Encompass Health

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Mike Manfred: Good afternoon, and thanks, everyone, for taking the time. My name's Mike Manfred (ph) from Morgan Stanley, and very pleased to introduce Encompass Health. The recently rebranded, Encompass Health. I'm very pleased to have with us Doug Coltharp, Executive Vice President and CFO, as well as Ed Fay, Senior Vice President and Treasurer of the company. As everyone is well aware, Encompass delivers inpatient and home-based care that helps patients achieve life-changing results. It's a credit that's been in our market for some time, almost $2 billion in unsecured notes. One of the strongest, most consistent performers that we see across the healthcare space in the non-investment-grade debt markets.

With that introduction, I will -- I'll turn it over to Doug, and looking forward to a good presentation. Thanks again.

Doug Coltharp: Great. Thanks, Mike, and good afternoon, everyone. Thanks to Morgan Stanley for hosting us this afternoon, and thanks to each of you for your time and interest. I am joined today by my colleague, Ed Fay, who's seated in the front row. Ed is our Senior Vice President and Treasurer, as well.

We've got a 40-minute time slot so rather than speak to you for 40 minutes, I'll try to address my comments in 20 or 25 minutes and try to leave ample time to address any specific questions that you might have. We've got a series of slides that I'm going to use as a discussion guide. For those of you who aren't familiar with our company, we actually, beginning in 2011, began producing a document which we update quarterly and post to the Investor Relations section of our website, known as the Investor Reference Book, or IRB. And that document was developed in recognition of the fact that we are -- were at the time, and remain, really the only publicly-traded company that has as its core or primary business, specialty inpatient rehabilitation hospitals. And those come along with their own specific set of Medicare regulations. And so, if we were to entice investors, both on the equity and from a fixed-income perspective, to study our story and become interested in investing with us, we felt like we had to make it as easy as possible.

So, the Investor Reference Book, which over time has grown to more than 120 pages, includes a Power Point slide for every question we've ever received except for a hand few that we threw out because they didn't make any sense. And so, it's voluminous, but I think it's well-organized. And again, you'll find that's at your disposal.

So, the requisite forward-looking statements and all of that other kind of stuff that goes along with that. But, maybe just start with an overview of the company. And as Mike alluded to, up until January 1 of this year, our company was known as HealthSouth Corporation. We rebranded the company to Encompass Health, and changed our NYSE ticker symbol to EHC effective on January 1. That rebranding is reflective of our

strategy to be positioned as an integrated provider of post-acute services. It also is an acknowledgement that we are no longer a regional player; we're a national player. And in just a moment, I'm going to walk through the actual geographic footprint for our two primary business segments, and I think you'll get a sense as to the geographic expanse of our business.

As Mike alluded to in his introductory comments, we operate in two complementary sectors in the post-acute space, which means that most of the patients that we're treating come to us after some type of malady has landed them in an acute care hospital. We offer both inpatient post-acute services, all of those administered through the inpatient rehabilitation segment. You will hear us from time to time reference inpatient rehabilitation hospitals, which are the specialty hospitals that we operate, as either IRFs, which is an acronym -- IRF -- for Inpatient Rehabilitation Facility, or just hospitals. We can't be a healthcare company without sprinkling in a lot of acronyms, and we do our share of that as well.

And then we complement our inpatient setting with a home-based offering, predominantly centered around skilled nursing and therapy services administered in the home setting, but a smaller, albeit rapidly-growing hospice business. And as we move deeper into the presentation, I'll make a few comments on where we see the relative growth rates in each of those three business lines heading, and some of the underlying rationale behind that.

This gives you a sense as to the overall geographic footprint. I think what's probably more useful is to peel back the layer of the onion, if you will, and look at each of the two segments in turn. So, the legacy business, and the larger of our two business segments, is the inpatient rehabilitation hospitals. And for those of you who aren't familiar with this setting, we're defined by Medicare regulations, and each of our business segments is focused on serving the Medicare beneficiary population. According to Medicare regulations, all of our inpatient rehabilitation facilities have to be licensed as acute care hospitals, and that means that we have to adhere to certain requirements of care. Those requirements of care include things like the provision of 24-hour-a-day, seven-day-a-week nursing coverage, and also a minimum of three face-to-face visits with the patient per week by the attending physician.

