Encompass Health Investor Day - September 27th 2023

Mark Miller:

Good morning. I'm Mark Miller, Encompass Health's Chief Investor Relations Officer. Before we begin, three quick notes. In the brochure in front of you on page two, there's the wifi information. On page four, there's a QR code for you to submit questions through. You can submit questions at any point during the presentations and we'll get to them during the Q&A session at the end. Any questions we don't get to, you can follow up with me afterwards. Finally, the forward-looking statements throughout the day. Today, we'll be making forward-looking statements. We encourage you to read the cautionary statements on this slide as well as the risk factors on our Form 10-K for the year ended 2022, Form 10-Q for the quarter ended March 31st, 2023. The Form 10-Q for the quarter ended June 30th, 2023, and in other documents Encompass Health has filed and will file. With that, I will turn it over to Mark Tarr.

Mark J. Tarr:

Well, good morning everyone and welcome to the Encompass Health Investor Day. It's great to have you here either in person. We also have a group that is joining this virtually, so we appreciate you being involved with it today. We have a busy schedule today from an agenda standpoint. We also have a lot of information that we're excited to present to you and management team that is excited to be part of it. So let's dive right in today. We're going to start with where we are year to date performance, and for the most part it's been a growth story for us this year. As you can see, we've grown discharges 9.6%. Big chunk of that was same store. We've had volume help to drive the revenue growth of 10.6% and adjusted EBITDA of 22.3%. So we're just three days from the end of Q3, but what I can say is that we've been very pleased with the volume trends that we've seen thus far.

Also, I would like to remind you that we are facing tougher comps in the second half of this year than what we faced in the first half of this year, so please bear in mind. From the regulatory front, many of you may be aware that the Medicare Review Choice Demonstration model or the RCD was to take place last month, August 21st to be exact. We are seeing some encouraging results from that so far. As of September 10th, we've submitted 440 records resulting in an affirmation rate above 95%. So it's still on, but so far we're seeing encouraging results. We are certainly benefiting from an improved operating environment thus far, but I think it's important to note that the results that you're seeing here just don't come by chance. They don't come through some linked with serendipity, but they are directly linked to execution on key strategic

initiatives. Investments over many years have provided us with important sustainable competitive advantages that benefit our patients referral sources and our payers.

A few examples of those investments that we have made since 2009, good example of that would be our clinical and information technology. A big part of that was our investment and commitment and collaboration with Oracle Cerner in developing clinical information system, develop a system that is specific to what we do in an inpatient rehabilitation hospital versus a department within an acute care hospital. What that's allowed us to do is develop large data sets collected from literally hundreds of thousands of discharges now. It's allowed us to develop clinical best practices, predictive models that minimize the chance or likelihood for acute care transfers. You also hear how it has benefited our reduction in terms of patient falls.

It's also helped us with our overall clinical outcomes as we look at our clinical outcomes specifically tied to discharge status, what percentage of our patients are able to go back home, back to the community? What percentage of patients have we been able to reduce that otherwise might've gone back to acute care hospital for a readmission? Or what percentage of patients did we have to send back to a skilled nursing facility? All those outcomes we're seeing very favorable results and historical highs.

This information also has allowed us to build best practices from an efficiency standpoint with our staffing and our management teams, and you'll hear more from our operators today in terms of how they've been able to apply some of these systems and benefit from that standardization. Second area of investment would be what you see for the de novo and bed expansions. We've invested over $1.8 billion now since 2009 in that. Clearly the de novo program has been a big part of our ability to expand capacity, provide us with an opportunity to grow. We first started the de novo program slowly. We developed our best practices using data that would help us identify what markets would have the best results.

We also started to identify ways in terms of our building design and building materials that we could standardize into a prototype across our platform. Since 2009, we've not only invested $1.8 billion, but we've opened 51 hospitals adding 1200 beds to existing hospitals and generating favorable returns. Most recently, you may have heard us referred to the prefabrication effort for our hospitals and we're proud to say that we're now building hospital in the Texas Medical Center down in Houston that will be 100% prefabrication. It helps us to get speed to market as well as contain our costs from a construction standpoint.

Another area that has contributed to our success is the culture of continuous improvement. It helps us to identify problems and solve those problems. A good example of that is how we responded to Medicare Advantage. 10 years ago, Medicare Advantage was only 8% of our payer mix and had an average payment of 30% discount to Medicare Fee-For-Service. Over time, 50% of our contracts were on per diem basis at that point. We recognized that MA enrollment was growing faster than traditional Medicare, so we began the initiative to increase parity in the rates by demonstrating our value proposition to the payers. We've now been able to work with MA plans to move to CMG or episodic rates and now have 88% of our contracts are on CMG basis and we've narrowed that discount to 6%. You can also see it in our recruitment and retention efforts. 2021, we decided to centralize the recruitment process, particularly for nursing for our company.

That whole centralized town acquisition invested in the recruiters and we've seen it in the results and our ability to recruit nurses. Let me give you an idea about what we've been able to do. So in Q3 2021 through Q2 2023, we had 895 net same-store RN hires in addition to the 730 RN hires for our new de novo hospitals. An emphasis on our buyer operators on retention has driven turnover of RNs down to 22.9%, which really takes us back to a pre-pandemic level. It's also lower than the industry benchmarks. This focus on recruitment and retention has enabled us to lower our utilization of contract labor going from a peak of Q1 of 2022 with 706 FTEs representing 2.9% of our total FTEs to Q2 2023 level of 476 contract labor FTEs or 1.8% of our total FTEs.

Now let's focus on financial results and growth is surrounded by a strong culture of compliance supported by well-defined policies and procedures. We have the benefit of scale and systems and expertise necessary to adjust to every regulatory and reimbursement change that faces our industry. We maintain a comprehensive ethics and compliance program where policies, procedures, and training promote a speak up culture. We think our initial success in responding to RCD as one of the many examples that illustrate the quality of our compliance programs. We're very excited about the growing demand for our services and our opportunity to fulfill that need.

You can see here the demand due to the aging population has some very significant trends facing us. This benefit comes from the continued fact that as the aging population of our age cohort, which is 76 with our average age patient, continues to expand the need or likelihood for an individual to need inpatient rehabilitation grows. Since January 2011, 10,000 people per day have turned 65 in the US and that's expected to continue for the next decade. You can see here in the graph in 2010 there were 39 million or 13% of the population were 65 plus. In 2020, that number was 55 million or 17% of the population. In 2030, 73 million or 21% of the population are 65 plus. During that same time period, 2010 to 2022, the number of IRFs has only grown by net 18 facilities during the same time period that we built 50 new de novos. There is a significant unmet need for rehabilitation qualifying patients. You can see here only 13% of the patients in acute care hospitals that have an approved diagnostic category for rehabilitation actually make it to a rehab hospital. So there's a significant unmet need.

We've developed important and sustainable competitive advantages deliberately assembled over time, supported with significant capital investment and further enhanced by our scale and expertise. These advantages include a deep bench of highly experienced senior leadership. Today we want you to have a chance for you to hear from that team. I got the team over here on the left. I think you'll see that the breadth and depth of this team and their experience is considerable. When we leave here today, we hope you have further understanding of factors that differentiate us from our peers and enhance confidence in the durability of our business model, the central tenets of our strategy. First, add capacity through de novos and bed additions to meet this growing demand, which should provide high quality outcomes in a cost-effective manner that generates strong returns for our shareholders.

We're going to start with a deeper dive into our de novo initiative, and it's clearly adding capacity has been a big part of our growth story, particularly the last three years when we've accelerated the number of de novos that we've been building and bringing online. So we want to give you additional insight to that with the next three speakers. We're going to start out with Doug Coltharp, who's going to talk a little bit about the financial returns. You're going to hear from

Melanie Lewis in terms of how we go about identifying a marketplace and how that has transitioned over time. Then you're going to hear from Tom Boyle just in terms of our design and construction efforts, our standardization of our prototype building, and also more about this prefabrication and how it helps us to have speed to market and bring on additional beds or de novos faster than what we could see our competitors. So with that, Doug.

Douglas E. Coltharp:

Thanks Mark, and good morning everyone. It's really great to be here today. It's no secret, and Mark has hit on this in his comments that the de novo growth is a really important part of our investment strategy right now. And what I'd like to do is just spend a little time talking about that evolution from when we restarted the de novo program in 2009 to the current state of it. And in doing so, I want to give you a sense not only as to the history of our development of the processes surrounding our de novo investment, but hopefully to give you a greater understanding of what gives us confidence in the sustainability of this program and the confidence to continue to invest at the elevated levels that you've witnessed for the last couple of years. I'm going to touch on some of those aspects and then I'm going to turn it over as Mark just suggested to my colleagues, Melanie and Tom, to go a little bit deeper into some of the facets of that program that you don't normally hear a lot about.

Melanie's going to speak specifically to the analytics and the processes that we've developed to analyze and prioritize markets, and Tom's going to give you a lot more information about the process enhancements we've developed around the design and construction process, and how those have been effective in combating some of the increases that we've seen in the cost of building our facilities over the last couple of years. I've got to remember along the way to advance my slides, which I've done. So as Mark suggested, since 2009, we've opened up 51 de novos, which set in the context of the industry is really quite remarkable. And we started slowly. So the program began in 2009 when we opened a single facility in Mesa, Arizona, and at this point I'd ask you, please don't panic, I'm not going to go year by year from 2009 until 2023.

Between 2009 and 2016, we opened up 14 facilities. So we were moving along and averaging one to two per year, and we deliberately started slowly and starting slowly allowed us to ascend a learning curve and on a small scale to begin to invest resources in many of the capabilities and the support areas that are required to support a de novo program. And those resources are distinct from what is required to operate existing hospitals. They have to be very complimentary, there's a lot of overlap between those skill sets, but they are distinct and so we started building dedicated resources to support the specific de novo activity. As we moved into 2016 and we were constantly looking back at the investments we had made, we were able to validate that the de novos that we had opened from 2009 to 2016 were generating a return that was well in excess of our average cost of capital.

And so in response to that, we began to gradually increase our investment activity. We opened between two to four hospitals per year from 2017 to 2020, so a total of 14 hospitals over those four years. And as we did so, we were now benefiting from the refinements that we were making to all of those processes. We also now were better understanding what specific metrics or characteristics of a given market were necessary to support a new IRF and how those correlated

to the success of our existing hospitals. We were getting a lot smarter about what kind of market density for instance was required and what other important attributes of a market needed to be present to enhance our probability of success. Those of you who have followed our company for a long time know that one of the real attributes of our business model is that we generate on a consistent basis high levels of free cashflow.

We have always complimented that by maintaining access to attractive sources of outside capital, and put together those two things allow us to fund the investment in capacity expansions. And so knowing we had that capacity and looking at what was the convergence over an extended period of time, and Mark alluded to this in some of his remarks of the supply and demand for IRF's services, we identified an opportunity to accelerate the investment in our capacity expansions and specifically into the de novo program even further. Along the way, another important element of the strategy is we identified through our experience that we were capable of opening new hospitals successfully, either as a JV or wholly owned. There was a period of time kind of in the middle of that timeframe that I just laid out for you where we'd be reticent to go into a brand new market.

By brand new market, I mean one that wasn't relatively proximate to an existing hospital. We'd be a little reticent to go into one of those markets without a strong relationship with a referral source. And the strongest relationship that you can get with a referral source is through a joint venture relationship. But we developed confidence over time in being able to say, "If we build it, they will come." And you see many instances right now where we actually will plan a flag and maybe even proceed with a wholly owned opening only to subsequently invite a joint venture partner in. I think I'm not keeping up with my slides here. Oh, I bypassed that. So on our last investor day, which many of you remember was March 4th, 2020, we announced a new target of six to 10 de novo openings per year. Of course, just weeks later, we all found ourselves in the middle of a pandemic. In response to the pandemic and a highly uncertain market, we found that many of our competitors began to pull back or pause their investment activity. And so we spent time as a management team and then convened with our board thought, should we still be committed to this six to 10 per year? Do we need to take a pause as well?

Ultimately, we felt like we could get a first mover advantage, and we felt confident enough in the resilience and the sustainability of our business model that we pressed forward continuing on that track of accelerating our investment to six to 10 de novos per year. Now, it's important to note that not withstanding the decision to press forward with that higher level of investment, when we received unsolicited more than $240 million of care relief funds, we sent it all back. We didn't keep a dollar of it, and we were the first of our peers to do that.

When we spoke to you back in March of 2020 about our plans to accelerate the de novo pipeline, one of the factors that we alluded to was the expectation that the CON regulations in Florida were going to be changed, and were in fact going to go away for building of IRFs, and our development pipeline over the last couple of years has benefited from the change in Florida's CON. You may recall that specifically back in March of 2020, we mentioned that we had already in anticipation of that deregulation, we had identified and prioritized 15 markets for de novo activity in the state of Florida alone. Since the revocation of the Florida CON requirements, we've opened seven new hospitals in that state and we have an additional seven that are announced and are anticipated to open by 2027, so we're really hitting that mark on that initial 15.

But it's really important to note that Florida's not the only place that is attractive for de novo development, nor is it the only place that we're building de novos. We are successfully opening de novos across the US. Our enthusiasm for continuing the de novo strategy, and I hope that's coming across in my comments this morning, is supported both by our track record of success and our perception of a national market for IRF services that remains significantly underserved. And you're going to hear us talk a lot through the course of the day. Mark started it, I'm going to reinforce it, you're going to hear from others about this divergence in supply and demand that really has been perpetuating for more than a decade. We estimate now that only approximately 13% of presumptively IRF eligible discharges coming out of acute care hospitals in the US on an annual basis are finding their way into an IRF bed.

At the same time, underlying demographic growth and the disintermediation of medically complex patients out of the SNF setting is going to continue to fuel demand for IRF services. Now, our primary barometer for measuring the success of our de novo investments is the achievement of what we refer to as stabilized ROIC, exceeding our weighted average cost of capital. So for us, stabilized ROIC is looking at the ROIC. The facility is generating in its third year of operation, and we seek for that to be above our weighted average cost of capital. The mature ROIC that is demonstrated by our de novos tends to be meaningfully higher than stabilized. So there's both a time element and a magnitude element that we're talking about in this specific metric. You're all finance people, so you know that weighted average cost of capital changes over time based on market conditions, based on company specific conditions as well. But for us, there've been kinds of puts and takes so that our WAC has been relatively stable at approximately 8% over the last several years.

If we look at these returns in a couple of different cohorts, starting with from 2009 to 2020 where we built 31 freestanding de novos, those 31 de novos in aggregate generated an ROIC of 19.2% in 2022. Now, that return did benefit from post-opening bed editions at 16 of those hospitals. And of course, you've heard us talk many times before about the fact that bed additions can be added to de novo hospitals as an important part of our overall investment strategy because it tends to turbo boost the returns.

Let's look at a different cohort. In 2021 and 2022, we opened an additional 16 freestanding de novos. Now these hospitals are still in ramp up mode, and for the most part, they do not yet include the benefit of any bed additions. Look first at the 2021 de novo cohort, and that cohort had a Q2 2023 trailing 12 month ROIC of 11%, already exceeding WAC by a pretty good margin with most of that cohort having less than two years, two full years of operation. The 2022 de novo cohort is projected to deliver ROIC well in excess of WAC in its year three as well.

