PARTICIPANTS

Corporate Participants

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

Other Participants

Kevin Mark Fischbeck – Analyst, Bank of America Merrill Lynch
Whit Mayo – Analyst, UBS Securities LLC
Pito Chickering – Analyst, Deutsche Bank Securities, Inc.
Ann Hynes – Analyst, Mizuho Securities USA LLC
Matthew Dale Gillmor – Analyst, Robert W. Baird & Co., Inc.
Matt Larew – Analyst, William Blair & Co. LLC
A.J. Rice – Analyst, Credit Suisse Securities (USA) LLC

MANAGEMENT DISCUSSION SECTION

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

Connected care, superior outcomes; it's what we do every day at Encompass Health. And today we're here to tell you more about just how we do that and to provide the longer term outlook for our company to you. I'm Crissy Carlisle, Chief Investor Relations Officer for Encompass Health and it's my pleasure to welcome all of you to our 2020 Investor Day.

At your seat, you should find this brochure. Inside is the agenda. And don't worry every time you see break; there will be food and snacks and drinks available for you. The WiFi password is on the back of this brochure. And if you have any other logistical issues during the day, please stop by the registration table just outside the ballroom doors and a member of the Encompass Health team will be glad to assist you.

At this time, I want to introduce you the members of the management team who are here with us today. We have our President and Chief Executive Officer, Mark Tarr; Executive Vice President and Chief Financial Officer, Doug Coltharp; Executive Vice President and President of our Inpatient Rehabilitation Hospitals, Barb Jacobsmeyer; Chief Executive Officer of Encompass Home Health and Hospice, April Anthony; President of Encompass Home Health and Hospice, Luke James; and our Chief Information Officer, Rusty Yeager. I'd also like to introduce to you all the other two-thirds of the Encompass Health Investor Relations team; Amy Rayborn and Brittany Jager.

Throughout the day, we will make forward-looking statements. These statements are subject to risks and uncertainties, many of which are beyond our control and actual results may differ materially from these estimates. We encourage you to read the cautionary statements on this slide as well as the risk factors in our recently filed Form 10-K.

With that, it's my pleasure to turn the stage over to Mr. Mark Tarr

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

Thank you, Crissy, and good morning, everyone, and thank you for being here today. I must admit months ago when we were planning this day and considering the various dates and all the factors that go into that consideration, not once did we think there could be a pandemic virus we'd be thinking about in that selection. We're very happy to be here today. We're very excited to have the opportunity to talk about our company and where we see ourselves going for the next five years.

It's been almost five years ago since our last Investor Day and those years have been very important to us. Those years have led to significant growth in both of our operating segments. We've executed on a strategy of integrating the care between our facility-based and home-based services. And in many ways, it has established the foundation which we find ourselves today. But we're not here today to talk about our past. We're here to talk about our future where we're going, where we're going to take this company in the next five years and the strategy that's going to get us there.

I want to talk today about three key areas of our overall strategic plan versus our quality. I am going to talk about our sustained growth and our new growth targets that we're introducing today and our advanced technology. We want you to leave here today with a thorough understanding of really three key areas:

One is our integrated care model, how it leads for us producing outstanding outcomes in very cost effective manner. Second is, how we utilize our technology. We've made significant investments in the past years and now we're able to use those investments and the data that those investments are producing. And then finally our growth strategy, the aging population is increasing the needs of both of our operating segments. We want to describe to you how we're going to be there, expand our footprint to meet those growing needs.

Before we move further, let's look at the facts of our company right now. And our overall profile. With 134 IRFs or inpatient rehabilitation facilities that puts us as the number one owner-operator in that segment. If you want to think about it from a market share standpoint, one out of every three Medicare beneficiaries that receive care in an IRF setting this year will receive that care in an Encompass Health hospital.

With 245 agencies, we're number four in the nation in home health and we've grown our hospice segment now to up to 83 facilities and that puts us at 11. And we have a large geographic footprint. We have facilities or agencies in 37 states and Puerto Rico. We experience a unique position in post-acute. We have scale in all three of our operating services. We have the opportunity in 89 of our markets, where we call our overlap markets to integrate care from both our hospitals into our home health agencies and we're located in some very attractive marketplaces, many of which we have market density which provides a great backdrop for us to provide efficient care.

Quite simply, our overall objective for our strategy is to be the leading integrated provider of post-acute services, and to provide those services in both a facility and home setting.

We differentiate ourselves with the following competitive strengths: Our unique combination of assets, home, facility-based, scale, market density, the quality of our clinical outcomes. We consistently produced superior outcomes in both of our segments. Both our segments are all also the most efficient providers in their spaces.

I talked earlier about technology. We want to go deeper today in terms of describing to you how we're utilizing that technology to increase and enhance the outcomes for our patients as well as what we're giving, for our operators to increase efficiencies. And finally the financial strength of our

company, our business model generates high levels of free cash flows and our balance sheet is one of the best in the industry.

Post-acute care is evolving and the market is changing towards more of a site neutrality. Site neutrality won't have the silos of LTAC, IRFs or SNFs; it'll just be a post-acute inpatient hospital. Given the types of patients that we treat and the high acuity of those patients, given the skills of our clinicians to care for that higher acuity in our IRFs already, and given the physical construct of our buildings, we think we win in a site neutral environment.

It's much easier for us to move up the acuity scale and take patients that you might find in an LTAC setting now or we can go down the acuity scale and right our staffing levels in a more efficient manner to take care of patients that aren't as acute. If you want to think about it in terms of our ability to pivot from the center, as you'll see here, we have the staff already both hospital staff as well as complement and medical staff.

We have the construct of our buildings that are all license as hospitals so we have the medical gases in each of our rooms. We have full complement of services whether that's pharmacy and outside necessary services to take care of the acute patients that we have. And all of our buildings are set where we have a centralized nurses' station and then corridors that pier off of that nurses' station. So we could have a corridor for high acuity, a corridor for IRF and a corridor for what you'd consider to be more of a skilled nursing patient which is low acuity on the acuity scale.

So, we think we win in a site neutral setting. And then you pair that up with our home health, which their specialized programs have a wide variety and capabilities of a few patients and treating once again a high acuity patient for a home setting or a low acuity patient. So combined with our facilities with our home health access, we perform very well in an integrated site neutral world.

The demographic tail wind increases, the aging population increases the needs for our services. Our patients are [indiscernible] (00:09:18) in nature. If you look at the average age of our patients 76 in our hospitals, 77 in home health, the types of conditions we treat are disproportionately impacting those age categories, those age cohorts that – if you want to consider that 75 to 79 age cohort are disproportionately impacted whether that's through stroke, fractured hips, other neurological conditions. Those are the types of conditions that we treat and you'll see this age cohort, that 75 to 79 has a CAGR of 5% through 2026.

Today we're introducing new growth targets. Given the fact that the trends with the ageing demographics and increasing need for our services, as well as the investments that we've made, we think these trends more than support these growth strategies for at least the next five years.

We've been one of the few companies building IRFs. If you look here you'll see that the number of IRFs or the capacity of IRFs in the marketplace has stayed pretty steady, there's pretty much an even line through there and that's in spite of the growing need for services. If you look at from 2010 to 2018 that's a 38% increase in the age cohort of the population, so there has been an imbalance in the supply-demand of IRFs to meet the needs of the patient population, but we have a very proven track record in terms of entering new marketplaces with our de novo programs.

If you look here, you'll see the various locations and hospitals and the marketplaces that we've built since 2009. So we had 18 hospitals here. If you go across, you'll see on the rows where the blue shaded number is where we have added beds. So you have this opportunity where we've gone into a new marketplace, we've established the hospital, we've grown the patient volumes there, we've put ourselves in a position to boost the returns on those hospitals by adding bed additions.

Barb's going to go into a deeper dive on the experience that we've had in our Stuart, Florida facility but you can see that hospital alone since we brought that on 2013, by the end of 2020 will have four bed additions applied to it. Then you can see the stats down below. By 2020, we will have

added beds to 56% of the hospitals that we've brought on since 2009. 28% of those will have more than one bed addition added to those. So we have a very proven track record in going into a new marketplace, establishing ourselves and then growing that facility.

Same thing with our joint venture relationships. You'll see that we're now at the – 47 of our 134 hospitals total are through a joint venture type of strategy. You'll see some of the medical centers and systems that we partner with there on the left hand side.

This is not a new strategy for us. We've been doing this for over 30 years. Our partnership with Vanderbilt University Medical Center was the first of our partnerships and we've utilized that going forward. It's worth noting that we have more joint venture partnership facilities than our competitors have freestanding IRFs. So, we know how to be a good partner and we know how to use this strategy in entering a new marketplace.

Same with certificate of needs; we have a very skilled team at going out and securing CONs and having the provider numbers that you see here on the lower corner of the screen was 68. So, we have 68 provider numbers, higher than any one individual competitor has facilities. Same thing with the number of CON beds, with 4,750, it's more than any other single competitor has beds.

So we are very effective in terms of our ability to work in at the various states, each state has a different CON calculation in terms of bed need and process. And we've been very successful in attaining those provider numbers.

State of Florida is a state we're very familiar with. We already have 12 hospitals there, we have some 20 home health agencies, we know the market, we know that state very well. So last year when the State of Florida announced that they would be repealing their CON rule, we saw that as a prime opportunity to accelerate growth in that state.

They had been talking about this for several years. So we were keeping track of where that was in the state legislature, so we were able to move very quickly in terms of establishing where we wanted to add beds to our existing 12 hospitals, you'll see here we highlighted five of the hospitals that we are moving on very quickly to expand capacity.

Four out of the five will be added by the end of this year and then one will be coming on in 2021, but we have 72 beds already in terms of bed additions to our existing capacity. The CON repeal not only applies to bed additions, but it also gives us an opportunity to consider new marketplaces in the state.

You'll see here we have identified 15 high potential de novo markets, some of which we have announced. We already had the CON that we had won for our Hillsborough County which is the Tampa marketplace where we're already building a hospital there. We announced this last week that we had acquired the land in Pensacola that we intend to build a hospital there and we have other sites where we have acquired land already, but those will be future announcements. So we're moving very quick first-to-market in terms of our ability to go out and take advantage of this repeal of the CON.

We've also decided that we needed to work with a project manager oriented contractor, so we have enlisted the help of Brasfield & Gorrie, which is based in Birmingham but has a high degree of expertise, lot of projects they've built in the healthcare sector and non-healthcare sector in the State of Florida. We believe that this will help give us the opportunity to have efficiencies, cost efficiencies and also the ability to bring these facilities on in a faster form versus working with a number of different contractors and having to bid out each one of these projects.

So, we believe that we are well-suited, well-directed to take advantage and accelerate the growth opportunities in the State of Florida via both bed additions as well as these new hospitals.

So, with that as a backdrop we've announced new growth opportunities, new growth targets in our inpatient rehabilitation sector. We've increased our de novos per year beginning in 2021 to 6 to 10. We estimate that 25% of those are likely to be joint ventures. In terms of bed additions, we have 100 to 150 per year starting in 2021 and then a discharge CAGR increase to 4% to 6% for the years of 2020 through 2025.

Let's move now to home health and home care. We're equally excited about the opportunities for growth in home-based care. And if you think about the fact that 9 in 10 Americans seniors now want to be treated at home. They don't want to have to go back to the acute-care hospital or an outpatient center, if they can receive that care in home, that's what they're wanting to have.

If you think about the aging demographics that also applies to home health, so it too will increase the need for the demand for home health, increase the demand for hospice services moving forward as well. And CMS should also be enthusiastic about home health. When you look here, the Medicare cost per day of $47, the home setting is clearly still the low cost setting to care for our seniors.

We have a multifaceted home health growth strategy. We'll get that both and organic where our 12 quarters, the last 12 quarters we produced 8.2% organic growth. We'll get that growth through our specialty programs where we have highly specialized segmented programs in heart and vascular, ortho and community care.

We have a strong sales structure to support that growth and then we also have the use of care transition coordinators which help enable the transition from facility base to a home base. These are roles that we've had not only in our inpatient rehabilitation hospitals and our overlap markets where they've coordinated the transfer of the care from that facility base to home base, but they've also expanded these roles out to other acute care organizations to assist in that process.

From a new growth standpoint, would be mostly through acquisitions and we have a strong track record and ability to integrate newly acquired facilities. Last year we had a major acquisition with Alacare. We'll prioritize the acquisitions into marketplaces that will allow us to increase the overlap with our IRFs and increase our overlap markets where we have 89 of those now. We want to make sure that if we have the opportunity, we want to build it through an opportunity to overlap with hospice markets, as well as the opportunity to build scale and density in existing markets to help that efficiency of providing those services.

We also want to continue to build scale in hospice. We think it has very attractive attributes to this as well. It pairs well with synergies, operating synergies where we have home health agencies. We also believe that the demographics will create an existing tailwind for hospice needs and you have this societal acceptance of hospice in general and you can see here, the chart on the lower right hand side, the percentage of Medicare using hospice in 2000 was only 23%, but that number increased to 50% by 2017.

So, we also think that hospice is a nice complement to our home services and gives us yet that third leg – that third service line to contribute to our overall growth. So, relative to growth targets in home health, we have 10-plus percent in home health admissions CAGR 2020 through 2025, we have to 10% to 15% for hospice for that same time period and then $50 million to $100 million worth of acquisitions per year earmarked for growth. You'll note here that that is not inclusive of larger scale acquisitions and those opportunities we may yet in the future.

Talked earlier about our clinical collaboration, that has been an opportunity for us to integrate care from our hospitals along with our home health and to do that in a very standardized approach. We think that by the year 2025, we can have at least 100 overlap markets and have achieved a goal of clinical collaboration rate of 45% for all payor groups.

Then we introduce the growth targets for consolidated CAGR, consolidated net operating revenues as well as adjusted EBITDA 7% to 9% and adjusted free cash flow of 8% to 10% that's 2020 through 2025. So I talked a lot about our clinical programs, I talked about our integrated care model. It's very, very important to us our patient outcomes and continuing to exceed the rest of the marketplaces and our competitors and our ability to get patients home in a home setting, for them to have a very positive experience and be able to keep them there. I think perhaps the best way for us to do that is to introduce you to a couple of our patients. This is the next best thing to meeting them in person through the video.

So with that, I'll queue the video.

[Video Presentation] (00:23:13-00:28:59)

Barbara A. Jacobsmeyer, Executive Vice President & President-Inpatient Hospitals, Encompass Health Corp.

So, as you can see, we do receive patients at their most vulnerable time, right. Their independence has gone. They didn't expect whatever caused their injury whether it's a stroke or a brain injury. And we have the opportunity to help them get their lives back again. So, I'm Barb Jacobsmeyer and I'm going to get a little bit into the weeds as it relates to the operations side of our inpatient rehab hospitals.