Medicare specific relations governing the IRF sector impose further requirements of care on the IRF setting, and those predominantly relate to the administration of therapy. So, licenses in IRF we're required to provide an intensive therapy regime to each patient in our care that includes on average, three hours of therapy, five days a week, with the preponderance interpreted as more than 51% administered in an individual versus a concurrent or a group setting.

And I point out these specific requirements of care because those are really what differentiates an IRF from a SNF. Sometimes, you will see a SNF refer to itself, or being loosely attributed to being, a rehabilitation facility. None of the requirements of care that I have just reviewed are in place for a SNF, and I'm not aware of any SNFs that actually take on the additional cost to provide those. From a personal experience, if you ever have a loved one who is recovering from a stroke and you're dealing with an attending physician, make sure you understand the distinction between the two. The aspects of recovery are dramatically different between the two settings.

So, our IRF business, I mentioned, is our larger of the two business segments. We -- this

cites 127 freestanding IRFs. We opened another one in April. This number was at the end of the first quarter. So, we're at 128 freestanding hospitals. To give you a little bit of further dimension around the IRF segment of healthcare -- so for all payer classes, including Medicare, the total IRF segment is probably roughly $10 billion in revenue and probably 80% of that is Medicare. So, at $3.2 billion, we're a very large player. As a matter of fact, we treated about 30% of all Medicare beneficiaries who received IRF services during 2017, and we have about 22% of the licensed beds that are out there.

There are two types of IRFs that operate in the United States. There are freestanding IRFs, and there are IRFs that are units housed within an acute care hospital. Between the two, there are roughly 1200 IRFs in the US. A little bit more than that. In terms of the breakdown of those aggregate IRFs, there are roughly 260, 265 that are freestanding, and the balance of 950 or so if my math are correct, are the units within an acute care hospital.

If you look at the industry data, it would show that not surprisingly, the units that are housed within an acute care hospital are generally smaller, and they're less efficient. They tend not to be the primary area of focus within an acute care hospital, whereas they are in the freestanding environment. We are focused solely on freestanding IRFs, and out of that roughly 200 to 265, again, we have 128.

The next largest aggregation of freestanding IRFs within any single company is approximately 25 within Select. Then you quickly begin to see that number drop with about 20 in the Kindred Hospital Group, which will now become part of the ownership with TPG and Warburg Pincus, and a number of other small portfolios that are out there. So, it tends to be a pretty highly-fragmented business beneath us, and even more so on the IRF side.

Again, I mentioned that this business last year generated about 80% of our revenues. We did $4 billion approximately in revenues in 2017. The IRF segment generated $3.2 billion of that. We administered care to approximately 175,000 patients in the IRF setting during 2017, through a dedicated team of almost 30,000 employees. And this is a business, again, getting back to moving away from the regional connotation that was present in our previous name -- I only say it once in our presentation -- we are now operating in 31 states and Puerto Rico.

This business is complemented by our home health and hospice segment, and again, our home health business is concentrated on providing skilled nursing and therapy businesses. It, too, has a broad footprint. We've got 212 home health locations. We've got another 56 hospice locations. Between the two, they span 30 states. Not all of these 30 states that we operate a home health and hospice business overlap with the 31 in which we have an IRF, so when you put the two together, we actually cover between the two business segments, 36 states I'm going to get into dimensionalizing some of the home health and hospice business in just a moment, but first I want to talk about the rationale for the two businesses being together.

We entered the home health business in a significant way at the beginning of 2015 when then HealthSouth -- I did say it twice -- acquired Encompass Home Health and Hospice. At the time, home health -- Encompass Home Health and Hospice was largely private-equity-owned but its founder, April Anthony, who remains the CEO of that business segment for us today, also had a significant ownership. It was a business that was very highly-regarded and widely renowned for the quality of outcomes and the high level of

compliance that it had.