Over the past several years, we have experienced some pressures on both the numerator and the denominator of the ROIC equation. The numerator pressure has stemmed predominantly from the increased cost of clinical labor. The denominator pressure is owed to higher construction costs that have been fueled by supply chain constraints and also by construction labor shortages. We believe that these pressures on both the numerator and the denominator have stabilized more recently and we're actually starting to see signs of abatement. But as we've dealt with these increased costs on both sides of the equation, we have not accepted these pressures passively. Instead of responded with enhanced processes to contain costs, speed our entry to market and accelerate our ramp up following reopening, we've increased the initial bed count over de Novos and the larger footprint creates leverage on the core infrastructure and staffing of the hospital,

thus serving as a partial mitigant to the higher cost. The de novo hospitals built between 2018 and 2020 had an average bed count of 42.

Our de novos opened and planned for 2023 through 2026, have an average bed count of 48. We've also moved to more modular construction. Prefabrication increases our speed to market, which accelerates our cashflow and aids returns on investment. And Tom's going to go into this in greater detail in just a moment. We expect that these strategies and our culture of continuous improvement will help drive strong returns on both the most recent and the future de novos. And so far the evidence that we are seeing is confirming of that assumption. We are very proud of how our teams have performed on constructing and opening de novos under challenging circumstances, and we continue to be excited about the substantial opportunity that is before us. And now I'm going to turn it over to our Chief Business Development Officer, Melanie Lewis.

Melanie Lewis:

Thank you, Doug, and good morning everyone. My name is Melanie Lewis, and I have been with Encompass Health, hard to believe, but 20 years. I have the great honor of serving as Senior Vice President and Chief Business Development Officer. Today I'm going to tell you a little bit about how we do things in business development, and I want to start by letting you know that our business development team leads our efforts in opening the six to 10 hospitals per year. We are very focused on first identifying and then prioritizing our opportunities nationwide and we work very closely with our business analytics team. Once identified, the development department is responsible for really coordinating the whole process. We are very lucky to have the ability to work with all of our many other departments, such as operations and treasury, regulatory, legal, real estate, design and construction and it really takes a comprehensive team to ensure success.

So as you've heard from both Mark and Doug before, Encompass Health is a data-driven company. And in business development we use a custom-built data-driven metrics-based model and ranking system that incorporates highly correlated metrics to existing successful Encompass Health hospitals. So in other words, what that means is we can use our own data to identify new markets that have similar characteristics to our existing successful Encompass Health hospitals. I think Doug may have mentioned that since 2009, we have opened 51 hospitals. I believe our largest competitor, I believe they have approximately 41 total hospitals. So we have over a decade of experience in opening successful hospitals. And when you do all of that, you have a lot of intellectual capital and a lot of data.

As you can imagine, there are a large number of factors to consider when we identify a new de novo market, and some of those factors are listed on this slide. First of all, we have to look at demographics and we have to look at the 65 plus population, the critical mass, and the growth of that population. We have to look at the existing conditions, the acute care hospitals, the size, number, and type of those hospitals, and also the types of patients that they're treating, the acuity level and the conditions that are discharged out of those hospitals. We have to be concerned about regulatory requirements. Does the market require certificate of need and how long do we anticipate that might take? We have to look at

Melanie Lewis:

... At the availability of suitable real estate, and the cost of that real estate. And then we have to look at the building site itself. Is it suitable for building one of our hospitals? We have to look at the competitors that might be there. Is there an acute care hospital that operates a rehab unit? Are there other rehab hospitals that are in the market? And we also have to look at potential joint venture partners. Is it a market where we would like to have a joint venture partner? Do we need a joint venture partner? And who might be available for that purpose?

Continuing on with our technology theme, as we've talked about, Encompass Health is a technology-enabled and data-driven company. We use both internal and external sources of data. We use our own hospitals, as I've discussed, to look at the many metrics that we have with our internal hospitals. We also have our operations team on the ground nationally, and so we get a lot of intel from the operations team and input. We also use external data sources. Largely, we use the Medicare claims and cost report data. We use all of the available resources to us, such as Advisory Board, Claritas, FORVIS, Definitive, a large number of those. But I think the important thing is that we take both our internal and our external data to combine that for meaningful metrics that we can use to rank and sort our different markets of opportunities.

So this is a really high level of how we approach our development process. We started out with our existing Encompass Health hospitals, and we started out with a regression analysis to identify the most highly correlated metrics. Then we developed an algorithm, and we applied those metrics first to a CBSA, which is a very high level look. CBSA stands for core based statistical area. And it's very similar to an MSA, but I'll tell you a little bit more about that in a minute. So what the algorithm is able to do for us, it's able to sort and rank markets in a variety of different ways, and it's going to lead us to the best opportunity at this high level, at the CBSA level. Once we have those priority CBSAs, then we're able to take a more granular look. We're able to break it down into a service area analysis.

Then we go and we meet with our regional presidents and our operational leaders, and we discuss our targeted markets and what our data has shown us. We get their input on what they feel about the market and any other intel they may have about the market. And then we decide how to prioritize those within their region, and it enters the development approval process.

So back to the CBSA. The CBSA is a government ... It's used by the US Office of Management and Budget, and it includes one or more urbanized counties within a metropolitan and a micropolitan area. So a metropolitan area is one that has more than 50,000 people living in it, and a micropolitan area is one that has at least 10,000, but less than 50,000. So the idea is that you've got a core population that's within the city and the surrounding area that is just the economic center of that area.

So this gives you a little bit more of an example of what I'm talking about. On the left there, you see the Atlanta CBSA. As you can imagine, that is a very large area. It would not be realistic to have one inpatient rehabilitation hospital that could serve that entire area, especially with the traffic patterns that we all know in the South to be true for Atlanta. So we look at breaking that CBSA down to the service area analysis. This is what you see in the orange. And if you look at the small box there on the bottom of that, you can see where that service area fits into the CBSA.

So Atlanta could have 10 to 15, or even more, inpatient rehabilitation hospitals in that service area, or in that city.

So back to the metrics, we use our internal and our external metrics, as we've discussed. And what this does for us, it enables us to be able to calculate what is the real need for inpatient rehab in this area, and then what is the unmet demand that is still available in that area. And that helps us when we look to size our hospitals.

I must warn you that the development pipeline is a very dynamic process, and it can change pretty easily over time. We have to back into the goal that we set. And that we tell you all that we're going to open six to 10 hospitals per year ... Well, we have to back into that to make sure that we actually hit that. So you may or may not be accurate in your guessing of when you might get that CON, or if you're going to get that CON.

Tom is going to tell you a little bit about construction, but along the way, we have weather delays, or there are unexpected conditions that we find on our site that can cause a delay. So it's a very dynamic process. And then Doug mentioned Florida. Another thing that can change is the regulatory environment. So we were well underway building our pipeline when Florida decided to eliminate their Certificate of Need. And so then we had to completely regroup and focus on Florida, because when an announcement like that comes out, everybody is heading to Florida. So it was very important for us to get there in a timely manner. So that rearranged our pipeline a little bit to prioritize the Florida projects, and then we were able to backfill with the other projects that we had in the works to plan.

So just keep in mind, we will hit our goals, but it is a dynamic process and it can change over time. So with that, I want to introduce my friend, Tom Boyle.

Thomas Boyle:

Thank you, Melanie. Good morning. My name is Tom Boyle, and I'm the chief design and construction officer at Encompass Health. And we do have a number of slides to go through today. But I want to start first with, before we get to it, is that when we say design and construction, I know instantly what comes to mind is like, "Oh, you guys build things." Well, we kind of don't view ourselves that way. We view ourselves is that we take the clinical ideas and the best practices and provide an environment for our care teams to be able to do their jobs. And that's difficult. You've got a myriad of different constraints, from regulatory, just building materials, sourcing, a myriad of different things that come together for us.

And so when we look at what it means to provide a design and construction space, it can be in various different formats. As you see the list up on screen, we have de novos that we do. We do bed additions. We have finish upgrade projects. We have infrastructure projects. And those are all going on simultaneously throughout the calendar year. We try to target de novos to open between the shoulder season, so to speak, because obviously our higher census is during the winter months. And so we try to plan accordingly, so that we either turn over in the springtime or we turn over in the fall and early winter.

But if we take a look at the tributes that make up an actual building, we're trying to provide this environment for healing. We've got people that obviously are immobile, and they need to be mobile. There's all different types of surfaces that we want to train for. People want to have a normal sense of mobility as much as possible, to be able to walk, to be able to get around, to be able to drive. And so trying to provide for that is what we feel like is our core strength, and trying to listen to clinical operations. And ultimately, that helps us as far as on discharges, for patients to go back home again.

And so then you wonder, "Okay, this continuous improvement process, how does that happen?" And it happens various different ways. There's always the informal ... Hey, you realize this doesn't work, and we need to change that. And then also there's a yearly update that we try to do, in that we go back to all of our previous class projects and really evaluate them. And we try to tear them down from the standpoint of how was it managed, what was our timing, what did turnover look like?

And over the last few years, we've developed processes to be better and better and better. We call it our keys to building success. And what it attempts to do is bridge that gap between when a construction project is finishing and when operations are taking back up. It's not like you just walk out one day and hire 100 people, and then they just start to work. Obviously, there's a ramp up period. And so part of the challenge on the design and construction side, again, it's not just building something. It's trying to facilitate an opening of a building. So we're very proud of our plan to check at ... Cycle of trying to go through and make things better and better and better. And in that way, just enhances the next project that we turn over.

What you see here is actually a prototype of our new 60-bed hospital. Mark mentioned it earlier, in Houston, Texas. You can see the core, the middle, the larger area. That's the chassis. That's where we like to say that the true care happens. That's where our therapy treatment area is located. It's where the dining and kitchen is located. We've got pharmacy, obviously the nursing support space. And then what radiates out from there is our patient wings. And in those patient wings, we've got centralized nurse stations that actually act as hubs for the nursing staff to not have to go clear across the building. They can stay right there. They can go out to the various patient rooms and be able to tend to patients. And then also there's day rooms in those areas as well, so that it is providing a number of different areas to provide patient care.

And then you'll see out back, where there's a future bed expansion, we've strategically placed these zones of expansion. And even though not every site is exactly the same, how we've tried to orient the buildings is you can flip it, and you can rotate it to where we're not having to redesign a whole entire hospital to be custom. That's the whole thing that takes additional time and effort, is creating this bespoke solution. And what we've determined over this last almost decade and a half is that we've got core treatment areas, we've got patient rooms, and then we've got a therapy treatment area. So trying to be flexible in our site selection, obviously, is important, but at the same hand too, we want to be able to plan for future growth. The one area that I would say that is part of the two-pronged approach to design and construction is actually facility upgrades and infrastructure projects. And that doesn't sometimes get a lot of the big billing when you think about, "Well, what are you doing for your existing buildings?" But we've tried to take another systematic approach like we have on our de novos, to go back into existing facilities, evaluate them.

If you think about this, we've got a hospital that's ... The oldest one is 100 years old in Worcester, Massachusetts, and our newest one is in Columbus, Georgia, that's just a few weeks old. So a 100-year span of time, and 160 hospitals, effectively, or 159 hospitals. There's some challenges there. And so what we try to do is work with the eight regional teams, and then further with all the CEOs, and actually develop a pick list or a batch list of projects that we want upgrade, that comes from replacing air handling units, replacing windows, roofs, finishes. I mean, you name it. Obviously, there's always a need out in the field.

So trying to evaluate these, year after year, and try to plan ahead, that also helps us from an overall procurement strategy in that we're able to group together vendors across the US that are doing like projects, so that we can get the benefits of aggregated buys. Similar to what we're doing from a de novo standpoint or from a bed addition standpoint, where we're specifying the same materials. We're working with manufacturers that are national firms that have a footprint of distributorship, so that we can get floor tile in Arizona that's the same floor tile that we get in Pennsylvania.

So we're proud of the inroads that we've made with these firms. And also what it allows us to do is just say, "Hey, if we've got this complement of projects that we're doing every year, we've got our six to 10 de novo, we've got half a dozen bed additions," and we can come up with that dollar demand, then that helps them from their manufacturing standpoint of, "Hey, we know that there's a consistent flow of buying from Encompass Health."

And so obviously, it's huge in trying to be able to overcome some of these supply chain issues that Doug and Mark mentioned about during the 2020 to 2022 time range, of labor issues, of material issues. And yet, we still were able to deliver. And a lot of our peers had challenges with that. And we're super proud of the fact that ... By keeping those relationships with manufacturers, we're able to get not essentially to the front of the line, but we were real time with information. And we knew the who, what, when, where, why, and how, and the reasons behind it. It wasn't just a third-party pass off. And so being able to have that kind of visibility helps us in predicting when a hospital is going to be able to be open, when a bed addition is about ready to be open.

So moving forward over the next few years, in these challenging times of costs going up ... Obviously, a price per bed, that makes it even more important that we're not the Johnny-come-lately, and we're trying to figure this out. We've been working on this for the last few years, and figuring out, "Okay, how can we abate these rising escalation costs?" If you look at the last ... I think it's the last 15 years for us, as far as what our cost structure is, there's a tick around four-and-a-half to 5% per year. That's been increasing. From 2020 to now, it's almost doubled that, and is by evidence of the slide here.

So part of the time and effort in 2020 and 2021 was trying to develop ... Okay, what techniques can we use to overcome it? And prefabrication started standing out as the top of the list, because it had a predictive material cost and a predictable labor cost. And to be able to aggregate that together and figure out, again, from the standardization front, what are our key elements that we like to use over and over and over again, it actually became apparent that the start was a bathroom, of all places.

And so if you look at the picture on that left-hand side, that's a picture of a manufacturing plant manufacturing bathrooms. And those are our bathrooms. And they're fully ADA accessible.

They're tile bathrooms, as far as floors and walls. You're able to be able to access the showers, just is an easy roll-in shower. And there's a solid surface sink. And everything that would compliment what you would find at an acute care hospital. And in some ways, it's actually enhanced better, because every single bathroom is ADA accessible, and it is large and you can get a wheelchair in there, and staff are able to be able to shower each of our patients every day.

And so we also determined, though, that it was actually a time constraint on building a building. Tile work takes a long time to do. And so what we were noticing is that we didn't have permanent power on our hospitals while we were setting tile. So then the quality of the work, once you turn the lights on, wasn't good. And so by switching to a prefabricated bathroom, we're able to get that consistency we're looking for. Now we're not, in a sense, stuck with waiting on tile showers to effectively open up a hospital, and allowed us to aggregate, once again, our demand. So if we look at the 2020, 2021, and 2022, and you add up all those patient rooms, and what we could start to do, it started to tell, for us, a map of ... Hey, there's a path forward here that we could roll this out across multiple projects.

