of the inpatient settings, predominantly disintermediation from the SNFs.

Kevin Fischbeck: All right. I think that's all we have time for. Thank you very much.

Doug Coltharp: Thank you.