PARTICIPANTS

Corporate Participants

Mark J. Tarr – President, Chief Executive Officer & Director, Encompass Health Corp.
Douglas E. Coltharp – Chief Financial Officer & Executive Vice President, Encompass Health Corp.
Barbara A. Jacobsmeyer – Executive Vice President & President-Inpatient Hospitals, Encompass Health Corp.

Other Participants

Andrew Mok – Analyst, UBS

MANAGEMENT DISCUSSION SECTION

Andrew Mok, Analyst, UBS

Hi. Good morning and welcome to the UBS Global Healthcare Conference. My name is Andrew Mok and I'll be hosting today's session with Encompass Healthcare (sic) [Encompass Health] (00:00:19), a leading provider of post-acute healthcare services.

With that, it's my pleasure to welcome CEO, Mark Tarr; CFO, Doug Coltharp; President of Inpatient Hospitals, Barb Jacobsmeyer; and Chief IR Officer, Crissy Carlisle. Welcome and thank you for all for joining.

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

It's great to be here this morning, Andrew.

Andrew Mok, Analyst, UBS

For everyone new to the story, why don't you take a step back and recap your start to the year and touch on the recovery assumptions embedded in the current guidance.

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

Sure. I'd be happy to. Let me just give just a few highlights of our Q1. Probably most importantly, first thing is that we're off to a very encouraging start. If you look at our first quarter of this year, compared to the first quarter of 2020, our consolidated revenue was up 4.1%; our consolidated adjusted EBITDA was up 2%; and our adjusted EPS was up 20.78%. So, really off to a very strong start. We increased our full year 2021 guidance. So, our consolidated net operating revenues now $5.06 billion to $5.23 billion; our consolidated adjusted EBITDA of $1 billion to $1.03 billion; and our adjusted earnings per share of $3.94 to $4.16 per share.

So, if you think about, Andrew, the key driver of our success in the first quarter has been the rebound of our volume trends that we started to see, really, midway through we started to see a decline from the impact of the pandemic. We didn't have near as many staff out on quarantine. We

didn't have near as many hospitals capped off from the impact of having to have patients in isolation because of COVID. So, we saw that rebound – at one point, in the height of the COVID pandemic, we had 30 some hospitals that were capped because of number of COVID patients. And now, we're down to literally only two hospitals that have any cap on volume. So, those all led to promising volume trends which contributed to the solid revenue and EBITDA growth.

We also are very encouraged by our future growth, which is supported through our attractive business development pipelines across all of our service lines. And then, we're seeing continued strength in our MA volume, the number of discharges for our IRF continues to grow, as well as were increased by the first few months as started in February, but the national contract for home health services with United, we're very pleased with the progress we've made with that. As far as the recovery expectations, we certainly are confident that the fundamentals of our business are intact and strong. We think that last year 2020 really showed the resiliency of our business model in face of the pandemic itself. So, we carry that volume momentum out of Q1 into Q2 with that same momentum coming into April.

Really, the volume growth is closely linked to really three areas. One is, as we see the number of joint replacement cases starting to come in from the acute care hospitals, that benefits both of our operating segments, both the IRF and home health. We've seen, I mentioned earlier, the mitigation of number of COVID cases on quarantine staff and number hospitals that had some limitations on caps. And then, for the home health, we've seen – starting to see a trickle of volume growth in the ALFs and skilled nursing facilities, which traditionally has been [ph] a nice feeder of admissions (00:04:35) for our home health.

So, with the return of elective procedures on both sides, we think that that will continue to increase – we've seen an increase each sequential month of this year in the return of electives. So, that's a bit – it varies from market-to-market but we are seeing some green shoots in the trend of elective procedures coming back. So, we think that the second half of the year will be void of any material impacts from the pandemic.

