Encompass Health

Q3 2019 Earnings Call

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PARTICIPANTS

Corporate Participants

Crissy Buchanan Carlisle – Chief Investor Relations Officer, Encompass Health Corp.
Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Executive Vice President & Chief Financial Officer, Encompass Health Corp.
April K. Anthony – Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.
Barbara A. Jacobsmeyer – Executive Vice President & President-Inpatient Hospitals, Encompass Health Corp.

Other Participants

Matt Larew – Analyst, William Blair & Co. LLC
Whit Mayo – Analyst, UBS Securities LLC
Matthew Gillmor – Analyst, Robert W. Baird & Co., Inc.
Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch
Pito Chickering – Analyst, Deutsche Bank Securities, Inc.
Brian Gil Tanquilut – Analyst, Jefferies LLC
A.J. Rice – Analyst, Credit Suisse Securities (USA) LLC
Frank George Morgan – Analyst, RBC Capital Markets LLC
Sarah E. James – Analyst, Piper Jaffray & Co.
John W. Ransom – Analyst, Raymond James & Associates, Inc.
Scott J. Fidel – Analyst, Stephens, Inc.

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health Third Quarter 2019 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] You will be limited to one question and one follow-up question. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Crissy Carlisle, Encompass Health's Chief Investor Relations Officer.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

Thank you, operator, and good morning, everyone. Thank you for joining Encompass Health's third quarter 2019 earnings call. With me on the call in Birmingham today are Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, President, Inpatient Rehabilitation Hospitals; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief

Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations. April Anthony, Chief Executive Officer of our Home Health and Hospice segment, also is participating in today's call via phone.

Before we begin, if you do not already have a copy, the third quarter earnings release, supplemental information, and related Form 8-K filed with the SEC are available on our website at encompasshealth.com. On page 2 of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release.

During the call, we will make forward-looking statements such as the expected impact of new CMS rule, which are subject to risk and uncertainties, many of which are beyond our control. Certain risks and uncertainties that could cause actual results to differ materially from our projections, estimates, and expectations are discussed in the company's SEC filings, including the earnings release and related Form 8-K, the Form 10-K for the year ended December 31, 2018, and the Form 10-Q for the quarters ended March 31, 2019, June 30, 2019, and September 30, 2019 when filed. We encourage you to read them. You are cautioned not to place undue reliance on the estimate, projections, guidance, and other forward-looking information presented, which are based on current estimates of future events and speak only as of today. We do not undertake a duty to update these forward-looking statements.

Our supplemental information and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliation to the most directly comparable GAAP measure is available at the end of the supplemental information, at the end of the related press release, and as part of the Form 8-K filed yesterday with the SEC, all of which are available on our website.

Before I turn it over to Mark, I would like to remind everyone that we will adhere to the one question and one follow-up question rule to allow everyone to submit a question. If you have additional questions, please feel free to put yourself back in the queue.

With that, I'll turn the call over to Mark.

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

Thank you, Crissy, and good morning, everyone. We're very pleased with the strong volume growth achieved in both of our segments in the quarter. On the inpatient side, total discharges increased 5.5%, with 3.1% coming from same-store hospitals. Home health total admissions grew 22.7%. Within that total, same-store admissions grew 9.7%, while the recently acquired Alacare locations contributed 11.6%. Hospice admissions grew 40.4% with Alacare contributing 32.3% and same stores growing 5.8%. On a consolidated basis, revenues grew 8.8% and adjusted EBITDA increased 3.3%. On a year-to-date basis, revenues were up 7.5% and adjusted EBITDA was up 7%. Doug will provide the specifics for each of our operating segments in his comments.

During the quarter, we made excellent progress on our development opportunities. We continue to expand our portfolio of inpatient rehabilitation hospitals by opening a new 40-bed joint venture hospital in Boise, Idaho, our first hospital in that state. We also opened a new 40-bed hospital in Katy, Texas, and added 31 beds to our existing hospitals, bringing our year-to-date bed additions to 112.

In addition, as a result of discussions with our partner to amend the joint venture agreement governing our Yuma Rehabilitation Hospital in Arizona, this 51-bed hospital changed from the equity method of accounting to a consolidated hospital effective July 1. Our development pipeline for IRFs remains robust with our new 50-bed hospital in Murrieta, California nearing completion, three new hospitals already scheduled to open in 2020, and two more scheduled to open in 2021.

On July 1, we closed the acquisition of Alacare Home Health and Hospice, which added 23 home health and 23 hospice locations across Alabama to our portfolio, including three new overlap markets. The IRF openings in Boise and Katy also created new overlap markets for us bringing our total overlap markets to

88 and enabling us to expand the benefits of clinical collaboration to more patients. Our two segments are doing an outstanding job working together to integrate care delivery and achieved a 35.6% clinical collaboration rate in the third quarter of 2019, a 130-basis-point increase over the third quarter of 2018.

We also continued our focus on meeting the needs of patients recovering from strokes. Earlier this year, along with American Heart and Stroke Association, we released the co-branded Life After Stroke guide as part of our efforts to continue to educate physicians, payers and patients on the efficacy of stroke rehabilitation in an IRF setting. In the first half of 2019, approximately 37,000 Life After Stroke guides were downloaded from the AHA/ASA website or distributed in hardcopy form by our hospitals. In addition, we have expanded our social media reach to include AHA/ASA channels, resulting in expansion of our digital audience by over 8 million people.

Progress also continues in our development of post-acute solutions that focus on improving patient outcomes and lowering the cost of care by reducing hospital readmissions across the entire episode of care. We currently have nine pilot sites for our 90-day post-acute readmission prediction model. All of these sites are in overlap markets and clinically collaborates with our home health agencies. As we continue to refine this model, we are also preparing a readmissions prevention playbook that will be part of the broader rollout of this model to all of our hospitals in 2020.

On the regulatory front, our focus remains on the reimbursement changes impacting each of our segments. Effective October 1, our hospitals transition to the CARE Tool payment system for inpatient rehabilitation hospitals. We believe our teams were fully prepared and I thank them for their tireless efforts in regards to this transition.

During the third quarter of 2019, we conducted training on the new Functional Outcome Measures for all 20,000-plus of our clinicians across our entire portfolio of hospitals, including documentation requirements and system changes. Our focus on this education continues to improve interrater reliability and our clinical documentation, which in turn is allowing us to revise our expectations for Medicare reimbursement rates. We now estimate the new payment system will result in Medicare reimbursement rates for our company that will be flat to up 50 basis points in the fourth quarter of 2019 and for the first three quarters of 2020.

