MANAGEMENT DISCUSSION SECTION

Frank George Morgan, Analyst, RBC Capital Markets LLC

I'm Frank Morgan, the Healthcare Services and Managed Care Analyst at RBC. And our first presenters today will be Encompass Health. We have CEO, Mark Tarr; CFO, Doug Coltharp; and we also have – I want to say hello to Crissy. Welcome to all of the crew.

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QUESTION AND ANSWER SECTION

<Q – Frank Morgan – RBC Capital Markets LLC>: And I guess, as we start today, I'd like to – before getting really any details here, we're just hoping to get a little bit of color around your strategic review process. I know you've said you will give us an update next quarter, but I was just curious could you provide us an update – certainly, you got news from April Anthony's announced plans to retire and to leave the company, but I guess my question would be, does this in any way this – his departure in any way change their strategic options available to the company?

<A>: Yeah. Well – good morning, Frank, and thanks for having us. And the answer to your first question is, no. April's departure does not impact the options that we have with the strategic review. We – as you note, we have said that we are well into the process. We certainly plan on providing an update as part of our Q2 earnings call. So we continue to make progress and happy where we are right now, as a whole in that process.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. And I know other news you recently posted an 8-K that included a update on the operating trends and I was hoping we can walk through some of those. I noticed the comparisons obviously year-over-year are kind of goofy because of where you were, your comp from last year. But maybe when you're looking at a more normalized basis, maybe can you give us assessment of where you see that the inpatient rehab discharges and how those look relative to plan?

<A>: Yeah. So, Frank, overall, very pleased with what we see in terms of the momentum around our volumes. And as we noted on our Q1 earnings call, we had commented then on the momentum we had in March and so that came over into Q2. I would attribute the volume momentum [indiscernible] 00:02:16 to a number of things. One, we're clearly seeing a significant reduction in the number of COVID patients. For us, you may recall that we had stated we had had as high as 30 hospitals at the height of COVID that had caps on volume because we had either so many patients in isolation and some in private rooms that we couldn't use the full capacity. Or we had a number of staff out to the point where we were limited on staff and capabilities and that to cap volume.

So as of this last week, we're down to two hospitals that had any type of caps on volumes. We're starting to see a more – what I would consider to be a more normalized referral patterns coming from the acute care hospitals. We're starting to see more elective procedures start back in many markets which will benefit both our hospitals and our home health segment. And so, we're starting to see what I would consider to be a more normalized cycle, which is to me it's also indicative that the general population is becoming more confident in accessing health care, which is good for us all.

<Q>: Got you. And you touched on home healthcare only on the hospital side. But I think you're released also said no real significant recovery yet on the senior – either the [indiscernible] 00:03:52 or the outside. So, any color there? Any thoughts around kind of why there's a delay in seeing the recovery that you're already starting to see on the hospital side?

<A>: Well, the good news is, we're starting to get access back to the [indiscernible] 00:04:07 and skilled nursing facilities. I think the challenge there has been their volumes have been down. We are starting to see that triple back up. That is not at the same recovery that we've seen the acute care hospitals. The good news is that our sales and marketing teams have redirected their efforts and, as we noted, we had 3,000 new referral sources in the first quarter. So, they are going out and reaching out to the new – to the patients and physician offices or surgery centers and other areas that our patient needs.

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<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. So, just sort [indiscernible] 00:04:51 though in terms of recovery. [indiscernible] 00:04:54 home health second, and then hospice third. Is that a fair way to think about it?

<A>: I guess that's fair.

<A>: I'd probably flip hospice and home health. Hospice never took that big of setback. It had more of a change in the length of stay there and that's been normalizing. But from an admissions or an ADC volume, hospice really didn't take that much of a setback. So, the greater recovery is – needs to happen within home health.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. And I guess that was going to my follow-up question. When you – when I think about the guidance, you know, you updated in that – to reflect when you reported the results in the first quarter, you updated to reflect basically [ph] the beat 00:05:36 in the quarter and then the extension of that relief from sequestration. So, I guess, that was going to be my question, was hospice what we're waiting on to see showing signs of recovery, but it sounds like maybe we should be looking at home health care before you might have a reason to rethink guidance. Everything else, you know, continue to trend as is. So, home help is what we need to watch closer.

<A>: It was really, Frank, trying to determine whether some of the trends that we witnessed in Q1 were going to extend all the way through Q2. Because you may recall when we issued our original guidance at the beginning of the year, we had assumed that there would be a pretty significant recovery across all three business lines in the second half. So, that degree of recovery is already built in.

<Q – Frank Morgan – RBC Capital Markets LLC>: Okay.