QUESTION AND ANSWER SECTION

<Q – Andrew Mok – UBS>: That's great. You mentioned the improvement in the home health elective volumes increasing every month so far this year. Can you help us understand the cadence of that improvement? Have you seen an acceleration in the elective procedures as vaccination rates surpassed the 50% mark in the adult population?

<A – Mark Tarr – Encompass Health Corp.>: That's clearly helping, Andrew. I mean, we've seen some markets seem to be more aggressive about returning back to historical volume norms. You still had COVID protocols in place in a number of the surgical suites, which slows down the amount of volume that they can do from a surgery standpoint. But yes, we are starting to see – it's more anecdotal than anything at this point in terms of just our sales and marketing people coming back and telling us they're starting to see the surgery schedules increase and volumes pick up.

So, not only the elective procedures but also access that we have now to the ALFs and the skilled nursing facilities there for a while with the pandemic we didn't have access to get into those facilities to get the referrals, and now we're getting access. We're just – we need the census to pick back up in the skilled nursing facilities, in the ALFs which we're starting to see somewhat. But that's a bit slower than what we've seen the return of the elective surgery procedures.

<Q – Andrew Mok – UBS>: Got it. So, the access to these skilled nursing and assisted living facilities has improved, but the census numbers still show some sort of lag? How do you think [ph] the SNF (00:06:58)...

<A – Mark Tarr – Encompass Health Corp.>: Yeah, that's correct. But, Andrew, I must say, we're confident that the volumes will pick back up and that the historical patterns of referrals we've had from those sources will return. It's just a matter of time before those – that census picks back up in both of those settings.

<Q – Andrew Mok – UBS>: Got it. Okay. So, you ultimately think the occupancy in those settings will restore to pre-pandemic levels?

<A – Mark Tarr – Encompass Health Corp.>: Yes. Yes we do.

<Q – Andrew Mok – UBS>: Okay. That's helpful. Throughout the pandemic, you added new referral streams, including 3,000 new sources in the first quarter of this year. Can you walk us through the response from the sales and marketing team since the start of the pandemic? What steps did you take to gain new referrals and what's been the contribution to grow from those new sources?

<A – Mark Tarr – Encompass Health Corp.>: So, yeah, we're very proud of the response in sales and marketing team in the first quarter. We had some 3,000 additional new referrals, sources; that compares to historical norms of around 2,500. So, the teams did a really good job on redirecting a portion of their time to other referral sources when they saw that the volumes were down in ALFs and skilled nursing facilities. So, they redirected to physician offices, surgery centers, other places where the response from the pandemic might have been a little more favorable than what we've seen on the ALFs and skilled nursing facilities.

So, they were able to offset some of that decrease in volume from the ALFs and SNFs by picking up the referrals and admissions coming from these other referral sources. So, we have reason to believe, as we have shown historically, that we do a really nice job on making sure we develop those relationships with the referral sources; that we can show them the quality of our outcomes, our responsiveness to the referral sources. So, we believe that we'll be able to maintain referrals

and admissions from these new referral sources. At the same time, we see our historical patterns return in the ALFs and skilled nursing facilities.

<Q – Andrew Mok – UBS>: And how is your sales and marketing department organized? Is that by region, by business segment, or a combination of the two? What allowed them to pivot quickly during the pandemic?

<A – Mark Tarr – Encompass Health Corp.>: It's a combination of the two. It's broken out by markets and regions. And so, yeah, we have a pretty good idea about the – what is going on in the marketplace. And so, they're pretty good at responding to the challenges in the marketplace and being able to pivot when they see changes in pandemic or any other major changes within the referral pattern, so they can adjust pretty quickly.

<Q – Andrew Mok – UBS>: Got it. And can you help us understand how admissions from new referral sources typically progress over time?

<A – Mark Tarr – Encompass Health Corp.>: We see – you see a building that the – you see a ramp-up in terms of, if you do a good job, you show the referral sources that we can have the quality outcomes or we're responsive to the referral sources, then you can become a favored source for them in terms of providing home health. There are a number of providers out in the marketplace, so we compete and we compete on both service and quality. So, you would expect a ramp-up from new referral sources as they begin to trust you and the care that you can provide.

