PARTICIPANTS

Corporate Participants

Matthew D. Gillmor – Analyst, Robert W. Baird & Co., Inc.
Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Chief Financial Officer & Executive Vice President, Encompass Health Corp.

MANAGEMENT DISCUSSION SECTION

Matthew D. Gillmor, Analyst, Robert W. Baird & Co., Inc.

Good morning to everyone. I think we're ready to get started. My name is Matthew Gillmor and I cover healthcare facilities and technology stocks for Baird. We're very pleased and excited to have Encompass participate again in the conference this year and I think as most of you know, Encompass is a leading post-acute provider, primarily focusing on inpatient rehab, home health and hospice.

Representing the company on stage, we have Mark Tarr, the company CEO; as well as Doug Coltharp, CFO; and then Crissy Carlisle from Investor Relations is joining us in the audience. So, Mark's going to kick it off with a couple of slides here to get everyone oriented and then we'll jump into Q&A. If you have a question please just raise your hand. I wasn't able to get the iPad to work yet. So, it'd be easier just to raise your hand.

So, with that, I will turn things over to Mark.

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

Thanks, Matt, and good morning, everyone. It's our pleasure to be back here at the Baird Conference and thank you for joining us. I'll start first with our forward-looking statements. Additional details, additional information can be provided on our website. If you have an interest in going there, I would encourage you to do so.

For those of you that may not be as familiar with Encompass Health, we announced last year that we are undergoing a rebranding initiative of two years. It started January 1 with the name change going from HealthSouth Corporation to Encompass Health, and the corresponding ticker symbol changed to EHC. After a series of surveys, working with a brand management company, we decided to change the name to a name that better represented what our strategy was as an organization.

In 2014, we acquired Encompass Home Health & Hospice, which was the fourth largest home health agency at the time. We did that so that we would have a footprint in both the facility-based as well as home-based as part of our overall strategy of being an integrated post-acute provider.

As you can see now, the company's made up of 128 IRFs or inpatient rehabilitation hospitals, 272 home health and hospice. We cover 36 states. We're committed to delivering high quality, cost effective care and are leader in the industry in both of those areas. And we're very proud of the fact that we're a good place to work as noted by our selection and qualifications for the Fortune 100 Best, as well as consistently mentioned in Modern Healthcare's Best Places to Work.

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The company is set up with two operating segments. The first segment is inpatient rehabilitation and it accounts for about 80% of the revenues for the company. And we are the largest owner and operator of inpatient rehabilitation hospitals with 128, 42 of those operate as joint venture with partnerships with acute hospital systems.

That's a strategy we adopted over 25 years ago now and continue to do that in marketplaces from a strategic initiative of partnering with these acute care hospitals, working with them to grow their inpatient hospital business, and work with a partner that has this as our primary objective.

We're also very proud that 109 of our hospitals hold one or more disease-specific certifications from the Joint Commission which is the major accrediting body for hospitals. As I mentioned, we are the largest owner and operator of IRFs. From a market share standpoint, we have 22% of the licensed beds and 30% of Medicare patients that received inpatient rehabilitation last year, received those in an Encompass Health hospital. We have locations in 31 states and Puerto Rico.

The second segment, and accounts for the additional 20% of the revenues is our home health and hospice with 215 home health locations that makes us the fourth largest Medicare-certified provider of skilled health services. At 57 hospice locations, that puts us in as the top 25 provider of hospice care.

We see that as another arm of growth for the company. We see that the demographics are very similar that drives the ongoing continued need for service for the aging population for home health hospice, as well as our IRFs. You see here, we're in 30 states. And we're also very proud of the quality that we have in our home health segment as well with 93% of our agencies have three stars or better for quality, as well as patient satisfaction.

Creating market overlap is a major strategic initiative for us and we define market overlap where we have both an inpatient rehabilitation hospital as well as a home health agency within a 30-mile radius. This gives us a chance to continue the process and strategy of integrating the post-acute care.