What attracted us initially to being in the home health business was our belief, really beginning in 2010 with the advent of the Affordable Care Act, that the healthcare delivery system was continuing to progress towards more and more episodic payment models and to more and more responsibility for extended periods of time for patient care and patient outcomes for both payors and providers. And we looked at two statistics specific to our IRFs at that time. First, the average length of stay for a patient within one of our IRFs was and remains less than two weeks. And when you started to hear about episodic payment models, or about readmission penalties, applying to periods of time that ranged from 30 to 60 to 90 days, we were only capturing direct responsibility for that patient for a very small portion of that time frame.

We then coupled that with an analysis of the discharge destination of the patients coming out of our IRFs, in the 2014 time frame. And what we identified is that about 55% of the patients who were being discharged from our IRFs required follow-on home health care, and yet we had a very, very small footprint in home health at the time, less than $25 million in revenue. They were hospital-based agencies and we were capturing only a very small portion of that.

We also looked as part of that discharge destination, and I'll circle back to this in just a moment, that about 15% of the patients we were discharging from our IRFs were going into the SNF setting, and that looked to us as both a problem and an opportunity. If you think about what that meant, because approximately 95% of the patients who come into an IRF setting come out of an acute care hospital, if we were discharging a patient from the IRF to a SNF we were hitting an inpatient setting three times: acute care facility, IRF, and SNF, and that starts to add up to a lot of cost.

So, with that strategy in mind, we were the successful acquirer of Encompass Home Health and Hospice, and we put them together and began on an effort that we have labeled, "clinical collaboration," which I'm going to get to in just a moment. First, I want to again dimensionalize the home health and hospice offering within our company. As I mentioned, we did about $4 billion in aggregate revenue in 2017. You saw the $3.2 billion attributable to the IRF segment. About $800 million is attributable to home health and hospice, and of that, roughly $720 million is home health, skilled nursing and therapy services, and about $80 million is hospice.

And a part of the reason for that is, we entered the hospice business initially beginning in 2012, utilizing what I borrowed from my days in retail as a strategy of gift-with-purchase. Which is, there were home health agencies that we wanted to acquire, and oh, by the way, they came along with a hospice business. And so, the strategy that we undertook beginning into 2012, was to take those businesses in, not attempt to grow specifically the hospice segment, but seek to understand that business and whether or not it could generate sufficient returns on capital. And also, to seek to ascertain whether or not we felt that we could take some of the same operating competencies that we were applying to both the IRF segment and the home health segment, and make those applicable to the hospice business.

I will front run the story and tell you we believe that we have ascertained both of those things right now, and we do have as an objective that we have been very public about, growing our scale in the hospice business as well. We're going to get into some of the specific reasons behind that, in just a moment. So, hospice business is a smaller piece of

the business.

You see some of the key statistics around that here, around this here -- home health and hospice segment has roughly 8,800 employees in it. We had 128,000 patients served by our home health business in 2017, and about a 5,500 patients served on the hospice business.

So, we look at providing an integrated care delivery model on the post-acute sector. In order to be integrated, we have to have both businesses present in the same market. And so, we track something called market overlap. And market overlap is simply when we look at the number of markets in which we own and operate a freestanding IRF, in how many of those markets do we also have a home health agency located within the 30 mile radius? The 30 mile radius is an arbitrary number that we made up. We think it's a reasonable proxy. In some markets, it's a great proxy. In other markets, you're going to encounter a river, or a county line, or something that make it less of a good proxy, but we felt as long as we kind of selected a number and stuck with it, we'd be able to track the progress from there.

So, our current market overlap stands at about 60%, meaning again, in 128 IRF markets we've got a home health agency that we own and operate, present in around 60% of those markets. We are frequently asked what the limitations are in terms of increasing that. We are seeking to increase the overlap percentage. That needs to be done almost exclusively through the acquisition of home health agencies. Given the certificate of need requirements and also the state moratorium that are present in most markets, we do think there are opportunities to continue to do that. If you look at the acquisition that we closed on May 1 of this year with Camellia Home Health, we added another overlap market in Gulfport, Mississippi and we have prioritized our acquisition pipeline within the home health segment to create more overlap markets.

