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<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

All right. Good afternoon, everyone. I think we're ready to get started. My name is Matthew Gillmor, and I cover health care provider and technology stocks for Baird. We're very pleased and excited to have the management team from Encompass present, again, at the company – at the conference this year.

As most of you know, Encompass is one of the leading providers of post-acute services focused on inpatient rehab as well as home health and hospice. Representing the company, we have Mark Tarr, Chief Executive Officer; and Doug Coltharp, CFO; and Crissy Carlisle from Investor Relations is in the audience. Mark's going to run through a couple of slides to introduce the company and get sort of everyone oriented on story and then we'll jump into Q&A.

I'll, of course, lead the Q&A. If there are questions from the audience, we'd love to hear from you. There is an iPad here where you can e-mail a question up or you can just raise your hands. So with that, let me turn things over to Mark.

<<Mark J. Tarr, President and Chief Executive Officer>>

Sure. Well, thanks, Matt. It's great to be here. For those of you that may not be familiar with Encompass Health, we are a national provider of post-acute services. We provide these services in two settings, one a facility-based setting, where you can see here where we have 132 IRFs, or inpatient rehabilitation hospitals, treat patients typically suffering – those suffered from strokes or other neurological categories, hip fractures, traumatic injuries, brain injuries and spinal cord. These are all patients that need to be in a facility, nondiscretionary in terms of whether or not there would be such an acute level that they could go home. So these are all patients that need to be in a hospital setting.

The other setting that would provide care is in the home setting with 245 home health locations. They too have very well-defined programs that treat chronic illnesses, such as diabetes, treat patients that are post surgery, lower extremity joint placement, those types of programs that, I could say, are very well defined as well. And then a growing segment, a growing service within that home health segment is hospice where we're now up to 82 locations, which puts us in – as a top 10 provider for hospice. We provide these services across 37 states and Puerto Rico. We're noted for our outstanding outcomes as well as we're the most cost-efficient provider in this space.

The key part of our strategy is to integrate our service lines. We do so in our – what we call our overlap markets where we have both, one of our inpatient rehabilitation hospitals as well as at home health agency, which is typically around 30 mile within the radius. It gives us a chance to integrate that care, make that transition from an IRF to a home health agency in a very

collaborative manner. We have termed this as our clinical collaboration initiative, where we have standardized all the processes that go in place, working with the patient, working with the physicians and care team as well as the families to make sure that we've taken care of every step along the way for patient transitioning from a facility base to a home base, which those of you that are familiar with health care know that, that has been a challenge for health care to do over the time period.

I mentioned our overlap markets. We now have 83 of our markets are overlap. It's a key priority in terms of as we assess acquisition opportunities on our home health side of business, we look first, as a priority, to create additional overlap markets where we compare those two together.

You can see here in Q2 of 2019, we're right at just shy of 35% on this current collaboration rate. We have our near-term goal of 40%. We think longer term, we can get that up to 60% to 65%. One of the most compelling aspects of our business is the driver for the demand for our services. Just a fact of why because we all age, the likelihood that we will need rehabilitative care in one aspect or another increases. Our average age patient in our hospitals is 76, it's 77 in our home health services. So you can see here if you look at the table on the right-hand side, where you can look at the bar graphs there with the baby boomers aging out into that 70, 75, 79 age cohort. You can see the corresponding CAGR of 5%, which is very strong and that compares an overall population growth of somewhere around 1%.

So this is very compelling part of our business. So it will be a compelling driver of the ongoing needs where both of our service lines benefit from this demographic tailwind. One aspect of our business that we're very proud of is our track record to address, mitigate, adjust to various regulatory changes that we're faced with throughout the periods here. You see that 41 of the last 42 quarters, we've brought in adjusted EBITDA growth year-over-year. So we're very proud of that. You can see the listing along the right-hand side of the graph of those different areas ranging from sequestration to the Medicare price rollback to implemented coverage criteria for IRF admissions.

In each of these cases, we've found a way to adjust our operators, adjust our patient mix and correspond according to these changes and mitigate to where we came out of that in very good fashion. And I mentioned earlier, our key focus is not only to have outstanding outcomes, but also to provide this service and this care in a very cost-efficient manner.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Great. Mark, thanks so much for the introduction. I thought I might start off talking about the IRF side of the business, which I think is about 80% of the...