<Q – Andrew Mok – UBS>: Got it. That's helpful. We've also seen a shift in elective procedures from the acute hospital setting to the ambulatory setting. How would you compare your [ph] actual (00:10:44) rates on qualifying home health procedures between these two settings?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, so we're – and this is anecdotal at this point, but we're starting to see more referrals directly from the acute care hospitals. So, we have reason to believe that a number of these patients that historically may have been set to a skilled nursing facility, now the acute care hospitals are referring them directly to us so we can treat them in the home setting. So, there has definitely been a shift out there. And in – from the elective procedures and some of the historical patterns that you may have seen that we think has some stickiness to it because, once again, we believe that we can continue to mature these relationships with the referral sources by our level of service and the quality that we provide for our patients.

<Q – Andrew Mok – UBS>: Okay. Let's move on to clinical collaboration. Since HealthSouth acquired Encompass back in 2015, collaboration between your segments has been a core component of your growth strategy. Can you speak to your ability to pursue clinical collaboration with independent home health agencies?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. Clinical collaboration remains a priority from a quality perspective in both our overlap markets and non-overlap markets. As you know, clinical collaboration was our ability to standardize that process of the discharge from our inpatient rehabilitation hospitals to home with home health. About 6% of the discharges coming out of our IRFs go home with home health, so it was in the best interest of the patients if we could standardize that process, make sure that this collaboration between caregivers and the transition from one setting to another was smooth and consistent and had very strong communication.

So, over the years, we have been able to modify and adopt some of those same standard processes that we had in our overlap markets, between our hospitals and our home health, to markets in non – where we don't have home health, we can use some of those same standardized processes with other home health providers. And part of that is due to the fact that, now, we have transparency of additional information from CMS, relative to the quality of levels of the various providers – post-acute providers in any market.

So, we know going into any new market if it's a new IRF or an existing IRF, and we now have information on all the other post-acute providers because CMS is making this available. So we know who the quality home health providers are or aren't in a marketplace, and we can develop relationships and have those same standardized processes or close to it that would [ph] mimic (00:13:46) clinical collaboration in our overlap markets.

<Q – Andrew Mok – UBS>: Great. And how far along are you on that journey in your non-overlap markets pursuing clinical collaboration?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, and we've made some nice progress on that. Barbara and her team have been working on that for over a year now, utilizing the data that's made available to them. And there was a time when we'd have, say, anywhere from 10 or 12 different home health providers in any one hospital and we would not know who the good home health providers were from the bad home health providers. And this additional information that we have now been able to capture through the transparency with CMS, we can eliminate the bad providers and make sure that we coordinate best with those home health providers that have the best outcome in any given marketplace.

<Q – Andrew Mok – UBS>: Okay. And there's about a 30 percentage point delta in the clinical collaboration rate between Medicare fee-for-service and Medicare Advantage. Can you remind us why that gap exists, and what steps can you take to close that gap over time?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. So, we – as we've had an increase in the number of admissions from MA into our IRFs, we have seen the – a bit of an impact, [ph] negative (00:15:05) impact on our clinical collaboration rate into our home health because we don't always have those contracts with those MA providers on the home health side that we do on the hospital side.

So, as we continue to work with the MA providers in any given marketplace and we work with them to show the outcomes and the value in home health so that we can get improved rates or rates that we think are reflective of the quality that we provide in our home health, we'll be able to better close the gap on that clinical collaboration rate in any given market.

<Q – Andrew Mok – UBS>: Okay, great. Let's move on to your cost structure. Last year, during this time, you made several changes to your cost structure in response to the crisis. Can you walk us through the impact of those cost changes and do you view your cost structure as more variable or flexible today versus a year ago?