In home health, we continue to prepare for the implementation of the Patient-Driven Groupings Model or PDGM. Based on our continued analysis of available data and information, we now believe the implementation of PDGM on January 1, 2020, will decrease our Medicare reimbursement rates by 1%, net of the 1.3% net market basket update. This estimate excludes the 8% proposed base rate reduction and any potential impact from the assumed behavioral adjustments. Recall that CMS-assumed provider behavioral changes will offset the proposed 8% reduction in the base rate. It is difficult with any level of certainty to estimate how much of the assumed behavioral changes we can realize as the largest assumed behavioral change is related to coding, and coding is a patient-by-patient matter.

As we wait CMS' issuance of the final rule, we remain hopeful that CMS will be responsive to our many requests to eliminate or at least moderate the impact of behavior-related base rate reductions in 2020, possibly spreading the impact over a multi-year period rather than risking destabilization of the industry with a large, single-year adjustment assumption.

In the meantime, we have continued to pursue legislative relief. We are both encouraged by the significant bipartisan support we are receiving in both the House and the Senate, and are pleased that legislators understand our concerns regarding the potential negative implications to beneficiaries and providers alike resulting from CMS' assumptions about what behavioral changes providers may undertake in the future. In the meantime, we remain focused on utilizing technology to drive incremental efficiencies as we prepare to implement PDGM.

As we've stated previously, neither of the new payment systems for our operating segments changes the long-term outlook for our company, an outlook predicated on the demographic trend driving increasing

demand for the services we provided. We believe we are well-positioned as a company to work through these changes and have a proven track record of being able to do so.

Based on our results for the first nine months of 2019 and our current expectations for the remainder of 2019, we are affirming our full year 2019 guidance for net operating revenues, adjusted EBITDA and adjusted EPS. The reaffirmed ranges can be found on page 15 of the supplemental slides that accompanied our earnings release.

With that, I'll turn it over to Doug.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer, Encompass Health Corp.

Thank you, Mark, and good morning, everyone. Mark summarized the consolidated revenue and EBITDA results, so I'll begin with cash flow and the balance sheet. I'll then discuss the revenue and EBITDA drivers for Q3 when I move into the operating segment results.

Adjusted free cash flow for the first nine months of the year was $379.6 million as compared to $424.8 million for the same period last year. The year-over-year decline primarily related to increases in net working capital and more specifically to the increased accounts receivable related to TPE activity in both segments. Our updated assumptions for 2019 adjusted free cash flow can be found on page 17 of the supplemental information. These assumptions result in an expected adjusted free cash flow range for 2019 of $435 million to $510 million, up modestly from our previous range of $425 million to $505 million, primarily due to a downward revision in our expected cash payments for income taxes.

During September, we took advantage of highly favorable conditions in the debt capital markets and issued $1 billion in new senior notes, divided evenly between $500 million of 4.5% notes due in 2028 and $500 million of 4.75% notes due in 2030. A portion of the proceeds from these notes was used to repay the principal balance of our revolving credit facility, which had been used to fund a $100 million call of our 2024 senior notes, the $217.5 million acquisition of Alacare and the $48 million DOJ settlement, all in the second quarter. Additional proceeds from these notes were used to fund the purchase of home health rollover shares and the exercise of stock appreciation rights in Q3.

Proceeds from these notes will also be used to fund a further $400 million call of our 2024 senior notes, which will settle on November 1. Our pro forma leverage ratio at the end of Q3, after giving effect to the aforementioned use of proceeds, was 3.2 times, with the capacity under our revolver replenished and our debt capital structure further enhanced by increased duration and the relatively low coupon rates on the new notes.

Following completion of the pending $400 million call, we will also have reduced our largest debt maturity, the 5.75% 2024 senior notes from approximately $1.2 billion at the beginning of the year to approximately $700 million. We continue to augment the returns of our operating investments with shareholder distributions. Through the first three quarters of 2019, we have paid $81.3 million in cash dividends on our common stock and repurchased $45.9 million of our common shares.

Moving now onto the business segments, IRF segment revenue for Q3 increased 5.7%, driven by discharge growth of 5.5% and a 1% increase in revenue per discharge. Revenue growth for the quarter was unfavorably impacted by a 20-basis-point increase in reserves related to bad debt and a reduction in outpatient and other revenue primarily attributable to the inclusion of $4.5 million in business interruption insurance recoveries in Q3 2018.

Same-store discharge growth for Q3 was 3.1% and was negatively impacted by approximately 20 basis points due to the ongoing effects of Hurricane Michael on the Panama City market. Our trend of positive traction with Medicare Advantage plans continued in Q3. MA discharges grew 21.6% in Q3 and are up 18.1% year-to-date. Revenue reserves related to bad debt increased to 1.5% as compared to 1.3% in the prior-year period, primarily due to increased TPE denials.

During Q3, we experienced our highest level of new denials, $11.3 million, since Q2, 2017. Approximately 85% of the TPE activity was generated by Palmetto. As we have stated previously, we have anticipated since our transition to Palmetto in February 2018 that at some point, they would initiate reviews. TPE notices were received by 30 of our hospitals and none of those have progressed to round three. We also had our highest level of collections of previously denied claims since Q1 2018. And although we did see a higher number of claims resolved through the ALJ adjudication process, no progress has been made on resolving the large backlog.

SWB, as a percent of revenue, increased 130 basis points over Q3 2018 to 52.6%. The increase in SWB occurred in spite of consistent year-over-year labor productivity as evidenced by employees per occupied bed or EPOB of 3.48 as compared to 3.49 in Q3 2018. There were four primary factors driving the increase in SWB. The aforementioned $4.5 million in business interruption insurance recoveries in Q3 2018 and a year-over-year increase in reserves related to bad debt accounted for 20 basis points and 10 basis points respectively. Preopening expenses and the ramping up of new stores accounted for an additional 40 basis points.

Since May of this year, we have opened three new hospitals. Each of these hospitals is larger than the three hospitals we opened in the similar timeframe last year and each began operations at a higher occupancy level than those opened in the prior year. While this is good news in the long run, it increases cost in the near term. Finally, training and orientation on the CARE Tool in preparation for the October 1 transition accounted for 30 basis points.