<<Mark J. Tarr, President and Chief Executive Officer>>

80% of our revenue base.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

It's one of the only inpatient setting, it's actually seeing decent same-store growth, and of course, you're the leading provider on the freestanding side. Mark, you hit on some of these points, but what's really driving underlying growth? And can you talk about also the share capture that you're able to achieve from some of the acute care hospitals as well.

<<Mark J. Tarr, President and Chief Executive Officer>>

Sure. It's a very fragmented business. We account for about 30% of the patients, Medicare patients treated this year and about 22% of the beds that are out there. So our main competition is acute hospital rehab units. So we attribute our growth to a couple things, one is you saw the demographic tailwind that has provided this ongoing need for the services. We have very well-developed programs, specifically one of the programs that we have put a greater focus on within the last 10 years or so is neurological patients and specifically stroke patients.

The stroke patient growth, we had 5.5% growth in our stroke program year-over-year in second quarter. So that is an area that we've seen significant growth. These are patients that respond very well to inpatient rehabilitation care. It's an area that we've been able to show the value proposition in terms of our outcomes and our cost-effectiveness through the Medicare Advantage plans, and we've seen that as a real growth in terms of not only the percentage of our revenue, but also in the terms of the total admissions that are coming into our hospitals.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

And then I did want to ask about sort of the bed additions this year. And I think you have some de novos ramping this year that's maybe a little bit of above and beyond what is normal. How much of a tailwind does that create? And would it be enough to get you outside of that 2% to 4% target on the IRF side or sort of TBD at this point?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

I think it puts us at the high end of that range. If you go into 2020 and assume that our same-store growth is in the same range it's been about the last eight quarters, which is roughly 2%, I would expect that the more than 300 beds that we added through capacity additions in the course of 2019 would provide another 1 to 1.5 on discharge growth in 2020.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Okay. Mark, you touched on the focus on stroke and neuro and that's been a real sort of tailwind...

<<Mark J. Tarr, President and Chief Executive Officer>>

It has been. Between those two categories, it's about 40% of our total discharges.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Where do you see that? And maybe just taking one step back, why did the company decide to focus on those cases? And sort of where do you see that mix going longer term?

<<Mark J. Tarr, President and Chief Executive Officer>>

Well, about 10 years ago, we moved our patient program focus away from orthopedic and more towards a higher acuity type of patient. And neurological patients, as we mentioned, do extremely well in our setting. We further developed protocols and program metrics around the stroke programs and have accreditation in 117 of our hospitals through the joint commission that is specific towards a stroke program. It also complemented well with the relationships and, in some cases, partnerships with acute care hospital systems that we have that also placed a focus on stroke program.

On the acute care side, it provided us with an opportunity to go in and provide a post-acute option for those patients that they were treating in an acute aspect.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

There remain significant growth opportunities on the stroke side. If you look nationwide on the per annum basis, there are about 800,000 strokes. And even with the kind of market share we have, we're treating about 32,000 of those. Now not all – every patient who suffers a stroke is going to require or be eligible for care in an inpatient rehabilitation setting, but a substantial number of those patients are still flowing into SNF and not receiving the same quality of care and resulting in the same quality of outcome that we produce.

I think evidenced the value proposition that we bring to the table around stroke is in the growth in our Medicare Advantage business. And strokes are currently about a one-third of our Medicare Advantage volume and on a year-to-date basis, our Medicare Advantage business is up 16.5%.

<<Mark J. Tarr, President and Chief Executive Officer>>

So we're very proud of – I mentioned our outcomes. We get almost 80% of our patients discharged back home after they're been treated in our hospitals and fewer than 10% of those are readmitted back to acute care hospitals further in our facilities. So both of those are way above the industry standards and it really is evidence of the type of quality we're able to achieve with these stroke patients.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

And what is it in particular, either about an inpatient rehab facility or Encompass specifically that drive those much better clinical outcomes? And if you can maybe either share some – what the benefits are either from a dollar savings or just from quality-of-life savings that some of these patients get by being at your facility versus the alternative post-acute settings?

<<Mark J. Tarr, President and Chief Executive Officer>>

Well, primarily, it centers around the intensity of what are the resources and the care provided. We are required to provide a minimum of three hours a day of therapy. We have a physician come in and do rounds on our patients at least three times a week, many of them more than that. We have therapy provided in our hospitals six out of seven days.