We have a lot of different topics to cover, but what I really want you to walk away with is what differentiates us from the other competitors in our markets, because it's a lot about the care we provide, but it's also about how we set our value proposition and we sell that for future growth, as well as how we use our technology to really be the best in the industry.

So, first, as Mark mentioned, we're the largest owner and operator of rehab hospitals with 134 hospitals, and as he mentioned, 47 of those are joint ventures and we'll touch on why that's important beyond being partners with them, but what that allows us to learn as it relates to our acute care partners.

So, who are Lonnie and Sondra and why did they come our way? Well, the first thing to know is that these patients need a lot of not only the therapy side, but the medical side of attention. And so, our hospitals aren't licensed as acute care hospitals, we're just a specialty hospital. And so, as you can see from these pictures, our hospital, when you go inside one of the rooms in our hospitals, it very much looks like a room inside of acute care hospital. It looks nothing like a room that you would see inside of a nursing home.

And so, a big differentiator for us is our physician engagement. Our physicians tend to see our patients almost daily in our hospitals, because of the needs that they have. In a nursing home, a physician may see the patient once only every month. And so, this is a big differentiator for us in having the physicians there on a daily basis attending to our patients' medical needs.

But as you saw from the video, our patients have more than medical needs. They have a lot of physical needs. So, we've a full team of physical, occupational speech therapist. We have pharmacists, dieticians, case managers, social workers. When it's an overlap market, we have our clinical transition coordinator. These folks all meet on a weekly basis to talk about our patients and to determine what are the barriers that are in place that are keeping the patients from being able to go back home with their families. And then as a group, we talk about how we're going to alleviate those barriers, so that they can have a successful transition home.

We have on-site pharmacy. Again, compared to a nursing home where they tend to get their medicines delivered once a day, we actually have a on-site pharmacy that stays completely stocked. We have full-time pharmacists in our hospitals. So, when our physicians are seeing our patients and they have a need that for a medication to be changed, it can be changed in that moment, and that allows us to continue to care for these patients in our hospitals.

We've a lot of specialized and intensive therapy. So, when patients come to our hospitals, they have to need and be able to tolerate a minimum of three hours of therapy a day five days a week. Now, some of our patients, because they may need dialysis or other things, they may need to have that spread over seven days. And so, as long as they're receiving 15 hours or more therapy over seven days, then Medicare says they can be inside an inpatient rehab hospital.

As Lonnie mentioned, we have a lot of specialized therapy in our hospitals. So, just to kind of take a step back here for a minute to share with you most of our patients have some sort of neurological impact, maybe it's a stroke, a brain injury, a spinal cord injury. And what that means is that the brain or the nerves have now impacted the patient that they can't do the things they could before, many of them can't walk, they can't get out of bed by themselves, maybe they don't even have the balance to sit by themselves. They can't dress themselves. Some of them can't speak or swallow. So, when you look at this picture of all of our technologies, it's really because the brain can be retrained, but it needs high-dose repetitive motions to be retrained and the technologies that we have help us to deliver that.

We have what we call our activities of daily living suite. This is a room in each of our hospitals that resembles the patient's home. It has a regular bed instead of a hospital bed. It has a washer, a dryer, a stove, a refrigerator, it's so that we can not only use the great technologies that we have, but we can also say what is life going to be like when you get home and what things maybe are you struggling with. It's a great way for us to communicate with our home health team to say, they're still struggling with making their own meals or doing their own laundry, so that this can continue when they go home.

So, who provides this great care? Well, I mentioned the full team of folks, but when you look at the majority of our staff in our hospitals, the majority is made up of by our nurses and our therapist, and we're very proud of our turnover being lower than our benchmark for both nursing and therapy. But a couple of things to draw out on how we're going to continue to focus on this in the future is that we have what we call CRRNs and that stands for Certified Rehabilitation RNs, so kind of like a nurse may claim her specialty is labor and delivery or ER or cath lab, we want our nurses to claim their specialty as rehabilitation.

So, there's an outside source that actually credentials them, they have to sit for a test. When they pass that test, we actually give them a bonus and an increase in their base salary, because what we've realized over time is when our nurses claim rehab as their specialty, our turnover is much lower. Our CRRN turnover is only 8% compared to our overall turnover of 22%. So, we're going to continue to invest in making sure that we can increase the number of CRRNs in our hospitals. We also have therapy clinical career ladders. While we have very low, 7% therapy turnover, again, we know that when we can help our therapists specialize in certain areas of care or techniques, again, they want to remain in our hospitals.

The other thing I want to call out is our Developing Future CEO program. As Mark talked about our future growth, we know that it's important for us to have strong CEOs that are managing our hospitals at the local level. So, a few years ago, we started a program called Developing Future CEOs where we hire outside and internally team members that we know have good management and leadership skills. They spend 18 to 24 months in one of our hospitals where we've a tenured experienced CEO. After that point in time, they are well-positioned to be ready to go into one of our new hospitals or if there's turnover in one of our other hospitals. So, we'll continue to invest in this program as well.

So, we talk about our quality outcomes and we're really proud of our quality outcomes, but I want to pause here and define a few of these, because in the next few slides I'm going to talk more about readmissions and acute care transfers. And so, I want to make sure that you kind of know when I'm talking about as I refer to those. So, obviously, the ultimate goal for us is to get our patients home and that's the discharge to community number, and we do better than the industry average in getting our patients home.

Some of our patients will need to go to a nursing home when they leave us. Our goal is to have that as a low of a number as possible, but it is true that some patients will come and not progress like we thought they would or maybe they don't have the family support that we anticipated that they would and they'll need to go to a nursing home. Again, we're working collaboratively with our home health department to really try to lower that number as much as possible by having home health really help the patients feel confident that they can go home.

But then we have what we call our discharge to acute. Discharge to acute means while the patient is in our hospital at some point while they're there, they have to go back to the main acute hospital because of a change in their condition. Again, we want that number as low as possible. When we talk about readmissions and we refer to that as either a 30, 60 or a 90-day readmission, that is when a patient has already gone home from our hospital, but at some point after they've been home, they have to go back to the main acute care hospital.

And why are those two things so important? The discharge to acute and the readmission things are both things that are a problem when it comes to the acute care hospitals readmission penalties. They actually receive penalties for the times the number of patients come back to their hospital. Also, if an acute care hospital is involved in an Accountable Care Organization or in a bundling initiative, every time these patients have to go back to the hospital, whether it's directly from our hospital or after they've been home, that creates cost. And when they look at the episodic cost for that patient, it's going to be an outlier if they've had a lot of readmissions.

So, we know the focus for us needs to continue to be on how can we lower the discharge to acute and how can we lower the readmission, and I'm going to talk about how we're going to use technology to really impact both of those. So, as we look at the technology that we've delivered, all of our hospitals are on the same electronic medical record system. That's huge for us, because that's a large number of patients that are in a repository where we can use that data now to really come up with some artificial intelligence on how can we better manage our patients.

One of the first things we did and this was to focus on that acute care transfer, so while the patients are with us how can we reduce the number of time they have to go back to the hospital. We used over 90,000 patients in our electronic medical record over a two-year time span and we said, of these patients that had to go back to acute care, what were the variables that were happening right before they went back. And can we look and say, yes, there's strong probability that these variables would actually be able to predict when a patient may have to go back. That helped us come up with our program called ReACT, Reducing Acute Care Transfers.

This is what it looks like. When I'm a nurse or a physician or a therapist and I go to my electronic medical record, I can actually look at what we call our ReACT score. It's those variables that we say could be predictive in a patient that may end up going back to the hospital. So, in this example, you'll see the very first row, that patient over the last 48 hours was green. They had a very low probability of needing to go back to the acute hospital. However, this morning, they turned red, which means a very high risk.

If I'm the clinician looking at this, I can click on that to drill down to say, well, what variable changed, what changed them from a low to a high risk and is that something I can manage here, maybe it was their blood pressure went up or they're not eating well or it's a medication thing, what can I do

now to manage this patient so that I can manage them medically here versus having to send them back to the hospital. This has been rolled out to all of our hospitals across the country.

We took what we learned from ReACT and said, okay, we're trying to tackle that return to acute while they're with us. How can we now attack the readmission after they leave us? So, we used over 400,000 patients for this one and these were patients that moved through our rehab hospital to our home health. And we looked again and said what variables, because now that they're home, those variables are different than they were when they were inside the hospital. So, what variables could predict a patient's higher risk of once they're home having to go back to the hospital.

We piloted this last year in our Houston market where we've eight hospitals to really learn and refine the system. And what we were able to see is, yes, we believe there are things that we can engage from the rehab side and the home health side to really manage these high risk patients to reduce that readmission. We were pleased with those initial results and we're going to be rolling this out to all of our hospitals in 2020.

So, when we look at our IRF value proposition, obviously, we're working on all the things on the clinical side, because we know absent those, we don't have a value proposition. But I would tell you that we tie that to we're so close to these 47 joint venture partners that we stay close to what's important for them, what's driving them, what's keeping them awake at night, what things are they focused on, because we want to be the answer and the solutions to the challenges that they have. So, our partners bring that sort of education to us.

So, I want to now kind of shift gears and talk a little bit about so how do we sell that value proposition. Well, we have access to all the Medicare claims data for every one of our markets. And I will tell you that there are many times that we understand a hospital's outcomes – an acute care hospital's outcomes better than they understand it themselves. This is a great example to show you what we bring to our acute referral sources and this is to all our referral sources in our markets, not just our partners.

So, this is our hospital in Albuquerque. If I'm the acute hospital and this is one referring hospital, I may look at that top section there where it says total 30-day readmission and I'm looking at my top volume, the places that I spend with most of my patients. So, it's our IRF, is another competitive IRF in the market, and then there's two volume skilled nursing facilities that they use. If I'm acute care hospital and all I'm doing is looking at that top information, I'm saying if I'm going to create a preferred provider network, there's really not a big difference between the providers that I'm using.

The problem with them looking at the data that way is the patients that are going to skilled facilities are very different than the once going to inpatient rehab hospital. So, in this situation, they're comparing apples-to-oranges, but many of them we find stop at this analysis. So, what we do is bring it to the next level and we look at it by diagnoses. So, for that same refereeing hospital what you see in the bottom there is their stroke patients. Well, look at the difference in the readmission at the different post-acute settings they use for stroke patients. Our 30-day remission is 16.5% versus one of their skilled facilities of almost 42%. But again, we find that if we don't bring this data to them, they're making their decisions off of that top information, which is inaccurate.

Another thing that we look at and I talked to you about costs, right. So, if I'm involved in an ACO or a bundle, the 90-day episodic cost is very important, because if I'm trying to hit a target price, I need to look at that. Well, again, if I'm in a bundle, sometimes I will make a short-sighted decision and say, well, nursing homes are a lot cheaper than inpatient rehab hospitals. So, I'm going to quit sending my patients to inpatient rehab and I'm going to send them all to nursing home. The problem is in that calculation what they've failed to take into account are the cost of those readmissions. So, again, this is data that we bring to our referral sources to say, if you don't take into consideration the full cost, then you're going to be making some short-sighted decisions, and in many diagnosis cases, we're actually the better value because of our low readmissions.

We also have independent research to support us. We have the American Heart/American Stroke Association, the Veterans Affairs and the Journal for American Medical Association that actually has published research to say, for stroke patients, if they can tolerate rehabilitation in an inpatient rehab setting, that is where their care should take place, and we're using these research articles to go and educate our referral sources.

One more thing on an acute care hospital and this is one of our markets and it was a referral source and they're looking at their stroke patients. Many of you know that in acute care hospitals, besides the readmission, another important thing for them is managing their own length of stay, right. If their patients are staying beyond the expected length of stay, that's a cost to an acute care hospital.

So, in this example, we're able to bring and show not only are our readmissions lower compared to skilled nursing facility in this example for the stroke patients, but we're able to pull those stroke patients from that hospital in 5 days compared to 7.2 days for the skilled nursing facilities. So, not only do we create a better value because our readmissions are lower, but we're actually helping that acute care hospital manage their length of stay.

We had one of our markets where, this is a non-overlap market and one of our referral sources said to our hospital, well, I don't know how much more I'll be able to use your inpatient rehab hospital, because as we look at our data, you're responsible for 25.4% of a 30-day readmission. Well, that just doesn't sound right. So, again, we go out to our Medicare claims data and this is a hospital that had their own home health. So, we went and looked at it and we said, well, actually we're directly responsible for 9.3%, because that's how many patients we're sending back while they're in our hospital. But ironically over 16% is actually happening after the patient gets home.

So, from again our claims data, we could tell and we tended to use a lot of their home health, 31% of the patients that we had referred to their home health didn't receive care within three days. What we know from working so closely with our home health that for these high risk patients, it's critical that we get out there within that first day. So, again, this information allowed us to go back to this referring hospital and say, hey, we recognize your 30-day readmissions are high, but let's sit at the table and work with you and your home health, so we can manage this better and really bring to their attention that part of this needed to be owned by them as well.

A lot of you've heard about our American Heart/American Stroke Association's strategic sponsorship. We kicked that off in January of 2019. We really did it in conjunction with, we were completely rebranded by January of 2019 and what better way to get our new brand out there than to cobrand with the American Heart/American Stroke Association. So, one of the first deliverables was our Life After Stroke guide. This is a guide that walks patients and their families through what to expect after having a stroke. This is one that's available on the American Heart/American Stroke Association website as well as on our website and through our hospitals.

But probably the number that I want to call out more than anything is that through this strategic sponsorship, there's been a lot of things that have been out on the American Heart/American Stroke Association's channels as it relates to our cobranding, whether with our Life After Stroke guide or videos on patient successful stories. But over 11 million people reached out on the Heart and Stroke Association's own channels to learn more about our strategic sponsorship. That's a lot of people that would be really difficult for us to reach on our own. So, we were excited with what we were able to produce after our first year and we're now into our second year of our strategic sponsorship, and the focus this year is on, how can we cobrand some healthcare professional education.

One thing you've heard us talk about on several of our earnings calls has been our Medicare Advantage growth. So, we've been really excited about the growth that we've had over the last few

years. And when you look at this slide, it basically shows for our total Medicare Advantage discharges and our stroke discharges, we have grown and outpaced what the growth has been in MA in our local markets. Again, it goes back to that value proposition. While we have access to Medicare claims data, we're able to use those outcomes to sit with our MA providers and really bring the whole value proposition to them, so that they even start looking at their things differently on how do you look at the impact of readmissions, because yes, SNF is cheaper than IRF, but maybe you need to think beyond that and the impact that it makes if you've high readmissions from those skilled nursing facilities.