So if you look at the map of the US, and I know some of the coloring is a little hard to pick up, but effectively, long story short, we've got 23 hospitals over the last couple of years that we've used some form of prefabrication, whether that was a bathroom or a headwall or exterior wall panels, or it's been a bed addition, such is the case of Katy, Texas, Montgomery, Alabama. And those projects are the ones that we were pushing forward to get into another frontier, which is basically a whole hospital.

So of course, you got to go slow to go fast. We started with the bed addition. So this is Katy, Texas, this picture right here. This was a 20-bed addition that we did back in 2022. And for all intents and purposes, it looks just like the hospital that was originally constructed. We'll call it a conventional model. And from a time standpoint, we ended up turning this bed addition over two months sooner than we would a conventional project approach.

And then again, where we want to go in the future, is, again, a whole hospital. So Houston's the first one, like Mark mentioned. We actually got a building permit on that on Friday this last week. And so we're going to be starting earnestly on that project. There is approximately 113 main components that go into that building. And you think, "Okay, it's close to a 75,000-square-foot building, 113 components. How is that?" Well, we'll see here in this video, these are big chunks of building, where you've got an exterior wall, you've got a roof, you've got a floor, you've got whole patient rooms, you've got a corridor, and all the mechanical, electrical, plumbing systems are running above ceiling. And it's a tight package to be able to deliver what we're trying to do.

So with that, we'll go to the video. This is just a drone shot that goes through the plant, which is in Bessemer, Alabama. BLOX is the name, and what they do is modular construction. They work for several large companies across the US, for not only Encompass Health. But here's, actually, the shots we took of the Katy project being installed. So you've got 20 patient rooms, and two patient rooms to each module. So you got 10 modules that were landed in there. And it took approximately ... I think it was eight to 10 hours to set all of these. And then the interesting part to all this is once you set them, then you have to stitch them together ... Is the unofficial word that we use, which means essentially sealing up the exterior, and then actually putting the floor down between the rooms.

And so where all this comes into play is that ... How can we deliver better, smarter, faster, cheaper? And this is an avenue to do it. We've got a quality model associated with it, that it all has to be manufactured there. I mean, the last thing you want to do is actually have to build something in the field. That costs more money. And so having everything planned out, yes, it takes a little more time on the front end as far as from a planning effort, but once we've got this whole hospital design, Houston, we're able to replicate that across the board.

So even though you have some jurisdictional changes, we've effectively engineered in our variation of what we need, if we need to do a 50-bed hospital or if we need to do a 40-bed hospital. So I mean, it really makes us nimble and be able to deliver the buildings in a systematic way, in a shorter amount of time than you would in a conventional build.

So this is a rough graphic here of time. If you look at the top bar, that's conventional construction. So overall, if you hone in on the middle bar there, 14 months is about our average time to build a building. And then with some prefabricated elements, the exterior walls, the bathrooms, the headwalls, we were able to cut that time down to about 12 months. And then where the next frontier is obviously the whole hospital. We want to cut it down to nine months.

So if you go from start to finish, it ends up being almost a 33% reduction in time, from a conventional construction to a full prefab. And obviously, everyone's going to be waiting with a bated breath on how Houston goes, but we've got a good plan put together. And we've got, actually, half of the modules are already constructed. We've got them wrapped and ready to go. So from the procurement standpoint, we're not going to have any issues there. I think our biggest limitation is weather. Coming into a little bit of the rainy season there, starting up site work, we're there in the med center. But we're looking forward to it, and we're going to see some great things come out of it.

This is just a few different advantages or benefits of prefab, just to reiterate the standardization piece, the speed to market piece. Safety's huge. I mean, one of the things that, on a conventional build ... And I was telling someone earlier this week. We did a job site visit, and there's still safety issues. People still walk up ladders. That's actually an OSHA violation, believe it or not. And there's fall protection issues.

And so having it in a manufactured setting, it helps basically the whole equation work from the standpoint of reduction of healthcare bills, as far as that end up coming through from a manufacturer, from a subcontractor, that eventually ... They get passed along to us as the owner. So we're trying to mitigate all that we can and remove all the variation effectively out of the equation because, again, we're delivering one thing, which is rehabilitation care. And with that, Mark, I'm going to turn it over to you. Thank you.

Mark J. Tarr:

All right, thank you. So in case you're worrying about the structural integrity of the prefabrication process, we did have the opportunity to see that firsthand last year. We had newly built hospitals in Naples and Cape Coral, Florida, which were right in line with the Cat 5 hurricane that came through there with Fort Myers, and those two hospitals came through

without a hitch. So we definitely think the prefabrication is a competitive advantage for us, in terms of not only the speed, the market, but there are many other opportunities to take advantage of that.

So next step is clinical innovation. Clinical innovation is a priority for our organization. There's a longstanding, existing collaborative effort between our IT group, which is headed up by our CIO, Rusty Yeager, and our lead clinical staff headed up by Elissa Charbonneau, our chief medical officer, and our vice presidents of therapy and nursing, Cheryl Miller and Mary Ellen Hatch. When you look at the use of data that's driven by our clinical information and how we're using that to move forward predictive analytics and other aspects that benefit our patients and the outcomes that we can achieve, I think you'll find it is, once again, yet another thing that sets us apart. So with that, let me welcome the team.

Rusty Yeager:

And thank you guys all for spending a little time with us today to reflect on the wonderful things that we have done together as a team, and with our operations team here to support our caregivers and their patients. It's been an incredible journey. And I think I'm maybe the baby on the stage here. I've been 22 years at Encompass Health, and everybody else is probably higher than that.

I want to talk about a few things today. Our strategy, how we do it, some of our systems, and then predictive analytics. And then Dr. Charbonneau will take predictive analytics to the next level. So our digital health strategy leverages our clinical expertise. We've talked about the people on the stage that have been with the company for a long time. We also have 50 people in clinical IT that are concentrated on clinical IT to support the caregivers. Many of them came out of our hospitals and actually learned IT. So that is a really compelling situation, because they understand the workflows they're implementing.

We also have developed large post- acute datasets. We've been putting in our clinical system since 2010. So we've developed a vast trove of post-acute data that we can use to better our patient care. We also depend on our business and clinical partners. You may have heard of Oracle and Cerner. We were partners with both companies. Now, we're partners with one company. And we see compelling things coming out of that. Also, we work with Microsoft and Nuance for voice recognition. We have proven capabilities in Enterprise EMR, data integration and data analytics and predictive analytics.

So this is an important slide to us. We've been talking about standardization and how it really enables these processes. So the first thing we do when we're thinking about a system implementation is make sure we've got a standard process. You can't automate something that's not standard. And when I mean standard, I'm talking standard across 159 hospitals. So when we put the system in, it works the same way everywhere, and we get the same data out. So once we automate that, we get data at scale, and we get the ability to scale. So when we started talking about doing six to 10 hospitals a year, wasn't a problem for us, because we'd been putting this clinical information system in 20 times a year previously. So that's where the standardization comes in.

Now, once you have the standardization, you get the data, what do you have the opportunity to do? You have the opportunity to process improve. And when you process improve, how do you get it out? We've got a single workflow system that is consistent across all hospitals, and then we can push that process improvement out.

So think about a regulatory change. When we get a regulatory change in, we work with operational teams, and we reflect on what do we need to do to put in the system. We test it and we put it out. Everybody gets it 7:00 on a Tuesday morning, for example. They've been trained on it and it's in the workflow. Because it's in the workflow, what else do we get? We get data at scale. The data's coming back. Are we compliant? Do we need to change the workflow? Anything? So it is really in our muscle memory when we go out and put a system in. Standardize the process, and then we get the things we need out of it.

So let's talk about our EMR. Mark mentioned it earlier. Back in 2009, you may remember the HITECH Act as part of the ARRA, which is incentivizing acute care hospitals to put in electronic medical records. And so at that time, we were pretty much on paper. But we reflected. We get 90% of our patients from acute care hospital that are getting incentivized for interoperability and using these things. Maybe that's something we should invest in. And we had looked at them before, but we weren't really sure the time was right. So we re-looked at them, and most of the vendors came back with ... Let's call it an acute care light system. But Cerner came to us and said, "We've worked with the Rehab Institute of Chicago, and we're interested in rehabilitation." So we selected Cerner, and we rolled out our first hospital in June of 2010. That was a de novo hospital. Then we went to one other de novo hospital.

And then in August of 2011, we went into our first existing hospital, that had been with the company for over 30 years. That's where we learned. And we spent several months learning with them, standardizing that process. Once we got that process standardized, then we started rolling. We did 20 hospitals a year for five years. And then as we started to grow, we continued that on.

Another system that we have that is truly unique to us, because we built it, is our digital patient journey. So our field marketing teams are managed by a customer relationship management system from Microsoft, but we've customized it to fit our particular workflow, because this workflow is different than most other CRM systems. So our leadership team can reflect on everything that those field marketing folks are doing at scale, from the individual contributor to the hospital, to the region, and all the way at the top. Mark probably looks at it every day. And so that's the compelling thing of standardized data all the way through.

So when it's time to do the patient referral, our patient referral team members have an iPad application that we built, that is reflective of giving the independent physician the reflection of the patient condition so that they can make an independent decision on the need to admit this patient or not. So once that's completed, it goes electronically to the physician. They review the data on the pre-screen as well as other contributing data, and they have the opportunity to accept the patient, deny the patient, or ask for more information, all within that process. If the patient is admitted, all that data we collected goes right into the systems, the EMR system, the patient revenue cycle system, and all of that. And then we also have automated forms. So we're truly digital through that process.

So Beacon ... You may have heard us talk about this over the years. What is Beacon? It's a big data thing. So we've been collecting data since 2004 in our data warehouse. And this is our data visualization of all the data that is coming in from all these systems, with metrics that have been designed by our operational teams, and they can run their business with these data elements. So a truly compelling management platform that, again, we built. And it works specifically for our particular workflows.

Now let's talk predictive modeling. Early on in our EMR journey, I reflected with other folks that, "Man, we're really starting to collect some data.

Rusty Yeager:

... what can we approve on? And someone said, "It'd be really neat if we could lower the acute care transfer level." So I thought, well, we got plenty of data. Cerner has some data scientists, let's take a look at it. So in 2015 we took a look at that problem. We identified 30 factors that contribute to that problem, and we rolled out a predictive algorithm for acute care transfer. And Dr. Charbonneau is going to spend much more time on that. And the one challenge that we had was how do we visualize the data so we could see everything. So a physician or a caregiver wants to know why, the why in these type of things. And so we hooked Beacon into ACE IT so that we could give the caregivers all the information they needed to reflect on that predictive algorithm. So with that, I'd like to have Dr. Charbonneau take the stage and give us a little bit more on predictive algorithms.

Elissa Charbonneau:

Thank you, Rusty. My name is Elissa Charbonneau, I'm the Chief Medical Officer for Encompass Health. I'm thrilled to be back in my hometown, I'm a native New Yorker, to talk about some of our clinical initiatives and how we have been really fortunate in our ability to integrate our tremendous data that we have collected over the years to improve patient care and clinical outcomes. So I'm going to expand a little bit on the ReACT model that Rusty was talking about. And when we look at what is probably one of the worst things that can happen to a patient in a rehab hospital, they come from acute care, they've had some life altering illness or injury, and they finally get to a rehab hospital where they're looking forward to improving and hopefully getting home and improving their function. We don't want them to wind up back in the acute care hospital.

We don't want them to get sick or have something bad happen to them now that they finally got to rehab and they're working so hard with our therapist. So reducing the risk for patients to get transferred back to the emergency room and get admitted back to the acute care hospital is something that we, as clinicians, feel very passionate about. And our ReACT algorithm, basically what it does is it gives patients a ReACT risk score that is reflective of the risk that they may have to need to be acutely transferred back to the hospital. And using these variables and the information that the clinicians can access from the EMR, we hope that we can intervene and share best practices to reduce that risk and keep the patient in rehab where they can continue

their rehabilitation. And you can see on this slide how our acute care transfer rate has been trending nicely downward since we initiated our ReACT algorithm. So predictive models are tools. We know that we still need the clinical decision making of our people that work in our hospitals to use these tools to better improve patient care. And so in order to do that, as Rusty mentioned, you need to have this information convenient for the physicians and other clinicians in the hospitals to utilize. And so our very unique partnership between our clinical leaders and our IT folks is really, I think, what sets us apart and enables us to develop these kinds of forward facing data points so that our clinicians can come in the morning, they can look at ReACT risk for all of their patients, have a huddle, see who is trending in the wrong direction. And maybe as the physician coming into the hospital first thing in the morning, I want to look at those patients whose ReACT risk score has increased overnight and see what variables have led to that increased risk score. Maybe I need to check a lab or go look at the patient and see what's going on with that patient so that I can address these potential medical issues before they become problematic.

So basically our ReACT general workflow, as Rusty mentioned, this starts when the patient is admitted, the patient gets stratified, and these different risk variables that we look at contribute to the algorithm and contribute to the patient's score. And then the clinicians look at that ReACT display right there in the chart. They don't have to exit the patient chart and then go into another application, it's right there, it's convenient for them to use because doctors are not going to do that because we're too busy and we're not going to take the time to go out and open another application and then go back into the patient's chart. So we were able to really integrate this information and make it convenient and easy for the clinicians to follow up. And then not stopping there, we have the ability, because of again, our tremendous ability to look at our data retroactively, to go back and then analyze why were patients going out acutely and are there things that we can do to mitigate those issues and reduce that risk.

And it's one of the huge advantages of being at a company of this size, that we can help our hospitals all across the country by sharing best practices and things that we've learned from a kind of macro perspective through our clinical leadership. So it's really very exciting for us. Another area that we've looked at is what is the risk of patients who may get readmitted to the hospital after they're discharged from the rehab hospital? So our motto is, we want patients to go home and stay home. We want them to go home, stay healthy and stay out of the hospital again. Well, this readmission prevention program was looking at what variables contribute to the risk of patients winding up back in the hospital after they're discharged from the rehab hospital. And we looked at over 400,000 patient records and came up with 40 clinical features which give these patients a risk score of readmission risk after discharge.

And what this does is we discuss this at our weekly team conferences and through our communication in an interdisciplinary fashion which all of our patients get, and we are able to identify these variables that may contribute to this risk after discharge. And these are things that, you've heard terms like health equity or risk factors for patients such as food insecurity, transportation. Can patients get to their doctor office for their follow-up visits? Can they get their medications? Can they afford their medications? Do they understand their medications? We collect all of that information as we're evaluating the patient with us, discussing the patient in an interdisciplinary format. And then the case managers can intervene, looking at those risk variables and see what can we address, what can we take care of before we send the patient out the door so that we can mitigate that risk of readmission after discharge.

So far, it looks like our Medicare 30 day readmission rate for patients who were discharged from 2020 to 2021 declined by 40 basis points. That's based on Medicare claims data, which is, as you know, somewhat delayed. The last model that I want to talk about is our fall prevention model. So I said earlier, one of the worst things that can happen to a patient is that they have to go back to the acute care hospital. One reason that sometimes happens is that a patient may fall and injure themselves while they're in rehab. We know that all of our patients are at high risk for falls, that's the reason that they're in rehabilitation. And the assessment tool that was used for years and years and decades, and by the way, I started at our hospital in Portland, Maine, right out of residency in 1992, so 31 years.