We're now at 30%, of our overall markets qualify as one of these overlap markets. It's a major initiative for us as we go out and continue to grow our home health segment. We'll look for opportunities to acquire and expand a number of overlap markets that we have and increase from 60% to hopefully at some point in the future [ph] we'll have (00:05:52) the vast majority of our markets will be overlap markets.

As part of this initiative, we have defined clinical collaboration as the process as we had a patient that completes their care in our inpatient rehabilitation hospital, and then transitions to a home health setting. About 60% of our total discharges from our rehabilitation hospitals are patients that are discharged home with home health. What you see here is clinical collaboration exist in those 60% of the markets that I mentioned earlier of our overlapped markets with the clinical collaboration of converting those patients from our rehab hospitals to our home health agencies in those overlapped markets.

Our near-term goal is to reach 35% to 40%. You can see here from this chart, we've made very significant progress of 460 basis points on a year-over-year increase from Q2 of 2017 to the second quarter of 2018. We believe this is a number that we can grow higher once we reach the near-term of 35% to 40% then we'll reset our goals going forward. We think longer term this is a number that can approach 60% in our overlapped market.

And then finally, we'd like to point out that we had very strong and sustainable business fundamentals. Both of our segments are in very attractive healthcare sectors that benefit from a significant demographic tailwind, the aging population. As you think about the population, the aging, the increased demand for the services of the aging population continues to increase, the likelihood

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of patients having a stroke or hip fracture or needing home care will only increase with that aging population.

I will point out that the baby boom portion of the aging population is just now starting to reach our – what we would consider to be our average age patient which is in our home health segment at 77 and 76 in our hospitals. So, we do have an aging population that should benefit our services. We have industry-leading positions where we are the low-cost high-quality provider in each of our business segments.

We take great pride in our financial strength. We think that our balance sheet is one of the strongest balance sheets in the healthcare industry with very strong free cash flow. And then, finally, that free cash flow helps to support our ongoing growth opportunities whether that's an expansion of the acquisitions for home health agencies or the continued growth of our de novo hospitals of four to six per year, as well supporting our same-store growth through the addition of bed additions and overall growth within each of our segments. So, we believe that these are very firm foundations for continued growth moving forward.

With that, Matt, I'll turn it back over to you.

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QUESTION AND ANSWER SECTION

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Perfect. Thanks Mark. And I was going to start on the IRF part of the business first, and maybe just one, sort of, foundational question, IRFs provide such high value in terms of clinical outcomes in terms of re-hospitalization. Are there some stakeholders that perceive IRF as being a high cost setting in spite of that? So, maybe just first remind us [ph] what are (00:09:40) the patients where you all sort of provide the most value in terms of re-hospitalizations? And then, how can you communicate that back to the stakeholders so they understand the value that an IRF is delivering?

<A – Mark Tarr – Encompass Health Corp.>: Sure. Well, our patients are medically complex patients. They're nondiscretionary in nature, meaning they don't come into our hospitals after [indiscernible] (00:10:02) procedure. In most cases, they've had either suffered from a stroke, suffered from other neurological conditions. About 10% of our overall discharges are brain injury patients. So, those hospitals that have a referral relationship with a trauma center, we tend to get brain injuries and spinal cord. So, these are all patients that need inpatient care. It's not a decision whether they go home or come in to a facility-based care.

As we think about cost effectiveness, we look at the longer term approach of care for that patient, more of an episodic approach. If you just look at it, which is the misperception that some people take, and they just look at the cost of a nursing home per day versus a longer period of time.

And the significantly greater likelihood of a patient being readmitted back to the acute care hospital, treated in a nursing home, then the value proposition for IRF-level care or rehab care in one of our hospitals becomes much more significant in terms of our ability to get the patient back home, keep the patient home without the readmission back to an acute care hospital, which – that's what really adds up to the cost. So, the value benefit of our quality becomes more and more apparent when we're compared against other alternative sites.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And case in point around this was the American Stroke Association/American Heart Association guidelines that came out, I guess, about two years ago that recommended if you or a family ever had a stroke, you need to get to an IRF particularly over a SNF. But maybe just remind us, what's your overall share of stroke cases? How has the company responded to these new guidelines?