Mark mentioned before about our growth. So, when we're able to share this value proposition, then the great outcome from that is our growth. And our Stuart, Florida Hospital is a great example of this. We opened in 2013 with 34 beds, because that's what we were able to get a certificate of need for at that time. If you look, you can see that not only we do a great job identifying that market as having a need for inpatient rehab services, but we grew. And by 2014, we were at 96% occupancy.

So, the great thing at that time is that the Florida CON allowed if you were above an 85% occupancy, you could expand by 10 beds every other year. So, we expanded in August of 2015 and we added 10 additional beds. Again, pent up need in that market, because by 2016, we're already at 98% occupancy. So, we expanded again in May of 2017 and added another 10 beds. And by then, we're producing $7.6 million in EBITDA, we have gone to 166 FTEs, and again by 2018, we were at 97% occupancy, so a great story in this Florida market. So, last year in December, we added another 10 beds, and when the CON was repealed, we said we know this is a market that really has the demand for these services. And so, we're adding 16 additional beds that will open at the end of 2020.

So, it's great that we have growth, right. As operators in the hospital, growth is a really great thing. But growth doesn't mean much if we're not managing it and if we're not becoming efficient providers. So, one of the things that folks will say your guys margins are really good on the inpatient rehab side and what we remind them is that we've very few outlier payments. So, when you look at us compared to the rest of the industry, we're not paid more. What it comes down to is that we're very efficient. We know how to manage our hospitals. And so, I talked about the technology and as it related to our clinical management. What I'd like to share now is some of the technology that we use as it comes to actually managing our hospitals.

So, we have a proprietary management system that's called BEACON. A lot of our systems feed into BEACON, so that we have real-time data access to our operators at the local market and I'm going to walk you through a few of these. We have over 40 BEACON applications and don't worry, I'm not going to take you through all 40, but I do want to give you some examples of the tools that we use.

So, the first is on labor productivity. This allows any operator in the hospital to see at a daily, weekly, monthly basis, how am I doing managing my labor. So, in this situation, I can look at it at the hospital level. So, when I was a hospital CEO, I look at this couple times a day. It allows a regional person to look at it from their whole region perspective and it allows us to look at it from a company perspective. We can drill this down as I mentioned by the day, the week, the month, the year.

In this situation, we can actually pick it out for a hospital, in this case the daily employees per occupied bed for this hospital, let's them see how they compare to their budget. If they look that they're having some days that they're over budget, they can say, well, what's going on here. They can drill down to understand, am I spending time in overtime, and if I am, where is that. So, in this hospital's example, the majority of their overtime that they've spent this current month has been in nursing. The next one following-up from there is housekeeping. So, they can drill down then to a department level, to a nursing level to say, okay, what's driving that, so that they can actually manage that real time and not wait for the end of the month to come and wonder what happened.

Another one of the tools is our care management tool. This gives us patient level outcomes in one report, so that at a hospital again, a region or a company level, we know how we're doing for our quality metrics, how we're doing for the discharge to home versus skilled nursing facilities versus back to acute care hospitals. It allows us to drill down for a diagnosis. So, if I want to know how that hospital or that region is doing for their stroke patients, I can drill down to a diagnosis level, I can drill down to a payor source level, I can even drill down to a referring hospital level.

So, if I have an acute care hospital that's wanting to get stroke designation certification and they say, well, Barb, could I understand how my patients that have stroke are doing in your hospital. I can go out there and say, sure, for last year, I can tell you exactly how your patients did in our hospital that had stroke. I can even look at trending for a region. And so, this is a metric of skilled nursing facility discharge and say, how is that region doing over the last year when you look at it each month and I can even drill down to the case manager level, so is our case managers in our hospitals that are helping to facilitate our patients getting home.

If I've a new case manager and I realize all of a sudden they have more patients going to skilled nursing facilities than my other case managers, so I need to do some education. So, I need to remind them of some of the resources that are available, so that I can help them kind of get in line with where everyone else is. We also have our business development analysis, so it tells me where am I as it relates to my admissions and my discharges for the month. I can even look at it by our clinical liaisons to say, I know how many contacts I need to make to create the referrals that I know then will turn into admissions and it helps me manage that at a clinical liaison or marketers level.

And then, the last one I'll share with you is the physician dashboard. We do not employ our physicians, so many times we're asked, well, how do you motivate your physicians then, if you're not paying them, how do you motivate them to have improved outcomes. Well, what we find here most physicians are very competitive in nature. And so, our physician dashboard allows us to compare the outcomes of our physicians within a hospital or region in the company. And that works in a great way to motivate the physicians to have them realize that these great outcomes are available and that we can help mentor them and coach them in how to get, if there's someone that maybe is an outlier.

I will touch on clinical collaboration. As Mark mentioned, when we talk about our clinical collaboration, it's in our overlap markets where we have a home health within a 30-mile radius of our rehab hospital. The rate is the percentage of our patients that are going home that need home health that go to our home health. So, our clinical collaboration BEACON tab allows us again to see that at a facility hospital level or at a regional level or a national level. But it also lets us understand if a patient is not coming to our home health, why, was it because of insurance, was it because they were outside our service area, was it because of patient choice, because when we know this kind of data and then we know what source of things can we be working on, so that we can improve that clinical collaboration over time.

Clinical collaboration is not only important to us from a financial perspective, but it's really important to us from a quality perspective, because what we have found is we've continued to try to improve our quality metrics. When you compare our overlap to our non-overlap markets, while all of our markets are showing improvement in quality outcomes, the speed in which we're improving in our overlap markets is greater than those in our non-overlap. And that's because we have this close connection with our home health team to really work together on making that a smooth transition home. So, you guys are going to be getting here a break, and after the break, this is a great handoff on clinical collaboration, because April and Luke will be coming back after the break to talk you more about the home health segment.

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

So, we're running a little ahead of schedule. So, we're going to bypass the agenda, and if everyone can be back, we'll get started at 09:50. Thank you.

[Break] (00:58:20-01:20:39)

April K. Anthony, Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

[indiscernible] (01:20:32)...so with that let's talk a little bit about our home health and hospice segment, not to mentioned, we are the fourth largest provider of home health and hospice services in the nation. We have 245 home health locations, [indiscernible] (01:20:55-01:21:00) it's really an administrative delivery side, it's really about 60-mile radius around each of those 245 facility sites where our administrative team works that's really where our care is delivered, and that is in a 31 state legion. As Mark mentioned also 89 of our 134 hospitals reside in a market where our home health locations can overlap with those hospitals, and it's in those markets that we see that care – that clinical collaboration opportunity exist, and it's the thing that we are seeking each year to grow and improve.

I believe when we started our partnership five years ago we were in the 20% range, 28% I think was the number something in that magnitude. And so we've seen a huge increase in our clinical collaboration rate now seeing north of 60% of our hospitals having the opportunity to collaborate with our Encompass Health home health and hospice locations.

I will also mention that our revenue in the home health and hospice segment is coming 82% from the traditional Medicare service line. And so we do have a growing percentage of our patients coming from Medicare Advantage, but not growing quite to the extent that we're seeing on the in-patient rehab side yet, we still have some work to do in the home health space to really prove that value proposition to those Medicare Advantage payors, and hopefully continue to see that Medicare Advantage proportion grow.

Our home health team consists of about 9,900 total employees that are a network of nurses, therapists and social workers, and home health aides who travel around in those communities that we serve caring for patients. Last year we had 159,700 total admissions of new home health patients, that's all payor sources within our home health arena, and in combination that created about a $900 million revenue business within the home health only segment of our organization. And so, that gives you a little bit of a sense of the scale of the organization that we're running in the home health sector.

And with that, let's get back to some of those reasons that we're excited to be in that sector. Mark shared with you a little bit about the demographics, I personally liked this view of it, if you kind of the we are here button in 2020 and [indiscernible] (01:23:16) forward to what happens over the next 20 years, you see that significant progression in our over 65 population.

But in particular, you see a significant progression in that yellow band, patients that are between the ages of 75 and 84. That is a sweet spot for home health care, and you can see that that yellow band in particular is growing and I think the lighter gray at the top of that those 85-plus patients are going to also be a patient [indiscernible] (01:23:47) grows as a proportion of the total, we'll see more and more patients coming from that range as well. And so, we have a lot of things to be excited about in the coming years as it relates to the inherent demographic wave and particularly the growth in the way that is most well-suited for the home health care space.

Another dynamic that's certainly driving our home health sector is that in addition not only are we seeing more patients, but we're seeing more patients who are experiencing a number – a large

number of chronic conditions. The data shows us that 36% of the Medicare beneficiaries have four or more chronic conditions, and that that cohort of patients is spending 75% of Medicare's dollars. It's particularly important reported when you think about that group of growing patients and that bundle of expenditure that's happening for those patients with chronic conditions that we find new solutions to some of the challenges that these patients are experiencing.

And as Mark showed us earlier, part of the reason we're excited is because we believe that solution that's going to be most palatable with this growing base of seniors is going to be the home health based solution. Medicare spends about $17.7 billion a year on home health care services, note that that's now a little bit less than they spend on hospice services, hospice at $17.9 billion, but the cost per day of care for a home health patient by the Medicare payor is $47 a day. Undeniably this is the most efficient way that we can care for patients, and like it, our hospice service line at $168 per day equaling an efficient level of care for patients from a cost perspective. And when you think about that growing demographic wave and couple it with the cost efficiency of these two service lines, we have a lot to be excited about.

Add to that the fact that patients prefer care in their home and survey after survey is telling us that 9 in 10 Americans say, they would prefer to age in place, and receive their care in the home. When we put all of that together, it gives us a lot of reason for enthusiasm about the future of our home health care service line. And I want to break down a little bit further, how we go about growing within those cohorts of patients. So that's Luke who oversees the sales and marketing area within our home health and hospice service line to break down for us a little bit about how we grow into that opportunity.

Luke James, President, Home Health & Hospice, Encompass Health Corp.

Thanks, April, and good morning, everyone. To talk, as April said, a little bit about, why we're so excited about the home health space in general, our size and scope that we are today, as well as the demographic tailwind that we have to look forward to into the future. I'm going to dive in a little bit into how we're unique in our growth strategy. I've broken – we've broken this down into four different segments here, the primary segments of our growth representing where our admissions come from. We've spoken quite a bit today about clinical collaboration and what that is, and unpacked the importance of that. We are very proud of the progress we've made over the past five years, but more so in the clinical outcomes we've achieved through our clinical collaboration efforts and programs.

You can see here the clinical collaboration admits attributed to that program represent a minority of the overall admissions that we bring into our home health service line. Our largest is through our care [audio gap] (01:27:09) today. This is a group of clinicians primarily made up of RNs that are in acute care hospitals and other facilities including our own IRFs. But these are those represented in facilities other than are IRFs here in this second box, representing 34% of our total admissions.

And the value that we can bring to hospitals and to payors in ensuring that patients are transitioning from a facility level of care to a home-based setting is critical. With 30-day readmission penalties, with hospitals and payors carrying more and more about the spend outside of their four walls, and with their members outside of hospital settings, these care transition coordinators bring a lot of value to the overall spend in preventing unplanned readmissions.

Our specialty programs, we have a number of these, they are evidence based. Our sales team members are trained and educating referral sources, and how they differentiate us, and the care that we provide. Our clinicians in the home follow the tenets of these programs in delivering high-quality care to patients that meet their unique needs based upon their unique set of diagnoses that we're treating for them in their home.

And then lastly what we would refer to is traditional settings, primarily made up of patients' primary care physicians, referring patients that are in need of home healthcare in many cases in a pre-acute manner.

Physicians see something going on with the patient in their panel, and refers them to home health in hopes of avoiding what looks to be a pending hospitalization or ER visit coming if an intervention isn't applied. And we have a great opportunity here in treating these patients, delivering great outcomes for them, because when those physicians hear about the outcomes that we have, it can pay dividends in the communities that we serve through our reputation.

Breaking down how we grow a little bit further, you can see here through the bars on this graph that we have grown the number of sales reps in the communities that we serve exponentially over the last five years. It's been a lot of growth on the team that has had – helped produce the organic growth rates that we've achieved. But I'd like you to focus a little bit on the yellow line here, which is the number of sales reps that we have per branch over this timeframe. And you can see that statistic has grown significantly over here as well. And you can kind of compare that to what was, Barb spoke about earlier, through kind of bed expansion in IRFs. This is our equivalent of that in the home health Space.

We're not expanding beds, but we have a service area and in order to get bigger market share out of that service area, we have found that increasing the number of sales reps in each of our markets creating smaller territories for our sales reps allowing them to focus on their top accounts rather than to be spread across a large number of them, that they're able to be effective, they're able to add more reps in each community, and in driving that overall organic growth rate up.

We think there's still significant room in this statistic as we look out into the future that will continue to help us do just that. The results of these efforts is illustrated on this slide, you can see we've experienced strong organic growth rates, and that is even with the amount of Medicare revenue that we've had. Many of our peers in order to achieve organic growth rates that they have, have had to diversify their payor sources in order to get more volume. We've been able to do this with payors that recognize the value of the services that we provide, and that reimburse commensurate to that value. It's a challenge every day, but that is what we've been able to do in the past and what we continue to look and strive to do in the future.

The new store growth has always – also been significant over this timeframe, several large acquisitions and a number of smaller acquisitions that allow us to achieve double-digit overall admission growth rate over this timeframe, and that we're projecting into the future.

We have a long history of being a successful acquirer of other home health and hospice providers across the country. Primarily those that expand our geographic service area and meet our stated objectives of increasing our overlap between our home health service line, and our inpatient rehab hospitals, as well as our home health service line and our hospice service line. What – it's important I think to take away from this graph is that while multiples may change over time, and what buyers are having to pay to get quality assets, one thing that hasn't changed is our ability to de-lever those multiples over a fairly short period of time.

While significant amount of work goes into identifying high quality providers to acquire in agreeing to terms and ultimately getting those deals across the finish line, the real work and our real success as it relates to our acquisitions is in the integration, in growing those agencies after we've integrated them into the Encompass Health family, in making them more efficient, and driving more dollars ultimately to the bottom line, and again de-levering that effective multiple that we've paid one, two, three, four and more years out to a number significantly less than what we paid at the time.

Our early experience in bundles with BPCI, the legacy BPCI as well as being preferred partners for ACOs across the country, demanded that we got better early on about six or seven years ago at expanding the – our ability to provide non-visit based interventions, and in applying greater technology to the care that we provide in the home. Harnessing the power of that data and AI can provide in predicting patient care needs, and in delivering the care that those patients need.

So what you see on the slide are the four modules from an organization called Medalogix that we've partnered with. We utilize each one of these four tools that they have, and it's just – just some of the tools that we utilize to drive the outcomes that we have.

On the top left from time-to-time we discharge patients that are no longer appropriate for the home health service line. But they still might have – be at risk to needing to go back to a hospital or an emergency room over the subsequent weeks. Nurture helps us identify who those patients are and allows us to stay in touch with those patients and help triage them to the most cost effective and clinically appropriate setting, many times not a hospital or an emergency room.