For the past 12 months, we have been focused on working with our hospitals to improve the documentation that captures a patient's functional abilities under the new measures. A majority of this training had been focused on a limited number of individuals at each hospital so as not to distract the majority of our employees from accurately using FIM, which until October 1, remained the basis for our reimbursement.

As Mark described in his comments, we expanded our CARE Tool preparation activities in Q3 by conducting system-wide training involving all of our 20,000-plus clinicians. This resulted in approximately $2 million of increased training cost as compared to Q3 2018. The new payment system is complicated and is very different from the FIM assessment we have used for years, and we will be investing in incremental training cost throughout Q4. As a result of these factors, IRF segment adjusted EBITDA for Q3 declined by 1.1% but remains up 2.2% on a year-to-date basis.

Moving now to our home health and hospice segment, revenue increased 19.5% in Q3, with home health revenue up 14.2% and hospice revenue up 53.7%. Home health revenue growth was driven by volume, with admissions increasing 22.7%, inclusive of 9.7% same-store admission. Home health revenue per episode for Q3 declined by 50 basis points, primarily due to the patient mix of the former Alacare locations. Excluding the impact of the former Alacare locations, Medicare revenue per episode was up 1.8% in Q3. The Q3 increase in hospice revenue was largely attributable to the Alacare acquisition but also included same-store admissions growth of 5.8%. Hospice ADC for Q3 climbed to 3,843, a 58% increase over the prior-year period.

During Q3, we continued to see positive trend in caregiver optimization with visits per episode of 17.3, down from 17.6 in Q3 2018 and cost per visit held relatively flat at $78 as compared to $77 in Q3 last year. Support and overhead cost increased as a percent of revenue in Q3, primarily due to the integration of Alacare. As a result of these factors, home health and hospice segment adjusted EBITDA for Q3 increased 17.6% over the prior-year period to $50.8 million.

And now, operator will open the line for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question comes from the line of Matt Larew with William Blair.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Matt.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Matt.

<Q – Matt Larew – William Blair & Co. LLC>: Hi. Good morning, and thanks for taking my question. I wanted to ask about the two updates to reimbursement dynamics in 2020. On the IRF side, it sounds like this is sort of a distribution of the training from a select number of employees more broadly, and that's kind of give you better confidence on the range for 2020. On PDGM, could you just give us a sense for what's driving that? It looks like the 200-basis-point – or over 200-basis-point increase in your expectation for next year, and whether there is any potential additional upside from additional learnings on the PDGM side.

<A – April Anthony – Encompass Health Corp.>: Hi, Matt. This is April. So, regarding the PDGM question, as we dug a little bit deeper into the CMS agency level impact file, which was the basis of the 4.1% we had originally reported, what we discovered was that CMS had included in that file the individual agency impact of some of the 8% behavior adjustment. So, they had sort of mixed the buckets together a little bit. And as a result, when we began to cull through that file and realized that what we found is that about 1.8% was – of our 4.1% impact was the result of the behavior adjustments that we would not be able to realize based on our mix of patients. And so, it was really kind of a classification component between the base rate implications and the assumed behavior change. We called it out because the reality is if the assumed behavior changes are to alter as a result of the final rule or potential legislation, we wanted to be clear what the starting point was for the impact there. And so I would say it's not as much as an improvement as it is a reclassification.

<A – Doug Coltharp – Encompass Health Corp.>: Matt, we've been focused on trying to separate the two, the impact on our pricing from PDGM specifically and then because there's so much unknown about the status of the base rate reductions that are proposed because of the assumed behavioral changes and about each individual provider's ability to make those behavioral changes, as we did in Q2, we tried to separate the buckets. What we discovered is that the CMS file that we had used that appeared to us and all other providers to be solely focused on the PDGM impact, also included for each provider the full amount of the proposed base rate reduction and then the CMS' assumption about the maximum level of the behavioral adjustment each provider would be able to make. We were able to reverse engineer and take that out and the impact that we're giving you now 1% is our true estimate of the PDGM impact.

<Q – Matt Larew – William Blair & Co. LLC>: Okay, understood. And then there's also a number of things you've done preparing internally, whether it's using Medalogix and other tools to try to optimize visits, you referred to clinical utilization as well then focusing on institutional referrals, just wondering if you have any update on some of those efforts that would be sort of separate and removed from the PDGM component?

<A – April Anthony – Encompass Health Corp.>: Yeah, we continue to see nice progress in our improvements in productivity and optimization, as Doug mentioned earlier, we are also seeing nice growth from an overall perspective, seeing an improvement in our sort of scale and density on a market-by-market basis, which helps leverage our overhead, but we're also seeing a nice move toward hospital-based discharges. So, not only are we growing but we're growing in the right cohort of patients to play well with PDGM.

We think all of that, combined with these enhanced technology components, which not only includes the Medalogix CARE Tool, which will help us with really developing that just right care plan for each patient but also enhancements that we're working with Homecare Homebase on in the scheduling module, which will further give us a new set of tools to manage productivity and optimization. All of that combined, we

think is going to help us mitigate some of the impact of PDGM and particularly be prepared if this same behavior changes stick as they are today.

<Q – Matt Larew – William Blair & Co. LLC>: Thank you.

<A – Doug Coltharp – Encompass Health Corp.>: But let me be clear, Matt. The movement, the 180-basis-point from 2.8% to 1% was not reflective of any changes in our patient mix from Q2 or of any mitigating strategies. It was simply understanding now that CMS has embedded some things in the estimating file that was not understood by the provider community.

<Q – Matt Larew – William Blair & Co. LLC>: Understood. Thank you.

Operator: Your next question comes from the line of Whit Mayo with UBS.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Whit.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Whit.

<Q – Whit Mayo – UBS Securities LLC>: Hey. Good morning, everyone. Maybe just my first question for April now that CMS is delaying the Review Choice prepayment demo, I presume this is a good thing for you but I believe it's still coming back this spring. So, can you maybe just spend a minute talking about this like what this delay means for you, how you're thinking about preparing for the phase in, in the spring (00:29:32) alongside PDGM? Thanks.