And the tool that we used to evaluate patients for fall risk was really a tool that was meant for acute care hospitals. And when you have a tool that says 80% of your patients are at high risk of falls, that's not particularly helpful. So what we wanted to do was again, look at our own data that we have amassed and look at our falls and see why they have occurred and what risk variables contributed potentially to those falls. And so we have developed this fall prevention model in conjunction with the data scientists and our clinicians. Again, a very unique interplay, I would say, for post-acute providers to have that really close relationship to develop tools that the clinicians know are clinically relevant and can talk with the data scientists. And we can come to a mutual understanding even though we kind of talk to different languages in terms of looking at different variables that are something that we can understand and address.

So we have 50 clinical elements here that feed into our fall risk algorithm. And now when patients come in, we immediately identify all of them as high fall risk and we have certain things that we initiate at that time. And then once the clinicians have done their evaluation and have assessed the patient's balance, how they move, how they walk, how they transfer, that sort of thing, we individualize a fall risk program for them that's individualized to their specific circumstance. So it's not a one size fits all, it's very individualized and it's been really very successful. And as you can see here on my last slide, our fall prevention model has resulted in a significant, again, downward trend line in falls per 1,000 patient days, which is how that gets reported. And we're very, very proud of and happy for our patients that we've reduced their fall risk and injuries with falls during this period since we started the model.

So with that, we're very proud of our investment in technology and in how our people drive our clinical outcomes. And I'm very pleased to introduce Dr. Cheryl Miller, our vice president of therapy operations, who will discuss some of these therapy technologies further.

Cheryl Miller:

Thank you, Charbonneau. Good morning, I'm Dr. Cheryl Miller and I'm the vice president of therapy operations for Encompass Health. I've had the privilege of working for Encompass Health for nearly 40 years. I do lead nearly 10,000 therapists that are physical therapists, occupational therapists, and speech therapists nationwide. And I'm excited to show you today a little insight to what's happening in the therapy world in our hospitals. I do want to talk to you today about how we select technology innovations in our hospitals, the ones that we use in therapies. There's lots of new products on the market that are high-tech, and we're really focusing on the technologies that are proven to impact functional outcomes, prevent hospital

readmissions, and provide an excellent patient and caregiver experience at our hospital, that's our priority, because everybody wants to sell us some kind of technology.

So we're really challenged to select really good technologies that are innovative and science-based. So we look at a lot of evidence. We're often required to make these choices based on regulatory changes, advances in science, because that's being published every day, newly developed technologies or advancements in clinical practice. In this slide, you see the model that we use to strategically approach the selection of innovative technologies. We have three main elements we look at, it's a pretty simple model, but we do it very scientifically. First of all, we look at the data. You've heard a lot about the data that we have available to us to help us with these decisions. Secondly, we use our subject matter excerpts, which is really our best resource, our clinicians, our physicians that help us select technologies that will be beneficial to our patients. And finally, we use the science and the evidence. There's lots of research that's published. We are evidence-informed organizations. So what we do in therapies, I can speak to that, is very science driven. We look at the published research.

We also follow a very strategic process to implement these technologies. We've used this model for over 15 years at Encompass Health to really make well-informed, evidence-informed selections for the innovations that are in our hospitals. I'm not going to review this model in detail, but I want you to understand that it's a scientific workflow, we identify a gap or a need or maybe there's an advance in the technology, so we need to move forward. From this, we really approach it after the gap by assembling our subject matter experts, all of our therapists, our clinicians out there. We look at the research, we look at the data, then we develop a pilot. We don't go out and implement something in 159 hospitals and maybe it might fail. So we develop a pilot, we learn from that pilot, we look at the feasibility, we implement the change, and then we develop a plan for sustainability, because just to implement a change doesn't mean you could sustain it in an organization our size.

So this strategic innovations implementation model is what we use at Encompass Health to make sure that implementation is compliant, it's effective, it's safe, and most importantly, it's of quality. I'd like to introduce you to our Encompass Health Therapy Innovations Committee. This is a very longstanding committee that follows the model on the previous slide. They kind of guide us through that selection and adoption process. This committee has a mission to assess and select innovative technologies that we're going to adopt throughout our organization. The TIC, as we call it, uses a standard selection criteria to identify these innovative technologies that align with our company values. You see our company values around the room, you're going to see in the lunchroom, we take these values to heart, and again, we're looking at safe, effective state-of-the-art technologies. First and foremost, we assess the potential impact to our patients. We collect opinions from our clinicians, from our physicians, and then we assess the technologies within our own environments to make sure they're going to work within our environments.

So evidence suggests, I'll give you a little view into the clinical world, evidence suggests that the neurological networks of the brain, after you have a stroke or an injury to the brain, have the ability to reorganize after that injury. Science has proven this. So a lot of the innovations we use, we kind of focus on the ability to change the brain. You're going to hear me say that probably over and over. And what is required is numerous repetitions to change that brain, to change the pathways of the brain around what's been damaged. And it's kind of a crude description of it. And some studies have shown, many studies have shown that you require over 30,000 repetitions

to change the brain. That's a lot of repetitions that we as therapists are required to reproduce in an expected manner to change the brain.

So many of the technologies I'm going to show you, and you're going to see some cool videos and some photographs, but we really have looked at the science. Does it allow us to provide that number of repetitions to change the brain with a required intensity? So there's a certain dosage that's required that we're looking at. All these technologies are used or provided by a skilled licensed clinician, by a physical, occupational, or speech therapist. We don't just plug them in and play. So our patients number one goal is to often walk again. We ask them, "What's your goal?" "Walk again." They also want to go to the bathroom again, but walking is usually top of the list. So body weight supported gait training is a long studied and proven method that we use in therapy to help patients walk again. This overhead harness system offloads some of that weight, which makes it easier to walk.

I mean, if you're walking the pool and gravity lifts you up, it's easier to walk, so this kind of does that. It's a body weight supported system that can be maneuvered, that one can be maneuvered over different terrains, it's mobile, but it's a static support. So you set the amount of weight that's offloaded, it's static, you don't change it, but you can take them outside, you can take them over different terrain. So it's mobile, which we really like. This technology you're going to see as a more dynamic track based system. So it's a big track that goes overhead and it off lifts the patient's weight. And it's dynamic, which means if the patient's weight need changes like they trip and fall, they're going upstairs, that's a dynamic system, the amount of weight we offload can change.

So these technologies protect our patients, but besides providing body weight supported gait training, it can also protect our patients and therapists from falls. So if they do trip and fall, the device will catch them, they won't get injured in therapy. Our therapists won't try to catch them and they won't get injured. So it's a pretty beneficial technology on many levels. All of our Encompass Health hospitals have some form of body weight supported device available to them. Our De Novo's do get the overhead track system, but it does add value to the services our patients receive.

Dysphagia is a swallowing disorder, again, that's also very common with a neurological population. This is a very risky, high risk impairment. It's difficulty or discomfort while you're swallowing or drinking, and it commonly happens after a neurological injury. It is high risk because if not properly diagnosed and treated, it can lead to high risk complications because the fluid, instead of going into your stomach, will go into your lungs and it can cause complications and it can cause hospital readmissions and going back to acute, up to and including death. So it's a pretty high risk impairment that we spend a lot of time on. As an added value, we at Encompass Health look at a lot of interventions and technologies. This is an instrumental assessment tool for dysphagia that we've adopted recently, and it's an endoscope basically, it's a disposable endoscope that allows us to look at the swallowing mechanisms. The reason we adopted this technology is that because the endoscopes require high level disinfection, it provides a high risk to our patients during that assessment process.

So this technology offers a disposable endoscope, so we're not putting the patient at risk for infection during the test. It also allows our physicians, we do this onsite, so it allows our physicians to make a more accurate and timely diagnosis of dysphagia, again, reducing the risk

to our patients. There's other technologies. These are just some of them, that we use to treat oral motor and dysphagia impairments or swallowing disorders. They offer electrical stimulation and biofeedback, some other really engaging activities for our patients because therapy gets a little boring. We want to engage our patients and keep them interested. They have to do 30,000 repetitions, we better keep them interested. So evidence suggests that these technologies, again, add value to the service we provide and reduce the patients at risk for dysphagia. This technology is a computer-based interactive touchscreen. Think about a really big iPad or cell phone, we all love those activities, they're very engaging.

They're science-driven kind of gaming, I'll understate it, but it promotes cognitive processing, memory, critical thinking, balance. You can see the patient's kind of in front of a touchscreen doing balance and cognitive activities at once, which improves motor and cognitive processing. And these are common impairments after a stroke or a brain injury or some type of neurological injury. So in the video, you're going to see here the woman's performing an activity to improve cognitive processing and flexibility. She's kind of touching A, B, C, D all over the screen. She's scanning the screen. These cognitive skills correlate in research with patient's ability to perform executive functioning, and I'll go as high as driving. If patients want to learn to walk again, the second thing they want to do is go to the bathroom, but then it's going to be driving. They always want to return to driving, which is a little bit frightening.

These types of interactive technologies keep our patients engaged again, in their therapies, allow us to provide the multiple repetitions they need to change the brain. The need to provide rehabilitation to obese patients has impacted rehabilitation like almost every other healthcare provider in the nation. And this treatment equipment allows us to help our therapists safely stand patients of size, stand and move patients of size and promote their ability to stand and walk again. It provides extra support with arm rails, safety guides, lifting assistance, allows us to treat those patients of size with reducing the risk of lifting injuries to our therapists of lifting those really high level patients. Along with this technology, it's the upper body robotic technology. So it kind of helps the patient through what we call active assistive range of motion. The patient can do some movement after a stroke, but the robot kind of helps them complete the movement.

You'll see he's kind of swimming with the fish there, he's moving his arm up and down, again, providing certain number of repetitions to change the brain after that neurological injury. So in summary, encompass Health has a responsibility to really thoroughly investigate new technologies that are on the market. We have a responsibility to our patients and our stakeholders to do that, but we want technologies that are proven to be advantageous to our patients. And what I really want to leave you with is that we have a well-defined process to ensure the adoption of technologies with proven efficacy. This process, I hope, gives you guys confidence that we approach these changes in a strategic way at Encompass Health. I'd like to now introduce my friend and colleague, Mary Ellen Hatch. She's going to tell you more about a technology nursing's adopted via our in-house dialysis program.

Mary Ellen Hatch:

Thank you, Cheryl. So you can see our patients are very busy and a lot of our patients need dialysis. And so if you're not familiar with dialysis, the very short explanation of dialysis is it is a

device that washes your kidneys if they can't do it for themselves. And so if our patients need dialysis, we typically in the past had a vendor that would come in and do that for us, and we found that we needed some help with that. We currently perform in-house dialysis now in about 72 of our hospitals, which is 45% of our hospitals, using a new device called a Tablo Dialysis System. We found that we needed to bring this in-house because we'd had a lot of success in our hospitals in integrating dialysis with all of these other technologies that we had seen, and integrating it into the care plan so that patients could go to therapy, get all the therapies that they needed, as well as their dialysis, and still be able to participate and get the benefits of both. The majority of treatments are performed in our hospitals, in a suite, which means the patient goes to a dialysis suit, they're designed specifically for that. Typically, those suites have about two to four chairs in them or two to four dialysis consoles. It's usually located somewhere away from the gym, away from the nursing area, so it's quiet and really a nice area for them to be in. The dialysis treatment staff is all RNs, so it's a very high level of clinical expertise they have. They're uniquely dedicated just to dialysis, so they're very experienced and skilled in that. And there is special oversight from Nephrologists for each one of those programs.

We're continuing to roll this out throughout the rest of this year and next year, and we'll eventually have Tablo in about 70% of our hospitals. We realized during the pandemic that we had problems with our vendors. They often would come in and not be consistent in our treatments. Issues that we found with the third party vendor is they would show up at unpredictable times, which meant they may come into our hospital late in the evening and dialyze our patients up to late in the night, 1:00, two o'clock in the morning, which did not fit with our therapy schedule. Certainly, you could not do the things that Cheryl just showed you if you'd been up late into the night. And then sometimes they wouldn't show up at all, and if they didn't show up at all, that meant our patients might have to go back to the acute care hospital, and that certainly is not acceptable to our patient population or to us. And so we reached out to find out what technology was available for us to do a better job with that.

So the benefits that we've seen with that really have been exactly what we wanted. They've exceeded what we felt like they would be. The process related that we've seen have been clearly better coordination with therapy, looking at how much they're able to participate in therapy has been amazing to see that they're going to therapy, they're not missing any therapy because of their dialysis schedule. It also allows our hospitals to take more responsibility of the patient care. This is all of our own staff, it's all of our own equipment, there's nothing from anybody else. And so we like that, you can tell we're very driven by our own data and using our own things. We achieve high quality outcomes we've come to expect. And we also believe that the patient benefits from using this new dialysis treatment. Using the Tablo system, it has a different flow rate than the typical dialysis.

It flows about 300 milliliters a minute versus six to 800 milliliters a minute. And so what that means for the patient is they have a slower rate and they have a more stable blood pressure, they have fewer dialysis system alarms, and they have a better adherence to dialysis. They want to go because it's a better experience for them, but yet they have the same outcomes. So it's just a kinder, gentler way to provide dialysis, and they appreciate that a lot. The patient also typically will want to continue to do that, and so they like coming to dialysis. We've also seen, as we anticipated, we've seen a 90 base point reduction in discharge to acute care for patients with dialysis, with Tablo versus the typical hemodialysis patient. The benefit for the patient and the

referral in the hospital and Encompass Health are great when we don't have to send them back to acute care.

Providing dialysis service to our patients allows us to take a higher acuity patient. Our referral sources are looking for us to do that. I think we've talked a lot about that in this particular section. We believe that it's a competitive advantage for us to be able to take these patients and to be able to treat them. A lot of our patient population requires dialysis. By sending patients to dialysis with Encompass Health, and referring acute care hospitals have a greater degree of confidence that we'll be able to take their higher level acute patient and not be transferred back to them for dialysis related issues. Finally, there's also a cost benefit using Tablo. Sending a patient to a third party vendor dialysis was costing us about $600 a treatment, and with Tablo, it's about $300 a treatment.

The patient, of course, is the most essential member of the interdisciplinary team, and they are the expert on their vascular device, how dialysis affects them, and how to live an active life while receiving dialysis. So we believe that when we give our patients in dialysis the best possible dialysis treatment while they're in our hospital, they get the best chance for recovery. Thank you. I'll turn it back over to Mark.

Mark J. Tarr:

Well, as you can tell, that particular group here can go really deep on subject matter. So we have been providing a lot of information to you for a couple of hours here as promised, but why don't we take a 10-minute break and give everybody a chance to digest what we've put out there. So thank you. Okay. Before we get started again, just want to remind everyone that on page four of your brochure here, we have a QR code for questions. Either we are being very informative and answering all your questions in advance, or not getting questions that you may have, but we want to encourage you to use the QR code. We'll collect all the questions and then have a Q&A session.