And if we can add one-third a question there, are there other, sort of, organizations or types of patients where you have data that shows that really differentiated level of value where IRFs could play a much bigger role?

<A – Mark Tarr – Encompass Health Corp.>: We were very happy when, two years ago, the American Stroke Association independently came out with a survey that said their research had shown that for a patient suffering from a stroke, that needed inpatient level of care, that those patients were best served with care delivered in an inpatient rehabilitation hospital versus a nursing home. So, we quickly populated that survey in all of our markets and made sure that potential referral sources, family members, patients, staff were all clearly educated on this release of information.

We've also developed a longer-term partnership with American Stroke Association, which next year we'll start co-marketing stroke prevention education and work together in a co-branding process, which we think aligns us very well with the American Stroke Association moving forward.

Relative to our market share of stroke patients, we have about 17% of the overall discharges of stroke patients that came from an acute care hospital that went into IRF level of care. So, there's about 68,000 patients discharged from acute that went into an IRF in 2016, which is the most

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recent [indiscernible] (00:13:31) data we have, about 17% of those came to an Encompass Health hospital.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And is there a reason why you couldn't get the other, I guess, 87%, did they have clinical conditions that would require them to stay in an acute care hospital or...?

<A – Mark Tarr – Encompass Health Corp.>: Well, certainly, in our market that's a huge focus for us – is go out and articulate our value proposition. To go out and make sure the referral sources, those physicians, those discharge planners see the difference between care provided in a nursing home versus a rehab hospital.

And even more so, the greater likelihood almost, well, over 80% of our patients at the time of discharge are discharged back home, which we're very proud of, and the fact that we now have a home-based level of care too makes that coordination from facility to home that much better.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And then, maybe thinking about the overall growth outlook for your IRF business. So, you all have targeted 2% to 4% growth for a long period of time and have done really well executing mostly towards the high end of that, and obviously, the key elements are the bed adds to existing facilities, the JVs for new facilities, and some de novos on top of that.

But I guess the question I want to get around to, and Mark you alluded to this, with the baby boom coming up in terms of age, will there be an opportunity at some point that's hitting your sweet spot, to increase that discharge growth target or is there some gating factor be it regulatory or [indiscernible] (00:15:23) laws that will, sort of, keep the company at 2% to 4% even if the population is growing above that?

<A – Mark Tarr – Encompass Health Corp.>: There's not a gating factor. We have 3% in our three-year business outlook that we've shared. We hope that that is the bottom of that number. And if we continue on the path we've had the past four quarters, we would evaluate that and see if it that [ph] should (00:15:45) move upward. But we think that the continued need and the demand for services are not held back by a gating factor.

<A – Doug Coltharp – Encompass Health Corp.>: And if you look at it specifically, Matt, the age cohort between 75 and 85 is projected to grow at about a 5% CAGR over the next decade or so. And the types of conditions that are treated in our facilities are going to continue to be resident in that portion of the population.

As Mark mentioned previously, the aging of the baby boomers is going to drive the growth in that age cohort, but the oldest of the baby boomers that were born in 1946 have just now turned 72 and average age of the patient that we treat in our IRFs is 76. So it hasn't quite caught up to us yet. If you look at the supply of IRF beds in the U.S., it's been relatively flat for the last decade. So, demand is going to begin outstripping supply and we believe that there is going to be an opportunity to accelerate not only are discharge growth through capacity additions, but that we should also see a lift in same-store sales, but that's still a few years in front of us.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Well, why don't we get on the home health strategy in the business and Encompass obviously was HealthSouth at that point, acquired one of the leading home health assets Encompass in 2014. And, Mark, you touched on the clinical collaboration strategy. Can you maybe just remind us of the benefits that the patients gets, that the company gets from that strategy? And now that you're at, sort of, 30% to 40%, have you talked about where you could be longer term? Do you have markets that are significantly above that?