Through Touch, we're able to identify patients that come onto our service that are at greatest risk of readmission, coming from a hospital and greatest risk of going back. And so it allows us to match the intensity of our services with the acuity level of our patients. And the ability to do that goes a long way in keeping those patients safe at home and out of the hospital. In addition it provides an IVR technology to our care management team to provide non-visit based interventions that are very cost effective, as well as effective at preventing unplanned care.

Bridge is a program that helps us identify patients on our home health service line that might be more appropriate for the hospice service line that are nearing end of life and allows us to identify those patients to have end of life conversations with them, their families and their physicians. Ultimately, if they are more appropriate for the hospice service line, and they elect to transition, we're able to provide them with a much more holistic hospice experience than they otherwise might have received.

Many patients on home health who are trying to improve and get back to a level of independence when they're nearing end of life find themselves with a very short hospice experience that can be measured in days many times in single digits. That's not what is intended for patients that ultimately like hospice. The benefit was designed to have months for the patient and the family as they reached end of life. And this is what Bridge helps us do to ensure that is the case for our patients that need that level of care.

And then lastly, you may have heard quite a bit about Medalogix Care over the last several months. This is a tool that we helped co-develop actually with Medalogix back in 2016 when we started co-developing this tool with Medalogix, it was to ensure that our patients had a just right care plan for every patient that came onto our home health services, that they had the right number of visits applied to achieve the desired outcome of discharging them safely to the community, and not back to a hospital after our care.

But it was built for that patient care, it wasn't built for a payment model, it was payment model agnostic. But we're fortunate over the last couple of years of developing, co-developing this with Medalogix, it has shown great results in achieving better clinical outcomes for our patients, and making sure that care plans are just right for every episode.

This is a quick view into what our clinicians in the field and our back offices who are supporting them see when they log into Medalogix, when they retrieve the recommended number of visits after we've performed an initial assessment on our patients, and admitted them under our care. This is a tool that's intended to equip our clinicians and the physicians overseeing care who ultimately decide the level of care that is needed for each patient.

We have found that the more tools like this that we can provide are clinicians, the better their clinical judgment becomes, and the more specific the care plans are for each one of our patients. We've seen a reduction in transfers to hospitals for patients on our service, and we've gotten more effective and efficient at the number of visits we're providing to each patient. So with that, I'll turn it back over to April to talk about how this – take you into the home where the care is actually delivered.

April K. Anthony, Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

Good. And I might mention too, on the Medalogix tools that the three tools of Touch, Nurture, and Bridge have all been tools that we've been using for a number of years, it's only the Care tool which is newly implemented in our organization or we began the implementation in 2019, anticipate that by the end of April, we will have 100% of the locations deployed on that tool. We're currently north of 70....

Luke James, President, Home Health & Hospice, Encompass Health Corp.

77.

April K. Anthony, Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

...77% deployed as of this moment. And so that tool is the only one that's a new piece of our arsenal to address care needs for our patients. But once we get into the home, Barb showed you all of the cool equipment they get to have in the hospital, all of the resources that they have at the hospital level, we get into the home, it's a very different game. We get into the home, we find out what's really happening and we've got very few tools that we can per se bring into the home to succeed. And yet, we've still got those great opportunities and it really starts with medications because it's so often that when the patient comes out of the hospital, we think they're going to do one thing that they get home and they open their medicine cabinet and there's all these leftover medications from last time, and they're confused and they start taking them again, and they aren't quite sure what to do and so one of the first things that we have to do as we admit that patient, which also has to happen in an extremely timely fashion, getting there we find 84% of the time we arrived within 24 hours of hospital discharge for all of our facility-based discharge patients.

We get there that at that timely admission what we often discover is that we've got to re-orient and re-educate that patient. We've got to tell them, don't take these anymore and these particular over-the-counter medications are no longer ones that are really going to work well with medications you're on currently.

We've got a lot of work to do in the medication reconciliation. So often what we find in readmissions is that it occurs within the first 72 hours of arriving back home. And so being there early in that 72-hour period really is essential to making sure that we minimize the risk that that patient's going to go back into acute-care setting. Getting their medications right early on is one of those keys.

Another thing that we deal with in the home health environment is as I mentioned, we don't have those equipment opportunities. We've really got to figure out how do we get this patient ambulating safely in their home, and in their surrounding community, and that means that we've got to use low tech equipment, therapy bands, and other things that we can do to say, how can I encourage and engage this patient in their therapy even though I don't have high tech equipment that they had in the hospital. And it's our therapist who really makes sure that that patient who may have appeared safe on a nice smooth slick floor in a hospital environment with a roller that could roll well down those halls.

As you heard with our patient, Sandra, when she got home, how am I going to get my walker down this narrow hallway to my bathroom safely, we'd address those real world problems. And then we also recognize that in home health our teaching really extends beyond just to the patient. We've got to bring that caregiver in that family into the network. If we're to leave that patient with home exercises, we need to make sure that caregiver knows how to administer those exercises, knows how to encourage that patient to do those exercises when their therapist is not present. All of those things look a little bit different in the home but they're essential elements to how we get that patient to return to their greatest level of independence.

And like the IRF side, we too rely heavily on technology. Of course, our technology base is the Homecare Homebase platform and as Luke mentioned, we add to it other tools such as Medalogix. Homecare Homebase for us has really been a game changer. And it's not so much solely the tool itself, it's really how do we use that tool. How do we make sure as an organization we create the kind of disciplined use of that tool, so that we drive the greatest outcomes with it. And it really produces outcomes across all avenues.

First, the tool helps us create an operational efficiency. It allows us to remove human effort where it's not necessary, to automate processes, to define business – the sequence of business activities so that we can ensure we come up with the most efficient operating model.

Second, with the tool helps us promote clinical consistency, because it's great if a great nurse can go out and deliver great care, and get a great outcome, but how do I do that always with every clinician, well I'll automate those processes. I bring clinical decision support tools to bear so that every clinician from the very best to the one that might not be at that same high level of experience can deliver the same consistent outcome. That's where our ability to scale and create consistency in our outcomes has existed and Homecare Homebase promotes that by putting in the hands of every clinician a device that allows them to see the patient's history, that guides them to the best clinical interventions, that helps them monitor where those behaviors are somehow resulting in inconsistent delivery or inconsistent expectations occurring for that patient. The tool drives that clinical consistency for us.

It also ensures in a world that is heavily regulated that we follow compliant processes. I was sharing earlier with someone that when we do acquisitions it's not so often that we find that the patients don't qualify. What we often find in our diligence is that the documentation is not well-founded that it doesn't support the care that was delivered. And sometimes, it will be so problematic that we'll actually have to walk away from an acquisition because they don't have a solid documentation process. But when that customer or that potential acquiree is someone that's used Homecare Homebase, like us, they got to process the guides compliance through the process. That ensures that every clinician knows exactly what needs to be done, the sequence in which it needs to be done, the requirements about what can happen before a bill can be submitted are all managed properly. And so, that compliance component is essential. And then, all of that works together to drive and enhance financial opportunity.

Like the IRF division, we're proud of our financial success. We too are rate takers, so we don't make more money because we charge more money, we make more money because of the efficiency with which we deliver care. And much of that efficiency comes because of the way we utilize the Homecare Homebase tool to drive that efficiency through our system. This is just an example of one of the reports that I wanted to share with you. This is what we call our key metrics report.

And these are reports that are updated every day that like the BEACON solution that Barb shared, we're able to look deeply into what's happening in our organization. We can particularly look at this example is showing us patients that are brought to us based by their source and timing. We can flip a switch and look at it by clinical category. We can see how many visits per patient are being done.

We can see the revenue for that particular category. We can see the projections of admissions and recertifications and what that's going to potentially do to our senses in this new world of PDGM. We can focus particularly on the percentage of episodes that are making it into that second 30-day period.

All of this information, including our management of our LUPA patients helps our clinical team at the local office be able to actually know what's going on in their branch to anticipate it, before it becomes a reality so that we can work collaboratively with our sales team for running behind on admissions. What are we going to do to catch up before the month comes to end? If we're seeing LUPA beginning to grow, how can we identify the reason for that and determine if it's appropriate? These kinds of reporting tools and the way that we've integrated them into our day-to-day management is really key to our success.

And from all that, we've been able to drive exceptional outcomes. Clinical quality outcomes as evidenced by our star ratings which concluded last year at 3.8 average stars across all of our provider numbers, our patient satisfaction rankings which came in at 3.7 stars, and best of all, our readmission statistics where we're performing above the national average. When national average 30-day readmissions are coming in at 17.5%, we're coming in at 16%, and we think that particular metric is really the most important one.

It is truly a claims based metric. Everything else is based on self-reporting and you can always have some subjectivity about that. But this metric is fully objective. Did the patient go back to the hospital and we think our ability to outperform the national average in this particular metric is the most important one not only for our Medicare partnership, but particularly for our future opportunities with non-Medicare payors.

With that I'm going to hand it back to Luke and let him share with you a little – pardon me, I'm not going to be there. I got the slide behind. I want to tell you a little bit about why I think we're able to achieve that. Technology, and tools, and processes are an essential part of it, but really built on top of all of our best practice processes is a best place to work type culture. And we feel like when we get the process right, then we have the opportunity to pour over that a culture, and I'm proud to tell you that we have now for five consecutive years in the home health and hospice division been named to Fortune's 100 Best Companies to Work for in the United States that's not just in healthcare arena, but across all segments.

In the modern healthcare rankings we are now nine consecutive years as being named Best Place to Work by Modern Healthcare. And finally the Great Workplaces Organization named us as one of their top workplaces as well and particularly called out our organization for being a Best Place to Work for Diversity and the Best Place to Work for Women those statistics that we're particularly excited about and proud of, but it's that culture that draws in the best people that then lets us deliver the best care because when I take those best people and I empower them with the right tools, with the right training, with the right resources, when I support them by recognizing their contributions and by telling them we appreciate them then I can challenge and to go deliver the best care.

And that's what we find as you saw in the outcome slides is exactly what's happening, and from that best care, I have a story to tell to my referral sources, and those referral sources build loyalty with us because of those consistent outcomes we can deliver and that ultimately helps fuel our long term financial success, but I believe wholeheartedly. It starts right here. It starts with treating our people right. Attracting the best people and then empowering them to go fulfill our mission. And with that is where our success begins.

But obviously the new payment model is something that we've been spending a lot of time talking about over the last couple of quarters of last year, and early into this year. And so I want to dive in and talk a little bit more about the PDGM model where we're experiencing now two full months into

that program and there's probably no greater expert in the country frankly on PDGM than Luke James, he sits on the technical expert panels for this, for CMS, has been deeply involved in our Washington efforts, and so Luke, come tell us a little bit about PDGM and our experience here.

Luke James, President, Home Health & Hospice, Encompass Health Corp.

Thanks April. I'll spare everyone the highly technical components of PDGM. [ph] Now what (01:48:15) we're going to focus our time on as it relates to that. But 2020 is a big year for the home health industry. Home health providers across the country are getting a lot thrown at them this year. The Patient-Driven Groupings Model is a brand new payment model that I'm sure everyone in the room is familiar with, completely different than the old payment model different incentives, different reimbursements for patient care, much more complex than the prior model was that we had for the past 20 years.

On top of that we have reviewed the Review Choice Demonstration. Think of it as a prior off getting put on to home health providers, a little bit different than that, but essentially that's what it does. Although, it's only going across five states this year included in those states are Texas and Florida two of the largest states across the country for home health – Medicare home health spend.

Medicare Advantage payors continue to grow at a fast clip as we all are well aware and historically haven't been as friendly to home health providers as it relates to rates and terms, ultimately paying on a timely and appropriately. And so, as they continue to expand and get a greater focus on to home health, there are both risks and opportunities lie with them. We know that CMS through CMMI is going to continue to develop and deploy new payment models, most of which bears some level of risk. And so, that too brings risk and opportunity for the industry as a whole.

But rather than unpack the Patient-Driven Groupings Model or PDGM, which we've done a lot of over the last year or so, I wanted to share with you today our strategy for success as we enter 2020 as the first couple of months are now under our belt. We feel strong about what we've seen so far, proud of what we did to prepare for it. I think that we prepared in the right ways. But it is still new and still getting [indiscernible] (01:50:07) I wanted to share with you what's most important as we see it under PDGM to achieve success.

PDGM as I said is a much more complex payment model than our old one was, it relies much more on the clinical diagnoses of patient and accurate coding for every episode of care that we deliver and ultimately bill. And so in order to be successful under PDGM it starts with getting as much information as we possibly can from the referral sources that send us patients to care for.

What we refer to as a complete referral would encompass every bit of information that that referral source has from the prior setting of care that that patient where they were treated from a hospital, from an in-patient rehab facility, from other settings of care, if we can get a complete referral we're going to set ourselves up for success in making sure that we're aware of everything going on with that patient that needs continued attention in the home as we transition them from a facility setting to the home setting and we're going to have everything that we need in order to accurately diagnose and then code the episodes of care we're delivering.

That coding and assessment has to be much more precise under PDGM, because of the way that the model works. CMS wants much more specific codes than they've received in the past for certain episodes of care that the industry delivered and that starts with better information on the front end that allows us to do that, ultimately bill for the correct reimbursement every time.

Care planning, we talked about the Medalogix CARE Tool in addition to other tools through home care home base that we have, but proven evidence based tools in the hands of our clinicians are – have always been important and even more so under PDGM. It allows us to make sure that every

care plan is individualized to the unique needs of that patient at that time that there's no generic care plans for patients that have CHF. That there there's not a one-size-fits-all for patients that come to us with diabetes or COPD or recovering from a knee replacement. But they are truly patient specific each and every time.

And then ultimately as you heard April talk about before care delivery, ultimately we're reliant upon our clinicians for delivering that care in the home and making sure that they are equipped with what they need with the tools that they have that they're passionate to deliver that great care, because they feel taken care of, and they're passionate about the organization that they work for as they're heading into the homes to deliver this care. But ultimately it doesn't matter how we're paid. It doesn't matter what payment model, CMS or others may try to actually do put on the home health industry, ultimately care has to be delivered the right way in the home in order to achieve great outcomes.

The Review Choice Demonstration or RCD, again is a little bit like prior off, CMS is trying to review all documentation related to the care that we're providing prior to approving payment for reimbursing us for the care that we provide. And so we've got to make sure that we're again getting a complete referral on the front end, it's heavily reliant upon getting all that same information we need for PDGM, also helps us with RCD to ensure that we have a robust set of codes – accurate codes and diagnoses to then submit to CMS through the [ph] Max (01:53:20) to make sure that we're being reimbursed appropriately for that.