Okay. Next up, we want to talk about joint ventures. You heard Melanie talk about the fact that as we evaluate marketplaces, one of the criteria we look at is this a marketplace that we want to go in and be 100% owned, or is this a marketplace that strategically we need to consider going in with a partner? And partnerships have been very important to us. I mean, the first one we have started with Vanderbilt University Medical Center back in 1991. So we're very proud that we've had a partnership that long. As a matter of fact, we've never had a partnership unwind. So I think we do a really good job in terms of understanding the mission for our partner, as well as what we're trying to accomplish and be able to find overlap and collaborate well. Most of our joint venture partners are primarily not for profit, faith-based and/or academic health systems. Each of our partners are unique and have different goals that we work together to accomplish. We make it a priority to make sure that we listen to what they're looking for in terms of their post-acute initiatives, and specifically with inpatient rehabilitation.

Today, we want to highlight one of our partners specifically, is Piedmont Health. We first got involved with Piedmont Health back in 2018. They acquired an acute care hospital down in Columbus, Georgia, that we were already partnered with, and Piedmont decided to keep the

partnership going as part of that. So Columbus Regional was the JV partner where we also had the Phoenix City, Alabama Hospital. Those two markets are very close together, and you have a state line that separates them, but little else. And that hospital, that partnership had been in existence since 2003. Over the last five years, our partnership with Piedmont has grown from that individual facility in Phoenix City location, to new hospitals in Newnan, in Henry County, Georgia, which are both outside the greater metro Atlanta area. We have one in Columbus, Georgia, which is down south. And then we have announced new hospitals being built, one in Atlanta in their flagship acute care hospital in Atlanta, Georgia, and then Athens, Georgia. So we thought it would be helpful for you to hear from our Piedmont partnership.

Video:

The partnership between Encompass Health and Piedmont Healthcare has been fabulous. As a neurologist, being able to ensure that our patients in the community have access to the highest level of care

Speaker 1:

... possible is really critical.

Mike Mandl:

One of the main benefits is that the patient can get the care they need when they need it in the most appropriate care setting. Then that patient's going to recover faster and have better outcomes.

Ronnie Wagley:

Piedmont Healthcare is so well known in the state of Georgia. They've been serving the patients of their state and the surrounding states for over a hundred years. If you live in the state of Georgia and you need advanced medical care, you're looking to get into one of the Piedmont Healthcare hospitals.

For a partner like Piedmont Healthcare to select Encompass Health as that joint venture partner, that speaks volumes to the level of care that we provide as an organization.

Mike Mandl:

We felt we don't have to own every segment of the continuum of care. We really wanted to look and see if there was a partner that would align with our values. With a high quality cost-effective partner, we just felt that it would make us stronger if we had a strong partner and could concentrate on other aspects of the business, and we found that partner in Encompass Health.

Speaker 1:

Prior to partnership between Piedmont Healthcare and Encompass Health, when our patients needed acute rehab care, they would have to travel one to two hours to other acute rehab facilities, so being able to access acute rehab in the communities where our hospitals were really was critical.

Ronnie Wagley:

Piedmont already knows the market. They know the community and they know the citizens that they're serving today. What we know is inpatient rehabilitation, so we know if there's an underserved opportunity to help better serve the community, that's what we bring to the table. We bring the expertise and how to deliver that the best in that community that'll represent both entities in exceptional way.

Mike Mandl:

As we grow into the communities, one of the first things we do is invite Encompass Health, do an evaluation of that market, does it make sense for the joint venture to expand in that market as well? And we bring those things together. So, as we've grown into new markets, we've asked the JV to consider building something. In some cases, our acquisitions had rehab beds and we transfer those out. We're doing that in several of the markets where we purchased HCA hospitals had inpatient beds, and they will become part of the Encompass Health and Piedmont JV.

Speaker 1:

My dad had a stroke in his 70s. He was this incredibly physically active human being and he had a right middle cerebral artery stroke, so he wasn't able to move the left side of his body and it changed him. He lived for another 10 years, but the last 10 years of his life was miserable for him because he wasn't able to go out for a walk. He wasn't able to go do all the things that he used to be able to do. When you have something as devastating as a stroke occur, which removes that ability to not be able to return patients to their former level of functioning is really a tragedy, not just for the patient, but for their loved ones. So, it touches me personally and why both from a professional standpoint but also a personal standpoint, I think it's so critical for our patients to

be able to access acute rehab care and especially care that's as excellent as that, that is provided by Encompass Health. I truly mean that.

I have just been so impressed when I sit on the board and talk about the metrics that we follow regularly, how much focus there is on continually getting better and doing a better job of providing care. So, really a wonderful company to partner with as a hospital and what I would want for my family. There is so much flow of information that goes on between the two organizations and because we're partners and because we speak the same language and have processes in place, the transition for the patients appear almost seamless.

Ronnie Wagley:

When we work together and we do the best practices that both health systems have established and learned, then we do a terrific job of delivering outstanding care in inpatient rehabilitation.

Mike Mandl:

I think it gives the communities and the care providers in that community confidence and comfort to know that that partnership exists.

Speaker 1:

It's been a wonderful partnership. It makes me proud to be able to offer it to the patients in our community, that level of care.

Mark J. Tarr:

All right. We are a very operations-driven company and I thought it would be helpful to kind of pull back the curtains from our operators and hear from them directly in terms of the benefits of scale and standardization and what a critical competitive advantage we have for our operators. I'm going to ask the team to come on up, and we're going to change the format a little bit and do this in a panel discussion format. I think we have a slide that shows each member of our panel. There you go. That gives you an idea about the tenure of the team and the geographic regions that they cover. All right. Let's go with our first question and we'll ask Pat Tuer this question. We operate a geographic regional management structure across their 159 hospitals, Pat. Can you describe how the model benefits our organization?

Pat Tuer:

Sure. First, I'll briefly describe the geographic regions of the company. We're separated into eight geographic areas. Each of which is led by a regional president. Below them is a regional team comprised of subject matter experts that closely mirrors the local hospital leadership teams. For me, I think there's many ways that this model benefits our organization. Three things stand out to me. One is pretty obvious. It's effective span of control. It allows us to quickly respond to negative variances that may pop up, challenges in a marketplace, and provide effective oversight and support to the hospitals that we serve. The second is a lens into what's working well in other hospitals or regions that we could scale into what we're doing in hospitals. Rusty talked about some of the data that we have, and we're able to see hospitals that may have challenges and compare those to hospitals in similar geographic areas, similar sizes, similar situations, and if there's some hospital that's doing better, we can apply what that hospital is doing in the hospital that's challenged.

And then, the third and final thing is bench strength. We have so many talented people within our organization and that serves us in a number of different ways. From the de novo growth that we have, we have many senior leaders who go and open those hospitals. We have many folks that participate in regional or national initiatives. And then, there's also a succession planning component to that where on our regional team or in our local teams, we may have folks that are nearing retirement age and we have a pipeline of people behind them to keep this growth and performance going. Ultimately, this model puts us in a position to deliver exceptional care for our patients and for our employees, and if we can do those two things, we're well positioned to deliver shareholder value.

Mark J. Tarr:

Pat, the next question is... Clearly, you touched base just in terms of the depth of our management team and developing talent and bench strength. Some of our regions have a vice president role that's part of that. Can you describe how that vice president role helps to support the team and the continued growth strategy?

Pat Tuer:

Sure. A regional vice president operates somewhat like a regional president but with a smaller scale, so they'll have a subset of hospitals within a region. Our regions vary in size from 17-ish hospitals up to... I think Brad has 24 in the South Central. And they'll have potentially eight hospitals that have different levels of challenges that they're able to intensely focus on. A typical path for someone to become a regional vice president and someone who's had a lot of success at one hospital as a CEO, who then has the opportunity to become what we call an area CEO, and they'll have two or three hospitals in addition to their primary hospital. And then, if they're able to prove success at a larger scale, they're typically a good candidate for a regional vice president role.

Aside from that intense operational focus that I talked about, it again ties back to some of the bench strength of the organization. All four of us who are regional presidents served in the organization as a regional vice president, and seven of the existing eight regional presidents that we have all served in that role within the organization. So, it supports our growth strategy in a number of ways. I think the primary way is... Melanie talked about development and the collaboration with the regional president, and that can be somewhat time-consuming, so the regional vice president role helps us focus on growth, whether that's from the same-store perspective in addressing the total addressable market in our service areas or bed additions for de novo growth from a new hospital perspective.

Mark J. Tarr:

Very good. Lori, you clearly have brought on a number of new hospitals in the past couple of years and have a full slate of new hospitals coming up in the next several years. So, you've had to kind of find a way to make sure to support that growth and you have the leadership development pipeline going with your region. You want to talk a little bit about the programs that we have and of the slide for the... There you go.

Lori Bedard:

Yeah. When we took on, we had reconfigured the Southeast Region to allow for the expanded capacity in the state of Florida. We knew that one of the challenges would be identifying talent to lead those hospitals. Last year, we opened three hospitals, so that's three leadership teams that you have to hire and onboard and train and prepare to be effective operators. So, when we established the region development of our management, bench strength was an important initiative for our region. So, our regional leadership team, as well as our hospital CEOs were tasked with identifying talented leaders within their organizations that they could develop to take on additional responsibility. You'll see on the slide that we've had really great success with our business development directors. All of them, for all those de novos, came from within the organization. We've also had good success with our directors of therapy operations and our chief nursing officers. Additionally, CEO talent is obviously key to the success of de novo, so we've used the Developing Future CEO program to develop CEO bench strength for our region, not just for our de novo hospitals, but also for our existing hospitals because we have seen a good bit of situations where a CEO will transfer from an existing hospital to a de novo, and sometimes it's easier to put a developing future CEO in an established hospital versus a de novo. But we did have one DFCEO that took on a de novo in our region. So, that has been a really helpful program for us. Currently, we have three developing future CEOs that are training in our region for future opportunities as well.

Another thing that we have found very beneficial in the state of Florida is our density of hospitals in the state and our proximity of our hospitals to each other is different than it is in other areas of the country, so it gives us the ability to share talent between hospitals pretty effectively. So, it's not unusual for us to have staff go from one hospital to another to work in staff taking care of patients, to work in an interim role in a hospital if we have a vacancy and we

need some assistance, or to assist with onboarding and training. So, that has been something that has been really beneficial for the success of the startups.

Mark J. Tarr:

Very good. Brad, you are very data-driven. We've used that term here quite a bit today, and that certainly matches up with you and your skill sets. Can you elaborate on the benefits of just sharing best practice information across the company and how you've seen that it really works to be a competitive advantage?

Brad Kennedy:

Absolutely. When I started with the organization in 2010, I quickly learned that my access to other hospital CEOs, other hospital senior leaders, and to subject matter experts at our home office was definitely a competitive advantage. There was this broad range of skills and expertise at my disposal when I had questions or when I wanted to learn about different ways to drive results. Additionally, oftentimes when we discover best practices, it's when individual hospitals are yielding great results. We take the processes that those hospitals are using. We pilot them. We analyze the results. We modify the processes as necessary, and then eventually, we spread those best practices to all hospitals enterprise-wide. Our culture supports this transfer of knowledge in order to unite us toward our shared goals and to drive our business performance.

Earlier this morning, you heard Rusty Yeager discuss BEACON, which is another way that we share key information across the organization. For us as operational leaders, BEACON is very valuable because it gives us access to real-time data that helps us drive results. In healthcare, we can get information from a variety of sources, including the patient care record, human resource systems, patient satisfaction scores. For us, BEACON pulls all that information together from those disparate systems in a way that aligns with our business objectives. In BEACON, we can look at metrics such as RN turnover, acute care transfers, patient satisfactions, and dozens of other operating metrics. We can then filter it down by hospital and we can quickly determine which hospitals are performing well. That may be an opportunity to spread best practices. Likewise, we can quickly determine which hospitals have opportunities with certain metrics, and in those situations, that's when our seasoned operators work to improve the metrics of those hospitals. This culture of learning and our experience bandwidth are among the many things that set Encompass Health apart in the industry.

Mark J. Tarr:

You mentioned several applications for BEACON, but the first application that Rust and his team put together was really helping us to managing our staffing, so as we would have fluctuations perhaps in our volume, we were able to staff up or staff down in response to the total

number of patients we had in our hospitals and to do it real-time because we had the data available to it. So, it enabled us to continue on our path of being a more efficient provider.

Lori, we've mentioned you have a number of new openings coming on in the next couple of years, and Tom talked about some of the challenges from just the construction and design of opening a new hospital, and I think sometimes we probably make it look really easy when people don't know what's going on behind the curtain. But maybe you can elaborate a little bit in terms of what all goes into it in terms of from an operator standpoint to get a hospital up, running, and the tasks before you take the first patient.

Lori Bedard:

I think one of the benefits we have is we have a standardized playbook for the de novo hospital openings. You'll see on the slide the various timeframes that are defined for each of the tasks to occur. We won't go through all 607 of them because we'd be here for a very long time, but they're very well-defined for the new leaders that come in, and there's a lot of collaboration between our corporate team, our regional team, and the hospital de novo team.

So, in addition to this playbook where everybody knows what needs to happen and what timeframe it needs to happen, we have weekly calls to discuss kind of where we are on projects. Is there anything that's holding us up? Is there anything that the hospital team needs support with? So, we can make sure that we stay on our timeframes to getting the hospital up and running and that we problem solve anything that may come up because things do come up in de novos. They all have their own little unique twists to them, but it has allowed us to be very efficient and effective in opening new hospitals. My team opens three last year. I said, as long as they're five weeks apart, we can manage it, but no closer than that, but it actually has made it much easier to open a new hospital.

Mark J. Tarr:

Very good. Troy, let's go back to the JV partnering a little bit. The Central Region has a number of very high-profile partnerships. Of course, the Vanderbilt University Medical Center, but you also have the BJC or Barnes-Jewish/Christian in the St. Louis marketplace. Both of those are academic partnerships, but you certainly have a number of them in the Central Region. You want to just elaborate why we would consider partnering or why a partner would consider partnering with Encompass Health?

Troy DeDecker:

Yeah, sure. I feel like when I'm working with the development team and we're evaluating a market, Doug commented on, sometimes we plan a flag and they approach us. Sometimes we evaluate a market and say, "This is a two-player town. This one player has maybe 60% to 70%

market share. Maybe that's the one we should talk to." Oftentimes, it is an opportunity for us to demonstrate what our value proposition is and what we can do to help them. Many of the health systems that partner with us have different goals in which they're trying to partner. Some of it is just the fact that our competency is around inpatient rehab and we get great outcomes and do a really wonderful job doing that. Some of it is around our ability to execute on pull-through.

Acute care hospitals are struggling with nurse staffing just like we are. Length of stay is a big issue for them, and our ability to respond to a patient that the physician feels needs inpatient rehab and our ability to pull that patient through within 24 to 48 hours certainly helps them on their labor costs, their efficiencies, and is important for our patients. Generally, in the acute care hospital, if the length of stay is a little bit longer, that patient's at higher risk for complications, which could tag that hospital with maybe bedsores that the patient acquired the last couple of days. And the reality is the patients that are high complexity that need to come to inpatient rehab, they really do need that therapy as quickly as possible. Most of that recovery happens within the first few days of that transition.