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<A – Mark Tarr – Encompass Health Corp.>: So, the clinical collaboration, I talked earlier about having 35% to 40% as our near-term goal, one of the things we did in 2017 was to standardize the collaboration process. And we use the term [ph] team works (00:17:45) which is essentially our company moniker for any initiative that we roll out and standardize where we've seen vast differences across our portfolio in terms of level of performance.

So, 2017, we developed the [ph] standardization (00:18:04) process working with KPMG and a group of subject matter experts from our hospitals and home health segment worked and looked at all the factors that went in to making sure that the transition, of course, leading with the patient choice for receiving home healthcare through Encompass was all in place whether that's due to staffing or the time of communication or reaching out with family.

Our ultimate goal is to make a smooth transition from one setting to the next, which is something in healthcare that has been challenging, not just in post-acute but in other areas of healthcare. We want to make sure that that experience goes smooth for the patient. We want to make sure that the patient medications are all taken into account. We want to make sure that all the patient education is taken into account, not only with the patient, but with the patient family. We want to make sure that the home setting is safe for when that patient is discharged and back into the home setting.

So, we believe that having this clinical collaboration will give us the opportunity on a quality indicator perspective to go in, and we're starting to see early indications of this where we'll have increased patient satisfaction particularly around those scores for the discharge process. We believe that from a family education, the families will be more comfortable taking in their loved one into a home setting.

And ultimately, we believe that this coordination will lead towards a decrease in readmissions back to acute care hospital after a patient has been sent home. We've already seen on the hospital side where we're sending fewer patients to skilled nursing facilities, we're finding opportunities to – appropriately safe manner to have a transition for patients going home instead to a skilled nursing facility at the time they're discharged from our rehab hospital.

<A – Doug Coltharp – Encompass Health Corp.>: And to elaborate a bit further, Matt, Mark alluded to the fact earlier that about 60% of all patients who are discharged from one of our IRFs require a follow-on home health services. And it's fairly easy to predict on the front end when a patient comes into one of our IRFs whether or not they're likely to require home health services after they're discharged.

The average length of stay in one of our facilities is about 12 or 13 days. And yet, historically, the family and the patient weren't introduced to prospective home health providers until sometime within the last 48 to 24 hours prior to discharge. That did not leave a lot of time for the clinicians in that home health provider, whether it was us or somebody else, to get fully up to speed about the patient's conditions and surroundings when they were going to be returning home. And it really didn't leave any time for the patient and the family to develop a relationship with that home health provider unless they had a preexisting one.

In the overlap markets that we have, we have now placed a care transition coordinator who's a home health employee in each one of our hospitals. And those individuals become involved with our hospital clinical team within typically 48 hours of admittance into the facility. So, we've flipped that around.

They're able to develop a relationship with the patient and with the family, to understand more about the surroundings that they'll be returning to. And so, the plan of care that is developed for that patient to be on our hospital [ph] whilst (00:21:47) into the next phase is much more detailed and much more clinically focused than it would otherwise be.

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<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Well, let me ask a guidance question here in the last 5 or 6 minutes, the year-to-date results have been really impressive. I think you've grown the EBITDA about 10% for the first six months of the year. The second half outlook implies a moderation in that growth rate. Can you give us a sense for what's causing that moderation, and then, I guess, our contention would be there's maybe some conservatism in the numbers. But I just wanted to hear from your perspective, what are you assuming that causes that moderation?

<A – Doug Coltharp – Encompass Health Corp.>: Your contention regarding conservatism is a widely held view, I think. There are two primary assumptions; they're both embedded predominantly within the IRF segment. The first is that, we have experienced a substantial reduction on a year-over-year basis in the first half of the year. And what was the item previously known as bad debt expense which [ph] is now account (00:22:48) for revenue item.