<A – April Anthony – Encompass Health Corp.>: Sure. So, we knew that that RCD could come back with 30-day notice at any time. We will admit to being disappointed when it came back for December 2, really one month before a total payment reform. And so, the industry at large really worked hard with CMS to say, hey, the timing of this relative to being one month before a new payment change is particularly challenging because it's going to cause agencies to have to basically create one set of processes for 60-day payments and a another set of processes just less than 30 days later for the two 30-day payment periods. And so, we were successful at advocating with CMS that that was really unfortunate timing. And as a result that was part of the reason that they suspended that until March.

The reality is, I think, we are going to continue to invest at the same pace of preparation as if it had been a December 2 day, recognizing that there's still some work to be done, primarily working with CMS and the intermediaries to ensure that we can build an interface between Homecare Homebase to take some of the administrative burden of the process away by automating an interface between the Palmetto system and the Homecare Homebase system that will let us transmit that data more efficiently. But we're continuing to prepare for that, fully recognizing that it'll come back in March for Texas and May for our large Florida segment. And so, we're preparing for that actively now and think that we will be prepared for it, but are certainly grateful that it got delayed so that it's all-in the new PDGM era and not half and half.

<Q – Whit Mayo – UBS Securities LLC>: No, that's helpful. And Doug, can you maybe just spend a minute back on the MA growth in the IRF business for the quarter? Just maybe talk a little bit more strategically what you're doing to target MA, just remind us the contracts, how they're structured and maybe how the payers are responding for FIM. And I think that the anticipated reimbursement in MA might be expected to be lower based off of the supplemental slides that you put out, maybe I'm misreading that. So, just any color around MA would be super helpful.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. So, we continue to see the positive trends both with regard to discharge growth and then also with the movement, and an increasing number of contracts now for the revenues under MA being paid on a case rate basis versus on a per diem basis. And so, as I mentioned in my comments, with regard to discharge growth, we were up 21% for the quarter; and on a year-to-date basis, 18%. That continues to be predominately focused around stroke and neurological. So clearly, the MA plans are seeing the value of the IRF setting and particularly of

Encompass Health's IRF setting around a higher-acuity, more medically complex patients. So, we think we've still got room to run there.

We are transitioning an increasing number of those contracts to a case rate basis. We now have about 82% of our MA revenue paid on a case rate basis versus the per diem. And the discount between Medicare Advantage and fee-for-service continues to shrink, there's some of the law of diminishing returns settling in. But we're down to about 9% in terms of the delta right there, so that is very favorable.

I think in terms of the rate assumption, the price rate increase for next year, as you move an increasing number of your contracts to the case rate basis, they're tied directly to the Medicare fee-for-service schedule. So, we should see those move relatively in tandem. I will say that if you look on a year-to-date basis for us, revenue per discharge within the Medicare Advantage plans is actually up 4.5% versus the 1.5% on Medicare fee-for-service.

<Q – Whit Mayo – UBS Securities LLC>: Yeah.

<A – Doug Coltharp – Encompass Health Corp.>: That predominantly reflects the fact that we're seeing more of the growth in the higher acuity patients.

<A – Mark Tarr – Encompass Health Corp.>: Whit, as you know, we've spent considerable amount of time selling our value proposition and focused on our outcomes and the reduction and the readmission back to acute care hospitals and more and more of the MA plans we're starting to recognize that and the impact on the overall cost of care and then that just ties hand-in-hand with our clinical collaboration between our facility-based and home-based setting in terms of working with patients and having those great outcomes. So, I think the momentum just continues to build with MA plan.

<Q – Whit Mayo – UBS Securities LLC>: Great.

<A – Doug Coltharp – Encompass Health Corp.>: And, Whit, just to elaborate a little bit because April and her team have continued to do a wonderful job also trying to lay out the value proposition for home health with Medicare Advantage plans. And you would think that that would be readily apparent to many of those plans. They are lagging in their awareness of the value proposition that is delivered to the table by quality home health providers such as us. And so, when you look at the rate differential in home health between MA and fee-for-service, it remains north of 20%. And as a result, when we see the rapid growth in Medicare Advantage on the IRF side, it actually is a bit of a weight, a counterweight against the progress that we're making on the clinical collaboration rate.

So, specifically, we measure the clinical collaboration rate the overlap markets based on all payers. Well, for Q3, our clinical collaboration rate for just Medicare fee-for-service, where you see the value recognition by that payer for both segments, is in the low to mid-40s. For Medicare Advantage in those same markets, it's 12%. And so, we're glad to have the growth on the IRF side in Medicare Advantage. We think ultimately based on the efforts that April and her team have underway and the results that they're posting, that they will raise their rates appropriately for home health and it will be able to bring clinical collaboration up across all payers. But in the near term, if we continue to see this kind of despair growth in the IRF segment for MA, it's just going to be a little bit of a counterweight on the progress that we're making in the quarterly clinical collaboration rate.

<Q – Whit Mayo – UBS Securities LLC>: Got it. Thanks guys.

Operator: Your next question comes from the line of Matthew Gillmor with Baird.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Matt.

<A – Doug Coltharp – Encompass Health Corp.>: Hi, Matt.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hey. Good morning, everybody. Hey, I wanted to follow up on the reimbursement outlook for 2020 on the home health side. I think I understood the changes to the estimate that Doug and April outlined. Does that updated estimate also impact the figures Doug provided on the last call regarding how that will influence EBITDA next year? And if it does, could you maybe update those for us?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. It does in both segments, Matt. So if you recall – and I won't put everybody through the pain on this call of walking you through all of the assumptions but the assumptions that we had for SWB growth, where the deleveraging was occurring in both business segments have not changed, and so all that has changed is the pricing impact in both businesses. And if you roll those through the same kind of analysis that I had outlined in Q2 call, whereas we were getting to an aggregate estimated EBITDA headwind carrying the 2019 consolidated legacy business into 2020 of $79 million, we rounded to $80 million, you now get a range of $49 million to $59 million. So it's gotten – depending on where we fall within the price range on the IRF side, it has gotten $20 million to $30 million better in terms of the headwind.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Okay. That's good to know. And then I wanted to also ask about the new capacity openings on the IRF side. It seems like you're running a little bit higher in 2019, especially with respect to the bed additions to existing facilities. And I know your go-forward outlook doesn't assume a higher rate of bed expansions in the future. But I was hoping you could just sort of update us on your feelings about that IRF development pipeline. Are the demographic trends now supporting faster and faster growth or is 2019 just happen to be a normally good year with respect to your ability to get new beds opened?