On Sundays, we help the patients, giving them a chance to rest and spend time with their family. So it's a very intense level of care of rehabilitation. We have a full complement of physician staff to assist our physiatrist or rehab physicians. So we have internal medicine and pulmonologist and others that help to look after patients that are medically fragile. So those are all aspects that help us to achieve these outcomes.

We also talked earlier about our ability to work and – in an integrated manner with our home health care and having that aspect, working together, our hospital staff, our home health staff, making sure that transition to home is as smooth as possible.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Patients who suffer an intensive stroke typically spend three to five days in an acute care facility. And during that time, they're bedridden and the focus is on getting them medically stabilized, not really beginning the rehabilitation process to make up for some immobilization, some lost speech and those types of things. When they get into our care, we typically have them for about 16 days. They immediately start an intensive therapy regime that is typically multi-disciplined and involves a lot of individual therapy versus just group or concurrent. And that kind of intensive therapy regime is demonstrated to result in a much higher recovery level.

So when you talk about the cost, if a patient instead goes into a SNF, they're likely to be there for a longer period of time than the 16 days. So even though you have a lower per diem, the aggregate cost the aggregate cost is ramping up. And unfortunately, in many instances, they're leaving that facility with not having recovered anywhere near the same capacity that they had pre-stroke as they do when they go into the IRF setting.

<<Mark J. Tarr, President and Chief Executive Officer>>

We talk about staffing, but it's also worth noting, if you go into one of our hospitals, you got an entire therapy gym, you'll see a full complement of equipment, in some cases, there'll be technology that is complementary for a therapist or a physician to provide care for that patient. You would see a setting that is quite different than what you'd see in a skilled nursing facility.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

And this might be a good time to talk about the collaboration with the American Stroke Association & Heart Association and they've come out in the last couple of years and said, if you have a stroke, IRFs are absolutely the place to be. So where do you – where are you with that collaboration and sort of what's the work that's being done?

<<Mark J. Tarr, President and Chief Executive Officer>>

So we entered into a three-year partnership with the American Heart & American Stroke Association to co-brand this stroke effort done on the prevention side as well on the rehab side. As you noted, they sponsored a survey that showed that outcomes are superior when patients that need stroke care receive that care in an IRF setting versus a skilled nursing setting. So we thought it was a great opportunity for us to pair up, brand our quality, our stroke program.

It also was a nice complementary time with our name change that we rolled out. We've had really good response in the various marketplaces relative to having activities, fundraisers, luncheons that all get exposure for Encompass Health, Encompass stroke care with a very credible organization like American Heart & American Stroke Association.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Why don't we transition over to the home health side of the business and you know you all, obviously, bought one of the leading franchises in 2014 and you touched on the clinical collaboration strategy. And I think you said you're at 35% in terms of the discharges that could go, maybe get up to 60%. Just – first of all, can you maybe just start and sort of pain the picture, where do you have home health overlap, how much more is there to go with the IRF portfolio?

<<Mark J. Tarr, President and Chief Executive Officer>>

So I think it's important to note that 60% of our discharges from IRFs go home with home health and that's in any of our markets, whether we have a home health site there or not. So it did give us a good opportunity to go in and think about creating these overlap markets and integrating that care. So 83 of our marketplaces now where we have hospitals, we also have a home health location, so they're, what we call, overlap markets. We think that we can get to 100% of that with time as we prioritize the acquisition of home health agencies within, like I said, that 30-mile radius of our hospitals.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

On the technology side of the house, and I guess this is the topic I want to bring up because I think it's somewhat sort of underappreciated and something that really differentiates Encompass versus the competition. And one of the areas where you've been doing some work is with Cerner. So I wanted you to talk about that. And sort of what are some of the things you can do using Cerner and leveraging data analytics to serve additional patients and ultimately sort of save the health care system money?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

I think one great example is the development of a longitudinal record that can extend from the acute care facility all the way through the home setting and through a post-acute inpatient setting. And so that ensures that there is a continuity of the patients' conditions as they are along that journey as well as all elements of their medication regime and so forth that reduces any kind of

medication errors. It eliminates disruptions in care as the patient transitions from one side of care to another. And so that's one example with Cerncer. We've got a number of interesting things that are happening with regard to predictive analytics. Right now, we've got a 90-day readmission project that's underway in the Houston market with our seven IRFs, all of which are in overlap markets there.