We believe that over the next five years, this 60% overlap should progress towards 80%. There are some limitations on ever getting to 100%. Those rely mostly in the CON requirements, the Certificate of Need of requirements that I mentioned before. To a much lesser extent, there is occasionally a joint or a non-compete feature to a joint venture relationship, that we have with one of our IRFs.

And I should have mentioned that back on the IRF slide. One of the factors that's somewhat unique to our strategy but also seeks to our position, or speaks to our position as an integrated provider, is that a third of our IRFs are operated in joint venture relationships with post-acute-care -- with acute-care hospitals. So, 42 of our hospitals are in joint ventures with acute-care hospitals.

To continue on here, we coined a term during 2015 to create a metric and measure the degree of progress we were making in having our two business segments work together for the benefit of payers and patients. And that is a term called, clinical collaboration. And so, clinical collaboration simply means a patient has come into one of our IRFs in an overlap market, qualifies for and requires home health services upon discharge, and receives those services from our home health provider in that market. So again, we started at a base where 55% of the patients being discharged from our IRFs required home health. Today when we look at that number, system-wide, not just in the overlap markets, it's closer to 59% of the patients. And within the overlap markets, it's about 63% of the patients are receiving home health services.

How did we get the number there? We started with about 15% of our discharges going to SNFs. Today that number looks more like 9%, so we have identified a portion of the patient population where early intervention and closer coordination between a home health provider and the IRF setting can bypass an additional inpatient post-acute setting and get the patient directly into the home following their stay with us, without incurring any deterioration in quality such as a hospital readmission.

In those overlap markets, we have been attempting to drive up the percentage of those home health discharges that are captured by our home health provider, and it's because that's where we're able to establish the tighter linkage and guarantee that the plan of care that is developed during the patient's stay in the inpatient setting, which is the IRF setting, is executed for a broader period of time.

Prior to acquiring the Encompass Home Health and Hospice business with that smaller $25 million business we had, our collaboration rate was about 7% to 9%. At the end of the first quarter of this year, that number climbed to 33.5%. So, we're making great progress, and we are starting to see evidence that those patients that stay within our network, if you will, are posting higher patient satisfaction scores and exhibiting lower 30- and 60-day hospital readmission rates.

One of the things that we're most excited about related to both of our business segments and all three of our service lines, is the tremendous demographic tailwind that is driving increased demand for the services that we provide. And so, the average age of the patient that we treat in the IRF setting and the home health setting, is 76 years old. If you look at some statistics around US population growth projected forward, the aggregate US population is expected to grow at a CAGR of less than 1%. But the demographic aged 75 to 80, from 2018 to 2026 -- so just over the next eight-year period -- is projected to grow at a CAGR of 5%. And this is driven largely by the aging of our population, most notably the aging of the baby boomers, and also to a lesser extent by an increase in life expectancy.

The good news for us, is not only is that wave coming, but it's still in front of us. The bulbous of that population is really yet to reach us. And I say that because the first of the baby boomers was born in 1946. That means in 2018, they're turning 72, and yes, we treat 72-year-old patients. But again, the average age of the patients that we treat is 76. So, that demographic tailwind is still in front of us, and it is going to drive demand for the services that we provide, which are non-discretionary in nature.

It's also the case that there is little risk of technological obsolescence around the types of conditions we treat. Around 20% of the patients that we treat in the IRF setting are patients who are suffering from a stroke, recovering from a stroke. Another 20% have suffered some debilitating neurological disorders. These are conditions that are born out of a lifestyle that has now spanned, for these particular individuals, more than 65 years. There isn't an exercise regime, a diet or a pill that they can now adopt that is going to meaningfully change the curve that they're on for experiencing these maladies, and somebody's got to be available to treat them.