<A – Mark Tarr – Encompass Health Corp.>: Hey, Matt. This is Mark. We are very excited about what we consider to be a very robust pipeline for both new hospitals as well as opportunities for bed expansions. We don't think 2019 is just a one-year positive blip. We see the continuing need for our services moving forward. As you noted with the demographic tailwind, we think we are well positioned to continue to grow the company and in both of our operating segments taking advantage of this tailwind we have.

<A – Doug Coltharp – Encompass Health Corp.>: Matt, there's always going to be a little bit of a timing issue that comes into play depending on whether or not we are able to get the doors open on Murrieta this year, which involves some approvals from California authorities, which can be a little bit difficult to predict. We'll be right at about 320 beds in total capacity this year. And that's a good year. And we may not be able to deliver that every year, but as Mark suggested, the demographics that are out there and we've referenced before, if you look back over the last decade, the aggregate supply of licensed IRF beds in the US has been relatively flat. So, we see opportunities. And again, there may be some fluctuations from year-to-year to consider both expanding the number of de novos we're targeting on an annual basis and also to – as we do that, that adds more candidates for bed expansions to the portfolio. And so, hopefully, we'll have the opportunity to consider raising that target as well.

<A – Mark Tarr – Encompass Health Corp.>: And we're also excited about the – some of the new states that we're developing hospitals in, such as the Boise, Idaho project this year. We have one schedule coming up for State of Iowa. So, we're starting to explore some states where we think there are some great opportunities.

<A – Doug Coltharp – Encompass Health Corp.>: And we're continuing as well to see the benefits of our expertise with regard to being able to procure CONs in states that have CON requirements. We have more CONs than any of the other providers of IRF services have units. And so, we have ascended a pretty steep learning curve and are able to leverage that expertise, and then throw into the mix, and we're still evaluating the opportunity, the revocation of the CON requirements in Florida. And there could be some exciting things happening with regard to the development pipeline in the years ahead.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Got it. Thanks very much.

Operator: Your next question comes from the line of Kevin Fischbeck with Bank of America.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Kevin.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Hey, guys. How are you doing?

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Kevin.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: I guess, a question about this change in the PDGM. I guess if I understand the way you're describing it correctly, you were saying that CMS originally in their impact file included an assumption for the amount of behavioral adjustment that you would not be able to offset. Is that 1.8% number? I guess, how do you think about that 1.8% number? Is that in total what CMS was assuming from a behavioral adjustment that you could not offset? Or is that a good way to think about that 8% and how much you might be able to do or is there nothing that we can really glean from that 1.8% from the outside?

<A – April Anthony – Encompass Health Corp.>: No. Actually, that is exactly what you should glean from the 1.8%. What Medicare is saying in that impact file is if the agency does everything that we've assumed you'll do in the proportions that we've assumed, our agencies can't realize the full 8% realization. They're going to be 1.8% light of that opportunity. And so that's exactly what that's telling us. So, in other words in the 41 they had already categorized what we could not realize of the 8% into the impact for us.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: But, I guess, I was asking, well, do you agree with that CMS analysis?

<A – April Anthony – Encompass Health Corp.>: Well, it is based on older data and so based on that dataset, we do agree that that is what they have done and that's the impact of it because they really took an episode-by-episode view and looked at all of the coding opportunities, the LUPA opportunities, and the comorbidity identification opportunities and kind of gave it the application in the proportions that they had expected. So, we agree with the data. The question going forward for us is, one, as the universe of patients changes and the opportunities and mix of patients from where their discharge changes, will that be an accurate predictor of the future? And I think that's always in question because 2017 patients won't be the 2020 patients. And so utilizing an older dataset could be a proxy but it will never be an exact match with patients that we'll be seeing then.

As a result, we also can't really predict, as Mark mentioned, the coding implications of what is realizable. Simply because a proportion was realizable in prior datasets doesn't necessarily mean that those coding opportunities will exist in a new set of patients that we'll identify in 2020. What we know is that we are training our staff to understand the coding rules, to apply them consistently and along with the coding guidelines that exist, and if that produces incremental revenue opportunities, great. If it doesn't, we still have to follow those coding guidelines regardless of what Medicare's assumptions are. So, we're certainly training to those rules as we always have, but we can't necessarily predict the impact that they'll have on our 2020 patient mix.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. That's helpful.

<A – Doug Coltharp – Encompass Health Corp.>: Kevin, look, as I've said, we continue to separate and we think it's useful to do this, the PDGM impact from both the reduction in the base rate and the assumed behavioral changes. On the PDGM impact, which is now a negative 1%, we believe that among other things, the continued evolution in our patient mix, which includes more hospital-based referrals, which has occurred since – in the timeframe from which this data was based, will be available to offset or will mitigate a lot of that 1% cut, so put us back into a flattish range.

When we then look at what kind of mitigating strategies we might have that would be available to impact any portion of the proposed base rate cut that we don't offset by making this in behavioral adjustments,

it's the productivity things that April has talked about before. But we want to remind you that we have been on that productivity train for a period of time. And we believe that we – and our margins reflect this, that we are further along that path than any of our primary competitors. And as a result, the same level of opportunity to use those types of mechanisms for an offset to unmitigated reductions in the base rate is not as prevalent as it is with some of the other providers.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Okay. Just to clarify something that you said earlier, you said that the wage assumption for next year hasn't changed at all. I just – you guys talked about a little bit more training costs this quarter. Does your labor assumption for next year, does that include all training costs on the new system and everything else kind of fully loaded or is there potentially something to come up like we saw this quarter where there's maybe an extra cost in there above and beyond and you're just giving us the wage inflation versus the training costs side?

<A – Doug Coltharp – Encompass Health Corp.>: Well, so, you'll have those training costs for 2019 built into the base, so if you use the same growth rate with the 3% SW and then it doesn't really change the benefit piece, it should cover us for most of the training. Now, if we get through the first quarter of utilization on PDGM and find that we're not generating the kind of consistency and results that we had anticipated as we now broaden the user group from numbered in the hundreds to numbered in the tens of thousands, then we may need to add to that. It's too early in the game to say whether or not that's the case. But right now, our base assumption is that those assumptions that we use with regard to SWB inflation are sufficient to cover next year's training costs.