So, our partners look at us for helping them with length of stay, helping them with quality outcomes. With the ever-changing regulatory environment for IRFs as well as the reimbursement changes, acute care hospitals just can't keep up with those changes. It's not something they're focused on. For them, inpatient rehab may not be in the top 20 service lines, so they look at us, look to us as their partner to help them with that. One of the things that Rusty touched on too is the EMR changes how we can make an EMR change, electronic health record change, that goes live at one time. Many of the acute care hospitals that have their own rehab, it's that type of event that triggers them to say, "Maybe we need to find a partner for this," because they can't keep up with all the changes that are required from a regulatory perspective or to defend our claims from managed care payers and the like.

Mark J. Tarr:

Troy, Piedmont does not report up through you, but you have other partnerships in your region that started out as a single site, but yet as the partner has grown their locations in terms of acute care hospitals, they've also looked to us to partner on new locations as part of the JV opportunity. You just want to talk about your experience. You've had it in Memphis. You've had it with BJC in St. Louis and Missouri and Illinois area.

Troy DeDecker:

Yeah. I mean, BJC HealthCare is one of the biggest health systems in the country. They have over the last several years, transitioned from maybe a hub and spoke model where the patients would go to the main campus for tertiary top care, to now where most of those services are provided at many of their hospitals. When we first started with our main Central West End location, most of the stroke patients were being admitted across the street and would transition to us for inpatient rehab. So, we opened a second location in St. Peters and have already expanded that location. Last year, we opened another location in Shiloh, which is across the river and into

Illinois with them as well. That hospital has done extremely well as well. And then, next June, we're opening our fourth location with them in West County on the western side of the suburb.

The one thing about BJC, we have a very strong corporate culture, but most of the organizations we partner with have strong cultures too. The value of our relationship really depends on the needs of the organization. With BJC, we're highly integrated. Our leadership team participates in their leadership team meetings. When they're having strategy discussions around what service lines they're going to develop, they invite us to talk about what impact we could have on their service lines. Oftentimes, because we are in a partnership with them and offer the inpatient rehab that allows, them to help recruit specialists such as neurosurgeons, neurologists, physical medicine and rehab doctors, so there's a lot of collaboration that goes beyond even just us operating the hospital.

Mark J. Tarr:

Very good. Let's switch over to managing the regulatory front and changes on that, and Julie Duck has as much, if not more institutional and industry knowledge of anyone up here in front of you today. So, Julie, you want to elaborate a little bit in terms of just as you have been involved with the IRF industry, how we've addressed the changes the past couple of decades?

Julie Duck:

As you can see from the slide above, Encompass Health and the IRF industry as a whole has gone through enormous changes over the last decade, whether it's been 60% rule, whether it's been the big change from FIM, to Section GG, to the IRF-PAI, to the QRP, there's been a lot of changes in the industry and we've been able to adapt to that really. As you've heard from many people today, it's been our benefit of our electronic medical record. We meet together as a group with many of the clinicians who you met today, determine what needs to be changed, how are we going to meet this regulation, are able to embed that into the electronic medical record, but also we're able to assign it to a workflow. Not every change impacts therapy. Not every change impacts nursing. It may be a pharmacy change. We're able to push it into their workflow, so they're aware of the changes.

A lot of these regulations are 400 or 500 pages. You can't expect a clinician every day to really understand how they're supposed to make that change, and we're here to help them with that. So, not only does that imply, it also allows us to have consistency across the organization, but also helps us to comply with that rule, and we're all able to see and make sure that those workflows are working appropriately and we're able to document correctly to meet whatever the regulatory changes that may come forth.

Mark J. Tarr:

Julie, I know there's a slide that goes with this, but you might just elaborate. Once we are made aware of a regulatory change, kind of describe the preparation and process of preparing to implement for that change.

Julie Duck:

Depending on the change, we do meet together with all of the clinical teams and we really try to understand first what is the change. I'll use the example of the IRF Patient Assessment Instrument first because that's one of the bigger changes. It went from 16 pages to 30 pages, and we had to assess now a much broader assessment of the patient. Not only did it impact the IRF-PAI, but it also impacted the IRF Quality Reporting Program, which therefore could possibly impact payment in the future for you if you're not complying with all these rules. So, we had to make sure that everybody understood what the changes were, what the impact was of the various clinicians because therapy had to maybe do something new at admission, nursing maybe had to do something new at discharge, pharmacy had to be involved now, the quality director, the case management director because it was a gigantic change of the assessment of the patient. So, not only did we have to teach them what they needed to do now, but at what timeframe they had to do this.

So, if you can imagine, for example, certain assessments can only have to be done now within the first three days. Some assessment can only be done on day four or day five, and then some assessments upon discharge have to be done within three days of discharge. And then, if you can imagine, discharge dates may change frequently, so you have to teach the clinicians, if that does change, how you still meet that regulatory requirement within that specific timeframe. That was one example of a change that we were able to accomplish by the deadline, but not only the deadline was October 1st of 2022, but that was for discharges. So, you really had to be ready for all admissions starting September 1st, so that you didn't miss a deadline for hitting those discharges that were impacted on October 1st. So, there was a lot of education. We used a vendor for credentialing our clinicians to make sure they feel comfortable with using their clinical judgment on these assessments as well.

Mark J. Tarr:

And then, the most recent regulatory change involved the inpatient rehabilitation hospitals in the state of Alabama through RCD Review Choice Demonstration. Julie really headed up our preparation and she continues to be one of the individuals that is very involved with this. You want to just kind of talk about where we are with RCD? I know we're early on in my comments. I mentioned that it started August 21st and at that point, we had submitted I think through September 10th, 440 charts. But you kind of want to talk about where we are in that?

Julie Duck:

Sure. One of the benefits of being a large provider is that we do have a lot of contacts with CMS, with the MAC intermediaries, so we began preparation for RCD very early. I remember Dr. Charbonneau and I going to our Huntsville location, Palmetto, came to that location. We met with them. Believe it or not, it was the first time any of these reviewers had been in inpatient rehabilitation hospital, so that was very beneficial we thought, to bring them to a rehabilitation hospital. So, when they read our charts, they know what they're seeing. We're very experienced. Unfortunately, sometimes in various audits, if you look over the past 18 months, we probably had 4,000 records pulled by various CERT audits, TPE, RAC audits, SMRC audits, so our value to them was giving them kind of what have we experienced. So, during all of this preparation, we were able to give them feedback on the operational guide. We're able to give them feedback on the checklist, all in preparation for implementation on August 21st.

Remember, there was no really changes in the process. It's a change on how we get paid, so we wanted to make sure that they understood along with us at what point in time certain documents can be completed. If they wanted us to submit, for example, the inpatient plan of care, that's only completed by day five, so we can't start that on day one. We're still going to admit the patients as we always have. Nothing is going to change there. Affirm or not affirmed, we're still going to do the right thing for the patient and continue that plan of care regardless of what affirmation we get back. But as to Mark alluded too, after a month, we have seen a positive trend and we hope that that continues and we will continue to meet with either the Alabama Hospital Association, Palmetto directly. We've got another call on Friday where all the Alabama hospitals come together on a call, with Palmetto, with CMS, with the hospital association, and we kind of talk through any issues that we've been having, but also other providers have been having.

Mark J. Tarr:

Brad, we have seven hospitals in the state of Alabama. I mean, how have you operationalized this change?

Brad Kennedy:

Yeah. At the hospital level, well in advance of the implementation of RCD, we spent time validating our documentation processes to ensure that our documentation accurately reflected the quality care we were providing and also met CMS guidelines. I should also mention that because of our resources

Speaker 2:

... our system capabilities, including our electronic medical record. The actual submission of charts to Palmetto has not placed any additional burden on our hospitals, so that they can continue to focus on the delivery of quality care and the accurate documentation of that care.

Mark J. Tarr:

Let's switch gears here, and go over to staffing. Pat, so during COVID, I guess, starting in 2020 and then throughout the next couple of years, we were one of the first post key providers to start accepting COVID patients. We worked with Dr. Sharvino and our clinical team to make sure that we could do a good job with them, but once that started, we certainly saw the response from our referral sources. They were looking for a post acute provider that would take COVID patients and do a good job with COVID patients. We told all our operators to go out, find the staff, even if it was contract labor, we wanted to go out and take that market share, and we would work the staffing down after we went through this transition. But, Pat, you've dealt with that up in the Northeast, just want to talk about what it's done for you with referral sources first, and then secondly, what it did with staffing? You've dealt with your share of contract labor up in the Northeast.

Pat Tuer:

We sure have. I think the strategy has helped in our relationships with our referral sources in two key ways. First, you have to remember, many nursing homes, skilled nursing facilities, they stopped admitting due to the pandemic. They weren't taking active COVID patients, they weren't taking COVID recovery patients, they were on admission lockdowns, acute inpatient hospital beds were full, emergency rooms were full, and through that entire period, with the decision our company made, we never stopped admitting. And in fact, we kind of doubled down with the expense we took on to do this. We remained a safe and effective discharge option throughout the entire three years of the pandemic, and had great outcomes with that patient population in addition to the normal patients that we served. As expenses started to come down, the volume growth has remained sticky, if you will, because, a, we were there for those referral sources and in the communities that we serve, but the pandemic also was a differentiator of the levels of post-acute care in a very real way. Just the fact that we were able to still admit patients and deliver care when other venues in post-acute care could not, I think really helped position our value proposition. We continued to move patients faster. We continued to have better readmission outcomes. So the key things that are important to the referral sources, we delivered on. Our value prop really became real to them, so I think that that has helped a lot.

But the strategy did require us to use a lot of contract labor, extra shift bonuses, sign-on bonuses, and some of that was compounded by a lot of different things. There's the largest national demand for nursing care, with an insufficient supply, which is naturally going to increase rates. You had people that decided to leave the workforce. I mean, we had, in the Northeast region, over a hundred employees out at any given time on COVID related quarantine, and you had people that were bonus hopping, or shift rate hopping, if they were PRN at multiple sources. There was a lot of things that were driving up those costs. I'm proud of our organization for making the decision to continue to serve our communities, to continue to serve the patients that needed post-acute care, and again, we really did a great job of providing that care.

Mark J. Tarr:

There was a time when we obviously gave all of our operators the green light to go out and get the contract labor, and do what it took. But then there was a time, the reckoning side of that, where we said, hey, why are our costs so high? What are we doing specifically to address the labor struggle? What are we doing on recruitment and retention, and really, to address the strategies and tactics that it would take to get our labor costs back in line?

Pat Tuer:

The Northeast, as I've kind of alluded, was one of the highest utilizers of contract labor and premium pay in our organization. Last year, we spent tens of millions of dollars in my region alone in those buckets. Great news with some of the things I'll talk about, we're down just over 50%, year to date, from where we were prior year to date.

I attribute that success really to four key things. The first, the organization made the decision to centralize our recruiting function, so now there's 73 full-time employees whose sole job is to bring excellent talent into our organization, and that's helped in other ways too, that I'll get to. But as a part of that, these people are experts in recruitment marketing in a way that our local folks weren't. They collaborate with the local people to understand the markets, but we are spending smarter from a recruitment marketing perspective than we had before.

In the Northeast, specifically, we centralized how we were negotiating rates from a contract labor perspective. We used our scale, we found that many of our hospitals were using the same vendors from a contract labor perspective, so instead of each individual hospital putting an order in for 10 nurses, five nurses, six nurses, we got the regional needs, we put a regional order out, we were able to do that and get a better rate while we did it.

And we also found that some of our hospitals, they're not all created equal in terms of their ability to negotiate. We were able to do that much more effectively. Kind of what Mark alluded to was this, we called it sensitivity testing in certain markets, and really we applied it to all of our markets, from an extra shift bonus perspective. So we also standardized, we stopped the crisis bonuses where you had a number of holes at the last minute so you'd offer these crazy bonuses to get people in. In the Northeast, we put out a very fair shift bonus on the front end, and no matter how bad we wanted to, we never increased that rate. That change slowly started to change the behavior that if you wanted that extra money, you had to be the first to get it. It was first come, first serve.

And then, one of the last things that we did in the Northeast was, in an effort to bypass the margins that were existing in the contract labor space, we created our own short-term contract programs. I have almost 50 employees that are in this bucket right now in the Northeast where we're paying dramatically lower than contract labor rates, but they're contracted with us for eight to 12 weeks, because ultimately we want to convert these to full-time employees or PRN employees to achieve additional savings. So we're gradually starting to bring those rates down, and I'm really looking forward to the progress we'll continue to make in the future.

Mark J. Tarr:

And all of our regions have taken the same approach, you have to deal with it market by market, hospital by hospital, in addressing that. And if we didn't know it before, we were certainly reminded that nurses are entrepreneurs as well as clinicians. So, one final question, it's about staffing. Lori, as we have brought on new hospitals, and you start thinking about what it takes to staff them, and what it means in the local communities in which we're doing business in, you just want to hit on some of the high points there?

Lori Bedard:

Sure. So when we do a De Novo, we start the hiring process concurrent with the construction process. Typically, we post our CEO and our Medical Director positions first, and those are about 10 months out. The CEOs usually start between five and six months prior to our scheduled first patient date, and then we progressively post the leadership positions and get those filled. Staff positions are posted about three to four months prior to open, that can shift a little bit depending on if there's a holiday that we're concerned about, we'll try to hire early.

There's a collaboration between our centralized recruiting team and the De Novo hospitals. We're very fortunate to have dedicated recruiters for the De Novo hospitals that have had a lot of experience doing mass hiring, because when you are hiring 125 positions, about a hundred FTEs, in a short period of time, it's no small feat. The De Novo recruiters are very used to this setup and they handle all the advertising for the employees, they handle the sourcing of candidates, they do all the screening, and they present the candidates to the hospital and get them scheduled for hospital-based interviews.

We've had great success with hiring for the De Novos as a result of the collaboration. They also have a weekly call between the hospitals and the recruiters so that we can make sure that we are on track for getting people hired. The staff usually generally start about a month prior to our open dates. We start them a little bit early because there's a whole lot of onboarding that has to occur in a short period of time. They get oriented to the hospital, they get oriented to their department, to the equipment. We allow them to shadow in some of our sister facilities so they can see what the workflow's going to look like once we have patients, because they're a little bit different than most of our hospitals where we bring in an employee and we've got existing staff and existing patients.

Additionally, they help us with preparing the hospital for surveys and getting the hospital ready for patient care as well. It's been a very successful process, and I think we've even spread those practices to our other hospitals as a result of the success in recruiting for the De Novos.

Mark J. Tarr:

We're very proud of the fact that for the last year and a half of bringing on the De Novos, brought on all those hospitals without any contract labor. Now, there's something a little bit easier about recruiting people to a brand new shiny hospital versus another hospital that's been in operation, but we are very proud of that fact, and Lori just walked through the reasons why. Thank you very much, appreciate it.

I think we're going to bring the podium back up on stage.