<<Mark J. Tarr, President and Chief Executive Officer>>

It helps to work with an organization like we have a long-term relationship with Cerner. We developed and crafted an EMR that's specific to what is done in a rehab hospital. So we – having this long-term relationship with them on the hospital side just made it a natural bridge then to the post-acute innovation center and having an opportunity to work collaboratively with them generating this data.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

And does it provide an advantage when you're either interacting with referral sources and/or joint venture partners that you have this clinical backbone that maybe someone else wouldn't. Is that a key point of differentiation or hasn't been that big of a deal?

<<Mark J. Tarr, President and Chief Executive Officer>>

No. We think it is key point of definition for us. We have interface – we're able to interface with all these other systems. We can interface with the acute care system and exchange information. It allows us to draw out certain data that we apply and whether it's predictive analytics or other areas that we're developing. So I definitely think it is a differentiator for us. It was a big decision at the time whether we move forward with that system several years ago, but we think it's been a very good investment for us.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

One very tangible example of how it can be a differentiator for an upstream referral source is the interoperability between our Cerner system and the systems that are in place at the acute care hospital allow us to respond to a referral much more quickly and get the patient out of the acute care setting and, if appropriate, into the rehab center much more quickly. That reduces the length of stay and allows the acute care hospital turn the bed faster. So that's a direct cost savings for them. And we can also demonstrate then that the EMR is instrumental in helping us administer the patient's plan of care when they're with us and it results ultimately in a lower hospital readmission. They're getting a financial benefit on both ends. They're getting that lower length of stay and the faster turn of the bed and they're not seeing a hospital readmission down the road.

<<Mark J. Tarr, President and Chief Executive Officer>>

Matt, as you know, about a third of our hospital portfolio are partnerships with acute care hospital systems. So having that interface with Cerner and the ability to interface with the Cerner

system or other providers, other vendors as one way to tighten those partnerships that we have on the marketplaces.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Why don't we talk about some of the reimbursement issues in 2020? And Doug, you went through on the last call sort of the three big items and you provided some dollar figures in terms of the headwinds on PDGM, the behavioral adjustment and then some of the IRF changes to care tool and there was some clarification on 8-K that you all put out. So maybe just sort of remind us what are the big items? How are you – what are some of the operational things you can do to help offset that? And ultimately what we're trying to understand is the prospects for EBITDA growth in 2020? And you have that nice slide with consistent growth, so we obviously hope next year is a green year as well.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

So Matt, first of all, we're very impressed that you got 20 minutes into this discussion before bringing up reimbursement…

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

Trying to butter you up.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

That has not happened in any other meeting that Mark and I have had in 2019.

<<Mark J. Tarr, President and Chief Executive Officer>>

Really appreciate it.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

And so quickly, we do face – we face major payment model changes for each of our two business segments as we move into 2020. Our latest assessment on the IRF side, and remember the IRF fiscal year begins on October 1st, as those will result in a payment increase in terms of Medicare fee-for-service and really Medicare Advantage largely follows that of somewhere between flat and 25 basis points for the first three quarters of calendar year 2020, and then we would expect a normalized increase as we move into the fourth quarter and new fiscal year. On the home health side, you've got PDGM going in. Home health is on a calendar fiscal year. The payment model changes that are running through home health, we believe that based against our 2018 patient data would result in a reduction of about 2.8%.

On top of that, there's behavioral adjustment of 8%, but we'll hold out that separately because we're optimistic about a legislative fix to that. So on the IRF side, if you assume that that's the pricing environment that would create incremental revenue off of the base that you'll carry from

2019 into 2020 of roughly $30 million to $35 million based solely on pricing, not accounting in any increase in volume. But against that, you're going to continue to have the same labor component that you got in place in 2019, and we're not in the type of employment environment where we could hold merit increases flat or not pass-through any kind of improvement in benefits.

So our assumption is that our SWB line against that base will increase as we go into 2020. And SWB is about 52% of each revenue dollar. Out of that, about 90% is SW. And we anticipate a rate of inflation there of about 3% and about 10% is the benefits predominantly group medical, and we expect a rate of inflation there of about 7%. So we got a blended increase on 52% of your cost of about 3.25%. So that's a $60 million increase in cost that offsets that $30 million to $35 million increase in revenue and results in about a $25 million to $30 million EBITDA headwind on the IRF side.