There are potential delays in cash flow that impact all providers and participating states this year, and so making sure that we get that information timely through our robust network of sales resources that we talked about a few slides ago is critical to not experiencing those significant delays in our organization.

One positive from RCD is that we're able to by selecting the pre-claim option, which is one of the options under the RCD. We're able to – if CMS the clinical reviewers find errors in our clinical documentation that we submit for affirmations to get approval and then ultimately get paid on the episode of care, if they find an error we're able to correct that error and resubmit that packet of information back to the clinical reviewer to then look at again, approve and ultimately move on with full payment the vast majority of the time.

And this is one of the great benefits we see from RCD, is that historically in post payment audits, we don't have the ability to go back and correct, maybe a missing signature, a technicality in a chart that might be inconsistent with other elements of it that ultimately leads a clinical reviewer to deny all or portion of the claims that we bill, under the RCD pre-claim option, we have the ability to correct that in advance, and then ultimately get paid on the back end, keeping us relatively immune from post payment audits on any episode of care that is deemed affirmed by the reviewer during that time.

But this creates an opportunity for larger more sophisticated providers, who can rely on technology to automate workflow and process, they don't have to add a lot of back office administrative burden to deal with the manual aspects of submitting all this additional documentation to CMS in order to get paid, it's an opportunity for us to continue to grow and outpace our competitors in the markets that we serve.

We would like to be in network with every payor in the country with acceptable rates and terms, that would be our goal. Unfortunately, not all payors see home health and the high quality providers that are in the industry for the value that we can bring to their members and their plans. But we believe we provide better care and better outcomes to the patients that we treat. We would like to extend that same level of care to payors that were not yet in network with, that we have not been able to negotiate what we would deem reasonable or fair terms and rates in order to be in those networks.

But we would like to extend that same level of care to their members and the same level of outcomes ultimately back to the plans.

But we do believe that we are well-positioned for the future of MA growth. Our participation in BPCI, where we produce significant savings across 90-day bundles for CMS and treating patients even outside of the home health setting for those patients that had discharged from home health during that 90-day bundle, but still needed some level of care, we invested heavily in our care management team and our ability to deliver non-visit based interventions to keep those patients in their homes. We believe we can rely on that expertise to become more innovative in the way that we work with Medicare Advantage, and ultimately deliver better outcomes for their members, better financial outcomes for the plans that create savings for them just like we did for CMS.

Over the past five years, we've been a part of a large plan across multiple markets, treating almost 70,000 members as a part of their plan through a capitated arrangement with this plan. And we believe that we can leverage the expertise, the outcomes that we've produced for that plan over those last five years to also grow in a manner like that, that is more innovative and not the typical fee for service approach or Medicare Advantage has historically reimbursed the industry in many of our peers.

But ultimately as April said, leading the way in hospitalization rates, whether that's readmissions for patients to come to us from a hospital and we keep them at home and safe and not back in the hospital or just reducing overall hospitalizations for patients to come to us from the community and not from a facility setting, ultimately and that is where patient satisfaction comes from. Patients don't want to be bouncing back and forth to the ER, back and forth to an acute care hospital, and ultimately that's where savings are going to come from, from the plans. So we believe if we continue to focus on that metric, continue to lead the industry in that metric, we're going to be well-positioned again to benefit from the ongoing growth with Medicare Advantage.

So with that, I'm going to turn it back over to April to dive into hospice a little bit.

April K. Anthony, Chief Executive Officer-Home Health and Hospice, Encompass Health Corp.

Yeah, just a couple of things on hospice. First and foremost, I want to tell you that most of what we've talked about from a home health perspective also applies to hospice. And our hospice service line we similarly have a growing team of area managers that are out communicating to the referral sources about the benefit of our services that are helping us grow and accelerate our growth from that confidence and our ability to grow Luke and his team [indiscernible] (01:58:19) have been able to help us build up base of services and give us confidence that we can continue to be an acquirer in the hospice space.

We similarly use advance technologies of both home care, home base, Medalogix bridge as Luke mentioned to drive a sophisticated care plan for hospice, all of the things that we've talked about, and particularly the culture of our caregivers brings us to the same level of confidence that the things we're doing that have proven so successful in home health will continue to help us succeed in the hospice service line. We've again in earnest in the hospice service line in 2011 with our first acquisition really began to accelerate our growth and expand that program in 2013 and now just a few years later have moved to being the 11th largest provider of hospice services in the nation.

We have 83 hospice locations, and just like we've done with the hospital division we recognize that when we can create overlap between our home health and our hospice service line, we can create great value for the patients as well as benefit for our organization and so you can see 77 of those 83 hospice locations are in overlap markets with our home health service line, operating currently in 18 states and little different from our home health service line the hospice service line at this point in time is still primarily funded by Medicare, 98% of our hospice revenues which add up to a little

over $200 million are coming from the Medicare payor. And so we're excited about what's happening in hospice.

And we think that there is a huge opportunity for growth in this service line, and Mark shared some of the reasons why. First and foremost, we think the demographic trend and the cost efficiency will drive the continued utilization of hospice services. We think increase patient and family preference for end of life care in the home is going to continue to grow and we believe that patients as you can see from the chart on the right that are beginning to accept hospice at a much faster rate, in 2000 just 23% of Medicare [indiscernible] (02:00:24) used hospice services, by 2017 that it more than doubled to 50% in 2017.

But even more important perhaps than the growth in utilization of hospice is the opportunity that still exist. You see even today, we find that 28% of the participants that utilize hospice services receive that service for seven days or less, and that is a huge opportunity. As Luke mentioned, this service was built to be a service that lasted for months not days or weeks. And it's in that opportunity to care for a patient through a season of the end of life period that we really see the great opportunities for growth in this service line.

We also believe that we have a lot of opportunities financially to improve our performance in hospice, although we already have strong financial performance. Our average branch size for our hospice branches is just 45 patients per branch, and we find a real inflection point, when we can get up to 50 to 75 patients, we find that the ability to create a more profitable infrastructure is – it really exist for us. And so we think a lot of our future growth is going to come in a very profitable way as we begin to move the scale of our branches just like we have in home health and hospice scale and density in our markets is the key.

In hospice we're just beginning to realize that density and that scale that will help us be successful financially. We also think that in addition to the acquisition base growth that there is an opportunity in our hospice service line to accelerate our de novo-based growth. Particularly when you think about those 245 home health locations, only 77 of which currently have a hospice location. We've already got infrastructure in place. We've got locations, we've got teams, we've got people, we've got a reputation that we've built in those markets for high quality care and home health. We think going into those markets with de novo opportunities when we can't find a desirable acquisitions are going to give us a great opportunity to grow our hospice service line.

And then, we also think that this industry just like home health is an industry that is right for consolidation. Over 4,500 players in the hospice space, a high percentage of those been mom and pop type players, we know that the consolidation opportunities will exist here. We know we've got a proven track record in our ability to do that.

And so, when you look at the balance of our home health opportunities and our hospice opportunities, we are very bullish on the future, confident in our ability to successfully grow, confident in our ability to use technology to advance clinical outcomes, confident in our ability to create financial results that are significant for the organization.

So, with that, let's let Doug come up and tell us a little bit about how we're going to execute on both our [ph] earth (02:03:20) home health and hospice strategies.

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

So, as Mark stated at the outset, we're very excited today to be able to share with you our new growth targets for the next five years. And as you've hopefully heard as well from Barb and April

and Luke, the pieces are in place, the investments have been made over the last decade to provide us with confidence in achieving these targets.

Here we go. But growth requires investment. Investment is going to come over the next decade in much the same way that it did over the prior decade in increased spending for de novos with an elevated target now of 6 to 10 per year, with an increased target for capacity expansions at existing hospitals, a 100 to 150 beds to existing hospitals per annum, and with continued investment via acquisition in home health and hospice. We have that marker there of $50 million to $100 million per annum, that's a marker that's been out there for the last several years as we've demonstrated that's not intended to represent a cap, where opportunities for larger acquisitions present themselves, we intend to be competitive for those.

We've had three great examples since we formed our partnership with Encompass home health and hospice, in CareSouth, and in Camellia and most recently in Alacare, we intend that incremental growth is going to require that investment, that investment is going to require funding. And again, consistent with our recent past that funding is going to come from two sources, it's going to come from internally generated cash flow and that's going to be augmented by maintaining access to the debt capital markets.

We are fortunate that one of the characteristics of our business model is that we generate consistently high levels of free cash flow. And one of the targets that Mark shared with you earlier is that we anticipate that will continue to be the case moving forward with a target over the next five years of free cash flow generation in the 8% to 10% level for our CAGR.

We'd like to take a very proactive approach to managing our balance sheet. It's a strategy of a no drama balance sheet. And so, this is a snapshot of what our debt capital structure look like at the end of the year, leverage is very manageable at 3.2 times and you can see there our debt maturities are all well-spaced with no maturities occurring prior to 2023.

Last year we had a couple of significant transactions in the debt capital markets. In September we issued $1 billion in new senior notes slip between 2028 and 2030 maturity that allow us to cleanup some funding that had occurred under our revolving credit facility for the Alacare transaction as well as a few other things, and also to extend the duration of our debt capital by engaging in a call on the 2024 notes and moving those maturities out.

Now you may recall as you can see here at the end of the year the balance on the 2024 senior notes was $700 million. As we entered 2019, the balance in that particular maturity was $1.4 billion. So not an uncomfortable level, particularly at that time five years still until maturity, but generally speaking we like to manage our maturity stacks so that in any particular year maturities are less than about 1 times EBITDA that becomes more important to us as the timeframe to that maturity decreases.

These are some of the specific criteria we look at in terms of managing our debt capital. Liquidity, the second significant transaction that we engaged in last year was to amend and restate our credit facilities, moving the maturity date out, improving the pricing in the covenant package, but most significantly increasing the size of our committed revolving credit facility to a $1 billion. We ended the year with only $45 million outstanding under that facility. It's going to be a little bit higher at the end of the second quarter or at the end of the first quarter largely due to the fact that we funded the remaining tranche of the home health put options and the SARs during the first quarter that was about a $260 million cash outflow. But still, quite a bit of extra capacity under that revolving credit facility. I talked a little bit about what we were able to accomplish with the new senior notes on, in terms of extending the duration of our debt capital, we actually moved the entire duration of the debt capital structure out by a year, with those two transactions.

We like to build a lot of optionality, so that we can be proactive in managing our balance sheet into our debt capital commitments and if you look at – go back and look at that [indiscernible] (02:08:33) structure that we just looked at, the more recent maturities 2023, 2024 and 2025 are all callable now. And the call premiums embedded in each one of those notes will continue to decrease with time.

We're fortunate given the environment that we are operating in, I don't know that anybody could have forecasted that the 10-year treasury would actually dip below 1%, but both our fixed rate and our floating rate which is represented by the bank facilities on the front end are very attractively priced pieces of debt. So, we have no debt with an interest rate greater than 6%. The $1 billion of senior notes, that we issued in September of last year at coupons less than 5%, we borrow at LIBOR+ 150 under the revolving credit facility and right now, one month LIBOR is at about 1.5% likely to go down, if the rest of the interest rates continue to trend that way.

And we maintain a lot of flexibility just in terms of not having restrictive covenants in any of our debt arrangements.

So, with that, again, we believe that we are well-positioned to continue to fund the great growth opportunities that lie before us for the next five years. I'm going to turn it back over to Mark.

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

All right. Thank you, Doug. I'll start up my presentation today with really three key objectives for us in terms of presentation and management team that we hope to achieve by the time we ended up today and by the team you leave this room.

One, start with a better understanding of the integrated care model, and our ability to integrate the care that we provide for our patients, the opportunity to do that through these overlap marketplaces. You've heard and seen some of the critical quality metrics that we use in all three of our service lines, ability to get patients back home, have a positive experience and able to keep them home and not have a reoccurrence of an acute care transfer back to the acute care hospital.

We've had a chance to take a look at some of the investments we've made in technology and how we're using that now. Finally in terms of how we're enhancing our clinical outcomes, but also how we're using them as critical management tools. In all three of our service lines, you've seen how we manage the labor, you've seen how we have the ability to provide tools for our clinicians to do that just right care plan and optimize the outcomes.

And then finally our growth strategy, obviously we have introduced new growth targets today which we're very excited about. We are very confident given the underlying nature of our business, the aging [audio gap] (02:11:31 to 02:11:37) in all three of our service lines, both of our segments that these are sustainable targets for the next five years.

Then you combine all three of these areas of what Doug talked about in terms our financial stability as a company and the ability to generate high levels of free cash flow and our excellent balance sheet, that's one of the tops in the industry. All of these are areas that make us very excited about the next five years and confident that we have the underlying fundamentals, the management team to deliver the results and take us to levels over the next five years and truly capture the opportunities that lie before us.

So with that, we're going to take a break and we'll be back for Q&A. Thank you.

[Break] (02:12:32-02:33:36)

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

So before we get into the official Q&A we thought it'd be helpful for us to give an update on COVID-19 and where we are as a company, obviously it's a very fluid situation. Every day is something different in the news and reports. I [ph] can't say (02:33:54) that we've had zero confirmed cases in our hospitals. Zero exposures for our staff which is great, we have of which we certainly appreciate that. I can tell you that we have been preparing for this and tracking for this for really the last two months.

Our Chief Medical Officer has had her eye on this and has been incorporating our medical staff leadership as well as some of our nursing leadership to make sure that we know exactly what the CDC was recommending, helping to educate not only our clinical staff, but our hospital staff and home health staff as well.

I can tell you that we are in full compliance relative to what CDC has rolled out just as a reminder, particularly on our hospital settings, it's not unusual for us to have a virus of some kind, there are specific protocols that our team use on a routine basis. Now granted the outcomes aren't always as severe as what we have with COVID-19. So it does take on a bit of the increased attention.

A number of things that we have done, it's really communication is key for any organization right now, as much as to eliminate what is not accurate as much as it is to identify what is accurate relative to the definition of COVID-19, what's involved to the coronavirus in general. We've made sure to educate all of our organization on travel restrictions or where CDC was with that. We have made sure that we work with our supply chain, so that we have all what they referred to as the PPE, all the cans, the masks, the gloves capabilities to make sure that we have access to that for our staff and our patients.

So I feel very good about, where we are as an organization, right now in terms of our preparation. I mentioned earlier this of fluid situation. So we give updates now on a very routine basis. As we get updates and additional guidance from the CDC, we'll certainly be in full compliance with that.

In the event that we do have an exposure, the protocol is, is that you work with the local health departments, who then in turn coordinate with the CDC, if we were to have a confirmed case or exposure from a staff member or a patient that has been confirmed, that's the protocols that we would certainly implement from that point forward. So we feel real good about where we are and hope that just from a macro standpoint that the whole news on the virus gets better than it's been in the last few days.