Douglas E. Coltharp:

I'm glad you guys were able to accomplish that without becoming patients in one of our hospitals.

Mark J. Tarr:

That's right. You've had a chance to hear about our De Novo initiatives and capacity expansions, heard a lot about our technology and working collectively on our clinical innovation, you've heard a lot about standardization, and our competitive advantage in terms of just our depth of knowledge in our industry. Doug is going to take the next few minutes and pull all that together in terms of investment thesis and why our company is positioned well for growth, and be a great investment in the future. Thanks.

Douglas E. Coltharp:

Great. Thanks, Mark. One competitive advantage that we enjoy that we've not talked about this morning is that we benefit from a Board of Directors, from the counsel and the oversight of a Board of Directors, that is comprised of highly engaged, well-experienced professionals. We're fortunate that we have three members of our Board of Directors present here today, Don Carrell, who's our Chairman, Leslie Katz, and then Joan Herman, and so I just wanted to acknowledge their presence.

Well, as you've heard from our team today, we are very excited about the substantial market that exists, and the opportunity for that market to expand for IRF services.

You start with Medicare annual spending on inpatient rehabilitation, it's approximately $8.5 billion. Now, again, Medicare data comes out a little late, so that's a bit lagging, but that was the last estimate we have. Within that, you have roughly 380,000 Medicare patients utilizing IRF services on an annual basis. When you include Medicare Advantage and the other payers, the inpatient rehabilitation market size increases to about $14.5 billion, and the number of patients receiving IRF services on an annual basis grows to 745,000. Medicare spending on inpatient rehabilitation services as a percent of total Medicare spending has remained really flat over the

past decade at about 1.7%. We believe that there is a significant unmet need, and that the total addressable market for IRF services is much larger than it is today.

Lack of awareness, of understanding, amongst physicians and case managers regarding the service differentials between IRFs and SNFs, misconceptions regarding the episodic value proposition among non-Medicare payers, including certain Medicare Advantage plans, and IRF bed supply limitations in certain geographies, have all served to curtail IRF industry growth.

IRF admission criteria and the requirements of care are well codified by Medicare regulations, but they nonetheless require significant clinical judgment. The IRF admission criteria are worth reviewing. Many of you have heard these before. You start with physician approval is required of the pre-admission screen and admission. At the time of admission, the patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational. The patient must also be reasonably expected to actively participate in, and benefit from, the intensive interdisciplinary therapy regime that we are required by law to administer in the IRF setting, and that is an average of three hours of therapy at least five days a week.

The preponderance of that therapy needs to be administered in an individual, as opposed to a group or a concurrent setting. The patient must receive at least three face-to-face visits from the attending physician, per week, during the course of their stay. That physician is assessing the patient both medically and functionally, as well as serving to modify the course of treatment if it is necessary to do so. And also, an IRF is required to provide 24 hour a day, seven day a week nursing coverage. All of these requirements must be well-documented, and as Julie mentioned in her comments, are subject to frequent and widespread audit programs.

Now, these requirements are not applicable to the SNF setting. So given the high acuity patients that IRFs treat, the expert clinical services and skilled clinicians required to provide this complex medical care, the highly regulated nature of the industry, and the significant capital investment required to construct and open a freestanding IRF, it isn't surprising that the number of IRFs has remained relatively flat. In 2010, there were approximately 1,180 earths in the US. In 2022, 12 years later, that number still remained below 1,200.

As you heard from Lori just a few minutes ago, the challenges to opening and operating an IRF are significant. This isn't like opening and running a Starbucks, or a fast food franchise. Encompass Health has the scale, clinical, and operational expertise, and the experience in assessing markets and designing and constructing hospitals, to overcome these challenges. Since 2010, we have opened 50 De Novo IRFs and added 1,143 beds to existing hospitals, even, as we just discussed, the overall number of IRFs has been roughly flat.

And Melanie mentioned this before, but the number of free- standing hospitals that we've opened since 2010 is greater than the total number of IRFs contained within our next largest competitor. This morning, we affirmed our plan to continue to open six to 10 De Novos per year, and to add, on average, 80 to 120 beds to existing hospitals. We'll do that through at least 2027.

Our pipeline of opportunities remains robust, and currently includes in excess of 50 active De Novo projects, including 20 that have already been announced and are under development in some stage. We're pursuing this growth because there is a significant unmet need for the services

that we provide, and because we generate sufficient returns on our growth investments. Based on the low conversion rates of presumptively eligible inpatient rehabilitation patients, that's at 13%, we mentioned earlier today, we believe that the overall IRF market is potentially two to three times its existing size.

Our growth strategy for capitalizing on this market opportunity is supported by four primary pillars. Investing further in De Novo growth and bed additions, facilitating the disintermediation of IRF appropriate patients from skilled nursing facilities, improving access to IRF services for Medicare Advantage patients, and continuing our focus on providing quality care to an increasing number of high acuity medically complex patients.

Our recent De Novos have contributed three to 4% to our discharge growth in each of the past seven quarters. Bed additions support our same store growth, generate attractive returns on capital, and serve to turbo-boost our De Novo investments.

As we have stated previously, early in the pandemic, we made the strategic decision to accommodate IRF eligible patients from our referral sources even when it meant utilizing premium labor to do so. You heard Pat go into great detail about that decision, and as he said, we believed then, and it has proven to be true, that the volume in mind share gains would be sustainable. Referral sources saw firsthand how we were able to quickly admit their patients and provide safe, effective care, generating high quality outcomes from medically complex patients. Much of the share we gained has been from SNFs. We believe the pandemic and it's related after effects have caused a permanent distant remediation of a segment of the SNF population that is eligible for inpatient rehabilitation care. In the past, we would've referred to those patients as somewhat of a jump ball. They clearly met the conditions and the criteria that we reviewed just a moment ago for admission into an IRF, but because of that lack of knowledge and awareness, sometimes within the physician community or with hospital discharge planners, they weren't finding their way into an IRF, and an increasing number of those patients are today.

More than 600 nursing homes closed in the last six years. We believe pressure on SNFs is only going to increase with the recently promulgated nurse staffing requirements.

In his comments, Mark discussed the progress that we've made with Medicare Advantage plans over the past decade. Our strategy during the pandemic further demonstrated our value proposition to MA plans. Namely, that we could keep their members safe and deliver high quality outcomes with lower episodic costs. That helped us capture and retain Medicare Advantage market share.

There's still a large opportunity for Encompass Health with Medicare Advantage. While nearly half the Medicare eligible population is in an MA plan, Medicare Advantage conversion rates remain below Medicare. That is due to restrictive MA pre-screening procedures and criteria which can serve to curtail a Medicare beneficiary's access to the most appropriate care setting.

We've made some headway in increasing MA conversion rates. As we continue to execute on our strategy of educating plans about our value proposition, including delivering superior outcomes and our willingness to participate in value-based payment models, we believe we can continue to grow our MA business. The emphasis placed by CMS on ensuring access to care in the most recent MA update should be helpful in this regard. You heard earlier about our focus on

evaluating and implementing new therapies and clinical technologies to improve the treatment protocols and patient outcomes. We've been successful in improving patient care across our patient mix. We focus on higher acuity, medically complex patients because there is a large and growing need for these services in an aging population, and the level of care we provide is generally not available in other care settings. Treating these patients successfully is challenging, and our ability to do so with great frequency differentiates us from our peers.

In 2016, the American Heart Association and American Stroke Association published guidelines strongly recommending that stroke patients be treated at an IRF rather than a SNF. Our strategy to grow market share includes educating our referral sources and payers, and the public generally, about these guidelines and our high quality outcomes. One hundred and thirty two of our hospitals have joint commission stroke accreditation, that's more than 60% of all the joint commission stroke rehabilitation accreditations issued in this country. We have grown our stroke volumes from approximately 30,600 in 2017, to approximately 39,000 in 2022. That increased our stroke market share over that period from 4.6% to 6%.

As you heard from Mary Ellen, we began implementing in-house dialysis services in 2021, and we currently offer those at 72 of our hospitals. To date, we've completed more than 21,000 dialysis treatments in-house. We expect to provide in-house dialysis services at more than a hundred of our hospitals in 2024. Our ability to provide these dialysis services onsite allows us to admit more high acuity patients, and to avoid disruptions to the therapy regime, and that increases patient outcomes and patient satisfaction.

Our focus on providing best-in-class inpatient rehabilitation services for high acuity patients enures to the benefit of the communities we serve, you heard that from our Piedmont partners, and enhances our position as a trusted partner for referral sources and payers. We have the resources and capital to pursue this multifaceted growth strategy. Our leverage ratio is currently three times, which we believe provides sufficient support for our services and our investment strategy. And when you think about leverage levels, it's important to think not only about the level of leverage, but also the composition of your debt capital. We benefit from having refinanced our debt proactively along the way, such that we have well-spread long-dated maturities at very attractive interest rates. Our next debt maturity, and it's only $350 million, is not until late in 2025.

We expect our investments in capacity additions to remain relatively consistent with the 2022 and 2023 levels through at least 2027. That's the confluence of the cost coming down a little bit from its highs, we mentioned that we had seen some signs of abatement there, and then the progress that we're making on prefabrication, together with the fact that we've renewed and extended our growth targets to 2027 as well.

Maintenance CapEx over this period is likely to increase moderately owing to our larger asset base. We keep adding De Novos, we've got a bigger base that requires maintenance capital. But with that, the expected growth in adjusted EBITDA over the next five years should result in increasing free cashflow. And to put a finer point on the CapEx, if you think about last year, and then the assumptions that we've been using within our guidance for this year, you're running a total CapEx of roughly $600 million. You would see, out of that, an expectation that maintenance CapEx would be somewhere in the 235 to 250 on an annual basis, and the balance would be in growth related CapEx.

Encompass Health holds a leading position in a growing underserved market and has significant challenges to entry. As we hope we've demonstrated today, we have a deep bench of experienced, highly competent leadership that is highly scalable. We are demonstrating that we are uniquely positioned to increase capacity and grow the market for IRF services. We have a strong balance sheet, and we generate high levels of free cashflow, giving us optionality for future value creating utilization of cash. We believe all of this makes for a very compelling investment case.

We thank you for your presence today, and I think now we're going to begin the Q&A.

Speaker 3:

Mark has been collecting the questions.

Mark J. Tarr:

Collecting the questions and ranking them by the number of questions we've gotten on topics, so you'll get the most asked questions first.

The 13% conversion rate of presumptively IRF eligible patients, how do we calculate the 13%? Where do the IRF eligible patients go who don't end up in an IRF? And how do we educate discharge planners so that we can increase the conversion rate?

Mark J. Tarr:

Our sales and marketing teams, you saw the reference to the business development officers, I think it was Lori and her presentation, reference to that group. That is the primary role for that group, they are the ones that are going out and talking to discharge planners and acute care hospitals, physicians, social workers, all those individuals in acute care hospitals that are in roles where they are looking for the next step of that patient that's in the acute care hospitals. So, it really starts with educating that group. There's a lot of just basic education in the communities now since the families and children of our patients are now making more and more decisions on their behalf in terms of what their route is and whether or not they're able to participate in post-acute care. We have been more active in our branding and social media to reach out to that group, so there are a lot of different ways that

Mark J. Tarr:

We are trying to educate the community on the differences between IRF and SNF and what types of patients can be treated in our hospitals. That all go into play in terms of helping to increase the

conversion rate of eligible patients that are in the acute care hospitals that may otherwise be sent to a skilled nursing facility or not get rehabilitation at all.

Douglas E. Coltharp:

So back to the 13%, we reviewed the IRF admission criteria previously and those admission criteria are applicable to a hundred percent of patients who come into an IRF. But there's another qualifying event and that is on an annual basis, each one of our hospitals has to make sure that at least 60% of the patients that we have served have had as a primary condition, one of 13 diagnostic categories that have been established by CMS Medicare administrator. And so those are referred to collectively as CMS 13. So to get to that 13%, we can get Medicare data on all patients discharged from acute care hospitals in the US.

And when they are discharged, they have a diagnostic code assigned to them. And so we look upstream and say how many of those patients were discharged with a primary code that was one of the CMS 13 categories. We refer to those patients as presumptively eligible. Because they have met that criteria, they now have to be assessed along with the other criteria. But what that tells you is that even estimating a market based on that 13% is low because that's only for 60%. You can still have patients who don't have a primary condition that is CMS 13 for that other 40% who meet all of the other conditions that are required. Why don't they wind up coming into our facility? There are a number of reasons. So first of all, even out of that CMS 13 pool, there are a number of those patients who aren't going to meet the rest of those criteria and so they would not qualify for admission into an IRF. When you just look at the map of IRFs and we talked about that supply and demand imbalance, that's only been widening over the course of last year. There are still a lot of markets where there just isn't an IRF bed available in the marketplace. And again, there remains this lack of understanding and awareness even within aspects of the clinical community and related discharge planners that does not differentiate between an IRF and a SNF. And as we've talked about, those requirements of care are substantially different.

What can we do to better address that? It gets to what Mark said, which is, it starts generate high-quality outcomes and then educate, educate, educate. And if you just look at our discharge growth this year and the progress that we're making across all payer categories and really all patient categories, we're demonstrating the effectiveness of those programs.

Mark J. Tarr:

One of our challenges in IRF is that people don't think in advance of when they have a stroke where they want to get rehabilitation. You think about acute care services in advance in all likelihood. If you have an orthopedic procedure, you pretty much almost shop in advance where you would have that procedure. Those aren't the same dynamics with an IRF, it's just not the way people think. So there is that ongoing challenge for us to make sure we educate people so that whether it's the patient or the patient family or whoever the decision maker is at that time of need, we are top of mind. Mark?

Mark J. Tarr:

What is embedded in Encompass Health's discharge growth outlook in relation to improving the conversion rate? And then also given all of the positive characteristics about the industry you've mentioned, why haven't we seen competitors building more hospitals?

Mark J. Tarr:

First of all, this is not an easy industry. Hopefully, one of your takeaways today, it's not that easy to set up and start up a rehabilitation hospital. Even if you had the capital to do that, the investment acumen to do that there is the know-how in terms of the process to do that. So we don't have a lot of competitors partly because it's hard. There are a number of smaller competitors that are out there, some PE-sponsored base. Many of those have leadership that used to be part of our organization. So there are some much smaller players that are out there, but the reason you don't see a lot of them is because it's really hard to do this and do it well.

Douglas E. Coltharp:

I think in terms of the 6 to 8% discharge growth in which of these initiatives or what assumptions underlie that, it's really all of it. And so we don't know the magnitude of the movement in any one of those particular metrics with great specificity, but we know we have enough arrows in the quiver that we have confidence that we can deliver on an annual basis discharge growth in that range. And so even from year to year, the balance of that 68% comprised of same store versus new store is going to have ebbs and flows. Some of that is going to depend... If you look at the same store, you've got a couple of components to consider. Next year in the first half, that same store number is going to be up against really tough CoPs. And we're also not going to benefit as much next year from bed editions that occurred this year because we've shifted some of those bed editions into next year.