<A>: And, of course, then when we incorporated the Q1 results, you got the benefit of those trends and really the only update that was not included there beyond the extension of sequestration suspension was the trend line in Q2.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. Okay. Well, maybe we'll go a little more division-specific here at a high level. How do you feel overall about the regulatory and reimbursement backdrop environment and maybe the update to the PPS seems to have updates in the system. Last year seemed to go without any answers or without any financial fallout. So, maybe just your expectations around the [indiscernible] 00:07:14 from a regulatory and reimbursement standpoint?

<A>: Yeah. So, Frank, I think that really the regulatory front in both segments is – could be termed as being stable. I think what CMS is doing, what they're still doing with the [ph] PHE 00:07:29 and if you look at the proposed rule that came out for [indiscernible] 00:07:33 that was pretty much as expected, market basket of 2.2%, everything else, the language within the rule pretty much dealt with just some technical areas. There was no mention of the [indiscernible] 00:07:50 choice demonstration. So I would definitely term the regulatory environment as being stable right now.

<Q>: Got you. And I know, when you – certainly, when you get your guidance, there does seem to be this focus on an acceleration of development activity really. You've seen it this year and next. So I'm curious when you – when you look at your portfolio, look at the organic growth opportunities, what's driving this – what do you see as the biggest opportunity to accelerate the development at the [indiscernible] 00:08:26 strategy?

<A>: Yeah, Frank – we're very excited about the pipeline that we've got now for both this year and next year. And what's driving is really you get this demographic tailwind, and you've got an increasing need for rural tailored services at the same time that the total number of facilities has

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been pretty stable across the US but the demand has increased. So we think we're well-positioned to take advantage of the increased needs a demographic tailwind.

Then you have the state of Florida which has – I've always see a land which as you know, that's a state that we've had 12 hospitals, legacy hospitals there. So we, for years, we've said what if we didn't have to deal with the CON in the state of Florida? Where would we like to either add beds to existing hospitals or what would be the potential to have new markets where we build de novos? And we have pursued in state of Florida [indiscernible] 00:09:29. We've gone very aggressive, being first to market.

And so whether it's the state of Florida or the other states where we've announced de novo hospitals, we've got eight coming on for this year, we've announced 12 for next year. So I'd say we're very excited about the pipeline for new growth opportunities.

<A>: I would say, Frank, also the – to add to that, one of the things we had rank also the [indiscernible] 00:09:51 one of the things that we hadn't counted on when we began increasing the amount of development activity we have in your sector was the fact that during the pandemic, we believe the differential in services between SNFs and IRFs has been extensively very positive way to the IRFs. I mean, that's going to drive more patient volume our way. And if you think about it on a national basis even before the pandemic starts and you just took it as an indicator of what the total addressable market for IRFs is there is out there only about 15% of CMS eligible – CMS 13 eligible discharges coming out of acute care hospitals in this country are winding up going into an IRF setting.

And so even if upon further review, some of those CMS 13 patients aren't appropriate for the IRF setting, more than 15% are. So, just clearly an unmet need out there across the country. And we think we're well positioned in terms of our free cash flow and our capital position as well as our operating expertise to be able to fill in that void.

<Q>: That's an interesting comment, an interesting fact. But I'm curious beyond the pandemic what else does it take to change. I mean, that seems like a massively under penetrated part of the market. And is -do you feel like that that's the case in the markets where you actually already think you're that underpenetrated or you think that this is more of a representative nationally?

<A>: I think that's a national figure. I think it has a lot to do with two things. One is Mark stated, if you look at these [indiscernible] 00:11:43 in the US for about a 10-year period from 2008 to 2018, it was relatively flat. As a matter of fact it may even have been down 1%. And yet, during that time, I think the age population, over 80, 65 grew something like 35% to 40%. So, it had a growing disparity between supply and demand. The incidence of the conditions that are treated in the IRF pay proportional within that over-65 population.

The second reason that conversion rate into IRF is so low is because you've still got many, many markets in this country that don't have an IRF offering at all. So, when it's not available, those patients are going to go to another setting. And that's why you see us adding beds in places like North Dakota and in Idaho and so forth, some less-populated areas than you might think of but still with a critical mass of Medicare-eligible beneficiaries to provide us the good occupancy levels.

<A>: Right. We've talked for a number of years now in terms of our ability to handle higher acuity patients, and be able to take a patient that may be medically complex that other rehab providers, other post Q providers would not take. And then comes the pandemic, which reiterates even more our ability to do a great job with a higher acuity patient.

So, I think that that really positions us well either in new markets or existing markets where you have the confidence of the acute care hospitals in terms of working directly with us and our

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willingness to take patients that they otherwise have not considered for rehabilitation and we can get those patients back home.