Operator: Your next question comes from the line of Pito Chickering with Deutsche Bank.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Pito.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Pito.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Hey. Good morning, guys. Thanks for taking my questions.

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

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: A couple ones here, and long time no chat, can you walk us through the Medalogix rollout at this point? What percentage of your home health agencies has adopted Medalogix? What's the rollout timing for 2020? And when we look at the agencies that have been using Medalogix for the longest, what reductions have you realized in the visits per episode?

<A – April Anthony – Encompass Health Corp.>: Yes. So, we are still in the early stages of deployment. We've rolled out 20 locations in the State of Texas at this moment. We have a four-way rollout plan that will get us to about a 70% deployment by early March of 2020. And then the remaining chunk will come from a few of our smaller branches plus the recent addition of Alacare. That final wave we haven't put a specific timeline on, but likely another 30 to 60 days after that early March timeframe. But we think we'll get the majority of the Medalogix deployment done before the end of the first quarter.

We are seeing some nice progress albeit on still a relatively small scale, where we're seeing visits decline as a result of the implementation of Medalogix without any decline in quality outcomes, which obviously is the important part of that, don't simply want to move visits, we only want to do so to the extent we can achieve that without any dilution in quality. And our data so far with the branches that are implemented suggest that we're achieving that perfect balance of improved efficiency with no decline in outcome. So we're encouraged by the early results there and believe that that will continue to be the same kind of results we'll see in our further deployments of the Medalogix CARE Tool.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: Okay, great. And then just follow-up on that, any sort of guidelines, I've been hearing 15-plus-percent reductions of visits sort of is possible using Medalogix without any change to quality, is that in the ballpark of what you guys have seen?

<A – April Anthony – Encompass Health Corp.>: Yeah, I would say, we would say it's probably more in the 10% range than the 15% range is probably a more conservative and realizable approach. As we get a little bit further into it, we may find added opportunities but I think we would handicap it more in the 10% range of improvement.

Operator: Your next question comes from the line of Brian Tanquilut with Jefferies.

<Q – Brian Tanquilut – Jefferies LLC>: Hey. Good morning, guys.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Brian.

<A – Mark Tarr – Encompass Health Corp.>: Good morning.

<Q – Brian Tanquilut – Jefferies LLC>: Doug, just with all these moving parts, I know there's a lot of discussion already on PDGM but just going back to the slide, where you show the change in your expectation for the CARE Tool impact that improved versus last quarter's expectation and then same thing for home health, obviously, just moving buckets, has your view on 2020 EBITDA changed yet in terms of your – how you're feeling about where that would land versus this year's EBITDA?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. I think as I mentioned previously, the primary thing that has changed is that the amount of headwind that we will carry into 2020 from the 2019 base across both business segments due to deleveraging of these price increases against WB, SWB has improved by $20 million to $30 million. And so when we think of what we need to achieve in 2020, solely on the back of volume growth, that burden has come down.

If you kind of do the math and again use the same math that we did in Q2, and so this is again before we get into any of the unmitigated portion of the proposed base rate cut in home health, not otherwise mitigated. But if you kind of do the math on that $49 million to $59 million headwind, it suggests that you need to aggregate volume growth depending on your margin assumptions of somewhere in the 4.5% to 5% range. And that appears to be a much more reasonable range in order to achieve consolidated EBITDA growth next year.

<Q – Brian Tanquilut – Jefferies LLC>: Now, it makes sense. And then I'd like to think about SWB, with PDPM impacting the SNFs or you changing the dynamic in the SNFs in the rehab side, does that open an opportunity for you guys to see lower wage inflation especially on the therapist side?

<A – Doug Coltharp – Encompass Health Corp.>: It doesn't hurt and I'll ask Barb to weigh in on this. It's still early to tell what we would see across a broader portion of our portfolio but there have been markets where we've seen some of the nursing homes have trimmed back on the number of therapists they have. So, just from a supply/demand and pressure on salaries, that could be an indication at least within certain types of therapists that markets would have a little less pressure on. But I'm going to ask Barb to weigh in on that.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah. I don't know if it will have an impact on the salary component because we're still competing against the acute care hospitals and other different areas where therapists work in our market. I do think we're already starting to see that it is improving the availability of the therapists. So, filling our positions will hopefully be a little bit more smooth, but I don't see it impacting what we're paying them.

<Q – Brian Tanquilut – Jefferies LLC>: All right. Got it. Thanks, guys.

Operator: Your next question comes from the line of A.J. Rice with Credit Suisse.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, A.J.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Hello, everybody. Just looking at some of the metrics in the quarter, same-store admits in the home health business were up 9.7%, but same-store episodes were up only 3.8%. That's one of the biggest divergences in those metrics we've seen. Anything to talk about there?

<A – April Anthony – Encompass Health Corp.>: Yeah. It's a little bit timing-related. Obviously, as you grow the admissions, the end of episodes are 60-days delayed. So, there's always a little bit of a timing lag when you see a strong growth in admission number. So, we're seeing a little bit of that. We're also seeing that we had a little bit of a decline in our proportion of research. Part of that is certainly driven by the Alacare mix of patients differing from our historic mix. But on balance, I think as much as anything, timing is a big part of that just because of the 60-day duration of episodes.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay.

<A – Doug Coltharp – Encompass Health Corp.>: A.J, we also had – I'm not going to name names, but we have one relatively large MA plan that elected to begin using a patient navigator. And that patient navigator in the markets that impact us, for not only us but for all other home health providers they use is declining recertification 100%. And we believe that that is going to be a short-term phenomenon because they are going to see higher hospital readmissions and then the payer will no doubt come around to a more rational approach regarding to recertifications. But that was a factor that weighed on the quarter. And again, I don't know that it will go away in Q4 but ultimately, that's going to prove to be a short-lived strategy.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. And then a follow up just to ask about on the acquisition side, obviously, you've had Alacare, you mentioned a couple times. How is that trending relative to your expectations? And any other comment about pipeline generally?

<A – April Anthony – Encompass Health Corp.>: Certainly, we're pleased with the Alacare integration and how that's going so far. We think we were confident going in that that was going to be a good fit. And now, 90 days into the partnership, we're confident of that and seeing good results from our integration efforts. There are still integration efforts to be completed, though, so although we're pleased with the progress, we also recognize that integrating an organization the size of Alacare's with the vast scale they have across Alabama that that's going to be something that's going to take longer than 90 days. So we'll continue down that integration process but we're pleased with the performance. We're pleased with the culture match and definitely pleased with the team that we've been able to bring on to our organization.