And this leads to what we believe are multi-faceted growth opportunities across our business. I mentioned to you previously the highly-fragmented nature of the IRF space. With this demand curve, we think there's a demand for additional IRF beds out in the marketplace. We currently have a base of about 8,800 licensed beds on the IRF side. We have stated objective of adding four to six new hospitals per annum. On average, each

one of those hospitals will bring 50 new beds and will offer opportunities for future expansion. And the category of future expansion, we're seeking to add another 80 to 100 beds per year to that total number of the bed expansions. Bed expansions offer very high rates of return at a relatively low risk, because we're building into an established demand and leveraging an infrastructure that's already in place.

That's what the growth profile looks like on the IRF side.

Also very attractive opportunities on the home health side, and I mentioned previously that on aggregate the IRF business is about a $10 billion a year segment. Well, each of home health and hospice, is about twice that size. And those are both highly fragmented businesses as well. In spite of the difficult reimbursement environment, that has now spanned more than five years, and in spite of some of the consolidation activity that's taken place during that time frame because of the reimbursement environment, and because of things like more onerous quality reporting requirements, the number of licensed home health agencies in the US still stands at 12,300. And 95% of those have less than $5 million in revenue. So, there are numerous acquisition opportunities that are out there, and they run the gamut.

Some of these will look like almost dormant businesses that happen to own a CON or a license for a very attractive geographic territory, and others are real high-quality operating businesses such as the Camellia business that we bought and closed on on May 1. We have stated an objective of trying to do between $50 million and $100 million of home health and hospice agencies per year. That's a marker, it's not a limit, and that's been exhibited by our activity already this year. The Camellia acquisition, which is one acquisition we closed this year, was a $135 million deal. As a result of that, we've upped the bogey for this year in our guidance from $165 million to $185 million.

Within those acquisitions, we will assign the highest priority to creating additional overlap markets between our home health and IRF business so that we can engage the clinical collaboration, again, inuring to the benefit of both payers and most importantly to our patients. And then, we'll also look at other attractive markets where we can create more density for our home health operations, because with density comes the ability to leverage scale.

On the hospice side, not quite as fragmented, but nearly as much; about 4,400 licensed hospice operators in the US. Some interesting statistics about hospice, and first I want to get a little bit more -- if you had followed any of our public statements, you'd know that we changed our (inaudible) and say, revised our (inaudible) slightly at the beginning of this year to really proactively assert that we are looking to build scale -- albeit off of a pretty small platform of $80 million in hospice. And moving into hospice in a larger way does not offer the same clinical collaboration opportunities that exist between IRF and home health, but it's still part of the continuum of services that eventually a Medicare beneficiary is likely to, or should be likely to, experience during their lifetime.

But, a couple statistics on that. Again, it's already a big business and we've already talked about the demographics that are driving the aging of the population. And these will be rough numbers, but in 2017, roughly 50% of Medicare decedents expired while on the hospice benefit. That seem high or low to you? Anybody? 50% is right in the middle. I think it's low. What do Medicare beneficiaries die of? Motorcycle accidents? Sky diving? I -- they die because they're old. And so why isn't that number substantially higher? Here's another statistic. Out of the 50% of decedents who expired on the

hospice benefit, 30% of those had a length of stay of less than seven days. The hospice benefit is a 180-day benefit.

What percentage of the Medicare budget, annually, is expended on a Medicare beneficiary's last 30 days of life? One-third. One-third of the budget is expended on the Medicare beneficiary's last 30 days of life. Link these things together, right? So there's all of these heroic activities that are taking place to try to extend the life of a Medicare beneficiary whose health is simply failing. When all of those resources have been exhausted, late in the day we transfer the patient to the hospice benefit, much too late for the patient and for the family to receive the benefits of true palliative care and the social work that goes along with it. The system hasn't saved any money. The patient and the family have a very unfulfilling experience. But a lot of this is changing, and it's changing not only because of the cost pressures that are being brought to bear as we try to bend the cost curve for Medicare expenses, but also based on societal norms. An increasing number of older patients want to expire on their own terms, in their home, surrounded by familiar belongings and by their patients as well.

And increasingly, in the generation that's aging out right now, you see the presence of legal documentation in the form of healthcare powers of attorney and living wills, which dictate these wishes.