<A – Mark Tarr – Encompass Health Corp.>: [ph] Yeah, and now I might ask (00:16:07) Doug Coltharp to weigh in on that.

<A – Doug Coltharp – Encompass Health Corp.>: Yeah. So a couple of things that were impacting our cost structure last year, and they were actually most pronounced in the second quarter of last year. The first, which was really a one-time item, was that we had about $43 million in incremental SWB expense that ran through the P&L in Q2 of last year; and that was because we elected to do a one-time extension of additional PTO benefits to all of our frontline workers in both of the business segments. Again, that portion will not be replicated next year.

We also, on May 1 of last year, we implemented a new compensation structure for the therapy clinicians within our home health division; and that did have the effect of making more of their comp variable and tied to the level of productivity than they have than fixed. Now, if they achieved a similar level of productivity today as they had a year ago, their overall compensation would not change but it did increase the variability. So, from a SWB perspective, those were the two major components.

We have, like virtually all other healthcare providers, since the outset of the pandemic, been experiencing higher supply cost as a result of increased utilization of PPE; and the increased procurement cost given some of the supply issues around that as well. We are seeing the utilization dissipate a little bit as we are confronted with fewer and fewer COVID patients within our care and also as the vaccination rates of our clinicians goes up. And so, we would hope to that would begin to come down.

Now, overall, when you look at our cost structure, on the IRF side, just over 50% of our cost is comprised of SWB which has a highly variable component in terms of being able to flex with regard to volume; and it's even higher, it's north of 60% on home health. Really the only fixed components of our cost base would relate to the administrative office and then the cost of occupancy and so forth related to our physical facilities.

<Q – Andrew Mok – UBS>: That's helpful. And can you help us understand how you allocate some of those overhead costs, corporate G&A between your two segments?

<A – Doug Coltharp – Encompass Health Corp.>: So, when you see the segment reporting right now, there's not a lot of allocation of home office costs out there. It really is pretty much the direct costs that are attributable to running each of those businesses. For instance, where we have shared IT expense that's coming from support in the home office here in Birmingham, we don't tend to allocate hours out into – in the segment reporting, that's all captured in G&A.

<Q – Andrew Mok – UBS>: Right. Segment reporting aside though, is there a way you think about the allocation of corporate overhead at the enterprise level even if it's not reported at the segment level?

<A – Doug Coltharp – Encompass Health Corp.>: No, when you look at – we're running less than 3% of total revenues in G&A. So making a distinction to try to allocate portions of that 3%, [ph] how to lead (00:19:21) each of the two business segments doesn't – just doesn't strike us as a value-added exercise.

<Q – Andrew Mok – UBS>: Okay. That's helpful. Labor cost...

<A – Doug Coltharp – Encompass Health Corp.>: If you look, we have a good sense as to the relative profitability and the returns on capital of each of those businesses based on what is included in the segment reporting.

<Q – Andrew Mok – UBS>: Understood. Labor costs have also been on the forefront of investors' mind throughout the pandemic. You recently commented that you're seeing slightly more labor pressure on the home health side than the IRF side. What do you attribute that difference to? Is that a reflection of geographic concentration or is there simply greater demand for home health nurses right now?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. Andrew, let me touch base on home health, then we'll ask Barb to weigh in on what she's doing with the hospitals and seeing on the labor front there because they've done a really nice job managing through it. We have seen a little bit more pressure on the home health segment. And it's in – it's market by market but it has been more specific to nursing.

And so, we have mitigated it and starting to see some nice traction in the number of marketplace where we've taken a second look at either the flexible schedules that the nurses are looking for. We've seen certain marketplaces where a number of the traveling nurses that went away to other markets that had a high COVID impact are now coming back to the marketplace and entering the marketplace, which has been added to the supply side. We've had to do some market adjustments.