On the home health side, from a development perspective, I think we're being cautious here certainly in the fourth quarter. With PDGM upcoming, it's not the ideal time to be jumping into another substantive sized acquisition. We do have some smaller things in our pipeline that we think are particularly key markets that can help drive future growth. But I think you'll see us take a little bit more of a measured approach in the next six months as we kind of get into the first – the planning of PDGM and then the first quarter of actual PDGM results. And then my guess is that starting in the second quarter, you will find us being very active because I think there's going to be disruption in the market that's going to create some really appealing opportunities for us to create some cost-effective acquisition opportunities in the back three quarters of next year.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay.

Operator: Your next question comes from the line of Frank Morgan with RBC Capital Markets.

<A – Mark Tarr – Encompass Health Corp.>: Good morning, Frank.

<A – Doug Coltharp – Encompass Health Corp.>: Hi, Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. Hey, just back to Alacare. I know you called it out specifically having some impact on some of the metrics, things like the recert rate and maybe even your overall rates, but I'm just curious what is the opportunity that you really see there. Is there much of an opportunity to kind of change that patient mix so that you do get better pricing for – on an overall yield basis?

And then when you think about Alacare as it relates to PDGM, are there any levers that they may have that legacy Encompass maybe didn't have because of where your labor mix was already or your business mix was already? So, I guess, going back to the earlier question, just the opportunity that you see there. Thanks.

<A – April Anthony – Encompass Health Corp.>: Yeah. We feel very encouraged by the opportunity we think we're going to be able to slowly, but surely improve the mix of Alacare. We think particularly with our hospital relationships with our IRF partners there, we'll be able to further expand our clinical collaboration in those markets. We think we'll be able to really bring some of our specialty programs that have proven very successful for us in building organic growth and in driving hospital relationships, our CTCs, our specialty heart programs, our specialty orthopedic programs, we think all those things are going to be available to the Alacare locations.

We generally don't start really pushing those new specialty programs into an acquisition until about the six-month mark because we're really working on a lot of the kind of administrative changes that come with being part of the Encompass family for the first six months. And then in the back – in the next six months, we'll really begin to focus on new program implementation there. So, I do feel like we'll be able to improve their pricing as a result of that. I'm also very confident that over time, we will see improvements in their margins that's very consistent with our experience with other large scale acquisitions, but again that takes a little bit of time, we got to first get them on our processes and then we'll start to enhance the results that they can achieve once they're kind of following the right formula.

<Q – Frank Morgan – RBC Capital Markets LLC>: And in terms of PDGM?

<A – April Anthony – Encompass Health Corp.>: PDGM I think is going to be a bigger positive for the Alacare branches than it has – than it will be for the base of the legacy business, partly because of that mix that was a bit more heavily nursing oriented than therapy oriented. And so, they will get actually a little bit of a better good guy in the case of PDGM than will the base business and so that'll help normalize some of that rate differential in the 2020 timeframe.

<A – Doug Coltharp – Encompass Health Corp.>: Hey, Frank, just to be clear though, the 2.8% estimate that we provided in Q2 and the 1% updated estimate in terms of the impact for PDGM, both include our patient mix inclusive of Alacare.

<A – April Anthony – Encompass Health Corp.>: Correct.

<A – Doug Coltharp – Encompass Health Corp.>: Remember part of the reason that we had the improvement in our estimate in Q2 getting to 2.8% was because that was the first time the estimate was inclusive of the Alacare business as well as the legacy.

Operator: Your next question comes from the line of Sarah James with Piper Jaffray.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Sarah.

<Q – Sarah James – Piper Jaffray & Co.>: Good morning. I wanted to get back to the fundamentals a little bit here. You've talked before about the big picture opportunity of taking share from SNF with Encompass [ph] caring (00:58:46) for 32,000 of 800,000 national stroke cases. And I'm wondering if you break this down to a local initiative level, if you have an example of the traction that you've been able to achieve in a single market, where you've made a push on acute hospital and consumer education level,

you've leveraged partnerships and you can kind of spike out an average case or a best case of how you've been able to move the needle on gaining share in [indiscernible] (00:59:15)?

<A – April Anthony – Encompass Health Corp.>: Sure. So, from the referral source perspective, we've taken a look at a lot of the Medicare claims data and have been able to bring that to just the stroke level to show that we are more successful at admitting a stroke patient from the acute care hospital in a lower length of stay at the acute care side. So, being able to pull them sometimes a day or two sooner than a skilled nursing facility can, we are actually helping the acute care hospital manage their length of stay on those patients.

But what's great is also the Medicare claims data has us have the ability to not only say we can move them quicker but that our readmission rate is lower. And in some instances, our readmission rate is half of what it is if those stroke patients go to a skilled facility. And so that type of information at a local market is shared with those key referral sources so that they can see the value that we bring to them and their patients.

And then from a consumer side, we're obviously using the American Heart/Stroke Association strategic sponsorship to really work on educating the communities on when a patient can tolerate inpatient rehabilitation, that stroke patient should be receiving their care. And that sort of thing in a consumer level is allowing those patients and families to be more advocates to ask for inpatient rehabilitation versus skilled care when they have had a stroke in their family.

<A – Mark Tarr – Encompass Health Corp.>: Sarah, we're very pleased with our partnership with the American Stroke Association. I think it's these activities that we do collaboratively with our hospitals and the various chapters of the Stroke Association and Heart Association in the local market that does help to gain additional exposure and the differences between what goes on in an Encompass Health Rehabilitation Hospital versus skilled nursing facilities in the market. So, we're very pleased with that and we'd anticipate having continued momentum going into 2020 with that relationship.

<A – Doug Coltharp – Encompass Health Corp.>: And, Sarah, I think a great way to look at how we're gaining market share both generally and then specifically around stroke is getting back to some of the numbers that I elaborated on previously with regard to Medicare Advantage. So, on a year-to-date basis, our total MA discharges on the IRF side are up 18.1% and we're up 17.4% in same-store. And yet, we've modestly also increased within our Medicare Advantage book of business the percentage that is within stroke. And we know the market isn't growing that quickly, so those patients are coming from somewhere else. Some of them are probably coming from other IRFs, but I would venture to say that the vast majority of those are coming from a SNF because of the better treatment and the efficacy of the treatment plans that we have on our facilities.