And so, Frank, we'll see many instances when we decide to put a de novo in a market where the historical conversion rate of the CMS-13 patients into an IRF setting has been in the low-single digits. By getting in there with one of our hospitals and educating the discharge planners discharge planners in the acute care hospitals by educating the physicians in that market and by educating the payers who serve that market about our specific clinical outcomes. We're able to drive that conversion rate substantially higher typically close to 20%.

<Q>: That's interesting. Does it – I know some companies have used the JV model as sort of as a way to partner with that local hospital system. It sounds like that the market is so under penetrated there. I mean, is that really a necessity? Is that just something you use in very unique circumstances?

<A>: No. We've gone out – third of our portfolio are joint venture arrangements with acute care hospital systems. As a matter of fact, our first JV was right there in your lone city of Nashville [indiscernible] 00:14:36. That was over 30 years ago. So we accessed each new de novo opportunity, each market as to whether strategically it's something that we should go in and partner with a predominant system within there, or is it something that we are comfortable and think it's sort of advantage to go in as the sole owner. And then we've also had markets where we'll go in to sole owner and then eventually partner with an acute care hospital system in that marketplace.

So, we set all these markets as whether we should partner or not partner. And very proud to say we've never had a partnership unwind in the 30-plus years we'd use that as a business model.

<Q>: Well, that's interesting.

<A>: Those JV arrangements usually come about one of two ways. Many times we'll look at a market that we think is attractive and is underserved from an IRF perspective. But there is an IRF unit within an acute care hospital that services that market and is running at some level of low productivity. And so, we can create a win-win by approaching that partner and saying we'll build a brand-new free-standing de novo on or approximate
to your campus.

You can get an in-kind equity stake in that new facility by essentially contributing to your unit, by contributing those licensed beds and the ADC and then you can, with a relatively low capital cost, reconvert those beds within your unit to more traditional medical and surgical purposes, which are more productive for you and still have a presence at post-acute, albeit with a better operator. So that's one model.

Second is, we're going to a market where an acute care hospital, very high-quality acute care hospital has no presence in the IRF space, but they have an interest in being more proactive in post-acute space. And so, they'll make a cash contribution to buy an equity stake in our facility that creates a good referral relationship.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. It's interesting, with these great growth – with the growth potential in this sector you are starting to see other people talk about post-acute, so I'm curious who do you see out there like for example in Florida where there's the COEN being 00:17:01 a lot of rules being changed there? And I that HCA here in Nashville has talked about their intent to develop some IRF assets and I think they called out Florida. So, are you seeing other people come into the market, other IRF operators or are you seeing more interest from hospitals getting more active?

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<A>: No. It's – we think it's been a big [indiscernible] 00:17:22 be first to market and be very aggressive about going in and buying real estate and announcing our presence. Yes. HCA has announced that they are looking at either adding or expanding units in the the state of Florida. We expected that. We compete or work with HCA and other marketplaces where we still get referrals in some other hospitals that have rehab units, that maybe at add capacity. But we've not seen a large number of people enter the State of Florida, we have some – there are some one-offs that are out there, that announced a [indiscernible] 00:17:58 government opportunities. But we would fully expect that there could be others, but we're very confident in our ability to go in and compete effectively and take market share away from those that may be in the marketplace.

<A>: And Frank, recall that getting into the IRF business is capital intensive proposition. And so, when we're talking particularly – depending on the market in Florida, where land can be quite expensive, the total capital investment for a 50 bed, all private room, in-patient facility can run $35 million to $40 million. And so, in addition to the capital investment, you've got to have the operating expertise. And there aren't a lot of providers and/or private equity funded businesses that are running around with a combination of both the available capital and the operating expertise.

HCA is a bit of an anomaly, not too many HCAs out there and they're in a lot of business lines. So, even as they increase their position and prosecutes specifically the IRF space, it's not really going to make a dent in the overall marketplace.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. Maybe we'll switch gears a little bit here and talk about your M&A strategy, that you seem to be taking a bigger interest in that area, having signed a contract with United and, I think, you called out some of the numbers. So, I'm curious, maybe if you could provide us a little bit more color on that strategy, on the IRF side. And then maybe also on the home healthcare side.

<A>: Well, for IRF, you've heard us talk for a number of years now, about how we take our guided proposition, which essentially are the outcomes that we go out to the regional medical directors from these innate plans or Out to the regional medical directors needs to make plans or the regional authorities that are helping to consider the [indiscernible] 00:19:48 request and show our outcomes and show that we can provide patients with the opportunity to get back home and have a lower occurrence of readmission back to our hospitals. So ultimately, it's a lower cost per episode of care. And that's been – we've had nice success with that. You've seen our growth in our overall innate discharges particularly with stroke. But then as we've seen the success we've had with that with our outcomes, that's also expanded then into other diagnostic categories, meaning those that may have a neuro basis. And once again, we think that's also the pandemic has given us an opportunity to increase our relationships with the innate plan. So the proposition definitely gained traction with innate payers for IRFs.