So with that, we'll open it up for questions.

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

So the rules of engagement for Q&A are as follows. You almost jumped the gun didn't you. So if you're on the webcast and you have a question you can submit your question via the chat box on your screen. If you're in the live audience, please raise your hand and wait for a microphone to be delivered to you. This ensures that we can hear your question as well as those on the webcast can hear your question.

Once you have the microphone, please state your name, your firm and your question and of course we will follow the one question, one follow-up question just to offer the opportunity for more people to participate.

With that who has a question.

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

Crissy always has rules.

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

Brittany would you get the door please?

QUESTION AND ANSWER SECTION

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Kevin Fischbeck, Bank of America. Question about the guidance as it pertains to the margins, because you've talked a little bit about some of the opportunity on margin expansion, I guess in hospice in particular, but you think about 7% to 9% top line growth, you usually think about Encompass being able to leverage that in some way shape or form, but you're talking about EBITDA growth being about the same. So talk a little about the outlook for margins, maybe by products and how it all adds up to stable margins despite the strong top line?

<A – Mark Tarr – Encompass Health Corp.>: Doug, do you want to help that?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah, so, first start with the consolidated and again Kevin your observation is absolutely right. The CAGR that we've put out there for the revenue growth is the same as EBITDA which implies a relatively constant margin and we think that that would be a victory just given the environment that we face from both a pricing perspective and also what will continue to be the SWB environment. So recognize that in our IRF segment about 52% or 53% of each revenue dollar is consumed by SWB, and the percentage is higher in home health and hospice, embedded in our growth targets moving forward specifically for EBITDA is the assumption that those two – that line item will continue to grow about at the level that has in the last several years.

So with the [ph] SW (02:39:28) component, it's about 90% of SWB, increasing about 3% per annum. And benefits probably moderating a little bit from the 2020 assumption, because we are coming off a low base in 2019 to somewhere back in that 6% to 8% range. So that would imply that you really need an aggregate pricing increase that is north of 1.5% and getting close to 2% before you experience any deleverage against the SWB line.

We do think with the continued growth in revenues and the scale of the business, we're going to get leverage in other line items that will offset that, but it's kind of neutral. So that's certainly one factor impacting the consolidated margin.

Second factor is that home health and hospice carries a lower margin, even though we have the best margins in the industry for our particular segment, and that business is going to continue as it has over the last several years to grow faster than the IRF business. So the business mix is a little bit of a drag on the consolidated margin.

And then a lesser factor, but one that factors in nonetheless, particularly for the first several years of that five-year period is that the initial acceleration in the IRF de novo pipeline will mean that there is more preopening expense and the ramp up associated with newer hospitals that is also impacting the P&L.

Again within each of the two segments, it's a pretty similar story. Obviously the de novo piece doesn't hit the home health business, but as we pursue a greater de novo strategy in hospice as April outlined, that will have a bit of an impact as well. So I think we're going to look at relatively beyond 2020, a relatively stable margin environment for both businesses.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: And I just [indiscernible] (02:41:13) a second question. When you outlined where you get your volumes from on the home health side, you gave kind of the four big buckets collaboration, transition, specialty and traditional, is there any – where do you think that those – are those numbers going to stay relatively constant as a percentage of total, or where do you think that the biggest driver of growth is going to be for home health going forward?

<A – April Anthony – Encompass Health Corp.>: Well, certainly as we increase our overlap markets with the IRF division, we hope that that 14% is coming from clinical collaboration continues to grow as we go from the 80 or so markets into the 100-plus that we projected. So we think that will be a growing bucket, and then I think we're going to see continued growth in the second bucket the care transition coordinator program, particularly when you think about PDGM and the motivation for institutional discharges that comes with PDGM, I think that's maybe a place that we focused a lot of our effort, a lot of the growth that Luke showed you in the number of business development folks that are working that segment. That's kind of a heavy emphasis for us in that growth trajectory right now.

<Q> - A.J. Rice - Credit Suisse Securities> Thanks. So I think in both businesses there's a hope to maybe be able to penetrate more of the MA marketplace and grow that. Does that entail in your mind taking on financial risk as you do that or are the discussions going in a different direction?

<A – Mark Tarr – Encompass Health Corp.>: A.J. I think that at some point in the future we will be able to do that. I think that with all the data that you've seen that we're collecting and how we're applying that to our patient population, we'll have a better idea about what risk we would actually be taking on. Given the fact that we have those IT resources in place and the fact that we have our integrated care model, I think it uniquely positions us to be able to go towards a pair and say okay we'll take your fractured hips or we'll walk you through stroke patients on some degree of risk. I think that's in relatively next two or three years we'll get to that point. I don't think it's a real near-term opportunity for us.

But yes I think we will be uniquely positioned and do that. Part of the reason that we aren't already doing has been difficult for the payors to figure out how to administer a different payment scheme like that, so it is something of interest that we'll pursue in the forward with particular emphasis on our ability to measure the risk that we'd actually be taking on.

<A – Doug Coltharp – Encompass Health Corp.>: And April highlighted during her discussion that we've already got a number of arrangements on the home health side, where we're doing just that. As Mark suggested right now we think we're more ready to move forward on that than the MA plans are.

<Q>: Okay. And then moving the discharge growth target from 3-plus-percent to 4% to 6%, obviously you're laying out the de novos and so forth. Is that the primary bridge, what's the bridge in your mind is getting you to that 4% to 6% rate and how much does Florida factor in that?

<A – Doug Coltharp – Encompass Health Corp.>: Well, Florida is certainly a significant factor, but the de novo pipeline outside of the state of Florida is also robust and you've seen us enter a number of new states, we're having a lot of success procuring [indiscernible] (02:44:43) in states that continue to have [indiscernible] (02:44:45). We've made several announcements recently on that. So it's more broadly the de novo activity.

You get a little bit of a boost by an elevated target for bed expansions as well that factors into the same-store number, but the same-store number hasn't moved materially from where it was, it's predominately the increased de novo activity.

<Q>: Okay.

<Q – Whit Mayo – UBS Securities LLC>: Thanks hey, Whit Mayo with UBS, back on the de novos, I'm just curious how many of those new de novos actually have a joint venture partner? Or how many of the de novos do you think you'll seek to have a joint venture partner? And over the hosts that have a joint venture partner, how many are just solely focused on inpatient rehab versus a more broad integrated inpatient rehab plus kind of a home health solution?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, we have noted that we estimate around 25% of the new de novo growth likely to be in a JV partnership. You might see some of those years to be greater, some years that are less. But we think somewhere around 25%, I would say that it's probably a mix between which partners have an aspiration to get in more than just the hospital product line. Some are absolutely interested in working with us on home health opportunities as well. Some of them have home health agencies that they consider to be an opportunity for us. But all those deserve to be looked at and determine whether or not that'd be a good match for us as the partnership goes.

<Q – Whit Mayo – UBS Securities LLC>: Second question I had just back on PDGM, and also the Review Choice Demo, I'm just curious given some of the revenue recognition changes how that may impact the business trending into the first quarter? And then, maybe just remind us on the Review Choice Demo how your experiences thus far, and maybe just the glide path of that program, maybe just refresh us a little bit? Thanks.

<A – Doug Coltharp – Encompass Health Corp.>: So, the biggest thing on the revenue recognition is the movement from a 30-day payment period from a 60-day payment period. Under the prior system, we recognized revenue ratably over a 60-day episode. Now, you have two 30-day payment periods and those payment periods can be different. So, we have to make an estimation of how much is going to occur in the first 30 days.

And it's probably going to take us and other providers a while to fine tune that. I can't tell you specifically what kind of impact we anticipate that happening or having on the first quarter, because we're really just now starting to see the results of the first 30-day payment ending, many of the patients that we carried into January were still on the prior payment system. But I would expect some noise in terms of timing issues between quarters. We should be able to highlight that to you specifically when we provide our quarterly reports.

<A – Crissy Carlisle – Encompass Health Corp.>: Luke, you want to take the...

<A – Luke James – Encompass Health Corp.>: Yeah, I can hit on RCD briefly, if you want. So, one thing we didn't talk about in the prepared remarks were that we've been on the Review Choice Demonstration in the States of Illinois and Ohio for some time, and an element of the program is that, if you maintain an affirmation rate, which is their word for approval under that program of north of 90% for a six months' timeframe you can elect to go off of the Review Choice Demonstration for six-month periods at a time.

And so in Illinois where we have been on for six months or more, we experience approval rates in all of our providers in that state significantly higher than 90% and did elect to come off. So there's that option for high quality providers that can submit their documentation and do so in a manner that gets that high approval rate to actually come off and not be on the program. I'd expect to see similar rates like that as we expand to other states and apply our learning's from Illinois and Ohio as it goes to Texas and Florida and North Carolina as well.

<A – Crissy Carlisle – Encompass Health Corp.>: So we're going to Pito Chickering's question next in a moment and then we'll move to Ann Hynes in the back.

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: All right. Pito Chickering, Deutsche Bank. Luke, thanks for being here, and I think you're on the board of Medalogix, so I'll just target this one towards you. Well, I acknowledge that the CARE Tool for Medalogix is not meant as a basic reduction [indiscernible] (02:48:54) for fund in terms of care for each patient. Can you refresh us on sort of the quality metrics in the [ph] base of (02:49:00) reductions that you saw in the first 20 pilot programs, how faster this programs do you able to sort of to get to those [ph] base of (02:49:05) reductions? And then the follow-ups are going to be looking at the 77% of the programs

you rolled out so far, how is it tracking relative to the poly programs in terms of getting signoff from your partners in terms of using that technology?

<A – Luke James – Encompass Health Corp.>: Yeah. So I know we talked about a little bit in the fourth quarter are we've been – we've had some pilot sites on that product for quite some time as it was continuing to be developed to small number. But we still really started to ramp up in July and August of last year and the initial branches that went on did overall reduced visits while also reducing hospitalizations, both numbers of significance and that was very positive for us as we consider rolling it out which as we said we now have the 77% of our locations on the home health side.

We saw increases in some instances and we saw decreases in others, and again what it does is it matches much more closely the number of visits that a patient needs in order to achieve the awful outcome of discharging safely to the community. And what we have found is that our clinicians without the tool tended to treat patients more similarly than their needs actually were determined by the Medalogix CARE Tools.

So increased visits where patients needed it, decreased where they didn't. And the end result was that patients got there just right amount of visits. And overall it was a reduction compared to what we had provided previously, but because we matched it more closely to their needs. We also said that I've seen that reduction in the overall readmission rate.

It's too early for what we've rolled out late Q4 and so far in Q1 to see that, because we're still measuring readmission rates over that 30 and 60 day timeframe. And so in order to get that full run out on the newer branches that have gone on, we're still waiting those outcomes. But we feel very good about the adoption of the tool from our clinicians, the buy-in as they're seeing the value it's providing to them in the field to deliver better care than they've been able to do without it and we'd expect continued outcomes not dissimilar from what we saw from those pilot locations I talked about in July and August.

<Q – Ann Hynes – Mizuho Securities USA LLC>: All right. Thanks. Ann Hynes, Mizuho. Going back to the Florida CON law, I know that's an opportunity for you, but also could it be a competitive headwind with [indiscernible] (02:51:23) maybe not for profit health systems, building up there IRF capacity, especially like someone like HCA. So maybe can you let us know if the HCA is a big deferral source for you?

<A – Mark Tarr – Encompass Health Corp.>: There will be other providers that will take advantage of this, HCA being one of them. We do have some marketplaces where we overlap with HCA, many of those HCA facilities already have rehab units. So, it's been a number of years where we've normally seen maybe overflow that would come out of their hospitals. I would not consider it to be a headwind. I think that you'll see those providers that are already in the industry or that sector may choose to expand, some may not. There may be some limited new providers get into it, but I feel like we've been aggressive. We have been on both the bed additions as well as bringing new hospitals on or pursuing that opportunity. So, we'll definitely get kind of first responder on this first to market benefit.

<A – Doug Coltharp – Encompass Health Corp.>: Almost all of HCA's business, IRF business is done through units. To our knowledge they have never built a freestanding facility. And remember that it's not only have IRFs services been deregulated from the CON perspective, but still have acute services. And so our anticipation is that HCA will probably first devote capital towards expanding existing acute facilities rather than thinking about trying to free up capacity in an acute facility by building a freestanding hospital. They'll continue to be a competitor, but we already compete very successfully with them in any number of markets and we compete generally pretty successfully in some CON markets with Texas being the greatest example.

<A – Mark Tarr – Encompass Health Corp.>: Barb?

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah, I was going to mention the Texas. So Texas has been a non-CON market and we have over 20 hospitals in Texas with many competitors sometimes across the street from us and we compete very well with them. And some of these markets like Florida where there may be others besides us going to market, it does increase the awareness of the acute care hospital to what IRF provides. So sometimes just elevating that awareness of inpatient rehab actually benefits us as we're out there marketing for our services.

<A – Mark Tarr – Encompass Health Corp.>: I mentioned it earlier in my comments, but this repeal of CON in Florida had been discussed for a number of years. So, we had a really good idea about what markets we'd want to go into if and when that repeal actually took place and that's exactly what we've done or in the process of doing.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: Hi. Matt Gillmor from Baird. Follow-up on Ann's question on Florida for the 15 sites you've identified. Can you actually go ahead and start building those facilities, so we could see some of that capacity maybe come online at the end of next year or do you just sort of buy the land and wait until the right day, then you can start actually building the facilities themselves?

<A – Mark Tarr – Encompass Health Corp.>: Yeah. Matt, we're working with the state to get clarification on that. As it stands now, the new licensure would take place in July 1st of 2021 for any new hospitals that would be coming online, relative to the opportunity to go ahead, acquire land which we've done in a number of sites, how much building we can do and at what point we could kind of work right up to the start line with our readiness. That's what we're seeking clarification on.

<Q – Matt Gillmor – Robert W. Baird & Co., Inc.>: And then as a follow-up Luke and April talked about the documentation from your referral sources and how important that is. Is that much of a change operationally this year from compared to how you've been doing last year, because [ph] it doesn't (02:55:15) place any particular burden on your referral sources themselves to make sure they're providing you all that information?

<A – April Anthony – Encompass Health Corp.>: Yeah, so I think two-fold; one, we've been seeking this sort of complete referral concept for a couple of years now, because we know the more information we get from the hospital or physician record the better we can care plan, the more quickly we can get a patient on. And so, it's not totally net new, what we do see that it is somewhat new and it's acquiring communication with our physician, so as you may remember there's a whole set of codes that technically are included in what home health will qualify patient for home health, but that are now considered, I think that you keep changing the name a bit, but questionable encounter codes is what it was most recently referred to. And so, we've had to work with our physicians, so when they give us a very generic code like unspecified muscle weakness, we have to push with that physician to say that won't work, you're going to have to tell us why you think they're experiencing muscle weakness, [ph] where you have (02:56:13) to get more specific in order to come up with a code that will be reimbursed under PDGM.