And so, for the first half of the year, we've been running in that 1.1% to 1.2%, which is down about 60 or 70 basis points on a year-over-year basis. And we can attribute that to two specific things. One is the roll out of the TPE initiative by CMS across all MACs that govern how they engage in new claims denials, prepayment claims denials. And the second is that our largest MAC which has been a problematic relationship for us got fired last year, and we transitioned to a new MAC, Palmetto in February of this year. And thus far, that relationship has been much more productive.

In our guidance for the second half of the year, we have assumed that bad debt goes back to the levels that it had exhibited prior to the second half of 2017. And that's because we believe that the trends that we're seeing with regard to both TPE and Palmetto are just too early to call right now. We're not seeing anything that suggests that we're getting off of that trajectory from the first half of the year, but until we get a little bit more evidence around each one of those, we're not going to call a new level that is below the most recent historical trend line.

And then the second piece is on group medical. And just to give you a sense of that, within the IRF segment, SWB typically runs at about 50% of every revenue dollar. And the SWB breaks down roughly 85% for SW and 15% for benefits – versus all the benefit expenses related to group medical where we're self-insured.

In 2017, we had a very favorable trend. And even though, we didn't see any significant changes to our covered beneficiaries or to the program structure around group medical, we actually saw a year-over-year decrease in our cost per employee or per beneficiary, excuse me, and in the aggregate cost of the program. And that was attributable to a very low incidence of high dollar claims and then frankly the absence of any kind of significant new pharmaceuticals like a HARVONI which tend to front-end load expenses.

As we met with our actuaries and some of our other consultants coming into 2018, they said that was great, but these programs tend to be somewhat mean-reverting when you haven't changed the structure or the beneficiaries. And so, we came into the year anticipating that those expenses would be up about a 10% level on a year-over-year basis. Through the first half of the year, they were only up about 2.5%, attributable to exactly the same factors. We just don't know if those factors are sustainable; and so for the second half of the year, we've continued to assume about a 10% increase.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Let me ask one reimbursement question, saving the best for last here, so maybe the 2019 update for both home health and IRFs are pretty favorable.

<A – Mark Tarr – Encompass Health Corp.>: Pretty positive.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: 2020, I'll just ask you about the IRF side for the second time. So, we have this transition between the Care Tool model and the FIM model,

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which is impacting the case rates for IRF discharges and I guess the projections are that for-profits will see a negative 2% impact because of that. I think you all have expressed some optimism that something that could and should be fixed between now and 2020.

And I guess could you maybe give some commentary in terms of your confidence level that it will be addressed and then what's the next data point that investors should be looking for to see if get some positive movement on that aspect?

<A – Mark Tarr – Encompass Health Corp.>: So, what Matt is referring to is that there'll be a transition in the rehab hospitals from something called the FIM Tool which is the assessment tool which has been essentially used in place now since the late 1990s [ph] 2000s (00:26:40) so for a couple of decades it's been used. They are going to be transitioning to something called the Care Tool which has been in development now for a number of years, which in proposed rule, they talk about bringing it out after only one year worth of data that's been submitted from the industry after significant lobbying, the final rule for IRF came out and they are going to have two years' worth of data submitted with data for the Care Tool.

So, we expect it to be a somewhat lumpy initial switch from FIM to Care Tool. It involves a lot of clinicians and hospitals. There will be a lot of continued education for the industry as a whole. CMS has come out and given some clarifications to some the questions that we had about the Care Tool for the last couple of years.

So, we think that the rule will certainly be ahead of the industry in terms of our ability to use resources to education our staff on the use of the Care Tool, so that that transition from FIM to Care will go as smooth as possible, but it will be a pretty major jump. We don't know exactly what the impacts will be on those because until that second year data is accumulated by CMS and then released by CMS, and probably will be the proposed rule for next year, we'll continue to lobby, we'll continue to make sure that CMS is aware of the significant change this will have from a provider standpoint, moving from FIM to Care, but there is lot yet to be unknown.

Matthew D. Gillmor, Analyst, Robert W. Baird & Co., Inc.

Well I think that's a good place to leave it. So, please join me in thanking Encompass for their presentation today.

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

Thank you.

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