So, there's really not one strategy or mitigating effort that works in every marketplace. But we're utilizing everything that we have at our disposal to make sure that we retain the nurses that we have and have the ability to recruit where we need to, to care for that volume. But it has been a little bit more distinctive on our home health side than our hospital side. I'm going to ask Barb to weigh in on what she's seeing with the hospitals.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Right. So, on the hospital front, it was interesting because at the start of the pandemic, as our volume was decreasing, we did see some employees go take travel jobs because of the premium they were going to get paid. We also saw some that decided to stay home because of kids with school issues. That timing worked well for us because it was a point in time where our volume was down. And so, it actually prevented us from having to do major reductions in workforce. As our volume has started to increase, it's been time now for us to begin re-recruiting these nurses. We have seen that, across the country, there's been a large decrease in the number of these travel contracts that are being renewed. That's helping us as we're working to re-recruit these nurses. We've also seen nurses now wanting to come back, now that they've either figured out the child care or they have other support. So, we really have done a good job re-recruiting.

I will say, as Mark mentioned, we do have some specific markets that are struggling with recruitment. We kind of tackle those on a market-by-market basis to look at, do we need to do market adjustments in pay; are there other things that we can do to recruit this personnel. On what we've seen that has been a little bit different for us is that, in our unlicensed staff – so those are our folks that are our housekeepers, our food and nutrition workers – that has been a little bit more of a struggle than historic. And a lot of that has been, I think, fear of the pandemic; some issues with child care; and in some of the states with the premium unemployment, it's made it difficult to recruit these employees. But again, we're seeing that start to subside state-by-state and we're doing a good job getting those folks re-recruited as well. So, the timing's been nice for us. As the volumes pick back up, we've been able to see ourselves regain these employees that had left during the peak of the pandemic.

<A – Mark Tarr – Encompass Health Corp.>: And we do think that there are a number of these factors that are pandemic-specific to nursing. You have nurses [ph] that would just say (00:23:34), they're just going to sit it out until the pandemic passes before they get back in the job market. I mean, there are certain things that we [ph] wouldn't (00:23:42) certainly expect to normalize with time; and in some of the markets, we are seeing it starting to normalize.

There was already a nursing shortage even before the pandemic, so this is just going to be exacerbate it. So some of these elements will pass and, once again, normalize out to pre-COVID patterns but we're being very aggressive in both our operating segments to make sure that we not only retain our staff but recruit the staff that we need to treat the patients that we have.

<Q – Andrew Mok – UBS>: You mentioned strong recruiting efforts within both segments. Is that a centralized effort or is each segment recruiting for their own discipline?

<A – Mark Tarr – Encompass Health Corp.>: So, we've put a lot of resources into adding centralized recruiting efforts; and that's one of the areas that we've seen benefit, particularly the hospitals this year. Home health does as well, so it's really twofold. One, we have a centralized effort on it but then there's also that local strategy, too, that the local facilities have to be able to respond to those that show an interest and have to have a good reputation in the local market. But we've added resources in a pretty material way here in the home office in Birmingham to help support the hospitals, not only the ongoing hospitals but we have all this de novo growth that we're bringing on at the same time. So, we knew that we had to have more firepower to staff the new hospitals coming on-line.

<Q – Andrew Mok – UBS>: Got it. That's helpful. Wanted to switch gears to some of the virtual platforms that you're highlighting this year. One of those initiatives is the home health virtual visit platform with national payers. Can you elaborate on the genesis of that pilot and what you're hoping to learn or build on from that?

<A – Mark Tarr – Encompass Health Corp.>: I think that was the virtual application there or telemedicine or – we have looked at and continue to try varying technologies as they help benefit our caregivers in the marketplaces and, ultimately, the patients. We will continue to be in the forefront of that. We've not seen anything that has a dramatic impact on that yet, or even with the telemedicine in terms of payers willing to provide a mechanism for payment on that yet. But we do think that there is certainly some benefit from technologies. You look and see what we do with Medalogix, and using that to work with our clinicians in the field to make sure they are as efficient and as effective with the patients as they can be. So, we'd like to think that we are in the forefront of technology and utilize it where it makes sense and can benefit either to help make us more efficient or benefit in terms of increasing the outcome for patients.