On the home health side, you do the same math, the 2.8% decrease against the legacy business creates a roughly $23 million revenue challenge. And then on top of that, the SWB deleverages – really the same kind of math there creates another $22 million. So you've got $45 million. So in aggregate EBITDA headwind before you start the year of roughly $45 million. Now there are some things that are available to us to offset that. First, you mentioned previously that through the course of this year we will have added some 310 beds or so to our IRF capacity. And so those will help drive incremental volume on top of same-store growth as we enter 2020. We'll be adding more capacity through the year in 2020.

On the home health side, we would expect to see, once again, high single-digit same-store admissions growth and then that will be augmented by nothing else a full year of the Alacare contribution, which should drive admissions growth into the low double digits and our hospice business should grow at about 20% clip as well. So good volume growth. And then finally, within the home health business, we are going to continue to drive through some of the labor productivity initiatives that you've seen gained traction through the course of 2019. And in each of the first two quarters of 2019, we've exhibited relatively flat cost per visit and a decrease in the visits per episode. And even though those are moving in relatively small increments, they're applied across a very substantial volume, and so the dollar savings and the favorable impact on margin are favorable.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

So I think in at least our math if you add up those elements and your organic growth, you'd still probably be in positive territory for 2020. I guess, I'm not asking you to endorse that. Why don't we then talk about the behavioral change adjustment, which is the wildcard. And I guess what I was hoping to get was the sort of the advocacy angle and Bill Dombi at NAHC seems pretty optimistic, I think investors are probably a little less optimistic. But just remind us what that legislation does and sort of what's the state of play in terms of getting that advanced?

<<Mark J. Tarr, President and Chief Executive Officer>>

So there are sister bills out there, one in the House and one in the Senate. They are both very well supported. The Senate has 20 cosponsors, the House bill has now up to like 60. So we continue to gain momentum there. We are very active in lobbying in D.C. We brought numbers of our management team in to make visits on the hill. We work with the trade associations. We continue to have discussions with CMS, so we remain very active. There is certainly hope that there'd be a legislative relief between now and at the end of the year. There will be opportunities to do so through preparations, bills that will be out there.

The bill themselves would eliminate the possibility for Medicare to do a prospective hit of the 8% on the behavioral. It would require any future change to be based upon data after the rule is put in place on January 1st. So be based upon the actual changes observed and it would limit through the year 2025 at 2% or less per year. So there would be an opportunity to whatever changes that we've got in place would be based upon actual observed data, not prospective data, which is very significant.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

And Matt, I think it's important to note that in the spring prior to the release of the proposed rule that is out there now on home health, a subset of the congressman who are supporting this legislation had written directly to CMS requesting that they reconsider the implementation of this behavioral adjustment, specifically citing cares about beneficiary's access to care based on the potential unintended consequences of the implementation. And CMS then responded by coming out essentially 45 days later with a proposed rule that actually not only kept the behavioral adjustment in, but increased it. It was viewed by many of those members of Congress as a real thumb in the eye. And so we think that, that was marginally beneficial in terms of increasing the likelihood of legislation.

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

And what's the next milestone for someone like us to be paying attention to, whether it would be CBO score and that sort of thing, what's the…

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

It's – potentially, we could see a CBO score that's likely to be signaled that is getting closer to being attached to a piece of legislation. As Mark addressed, I think one of the things that we're optimistic about is that when the budget deal was struck in the early part of August that now gave rise to a series of opportunities that should exist this fall. And that is as Congress reconvenes from its recent recess, they will start a series of appropriations bills. And any one of those bills could effectively serve as a vehicle on which this remedy could be attached.

There are two schools of thought that are out there. One is that Congress has seen all it needs to see and there's enough advocacy that they won't wait for CMS to finalize the rule to see if they've addressed this themselves. They've already had the chance to do that on the proposed rule, so they'll try to get ahead of the final home health rule. The other school of thought says, "No, let's

give them one more shot to try to solve it themselves. If they haven't, then we can address it in the period of time it will exist, probably between November 1st and the end of the year."

<<Matthew Gillmor, Analyst, Robert W. Baird & Co. Inc.>>

All right. Well, I see we're just out of time, so we'll have to end it there. Please join me in thanking Encompass for their – attending this presentation.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Thank you.