So that is a new added burden. CMS is sort of trying to help in communicating, they're not being real aggressive, but they have put out some documentation and communications so that we are at least armed to get back to the physician and say it's not just us trying to be picky, we actually have to do this and here CMS' guidance to you about why they need more specificity. So, that's a little bit new, but the complete referral concept is not new.

<Q – Matt Larew – William Blair & Co. LLC>: Matt Larew with William Blair. I spoke a little bit about this [indiscernible] (02:56:57) opportunity. Could you just give us a sense for where you think

we are today potentially the timeline [indiscernible] (02:57:04) actually you have legislative changes and anything you've learned in the last year so that's change of mind?

<A – Mark Tarr – Encompass Health Corp.>: I'm sorry, what was the opportunity?

<Q – Matt Larew – William Blair & Co. LLC>: Site neutral.

<A – April Anthony – Encompass Health Corp.>: Oh, site neutral.

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

<A – Mark Tarr – Encompass Health Corp.>: Well we have the diagram that we have on the one slide where we feel very good about our position per site neutrality. Certainly as you see CMS rollout a number of their initiatives of site neutralities, it seemed to be what they're rolling to in terms of not having the various silos or eliminating the various different payment methods for IRF, SNF and LTAC, and eventually get to a site neutral world. That's not going to happen anytime in the near future just because of the complexities and comprehensive changes that would be required to do that. But I do think that if you look at the indications from CMS part of what they've done through the IMPACT Act trying to come up with one common assessment data from which to look at the various sites of care. I do think all of that leans towards a site neutral world.

<Q – Matt Larew – William Blair & Co. LLC>: And then April what do you see as the key to getting paid more fairly by MA rather than just sort of a slow drip of slight increases for you or is it brisk? Is it some of the data that you've started to accumulate? And you mentioned, Luke, that there are some payors in you're in network with maybe what the key things are?

<A – April Anthony – Encompass Health Corp.>: Yeah. I think it's both of those, I'm going to Luke comment as well because he works very closely in this arena, but I think having the data to support, and Barb gave you sort of an example in the IRF space, and when you say, when you just sort of put us in this general bucket, we don't look this distinctive, but if you look through the stroke bucket, we look really distinctive, and the total cost of care related to those patients. I think we've got the same opportunity in home health to say, you just, who can go deliver visits, then sure take the lowest cost guy, but what are you trying to really accomplishing that cost scenario.

So I think partly it's providing that incremental data, I think partly it's giving those, because you can go and have a great conversation with the Medical Director of the plan and then not get anywhere when you get down to the contracting folks, and then I think risk is part of it too.

Luke, you want to chime in for some of your recent conversations?

<A – Luke James – Encompass Health Corp.>: Yeah. We've definitely been throwing all of that at them for years now, and none of them have cleared in the magic bullet to-date, a couple people Mark remarked earlier that, we're ahead of them in our willingness to take risk, but even for those that are willing to entertain those discussions and going down that road, with some times it's simple as we're unable process claims that way, because the way our systems are built.

And so they're – they know that. They're working on all those things. I think that we are much more closely aligned with MA today in our ability to bear a responsible amount of risk from them, whether it's a lower rate, and then upside only if we achieve certain metrics that are agreed upon beforehand that should create savings for them or up and downside risk than we've been anytime in the past.

And so confident that again with our resume, with our ability from a balance sheet perspective, and just expertise perspective to bear risk responsibly that we're going to be able to get there with a growing number of payors. Couple of larger ones are starting to become more and more

progressive in what they're at least talking about should be coming down soon, in terms of starting with a low amount of risk, but building from there.

But we're excited about what we're seeing from MA now, and expect that, we'll definitely see some continue – some better growth, higher growth rates in the future. Again on plans that we're paid fairly for, we could have had a significant amount of MA growth in the past and home health if we wanted to, it would have come at low rates, and it wouldn't have been driving our margin, it would have driven overall admission growth rates higher. But that's not what we're looking for, looking for what payors that really see us as a partner, and really see us for the value we can drive not just willing to take a little rate that works for them.

<Q – Matt Larew – William Blair & Co. LLC>: Okay, just one more for Barb. The pilot in the Houston, you're not going to rollout target hospitals. Did you see anything in terms of increased market share, particular discharge category is that your [indiscernible] (03:01:22) responded to and over what timeframe during the pilot did that.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah, it's hard, we only know that we have felt an improvement in our readmission because of the patients that were high-risk that we tracked, the issue is that Medicare claim status is always three quarters behind. So we won't actually have full Medicare claims readmission rate information until the second quarter of this year. And that's really going to be the information that we're going to be able to those referral sources because that's obviously the third party data. So I do think that when we count our referral sources and explain to them what we have in place they've been very excited about it. Some of them have said they've been trying to develop something like that themselves and have not been successful. So it's been well received, but we won't have the data till second quarter to actually bring back to show the results.

<A – Crissy Carlisle – Encompass Health Corp.>: Brian Tanquilut of Jefferies is on the webcast. And he asked, please remind us of the difference in economics of Medicare Advantage versus traditional fee for service Medicare admissions in the IRF segment?

<A – Mark Tarr – Encompass Health Corp.>: Yeah, so the we've discussed in many of our earnings calls that we've been successful in not only increasing our growth rate on the IRF side for Medicare Advantage discharges but also narrowing the pay differential. And if you had wound the clock back about five or six years ago at one point in time that payment differential was large about 25%, and for 2019 the payment differential was 9%. And that coincides with a higher percentage of our Medicare Advantage contracts moving from a per diem basis to a case rate basis, and that case rate typically matches fee-for-service.

We're very pleased with the progress we have made in that regard. We think as we continue to demonstrate our value proposition specifically around categories like stroke and I think Barbara did a great job of highlighting that value proposition that there's going to be an opportunity to convert even more of that MA book business to that case rate basis and to narrow the pay differential further.

<A – Crissy Carlisle – Encompass Health Corp.>: Anyone in the room has a please raise your hand high so those with the microphones can see you.

<A – Mark Tarr – Encompass Health Corp.>: Somebody has to ask Crissy a question.

<A – Doug Coltharp – Encompass Health Corp.>: We've brought them all the way up here. Hi, AJ.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Hi. It's A.J. Rice from Credit Suisse. I'll ask you another one then. We've heard some discussion about the small agencies and regional

agencies having some issues already and starting to talk about aligning or closing down. Are you seeing any of that activity in the post PDGM world and any discussion from CMS you had about whether they'll take another look at the rates?

<A – April Anthony – Encompass Health Corp.>: I think we're seeing a little bit a trickle of activity. As a matter of fact, we closed the transaction on March 1 when I was in Lynchburg, Virginia last week to introduce that to the new employees. And the seller's first comments was – were in PDGM we wouldn't be able to survive. And so we found you a new home. So I definitely think we're seeing a little bit of that. I wouldn't say that it's a wave yet, but we're definitely seeing a trickle of activity in that regard. And I'm going to let Luke kind of answer the second part of the equation to you and chime in on some of the acquisition activity.

<A – Luke James – Encompass Health Corp.>: Yeah. I'd say it's more anecdotal right now than specific numbers that we have for you. We've kind of had an over-under for a while now that kind of that April-May even as late as June timeframe is probably going to be when you start to see a lot more activity here. Doug mentioned that you've got especially in the first quarter in January and February a lot of bleed in from the old payment mode, still it's phasing out and the payments that come from the final claims related to those episodes are still going to be here for a little bit once we get fully on PDGM.

And I would say too, especially in states like Texas and Florida where if you were to breakdown agencies per over six per Medicare beneficiary for instance, those ratios are much smaller in those states than they are CON states or even some other non-CON states. When you bring in the review choice demonstration in addition to PDGM, in addition to the reduction in the RAP payment going from 60% to 50% to 20% in 2020, and then gone next year. That combo of PDGM RAP payments in RCD on smaller, less sophisticated providers that may not have been able to prepare adequately for it. I think you're really going to see something again in that April-May timeframe in Texas especially and maybe a little bit delayed in Florida with RCD not coming there until May.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. And is anything from CMS yet on where they might take another look at the home situation?

<A – April Anthony – Encompass Health Corp.>: Yeah. So your question on rate. We really haven't heard anything more. It is our belief based on looking at regulations and rules that CMS really does not have the statutory authority to do further assumed behavior changes that they had a one-time authority for that. And so at this point they would have to have observed data in order to make further changes. We think it's highly unlikely that for the 2021 rule making process that there will be enough observed data is a matter of fact. You know we're two months in and we really have very little data at this point, because we're phasing off the old system. So we think for 2021 the potential that they will have a meaningful amount of observed data to support a further [audio gap] (03:06:48) where they still have a limited pool of data and we're not likely to see further rate cuts. So, I would say I'm not expecting one in 2021 and I'm very hopeful that there will similarly not be a rate cut in 2022, and then there will kind of be a fresh set of review in 2023.

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: Okay. And then, you talked couple of times about having the 345 home health locations and you've got 77 of those, also a hospice jumping off point branch, whatever. Is the goal to grow that number significantly over the next few years and what's the margin – I don't know how many hospice locations you have away from a home health branch, but are those much more profitable than the other ones for – because they can leverage overhead or something?

<A – April Anthony – Encompass Health Corp.>: Yeah. Just to true up the numbers there for a minute, 245 home care locations.

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

<A – April Anthony – Encompass Health Corp.>: 77 of those have hospice overlap and that leaves six that do not have hospice overlap.

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

<A – April Anthony – Encompass Health Corp.>: So, I would say we're not seeing – because it's such a small universe that don't overlap, I'm not sure it's a materially significant comparison, I will say though that what we find is that we can hit that kind of that breakeven inflection point and really like a 10 to 15 patient census on hospice because we can share infrastructure, share office space, telephones systems, receptionists, conference rooms, all those kinds of things. We tend to put a dedicated hospice team in place from a leadership team perspective, but we can usually wedge them into the office space that we have until they become of substantive size, at which time, we may need to take an office space expansion or even potentially get them their own adjacent office in same complex or same building.

[indiscernible] (03:08:34)

<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>: ...looks like in three to five years?

<A – April Anthony – Encompass Health Corp.>: We really have kind of a hierarchy of approach on business development and on growth. It's first to build our overlap markets with our IRFs, because we think that is a highly successful strategy both from a financial perspective and a patient care perspective. Second is to do the same thing, build the overlap strategy between home health and hospice. There's lot of patients in home health that need to appropriately transition to hospice and they're much more comfortable to do that when they can do it with a trusted partner that's been delivering our home health services. And our third objective is to really build scale and intensity in all the markets that we serve, because we know there's significant margin enhancement opportunity when we do that as well as market penetration for reputational perspective.

And so, absolutely, you will see that 77 market increase and perhaps even faster than you see the overlap happening in the IRF division, simply because at this point, we're getting to a place where in the IRF space, it's getting harder. We got a lot of CON markets that we'd have to go by CON and South Carolina is a good example of that. So, a lot of the markets where we don't have overlap, there are some barriers that could slow down the progress, still think we can get to that 100 market overlap in the next five years that Mark mentioned to you, but it's not going to be as fast as it's been in the last five.

<A – Luke James – Encompass Health Corp.>: And A.J., I might just add a really briefly statement, it might be helpful to think about it this way. We don't necessarily need a 1:1 ratio between home health and hospice locations. What we care more about is our hospice locations that we do have being able to service the service area of our home health discharges, especially those that would might need to go to hospice. And so, today, even though the ratio of 245:83 that April mentioned is not near being equal, those 83 cover about roughly half of our overall home health discharges. So, we've placed those hospice locations where we have larger home health locations or larger numbers, but we don't necessarily need a 1:1 count, it's more about being able to service that geographic area.

<A – Mark Tarr – Encompass Health Corp.>: Pito?

<Q – Pito Chickering – Deutsche Bank Securities, Inc.>: All right. Pito Chickering, Deutsche Bank again. On the IRF side, there's still a lot of white space [indiscernible] (03:10:41) large, the concentration is whether there's new states or states where you have capacity, but not a lot of focus there. So, if you take areas like California, it's obviously in the high growth market, huge population there. What is the difficulty expanding from California when you build new facilities,

whether new states or any markets, who is your primary competitors at that point? And then for Rusty, when you're entering these new markets, how can you leverage your IT capabilities to help go against the local competitors?

<A – Mark Tarr – Encompass Health Corp.>: So, I'll take the question on California right from the start here. We have looked at California strategically now for several years. We have two longstanding hospitals in the State of California, in Tustin and Bakersfield, and then we've added over the years, Modesto, this last year we just brought on Murrieta. We own land down – closer to San Diego. In spite of population base that is very attractive a clear in the State of California, it's very difficult to do business in the State of California, it's very difficult to go through the process of getting a hospital built there with the guidelines and one of the challenges we've had is that no two markets are the same there in terms of how the building process has to go and the review and the regulatory front within the State of California.

So, it has given us reasons to be very careful about any future hospitals we're building there and making sure that we fully understand what the ramp up would be, because it's pretty much a sure thing that it's more expensive from a real estate and a building perspective to enter a market in the State of California under the existing guidelines than it is other opportunities that we might have in our de novo pipeline.

<A – Doug Coltharp – Encompass Health Corp.>: The labor situation in California is also very difficult on two fronts. One is the regulations and the degree of litigation around labor-related issues is extensively greater than it is in other states. And then, the second is just the overall environment has created more difficult employment conditions for clinicians in other markets. Take a market for instance like San Francisco and they've basically priced out the ability of nurses and therapists to live approximate to where the population is it would rehabilitation services. There are too many other good places in the country for us to build hospitals. And so, we just can't continue to concentrate efforts on California. Rusty?

<A – Mark Tarr – Encompass Health Corp.>: Rusty?

<A – Rusty Yeager – Encompass Health Corp.>: So, on the ability to scale the platform, it's really beautiful. And so, like when we just open our hospital at Murrieta, on day one, they come out of the gate with the full platform. So, all the way from our sales and marketing process, that's automated, through our [indiscernible] (03:13:53) which is our EMR situation, they come out of the box, we have our standard processes, right. So, we've talked about we standardize a process, we automate the process, then we pull the data out of the process, and then we use that to improve. So, for the last I'm going to say eight years or so, we've been improving on that platform with the data that's coming out of it. So, you open up in a much better stead than a hospital that we opened up eight years ago, because we've got all that history of how to make this thing work better.

<A – Crissy Carlisle – Encompass Health Corp.>: So, we've got another question coming in from the webcast. It's from Chuck Goldblum with Hurley Capital. He asked, have you changed your leverage range to support growth?