<Q – Andrew Mok – UBS>: Got it. And whether it's virtual or physical, there's been a higher number of clinicians across the care continuum trying to establish touch points in the home. Does that impact your business or ability to deliver care in anyway?

<A – Mark Tarr – Encompass Health Corp.>: If anything, I think it enhances it. I mean, ideally, you're going to have technology that can't really replace that face-to-face visit with a patient from a one-to-one standpoint, but it can complement a caregiver and it can complement the overall care providing – being provided to a patient. I think that people are looking for technology to substitute for that hands-on approach from a caregiver to a patient, and that's just not what we're seeing right now. It's not a full substitution. It can be a complement, but it's not a full substitution for a face-to-face visit.

<Q – Andrew Mok – UBS>: Got it. Let's shift to the inpatient rehab business. Directionally, you've communicated that the mix shift impact from returning elective procedures will likely drive moderating acuity in your IRF segment, but you've also commented that acuity may be re-based higher longer term. How do you see this playing out over the next 18 months? Do you ultimately think that your CMI will settle higher than pre-pandemic levels?

<A – Mark Tarr – Encompass Health Corp.>: Barb, you want to weigh in on that?

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Sure. So, I think there are a couple of driving factors here. One, obviously, as our number of COVID cases have decreased in the hospitals, those patients came with a very high acuity. Many of those have – had spent weeks, sometimes months, on a ventilator so they came at a really high acuity. So, as we see that patient population trend down, that impacts the CMI. But also, as you mentioned, as the electives come back, the electives will dilute the higher CMI because they tend to come in at a lower acuity.

I do think, though, that we will see probably a little bit higher CMI maybe as our Medicare Advantage patient population continues to grow, because while we are selling our value proposition to MA they do tend to send us the higher acuity patients. So, that is having an impact on our CMI and I think that will continue to have an impact. So some things weighing down on it but some things that I think, certainly, are having an impact and then have it be little bit higher.

<A – Mark Tarr – Encompass Health Corp.>: Andrew, I think the pandemic gave an opportunity to – that really showed that not all post-acute settings are created equal when it comes to their ability to handle a challenging higher acuity patient. I'm very proud of the results that both our rehab hospitals and our home health segment were able to get. We treated COVID patients from the very start. We already had a reputation for being able to do a really good job with higher acuity patients.

I think that, clearly, we showed that during 2020 and continue to show that in our work with COVID patients.

And I think that has clearly provided an extra amount of goodwill for our referral sources in terms of our ability to work collaboratively with them, to be there and help them last year when they were trying to work patients and free up beds in the ICUs, in the med/surg force for the COVID surge. And so, I think that we showed that we can handle high acuity patients which will carry-over and have, what they refer to as, that stickiness into the future years and from a reputational standpoint.

<Q – Andrew Mok – UBS>: Got it. You mentioned that strong MA growth. Stroke and neurological diagnostic categories have contributed to that growth. What other patient categories may be under penetrated today that could see higher uptake from MA plans?

<A – Barb Jacobsmeyer – Encompass Health Corp.>: I would say, historically, many hospitals sent hip fracture patients to skilled nursing facilities, mainly because they don't tend to need the speech component but they need the physical and occupational therapy. But what we've seen during the pandemic is these patients reluctant to go to skilled nursing facilities. And so, we've been able to bring more of those patients to the IRF. And with that, now, we're able to show the outcomes for these patients – the better ability of being able to get them home, [ph] and let them (00:31:38) stay home. So, I think that's definitely a diagnosis that we're going to continue to focus on.