Looking out to 2025, that's going to get a tailwind from the bed editions that come in next year. You've got the maturation of hospitals opened in 2022 and the early part of 2023 that will flip into new store growth at some point during next year. Well, all 22s will be there and some of the 23s will flip in the latter part of next year and those will benefit because they'll still be in ramp-up mode. But whether it's thinking specifically about the progress we make on Medicare Advantage conversion rates, the progress we make in new geographies or in certain patient mix, all of that goes into building our confidence around that 6 to 8% CAGR and its sustainability.

Mark J. Tarr:

Is there anything wrong with assuming 2 to 3% pricing on top of that and stable margins to get to 8 to 11% EBITDA growth? If not, why not? And is there an opportunity for margin expansion?

Douglas E. Coltharp:

So we did not put out today... I think it's probably not lost on anybody here. We did not put out five-year financial metric targets and we had considerable discussion about doing so internally before we did that. There are things that we can control and there are things in any particular period that are exogenous to our control. We are a price taker. If you look at that 2 to 3% assumption and most of our history, over the last 10 to 12 years, that would suggest to you that that's a pretty good assumption on average. But there will be fluctuations based on rule changes and that makes it difficult to predict in any particular year what the level of pricing increase might be. We also have found in the past, and I'm sure nobody in this room is guilty of this, that when you put out a three or a five-year CAGR, it gets interpreted as a series of annual targets within that range as opposed to an average over that three or five year period.

And then it comes with an expectation... I think I got cut off. That those goals, those objectives, those ranges will be either reaffirmed and are recalibrated with every quarterly reporting period. And when that's happening, we're losing sight of the long-term position of the company and the sustainability of the business model over a longer period of time. With regard to margin expansion, we've had some very nice margin expansion this year and that's been driven by the improvements in the premium labor categories, the focus of the great operating team over there as well as just operating leverage from the discharge growth that we have been experiencing. We're going to continue to focus on opportunities to drive margin growth, but again, within the P&L structure, your ability to get that really depends a lot on what kind of annual price increases you're getting and whether or not we see some anomalies that tend to pop up. Do you have a bad year with regard to utility expense because it's hot across the country in July and August? So a meandering response on that.

Mark J. Tarr:

ROIC for the cohorts 2009 through 2020 was 19% in the aggregate for 2022. You mentioned the class of 2021 already at 11% on a last 12-month basis, but where do you think ROIC can go for these newer builds given the rise in cost per bed?

Douglas E. Coltharp:

So by newer builds, I'm assuming we're not... We really saw that and so you're already embedded in that 11% for 2021 and the slide that Tom showed before, we've seen this tick up really over the last three or four years. So some of the increased cost is embedded there. We're seeing really encouraging signs from the 2022 class. That's a class that had the higher construction cost embedded. We were close to $1.2 million per bed on virtually that entire class, and that covers a

period with elevated labor costs. So the fact that we're building these larger facilities and then we're ramping them up so much more quickly, this really gets to the fact that we have standardized so many processes as Lori alluded to before, around not only the pre-opening activities associated with the de novo, but once that hospital opens, getting up to a level of occupancy that generates positive returns very quickly. We have seen the ramp-up time decrease on new hospitals and that should speak well for us being north of the ROIC on future classes, certainly by that year three with headroom above that for continued expansion.

Mark J. Tarr:

That startup period in terms of just operationally ramping up within that first six months or so is particularly key within any marketplace because if you're trying to establish your credibility and your prospects of referral sources seeing you as a good option, it's important that you have smooth operations, that you're doing a great job with the patient, that the communication is good, backed with the referral source. And if that gets out of line and is not done in a competent manner, you can do longer-term damage that will impact your ability to ramp up the volumes. As Doug said, we've seen really nice luck, particularly the last several years as we've ramped up our de novo, but we've also seen markets in past years where we've kind of learned from our own lesson that, boy, that first six months of operation is really key in terms of establishing your credibility and reputation in the market.

Douglas E. Coltharp:

And Lori's slide I think did a great job of showing which task get done within which period of time proceeding the opening. And what would be interesting at some point is if we laid that process that exists today against what it looked like even just five years ago. And there was a lot that was not happening far enough in advance or not happening in advance at all, that contributes to the ramp-up of the hospital. We start a lot earlier in the process to establish relationships with key referral sources in the market. We start a lot earlier in the process now to make sure that payer contracts are going to be in place the day that we open the facility. If you think about our overall growth and that MA book of business where it's gone from that 8 or 9% to now 17 or 18%, it's really important that we have those contracts set up the day that we open the hospital.

Mark J. Tarr:

On the split between de novos and JVs, does rising construction costs change the thinking between JV versus non JV and is there any difference in ROIC between JVs and non-JVs? If so, what are the sources of our performance?

Mark J. Tarr:

I mean just the first part... Actually, the last part of that, just assessing a marketplace as to whether it's a JV or not JV relative to construction costs, that's not really a big part of our discussion. We're looking at it strategically and whether or not we think that we could go in that market and be successful wholly owned or if there are certain circumstances that just make it in the best interest of entering a marketplace that would pair up within acute care hospital system. As system, you could be in a marketplace where you've got two acute care hospital systems and they employ all the physicians in that marketplace or have all the major insurance contracts in that marketplace. That'd be an example of when we'd say, "Okay, we're probably better off partnering." If there's an existing provider in the marketplace, either that we've reached out to in an outgoing call or perhaps they have an incoming call when they have rehab unit, they're willing to put a third-party assessment on that and apply that to an ownership and a partnership with us.

Douglas E. Coltharp:

If we look at that existing pipeline of 50 active projects that I mentioned to you previously, right now a little under 40% of those are tagged as likely to be joint ventures. Either because we've had substantive discussions or we think it's so important to that particular market that we're going to pursue that aggressively. Over time, we would expect that number to trend a little bit north of 40% because as we get further along in the development process that tends to happen. In terms of whether or not the increase in construction costs have created any kind of burden or created any kind of dynamic that influences that. The answer is really no. It was just... I'll use the term interesting because I can't come up with a better one right now. But you had this period of time from 2020 to 2022 where already rising construction costs just went like that for all the factors related to the pandemic that we've all discussed.

And what became challenging during that time frame is we had to go to joint venture partners where we had a project in development, where we had previously shared with them our thoughts about what the construction cost would be and what the likely pro forma was going to be and say, "We got a new projection. The construction cost to complete this have gone up. And by the way, you may have noticed that labor costs have gone up as well. So here's what it was going to look like, here's what it looks like right now. Here's some of the things that we can do to combat that." We didn't lose a single joint venture partner along the way. And in many instances the facilities that we are joint venturing with also have other construction projects underway. And consistently we heard from them, "Well, we knew you'd be coming back because we're experiencing this as well and what you're seeing on the labor side and what you're seeing on the design and construction side, you must be doing something really well because our folks are coming to us with higher increases in both of those categories."

Now we're kind of past that point. We've got the new assumptions baked in and so those discussions are taking place on the front part. One of the things that was mentioned in the Piedmont video that is really helpful in terms of combating these higher costs that comes along with the joint venture is when a unit gets folded in. Because we've talked about how important that ramp and initial occupancy is and if a unit is getting folded in... And we have to use that term carefully because we can't just take those patients and transfer them over, there has to be an independent decision that is made for each one of those patients. But it helps with ascending that curve from an occupancy perspective.

With regard to any differences in ROIC, that is one factor that contributes to it. The second for us is that we manage the facilities when we open a joint venture, and so we get a management fee. Typically, 3 to 5% of revenue in order to do that. And so if you're just taking, as an example, a joint venture that would be 50/50 and you're splitting the capital investment that way and we're entitled to 50% of the economics plus a 3 to 5% management fee, that's going to drive a higher ROIC than a wholly owned facility where there is no management fee.

Mark J. Tarr:

One final comment on that. We've had a number of our joint venture partners, Piedmont, among them now, that once they heard about the prefabrication and saw the prefabrication, they want to go tour the facility because they're interested in potentially doing or utilizing some prefabrication in some of their construction projects. So it's been interesting to see their impressions of this and how it strategically can be used. Mark?

Mark J. Tarr:

Is there anything new on potential changes to home health transfer rule for IRFs and could potential changes be enacted via legislation if not enacted via the annual IRF update from CMS?

Mark J. Tarr:

We continue to stay very involved in Washington and communications with CMS and others. We've not seen any indications that the home health transfer rule is imminent. It was kind of the same situation last year. I mean there was not a lot of priority put on it. We can't say that it won't raise its head again, but right now we're not hearing anything that would make that sound like it's a priority for CMS.

Douglas E. Coltharp:

Just remind everyone to look back at that slide that Julie shared that showed the major regulatory changes that have occurred within the IRF industry looking back over the last 12-plus years. We are a very resilient company with great change agility. The need for the services that are provided by IRF providers is not going to change. Again, it's medically complex, high acuity patients in an aging population. There's no magic pill on the horizon that's going to make strokes go away or the other conditions that we treat, somebody's going to have to provide that care, and adequate reimbursement has got to be put forth by the payers in order for capital to remain in that business.

So is it possible that something along that line comes up or a regulatory change that we don't foresee right now? It's not only possible, it will happen, right? We'll get a regulatory change that's not on our horizon right now. And as we have done in every one of those other instances, we'll adapt and overcome. And usually, when that happens, in almost every case when that happens, it takes out the weak and the strong get stronger.

Mark J. Tarr:

Several questions on Medicare Advantage. For those MA plans paying on a CMG basis, what rate do they pay relative to fee for service? Is there room to narrow that discount and is there also room to move more MA plans to a CMG?

Douglas E. Coltharp:

So with regard to the differential on the MA plans that pay on CMG or an episodic basis, those can range from a discount of 10% right up to parity with the Medicare rate. Because the aggregate differential is more in that 5 to 6% rate, it would suggest to you that a significant percentage of those contracts are at a discount of less than 10%. And it's not unusual for us to use a strategy of upon conversion of a contract from a per diem basis to an episodic basis to start at 10% and then most of these contracts exist on an annual basis and then in subsequent years look for rate updates that progress towards parity.

We will continue to focus on converting more contracts from a per diem to a CMG basis and we do make progress on that. We've had a couple of nice wins during the course of this year that should push us up from kind of that 88% more towards 90%. As we've talked about in some of our earnings calls. We expect to see a little bit of fluctuation within the aggregate discount between the two really just because of what we're seeing is more of a normalization in the acuity mix in our overall book of business. And that's just associated with more normalized flows throughout the entire healthcare system, but don't expect it to move a great deal.

Mark J. Tarr:

At the margin, are things getting better or worse with Medicare Advantage?

Douglas E. Coltharp:

I think a lot better.

Mark J. Tarr:

Better.

Douglas E. Coltharp:

Yeah. We've said conversion rates are up, growth is really good as we've been able to demonstrate. As we've said, the traction that we really started to see in mid-2020 associated with the disruption elsewhere in the system related to the pandemic has proved to be sustainable.

Mark J. Tarr:

We've been talking about our value proposition with MA plans for years and it's all goes to our outcomes. You guys had a good chance to hear about the focus on our outcomes, particularly around discharge or the reduction in acute care transfers. That all fits into the value proposition in terms of overall episodic cost and that is where we are absolutely gaining traction with MA plans.

Mark J. Tarr:

In the 8-K today and Encompass Day it is pleased with volume trends in this quarter. At the same time, many hospital operators and other healthcare providers have given strong reminders recently about seasonal softness in Q3. Can you remind us of any seasonal trends for IRF and Encompass Health specifically that investors should keep in mind for this calendar year Q3 or for going forward Q3? Has the pandemic sort of normalized in terms of seasonality?

Mark J. Tarr:

Historically, the wintertime has been a period that we have seen some fluctuations on the upside. Colder weather has a tendency to irritate any patient with respiratory issues and it kind of ties into comorbidities. And then you have some fluctuations during holidays that might tie into seasonality, but really nothing different this year than maybe what we've seen in past years.

Douglas E. Coltharp:

That really feels like over the last 15 to 18 months we've returned to our historical level of seasonality.

Mark J. Tarr:

Do you expect higher minimum wage requirements for nonclinical FTEs to impact the P&L?

Douglas E. Coltharp:

We have very few that would fall into that category and the impact would not be significant.

Mark J. Tarr:

Okay. I am running low. How will a full prefab hospital construction change the way startup costs impact profitability going forward? Have there been any changes on how you're thinking about startup costs through the remainder of this year and how they may layer in, in 2024?

Douglas E. Coltharp:

Startup costs really aren't impacted very much, if at all by the movement towards prefabrication. The timeframe and the tasks that need to be completed pre-opening as Lori described, will reflect the projected faster opening time, but the same things and the same staffing model will continue to exist. We're not seeing any real fluctuation or pressure on startup costs, nor do we see significant opportunities to reduce those.

Mark J. Tarr:

How are you thinking about hiring over the next few years? How do you balance hiring for existing hospitals with staffing de novos in terms of recruiting resources?

Mark J. Tarr:

We look at that a lot in terms of resource allocation. And matter of fact we saw such progress made on the de novo recruitment that we said, "Wow, can we take a subset of those recruiters and apply them to some of our existing marketplaces where we had seen to be really challenged with contract labor and we saw success with that." This whole recruitment game is a lot different than what it was 5, 10 years ago. And so by centralizing that at the home office with full-time recruiters that know how to take advantage of Indeed and some of the other platforms that are

out there, it proved to us, A, it's a good investment, but B, they can make a true difference. So yeah, looking at existing hospitals and the ability to recruit to those, at the same time, in terms of some of the things that we've learned in terms of recruiting for de novo hospitals, we are applying that across the whole platform and we'll allocate the resources that are in our best interest.

Douglas E. Coltharp:

Bear in mind, the day a hospital opens, the focus of the management team from the hospital level all the way up to the regional level shifts from recruitment to retention. So you still have to recruit to replace what you've lost, but the real emphasis then becomes on retention. And fortunately, it didn't happen again through serendipity, it happened through a lot of focus and hard work. As we quoted in our Q2 call, our end turnover rate had dropped down to about 22%, which is at the low end of where it was pre-pandemic. So we're making some good progress there.

Mark J. Tarr:

Great. And our last question, how do you think about the dynamic where MedPAC remains negative on the industry but where CMS and Congress continue to be relatively constructive? While MedPAC hasn't been a force in DC, is their industry analysis off in relation to their recommended payment updates?

Mark J. Tarr:

Well, we've just seen very little correlation between MedPAC recommendations and CMS embracing those recommendations now for many years. So that's a common question we've gotten asked over time and it just seems to be that one does not lead to the other.

Mark J. Tarr:

All right.

Douglas E. Coltharp:

Thank you all very much.

Mark J. Tarr:

Yeah, thank you all for being here. Hopefully, you found this of value. I mean, if there's one or two things that we are certainly hoping that you're leaving with here today, A is the tremendous opportunity for growth that we have as an organization and how we're seizing that opportunity. B, just the competitive advantages that we have developed within our program and in terms of operations and clinical, and then also the impact of our scale and standardization relative to our ability to continue to focus on what we can do relative to growth and seizing the opportunities that we have that lie in front of us. Thank you all for being here.