<A – Doug Coltharp – Encompass Health Corp.>: We continued to believe that we'll have a run rate leverage ratio of around 3 times, not inclusive of any large acquisition opportunities that we might choose to act on. Again, we ended the year with the leverage of 3.2 times. It's going to be up a little bit from that at the end of the first quarter, because the growth in debt is going to be greater than the year-over-year growth in EBITDA and that growth in debt is largely due to the first quarter funding activity around the home health segment equity put options in the SARs that we mentioned previously. So, it will move up and down, but generally speaking, we think something in the 3 to 3.5 times is the right place for us to be positioned. That allows us to really be in a position to capitalize on all of the high quality growth opportunities that come our way.

<Q – Whit Mayo – UBS Securities LLC>: Hey. It's Whit Mayo with UBS. I have a question for April just about the hospice environment now. We've obviously experienced a very favorable environment for the better part of five-plus years or so. And I'm just curious from your perspective, what you think the most important two or three risk factors are to that industry today?

And my second question is just around the de novos. I'm curious what are the construction cost on the new hospitals and how you're able to – maybe how you're reorienting some of the engineering now versus facilities were rebuilt 10 years ago or so just from a productivity standpoint with nurse stations, I'm just curious, like from a physical plant standpoint, how any of that's evolving? Thanks.

<A – April Anthony – Encompass Health Corp.>: So, on the hospice question, I would say that the top two or three things of concern I think [indiscernible] (03:16:17) hospice services into the Medicare Advantage plans, particularly concerning for us right now. We know from the home health side of the equation that we haven't really enjoyed that experience with Medicare Advantage so far. So, we're sort of opposed to that. I think it's an interesting time, because we're not sure frankly whether the Medicare Advantage plans will want that either. And so, I think in the next year as this program starts to come to life, we'll start to see really the interest by the Medicare Advantage payors and having hospice services. But I think that's, kind of, an imminent issue. You saw an earlier slide that hospice now, total Medicare spending has exceeded home healthcare. That has happened pretty quick and pretty dramatically if you look at where the delta was 10 years ago and now to see hospice being ahead of home care says that the growth in hospice has been pretty tremendous.

Obviously, it's a cost efficient way to care for end-of-life patients, but at the same time, just the raw dollars that are being spent there; I think it's highly likely that we'll see enhanced scrutiny coming from Medicare in form of expanded rules, regulations and possibly even some tightening of reimbursement.

So I think there'll be players who are better positioned to manage that than others. And I think those of us who have playing in the world home health and have lived under an expanding regulation and a falling knife of reimbursement will fair far better in that kind of environment, but I think that's likely to come to hospice as well. So I think those are probably big things, I would say.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: And from the hospital prototype, so we did reach out a few years ago to any of our hospitals that have been built in the last five years to say, you know if you could do anything different compared to this design what would you recommend and really got some really great feedback.

You can imagine, it used to be that we had to have really large nurses' stations because we were on all paper. And so there would be a lot of folks sitting at a nurses' station doing their documentation. As we've gotten all of our hospitals on the electronic medical record, we've realized that they actually take that with them as they are in the hallways. And so we're able to look at things like making our nurses' station smaller, looking at how our hallways are configured, so that they're not having to walk down long distance of a hallway, so we can increase the efficiencies of the staff.

We used to send a lot of our patients out for dialysis and we've realized over time that it makes sense for us to have a dialysis unit inside of our hospital and then contract for those services to be provided inside. So we're not having those costs of transportation and we're not struggling with meeting our three-hour therapy rule, because of having to send them in and out for dialysis. So there's been other smaller changes, but I would say those are some of larger changes that we've made.

<A – Doug Coltharp – Encompass Health Corp.>: So from a construction cost perspective, even though we're building largely to a prototype facility right now. There are three primary variables depending on where you're building the facility, land acquisition cost is certainly one, construction

cost based predominately upon the labor conditions, because we try to use local labor, and then the third would be just the initial size of the facility.

But generally speaking, if you look to say 40 to 50-bed, all private room facility built on somewhere between five and seven acres to accommodate future bed expansion, such as the Stuart, Florida example that Barb walked everybody through, you're looking at a spend that's low end of $25 million and typically a high-end, California not included, of about $35 million.

Mark mentioned when he was talking about Florida that we're partnering with Brasfield & Gorrie, a Birmingham-based national construction firm on some ideas to help us generate cost savings and to speed our construction timeline as well. And we're doing that in Florida. But we've also got a couple of other great partners on the GC side and it's fortunate that they just happened to be based in Birmingham as well, and they concentrate on healthcare facilities, and those are Robins & Morton and Hoar and we're working closely and I'm going to ask Rusty to chime in on this as well, because design and construction also reports to Rusty, but we're going to be partnering with them to come up with what we think are some pretty innovative and pretty avant-garde ways to reduce construction costs without sacrificing quality and increase the speed to market.

<A – Rusty Yeager – Encompass Health Corp.>: Right so, we're continuing to invest in this area and one of the things we're looking at is we enable to do some modular stuff, so that we can potentially be faster with it as well as hopefully be cheaper with it. So one of the things we're looking at is modular bathrooms.

<A – Doug Coltharp – Encompass Health Corp.>: And in order to take advantage of modular construction, you have to have scale. If you just doing it on a one-off transaction, it actually is additive to the cost and it doesn't decrease if you can get scale it becomes not only faster to build a facility, but lower cost and because we're accelerating our de novo pipeline from that 4 to 6 to 6 to 10 that's going to create the kind of scale that we need to take advantage of those types of programs.

<Q>: Hi. Couple of follow-up questions: First, MedPAC...

<A – Crissy Carlisle – Encompass Health Corp.>: State your name and your...

<Q>: I'm sorry [indiscernible] (03:21:28). Couple of years MedPAC has been talking about integrated post-acute bundling and just trying to get a sense from you, has CMS made any progress in terms of rulemaking even if it's 2022, 2023. And are you planning for that?

<A – Mark Tarr – Encompass Health Corp.>: So as we noted a number of times we think the integrated model that we have is ideally suited for some of the payment changes, methodology changes that would be expected in the future. As you know, sometimes and more times than not there is or can be a disconnect between MedPAC and what CMS actually incorporates in some of the recommendations coming from MedPAC.

So we know that CMS has been at least working around the fringes of moving towards this site neutral environment. That site neutral environment would incorporate an episodic payment where you'd be responsible for the patients care for a 60 or 90-day period of time, which the fact that we have both facility-based and home-based care, we think would be ideal in terms of responding to marketplace like that.

As a matter of fact, we feel we win in a site neutral environment. So, we work very closely with CMS; part of our recommendations and our lobbying initiatives to them have been, if you're going to make a bold change in the payment model like this and move towards a whole different system or asking them to test – pilot it in in a marketplace before you do a national roll out, pilot it so that any changes that can be made or should be made so that it doesn't negatively impact patient care

or the number of providers that might be out there necessary to provide the coverage for the Medicare beneficiary.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: And there is a technical expert panel that is discussing site neutrality and we have members of both our inpatient rehab and our home health teams that sit on that tap.

<Q>: All right. Okay. Thank you. And Luke I'm sorry for a follow-up question for you. I'm just trying to get a sense of what are the impediments to MA contracting in your services, is that [indiscernible] (03:23:53) now the firms are willing to give you more than a very low per diem, and what are the impediments and how are you going to loosen that up and perhaps increase MA penetration?

<A – Luke James – Encompass Health Corp.>: Yeah. So it's a couple-fold, one, if they look at it as a percentage of their spend then we're 2%, 3%, 4% depending on the plan and it's tiny and it gets put on the back burner all the time and they're more interested in negotiating with hospitals and physicians than they are with ancillary providers like home health would be for them.

Many of our competitors over many years have done a phenomenal job helping MA commoditize home health. It's been a race to the bottom. They've been willing to take essentially any rate that they can get, even if they lose money on it because many of our smaller providers don't have great star ratings to go sell to referral sources. They don't have great re-admission or hospitalization rates that they can take in as their value proposition.

What they have is that we can take any payor on your panel. And so making one call and you don't have to worry about me saying, I'm not in network with that plan and because nobody else is because their rates are so bad. But I'm in network with everybody; discharge planner from hospital A, call me on a Friday and I'll be able to take them, you don't have to worry about not being able to find a home for them.

And so that value proposition approach has been one that has worked for smaller providers because they didn't have a better one, but as the industry is consolidating more, is becoming more sophisticated or more sophisticated in larger players then I think we're seeing that dynamic change. I think Medicare Advantage payors are seeing that there actually is value that that they even spend a little bit more because they have to pay a higher rate.

The yield they get on that return is pretty attractive because they are getting better outcomes for their members. And as they want to try to keep their members in their own plans and to prevent turnover year-over-year for those that receive bad home health services, I think there's that dynamic at play too that's again in the favor of higher quality home health providers that just haven't been willing to commoditize ourselves, we'd rather reinvest in our clinical model and the outcomes we're producing and play the long game of ultimately being the provider of choice once they come around.

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

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: Yeah, Kevin Fischbeck from BofA again. Can you just remind us a little bit about the PDGM ramp that you guys are expecting in your guidance, I guess if we've had another company come out and, kind of, provide a little bit lower Q1 than maybe people were thinking a little bit higher Q4 exit rate [indiscernible] (03:26:18) thinking. So just wanted to understand how you guys were thinking about it and to the extent that you understand how CMS is thinking about it and when they did that impact analysis on how they expected companies to respond during the year, Are you kind of seeing the industry ramp, are you seeing something better or worse?

<A – Mark Tarr – Encompass Health Corp.>: April you want to take that?

<A – April Anthony – Encompass Health Corp.>: I think we see a little bit of the first quarter is going to blend because you've got the old episodes were under PPS phasing out throughout half of the first quarter and then the new episodes starting. So I think the first quarter you, kind of, moderated a little bit from the rate impact that hits in PDGM because you're really only getting half of the quarter where you're fully kind of into that payment mode.

I think the ramp of improvement will really just be, how quickly can you mobilize those behavior changes to mitigate some of those, I think we feel pretty good about the fact that we're going to get most of that activity mobilized by the time we get into that second quarter. And so I think we think the year will be pretty balanced as far as the PDGM impact. Luke anything you would add there?

<A – Luke James – Encompass Health Corp.>: I can comment on the second part of, if you like; CMS, their expectations, they clearly knew that the old payment model was going to bleed into the first quarter. So no surprises there from them. Their behavior assumptions assume for all but one that at the stroke of midnight behavior would change on January 1st of 2020. So that's the expectation built into the behavior change reductions that came along with. PDGM for this year so I know they'll be looking at that throughout the year, but technically what they forecasted or what they implemented, if you will, was assuming it would happen at that one time.

<A – Doug Coltharp – Encompass Health Corp.>: And if there's not enough going on there, I would direct you back to the question regarding revenue recognition which is we're going to have to get through a little bit of time here before we fully understand whether or not we're utilizing the correct estimation procedures between the two 30-day periods.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: So you talked basically about, kind of, like a, I guess a quoting kind of impact at that point. Is there anything from a disruption perspective when you think about making that transition that happens in Q1 that might make the impact different than just the revenue recognition around the quotes?

<A – Barb Jacobsmeyer – Encompass Health Corp.>: Yeah. I mean you've got to make sure that your teams are paying attention to [indiscernible] (03:28:40) between the two 30-day periods. You got to make sure that you're getting that full cohort of quoting opportunities, so that you can realize when is it appropriate to choose one of those higher value quotes. So, there's a little bit of education and effort associated with both of those things.

But on balance those aren't the hardest things to teach and train to, and so far I think with our approach to early quoting identification that we've got in place, so the complete referral process that Luke talked about, I think we think we're going to realize. Now we've never thought we were going to realize what Medicare thought we were going to realize, because we think that's inappropriate from a quoting perspective, so we think we're going to hit our realization level that we thought was realizable pretty early in the year, I don't think we're going to realize what Medicare proposed was possible because I don't agree that it is possible to get there that 100% of the time you would up-quote patients that doesn't align with the reason that we're in there to care for that patient, it doesn't align with the physician's documentation, not clinically appropriate, so we've never thought we would realize what Medicare thought we'd realize. I think we can get to our realization early in the year and moderate that out pretty quickly by the second quarter.

<Q – Kevin Fischbeck – Bank of America Merrill Lynch>: And just last question, you mentioned the sales force additions you've had over the last few years. You said, I think there's a significant opportunity to continue to add salespeople per branch. How do we think about that? What does adding another sales person to branch do as far as – is it as simply saying if you have three add at one more, that's a 30% increase or is it something less than that or do we think about the returns of adding the incremental...?

<A – Doug Coltharp – Encompass Health Corp.>: Yeah...

<A – Luke James – Encompass Health Corp.>: [indiscernible] (03:30:17) break it down exactly like that every market is different, CON markets are going to produce a lot higher admits per rep than you know in Dallas, Texas or Houston or something like that. We have a lot more competitors in a the non-CON market. It certainly does increase the overall account typically you see a little bit of a dip when you're adding a new territory and taking business away from existing reps, but they're quickly able to add that back, as I said earlier, by focusing more on their core accounts and what we find is that when they do that and they spend more quality time with the core accounts that have the ability to send more than they've sent in the past that, that's exactly what they do.

So they may lose some of the accounts that weren't producing very well in the past and then that new person that comes in takes maybe not the most ideal territory because we're not carving out the highest producing accounts for them, try to get a good mix, but I wouldn't necessarily think about it exactly like that. I think I would think about it in terms of in order to achieve the organic growth rates that Doug and Mark outlined previously over the next five years that's an approach that we'll continue to take in order to achieve those what are really leading a lot of our peers in terms of especially Medicare organic growth rates of new admissions.

<A – Barb Jacobsmeyer – Encompass Health Corp.>: And what that really requires is the right level division manager support, so we find that a division manager can successfully manage sort of 8 to 10 sales reps and if it starts growing where they've got 12 or 14 they'll start to be less effective, so we'll split that into territories and split it in half and let both of them kind of grow back up.

And so I think the reason we've been able to increase our sales reps per branch from 2.2 to 2.9 has really been because we've not only invested in the personnel, but we've also invested in the leadership layer that supports that continued growth and development of those resources while we've been growing our reps per branch, we've been able to really hold our admissions per rep as Luke mentioned, you kind of have a initial little bit of a dip when you split a territory, but on balance over the course of the year we've been able to hold our admissions per rep consistent even with that pretty significant increase in reps per branch.

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

Okay. That concludes the Q&A portion of our presentation. If you have additional questions, please don't hesitate to call or send an email to me. My business card should be in the conference materials at your seat. So, earlier today, we said our story is best told by our patients. So, we're going to let [ph] Lonny and Sandra (03:32:40) wrap things up for us.

[Video Presentation] (03:32:49-03:33:54)