<Q – Andrew Mok – UBS>: Got it. And then, on the payment side, the spread between fee-for-service and MA has narrowed over the last decade and is now around 7% to 8%. What have been the key drivers to narrow that payment spread and do you think there's more room to narrow that further?

<A – Mark Tarr – Encompass Health Corp.>: I think as we – we've worked with the payers now on the value proposition for a number of years, and we've also worked with the payers on the contract. So now, we have – I believe, it's 83% of the contracts with MA providers are based on CMG versus a per diem rate. So, we've – quite frankly, it kind of goes back to our quality outcomes and our ability to show the value proposition, and they've been willing to move these contracts to a CMG basis versus that lower per diem rate.

<Q – Andrew Mok – UBS>: Got it. And in connection with higher MA revenues, bad debt expense has also increased. Is the higher bad debt expense purely a function of that higher MA revenue or collection's down within the same-store book of business whether it's plan design or economic impact from the crisis?

<A – Doug Coltharp – Encompass Health Corp.>: It's predominantly the latter, Andrew. What we've seen is that many Medicare Advantage plans have been modifying their plans to increase the level of responsibility for the patients deeper into their care continuum. And so, the existence of co-pays or higher deductibles [ph] that was there (00:33:16) before. And in many instances, particularly given the patients that we're dealing with, just the age of the patients, the fact so many of them come to us with some degree of cognitive impairment, there's confusion about what their level of responsibility is.

I will also say, from our perspective, administratively, we just haven't been accustomed to having to make those collection efforts at the frontend when a patient is admitted so it hasn't been an area of focus for us. We're looking at ways that we can appropriately revise those procedures right now. We want to be very careful about how we do that. First of all, even with the uptick in bad debt and we don't want to leave any money that were due on the table, it hasn't been significant and we're just very sensitive to the needs of our patients and the trauma that they are experiencing and their families are experiencing when they're suffering from a malady that ultimately lands them in one of our facilities.

<Q – Andrew Mok – UBS>: Is that higher of cost share a trend you're seeing across your M&A book or is that more specific or narrow to a few plan designs?

<A – Doug Coltharp – Encompass Health Corp.>: I would say there's a consistency to it.

<Q – Andrew Mok – UBS>: Okay. That's helpful. Well, we are at the – past the 30-minute mark. I do want to make sure we get to audience questions. It does not appear that there are any audience questions at the moment. I will give some time for members to submit questions.

In the meantime, let's shift back to M&A and development. On the de novo side, you've called out the supply demand in equilibrium on the IRF side in the past. Given that imbalance and the population growth of the 75-plus age cohort, should we expect to see continued de novo openings within the upper half of your 6 to 10 target range over the next few years.

<A – Doug Coltharp – Encompass Health Corp.>: It could have some fluctuations within that range just based on timing from year-to-year, so I would continue to use the range. But certainly, for the next couple of years, we're looking to be north of the upper half of – with 12 already announced for next year, we're above the outer bound.

<Q – Andrew Mok – UBS>: And what are your criteria for building de novos from a market and financial perspective?

<A – Doug Coltharp – Encompass Health Corp.>: It's pretty sophisticated model we have to assess the viability of the model or of the market. It looks at things like the critical mass of Medicare beneficiaries and the anticipated CAGR of the Medicare beneficiary population. It looks at the number of acute care beds that are serving that market and what level of CMS-13 discharges they currently have. And ultimately, the conversion of those CMS-13 discharges into IRF beds versus some other post-acute situation. We look at the payer mix in the market and the experience we've had with the non-fee-for-service payers; and we look at the composition of the physician base in that market, particularly the presence of PMRs who are going to be more familiar with the specific offering of a rehab facility; and also just the ownership of – structure of those physician groups.

All of those things get put into the market analysis with regard to a financial return. On a per-project basis, we're looking for a 13% pre-tax IRR. I will say that, in almost all instances, we're constructing a facility usually in that 40- to 50-bed single bed or single occupancy room structure but we're acquiring enough land on the frontend to accommodate future bed expansions. And it is pretty typical when we see a bed expansion because we're leveraging components of the infrastructure into a market where we know the demand already exists, that we'd see a return on that incremental capital that would be in the 35% to 40% range.