<Q – Sarah James – Piper Jaffray & Co.>: Great. That's very helpful. And then, just the other side of that, being able to accommodate this increase in demand, I know you guys build out excess capacity into the footprint. Can you remind us what leverage there is for being able to add excess beds within the existing walls or properties that you have?

<A – Doug Coltharp – Encompass Health Corp.>: So, every one of the de novos that we build is the typical floor plan for us is we'll build either 40 private rooms or 50 private rooms. In all instances, when we're building a de novo, we're acquiring excess land to accommodate bed expansions. Depending on the particular market opportunity, we'll buy enough land and we'll build the initial central points of the infrastructure like the therapy gym and the nursing stations and so forth to accommodate an expansion typically in 10-bed increments up to 80 to 100. We see very high returns on bed expansions. It is not unusual and may even be typical that we'll typically see an IRR on the bed expansion that will be in the mid-30% range.

Operator: Your next question comes from the line of John Ransom with Raymond James.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, John.

<Q – John Ransom – Raymond James & Associates, Inc.>: Good morning. We had heard from some of your peers that one of the challenges of PDGM is that patients that had a code in the old system did not have a code in the new system. So, I just wanted to see if you had also found that and if so, is this bigger than a breadbox?

<A – April Anthony – Encompass Health Corp.>: Yes, John, that is absolutely the case. Back in the old kind of prior iteration of PDGM, they called these questionable encounters. It sort of left them nameless in the new PDGM rule but they're effectively codes that are less specific, take generalized muscle weakness unspecified. And so if you don't know the basis for why a patient has muscle weakness, you can't utilize that diagnoses any longer. And so, there's certainly a cohort of patients across the home health spectrum with an all-provider groups that were using these less specific codes.

Going forward, in 2020, we're going to have to work more collaboratively with the physicians to get more specificity about the basis of why a patient is experiencing a certain combination of symptoms and really make sure that we can code that more specifically. We're also utilizing tools within the Homecare Homebase system to alert the clinicians so that if they choose one of those codes that's no longer going to receive payment, that the system's going to literally stop them and say, you can't admit this patient with that code. That's no longer an acceptable code for which reimbursement will be provided and so go back to the physician and find that. So it is something to be concerned about.

Is it bigger than a breadbox? May be. It has the potential to be significant, if not dealt with. I don't think we'll find it being that terribly significant. I just think it's going to take a lot more collaboration with physicians and possibly even some incremental testing that the physicians will have to do with the patients to identify the basis for the diagnoses where in the past it was just sort of, hey, what are they experiencing.

<Q – John Ransom – Raymond James & Associates, Inc.>: And so the corollary to that is it wasn't so much can Encompass deal with this. Isn't this just yet another brick in the backpack of these small mom-and-pops, I mean, between the partial episode financing going away and now this and then the cut? Do you – has your view changed about market share shifts and agency closures just given the more you learn about the PDGM? And if so, are we going to be a buyer or are we just going to be, let's see how bad this is and maybe we can scoop up some share for not much capital outlay?

<A – April Anthony – Encompass Health Corp.>: Yeah. I think you're right. I think this – changes like this just further complicate the environment for the small providers and for those who lack a sophisticated technology solution to help their clinicians manage through it. So, we do think that there's going to be disruption. To my earlier point, I think that we will probably see that disruption really begin to take hold in the second quarter if you kind of look at the timing of the decrease in the RAP payment amount, if you look at what I think will probably be some challenges on the part of the intermediaries to even process PDGM claims in the first few weeks out of the gate.

We think by early April timeframe, there are going to be some agencies that are really feeling the pain of all of this and that there will likely be buying opportunities that will either be cost effective. And that similarly, there will be opportunities just to take market share, where folks are either just going out of business or they've got enough issues around their business that we wouldn't be interested in buying it, but we may be able to step in and support the patients in that community, the referral sources in that community as well as hire some of those caregivers. So I think it's going to be a little bit of both, but I do think the disruption to small scale providers is going to be pretty significant. We'll see it hit pretty hard beginning in the second quarter.

Operator: Your next question comes from the line of Scott Fidel with Stephens.

<A – Mark Tarr – Encompass Health Corp.>: Hello, Scott.

<A – Doug Coltharp – Encompass Health Corp.>: Good morning, Scott.

<Q – Scott Fidel – Stephens, Inc.>: Hi. Good morning, thanks. First question, just on the payer mix in home health and hospice, I noticed that it was down year-over-year in MA, which obviously was quite different than we saw on the IRF side. You may have actually answered that before. Did that relate to the one large payer using the navigator and that affected it or just want to clarify whether there were any other factors as well?

<A – Doug Coltharp – Encompass Health Corp.>: That was a factor and the Alacare mix was a factor too.

<Q – Scott Fidel – Stephens, Inc.>: Okay, got it. And then just my second question is just do you have a total estimate of what the costs are that you're incurring in 2019 for the preparation for PDGM?

<A – April Anthony – Encompass Health Corp.>: We don't have a specific estimate that we're sharing yet. The reality is it's going to be a kind of an ongoing training. We began those training processes really in September of this year with a large scale leadership meeting that focused on that. We got a training going on this week for our preceptors around the country that are here in Dallas going through a couple day training session on the impacts of PDGM so that they can go back and be trainers to their field locations. And it's great to do this advanced sort of preparatory training but I think there'll also be things that we'll learn in the first three to four months of PDGM that'll cause us to have to go back and sort of reinvest and do some more ongoing training. And so, as we think about 2020, we think it's probably going to be a year of transition. It's not all going to be prepared for in advance because this is a transformative payment change and it's going to take some time to really learn the implications of what it means to the way we care for patients and the impact of coding rules and all kinds of things. So, I think we'll see it ongoing in the home health division throughout the year and kind of bake that into our planning.

<Q – Scott Fidel – Stephens, Inc.>: Okay. Thank you.

Operator: That concludes our question-and-answer period. I will now turn the call back over to Crissy for closing remarks.

Crissy Buchanan Carlisle, Chief Investor Relations Officer, Encompass Health Corp.

Thank you. If anyone has additional questions, please call me at 205-970-5860. Thank you again for joining today's call.

Operator: Thank you for joining today's call. You may now disconnect.