So, good growth opportunities. Moving more perhaps to the things that are more germane to the folks in this room, we're a business that generates significant levels of free cash flow and consistently high levels of free cash flow. And so, this is a chart that compares 2017 with our 2018 assumptions. One of the reasons that I put this up here is that for a lot of other companies, if they were showing you this, you might see a significant decrease in the anticipated cash taxes from 2017 to 2018, because we had this little thing called tax reform. And we benefit from tax reform as well. Our effective tax rate has gone from 40% to an estimated 28%, but through the first quarter of 2017, we were still working through a Federal NOL. And so, we paid no cash taxes in the first quarter of 2017.

And so, the combination of higher pre-tax income and paying taxes for a full four quarters this year, means even at the lower rate our cash taxes are going up nominally but still generating very significant levels of free cash flow, and we've got great places to put it to use. As I mentioned, we've got good growth opportunities within each one of our business lines. This just takes some of the numbers that I cited to you previously, that were quoted more along the lines of capacity additions, and breaks it down into dollar spend.

We do have a regular dividend on our common stock. It's currently at about $100 million a year. And from time to time, we have engaged in opportunistic share repurchases. The number that you see here, that $65 million, really relates to kind of the unique setup that we have with some of the -- April Anthony and some of her management members in the home health business who rolled over equity from the private equity transaction when we purchased the Encompass Home Health and Hospice business in 2015.

And then just a couple comments specific to the balance sheet. When Ed and I began working together in 2010, we put together a strategy of really wanting to manage our debt capital structure along the lines of an investment-grade company. And that meant setting up our debt capital structure so that the front end, the nearest maturities, were comprised

of very flexible, very efficiently-priced bank facilities here in the form of $700 million revolver and then Term Loan A commitment. And with that, then supported by layered maturities of senior unsecured notes.

Took us a number of years to get that in place and to work through some of the legacy notes and so forth that were in the capital structure, but really this is the structure that's been in place for us for better than five years right now, and we think it serves us very well and provides us with a lot of flexibility.

That's another look at that -- terms -- I should comment that, on terms of current leverage level, we set as an objective trying to stay generally within a range of 3 to 3-1/2 times. We're currently at the low end of that range. At the end of the first quarter, our leverage ratio was at 3 times. With no debt maturities prior to 2022, we feel like that's a pretty good combination that gives us a lot of flexibility.

I think we take a relatively conservative approach to managing the balance sheet, even though we feel very good about the long-term demand for our services and don't think that there are going to be any really substantial revisions to the Medicare support for those programs. We do recognize that our business is about 80% Medicare funded, and so we just have to be cognizant of any potential short-term disruptions that can occur.

We also position the balance sheet so that we can be opportunistic. If another opportunity like the Encompass Home Health and Hospice operations were to arise again, if you reflect back on 2015 within a ten-month period of time, we made three -- for us -- good-size acquisitions within that ten months. We acquired Encompass Home Health and Hospice at the beginning of the year for $750 million. At the end of the third quarter we acquired the Reliant Hospital Group for $750 million, and then a month later, acquired Care South which was a home health business, for $175 million. All of those funded with cash and with debt. That took our leverage ratio at the end of 2015 up to 4.6 times.

We did that publicly stating that we were highly confident that we had good visibility into reducing the leverage ratio to back below four times by the end of 2016. In fact, we hit the bid by the end of the third quarter of 2016. So, if you just want a proxy as to how we view the flex in the balance sheet, I think that gives you some sense.

And then finally, an important note -- unlike I think any of our peers in the post-acute sector, we have a strategy of owning a very substantial portion of our real estate. So, currently about 70% of our real estate is owned and unencumbered on the balance sheet. We think that gives us a great deal of flexibility in terms of how we manage the portfolio, and importantly, in an environment where we are a price-taker it means we're not subject on our occupancy costs to annual rent escalators in onerous leases, which has proven very difficult for some of our competitors.

So, I think that leaves us with just seven or eight minutes, and Ed and I would be happy to entertain any questions you might have. You going to let me get off easy? Okay, very good. Once again, thank you to our hosts at Morgan Stanley, and thanks, all of you, for your time and consideration of us.