<A – Mark Tarr – Encompass Health Corp.>: Andrew, as Doug said, it's a sophisticated model but we've done this enough times now over the years where we've been able to refine that model. We know what criteria seem to carry the most weight in evaluating a marketplace, including whether we go to loan or whether we should JV with a partner in there, which has been a very successful business model for us for now over 30 years.

<A – Doug Coltharp – Encompass Health Corp.>: And, for instance, if you look at Florida, it looks like we moved very quickly because we did but we were fully-prepared for that. We had been anticipating for a number of years that there was going to be some liberalization of the CON provisions in Florida. It just didn't make sense given the rising demand in that marketplace. And so, we had already done very thorough market analyses, and had prioritized the markets that we would want to go into were there to be any kind of lifting of the restrictions around the CON. That positioned us to move very quickly and, I think, to achieve a first-mover status in many of those target markets.

<Q – Andrew Mok – UBS>: Right. And can you remind us what the profitability curve looks like for these de novos?

<A – Doug Coltharp – Encompass Health Corp.>: We'll typically see – and it vary a little bit based on the market with the most significant component being the payer mix. But we will typically see a de novo hospital become four-wall positive EBITDA within the first 6 to 12 months and with that – the midpoint of that being – probably being the sweet spot.

<Q – Andrew Mok – UBS>: Got it. Okay. And then, moving on to broader M&A. Hospice makes up about 20% of revenues in your home health and hospice segment. Within that business, do you have a long term target mix between home health and hospice?

<A – Doug Coltharp – Encompass Health Corp.>: No, the – we do – if you look over the last several years, based on a higher organic growth rate, based on the composition of the more significant M&A transactions we've been doing, those have been slightly more heavily-weighted towards hospice. And so, hospice is increasing as a percentage of revenue within our home health and hospice segment. We don't have a target level that we want to achieve. We're going to be opportunistic about how we grow both of those franchises from an M&A perspective. I do think the organic rate is going to remain higher for hospice for the foreseeable future. Within the home health business, we continue to prioritize establishing more overlap markets with our IRF business as well.

<Q – Andrew Mok – UBS>: And are there any additional capabilities you like to add to complement the home care business?

<A – Doug Coltharp – Encompass Health Corp.>: We're keeping our – an eye on what's happening with regard to [ph] those (00:40:00) personal services. And at some point in time, we think that Medicare and other payers are going to recognize the value that may be had in palliative services. But right now, we don't feel like the compensation structure for either of those two service lines is sufficient for us to devote capital to them; and we want to continue to focus within home health and hospice on clinical services.

<Q – Andrew Mok – UBS>: Got it. That's helpful. Let's check back in with the audience questions. We do have one question here. What percentage of your home health referrals come from SNFs and assisted living facilities? Can you comment on the contribution of those facilities to your overall home health referrals and volumes?

<A – Mark Tarr – Encompass Health Corp.>: Historically, that number is about 15% to 20% of our admissions, between the ALFs and the SNFs.

<A – Doug Coltharp – Encompass Health Corp.>: And there wouldn't really be any margin differential between those that we'd see on a patient [ph] coming from (00:40:58) anywhere else. There's not really a significant difference in terms of the nursing therapy ratio around the patients that we're seeing in those facilities.

<Q – Andrew Mok – UBS>: Okay. Well, I'm seeing no more questions. And if that's the case, let's end it there.

Andrew Mok, Analyst, UBS

I want to thank Mark, Doug, Barb and Crissy for all joining today. And please enjoy the rest of the conference.

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

Thanks for having us, Andrew.

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

Thank you.

Andrew Mok, Analyst, UBS

Thank you.

corrected transcript