On home health, we've been very discerning in terms of which contracts we've worked with and signed. We didn't want to just chase low paying volume. We wanted to make sure that strategically, we were working with payers that had a sense of the value for the quality that we can provide. And we felt that's the case with United. Clearly, we have a short history with them. The contract went into effect in February. So we've got a few months.

We've have been happy with the volume we've seen from it. And we think that strategically, it's going to be beneficial. But we want to make sure that we are not chasing contracts where the innate payers themselves just view home health as a commodity but have some recognition of the value of where it plays relative to quality and care for the patient. I think that's a fact. You've seen some of the payers get involved with home health there, you got Humana, for instance. So, clearly, the payers are starting to recognize the value of home health and the role it can play not only in the quality of the outcomes but overall cost of care with patients.

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<Q>: And the contract terms there. Are you getting with United – is that an episodic payment model or is that a per diem?

<A>: It's per visit.

<Q>: I'm sorry [indiscernible] 00:22:14. That's on the home healthcare side and the IRF side as well?

<A>: On the IRF side, we're now at – 83% of our contracts are based upon [ph] CMG 00:22:23. So, there's about a 7% discount on the innate plans to the Medicare fee for service, which we've significantly closed the gap on that over the years.

<A>: And, Frank, just a point of clarification, the United contract that we announced several months ago, that national contract is [indiscernible] 00:22:41 the home health services only.

<Q>: Okay.

<A>: The IRF business, we do a lot of business on the IRF side. With United, it's not subject to a national contract. The rates are negotiated on a regional basis.

<Q>: Got you. Thanks for the clarification there. I guess one of the side effects of this is that with the MA, I noticed in the most recent quarter you referenced the bad debts being a little bit higher, and I think you attributed to the MA side with copays and deductibles. So, is that something that you would view as sort of an isolated event, or is that something that we should watch as a potential trend?

<A>: Well, to put it in context, our bad debt rate picked up about 10 basis points, so it was not overly significant. It is reflective of the fact that we have more MA patients coming through and that those MAs have different – those MA patients have different payment plans than certainly our service patients and they have different payment plans and different responsibilities [ph] for deductibles 00:23:48 and co-pays than they had in prior years. And so, our admissions teams have not been really set out to go through the process of making sure they're collecting what's due at the outset.

There are some things that we can do administratively that we believe will address that. We also want to be careful, you probably saw some of the articles that came out recently on community, in some other community health, some of their collection efforts. We're not opining this to whether or not those were appropriate or not appropriate. But there's a sensitivity particularly in this environment about getting too aggressive in trying to collect some of those payments. So, we'll be very prudent about any revisions we made to our operating procedures there.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. We're very close to the end of our time. So, maybe just one last quick one. As it relates to labor, really, you know, sort of the hours of contract labor and the rates on contract staffing certainly have been a major topic through the pandemic. Maybe talk to us about some of your experiences today and what the effect from an utilization and then from an actual rate there is and where you see those trends now.

<A>: So, Frank, we had our operators in this week and we had a chance to get their updates in terms of what they're seeing in the marketplaces. And clearly, the post-pandemic here there are a number of factors going on, some of them which will normalize out, I think, with time. We're already starting to see some of that. But what we're seeing on labor is particularly tied on nursing. It is more of a market-by-market versus a national trend. We've seen it being a little bit more of a challenge on the home health side than we have on the IRF side. But those segments are really focused on retention.

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We have aggressive recruitment efforts going to build open physicians. You've seen a number of markets with nursing in the years – particularly with the pandemic last year. Nurses have just – they're setting it out right now and waiting until after the pandemic to get back in the marketplace.

You've seen other markets where they've seen a migration out because nurses went to other areas and traveling programs where they got paid a significant premium to go to markets that had a surging COVID incidence. And now, they're coming back because those contracts are no longer available to them.

So, yes, right now, we're paying a premium for contract labor. And we had – some the markets are already starting to see that come back down a little bit, in terms of what they're paying per hour for contract labor. But it's got our attention. We're focused on it, in both of our operating sites.

Frank George Morgan, Analyst, RBC Capital Markets LLC

Okay. Thank you very much, Mark, and Doug and Crissy.

Unverified Participant

All right.

Frank George Morgan, Analyst, RBC Capital Markets LLC

Thank you, all, for being with us today. And that concludes this fireside chat. Everyone, have a great day.

Unverified Participant

Thanks for having us, Frank.

Frank George Morgan, Analyst, RBC Capital Markets LLC

Bye. Take care.

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