# ENCOMPASS HEALTH
# Q1 2018 Earnings Call Transcript

## PARTICIPANTS

### Corporate Participants

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

### Other Participants

**Matt Larew** – Analyst, William Blair & Co. LLC
**Kevin Ellich** – Analyst, Craig-Hallum Capital Group LLC
**Frank George Morgan** – Analyst, RBC Capital Markets LLC
**Matthew D. Gillmor** – Analyst, Robert W. Baird & Co., Inc. (Broker)
**A.J. Rice** – Analyst, Credit Suisse Securities (USA) LLC
**John W. Ransom** – Analyst, Raymond James & Associates, Inc.
**Kevin Mark Fischbeck** – Analyst, Bank of America Merrill Lynch
**Dana Hambly** – Analyst, Stephens, Inc.

## MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to Encompass Health's First Quarter 2018 Earnings Conference Call. At this time, I'd like to inform all participants that their lines will be in a listen-only mode. After the speaker's remarks, there will be a question-and-answer period. [Operator Instructions] You'll be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

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

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

Thank you, operator, and good morning, everyone. Thank you for joining Encompass Health first quarter 2018 earnings call. With me on the call in Birmingham today are Mark Tarr, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Barb Jacobsmeyer, President, Inpatient Rehabilitation Hospitals; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations. April Anthony, Chief Executive Officer of our Home Health and Hospice segment also is participating in today's call via phone.

Before we begin, if you do not already have a copy, the first quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website at encompasshealth.com.

On page 2 of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risks and uncertainties, many of which are beyond our control.

Certain risks and uncertainties that could cause actual results to differ materially from our projections, estimates and expectations are discussed in the company's SEC filings included in the earnings release and related Form 8-K, the Form 10-K for the year ended December 31, 2017 and the Form 10-Q for the quarter ended March 31, 2018 when filed. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented which are based on current estimates of future events and speaks only as of today. We do not undertake a duty to update these forward-looking statements.

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

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

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

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

Thank you, Crissy, and good morning to everyone joining today's call. The first quarter was a good start to 2018 with consolidated revenue increasing 9.3%, leading to a consolidated adjusted EBITDA increase of 11.2% and an adjusted earnings per share increase of 32.9%. These results were achieved with strong volume growth and effective labor management in both segments.

Our Inpatient Rehabilitation segment grew same-store discharges 4.8%, the largest same-store increase we've experienced since the first quarter of 2012.

The widespread incidence of flu across the country led to capacity issues in many acute care hospitals. This had a positive impact on downstream volumes as we could leverage our efficient referral and approval process to assist the acute care hospitals in the timely discharge of their patients requiring an IRF level of care. The timing of discharges around Easter and Passover also contributed to discharge growth as both fell later in April or the second quarter of 2017. We were very pleased with our inpatient rehabilitation hospitals manage this increased volume in a disciplined manner and achieved higher labor productivity.

Our Home Health segment grew total admissions 9.9% and grew same-store admissions 7.4%. This growth was achieved against a difficult comp of 13.9% same-store growth in the first quarter of 2017, which included a strong improvement by the former CareSouth locations. In addition, our Home Health team continues to make improvements to caregiver productivity and efficiency that are allowing us to lower our visits per episode in ways that do not compromise quality or patient satisfaction as evidenced by our consistently high quality ratings.

As a result of this increased revenue and earnings, as well as some favorable working capital changes, we also increased adjusted free cash flow by 15.4% to $170.2 million for the first three months of 2018.

We're investing this cash in our strategic initiatives, which include growth opportunities in both of our segments, increased clinical collaboration between our two segments, implementing our rebranding and name change and the development and implementation of post-acute patient navigation tools. In April of

this year, we opened a new 34-bed inpatient rehabilitation hospital in Shelby County, Alabama and we have seven other IRF development projects underway, including hospitals in North Carolina and Idaho, which are new states for us.

In our Home Health segment, we recently announced a definitive agreement to acquire Camellia Healthcare. Camellia operates 18 hospice, 14 home health and two private duty locations across Mississippi, Alabama, Louisiana and Tennessee. We expect to close this transaction prior to June 1. While we continue to maintain an active pipeline of opportunities in our Home Health and Hospice segment and remain opened to various opportunities, we plan to focus our attention on integrating the Camellia transaction this year.

We are very pleased to report we achieved a new high watermark for clinical collaboration at 33.5% in the first quarter of 2018, up 460 basis points over the first quarter of 2017. We attribute much of this increase to the full deployment of our TeamWorks clinical collaboration best practices across our overlap markets. It's important to note the objectives of clinical collaboration are not simply to drive higher revenue in admissions growth. The primary objectives of clinical collaboration are to improve the patient experience and outcomes and to reduce the total cost of care across a post-acute episode.

While it's still early, we are seeing increasing evidence these objectives are being achieved. The coordination between our IRF and Home Health teams is resulting in lower discharges to skilled nursing facilities and higher discharges to home and overlap markets. And within our overlap markets, patient satisfaction scores are increasing, while hospital readmission rates are decreasing. We also continued implementation of our rebranding and name change, spending $3.6 million during the first quarter of 2018.

On April 2, our inpatient rehabilitation hospitals and home care agencies in Texas, Alabama and Arkansas transitioned to the new brand. Local migrations will continue throughout 2018 and are expected to be completed by the first quarter of 2019.

We continue to focus on building the tools necessary to serve as a value-added partner to payors and acute care hospitals for all their post-acute needs. In January of this year, we began a pilot project in our overlap market of Tyler, Texas with CHRISTUS Trinity Mother Frances to managed care navigation for all of their hip fracture patients.

Data has shown that for fracture patients, quality rehabilitation can mean the difference between a full recovery and long-term issues. By collaborating to provide proactive care, seamless transitions and constant management through the use of care navigators, we are already positively impacting both care and costs. In the first quarter of 2018, 40 hip fracture patients were part of this collaborative effort, which represented [ph] 18 (9:55) more hip fracture patients than we treated from this acute care hospital in 2017. Of those patients, only one has been readmitted to the acute care hospital.

This project also carries over to our work with the Post-Acute Innovation Center, where we're developing advanced analytics and predictive models that don't exist in the marketplace today. We're leveraging existing Cerner solutions for care management workflow and documentation, combined with data from our rehabilitation specific electronic medical record system, home care home-based and acute care hospitals' Epic system to create a longitudinal patient record to manage patients across the post-acute continuum in Tyler, Texas.

This patient record uses algorithms to identify patients for post-acute care navigation, provide a documentation platform for care and coordination, includes evidence-based assessments to support complex case management and includes care plans that can be easily communicated to primary care physicians and other service providers and caregivers.

In addition to this active project in Texas, the Post-Acute Innovation Center is working to develop a 90-day post-acute readmission prediction model to identify patients at risk for readmission across all post-acute settings. As we begin developing post-acute networks in various markets, the center is also working

to better define what it means to be an effective and efficient post-acute provider and developing a post-acute determination support tool.

Once we're ready to expand our post-acute management ability to other markets, these tools will help us drive outcomes and costs by placing patients in the right post-acute setting with the right post-acute provider.

Before moving to guidance, I want to comment on our market consolidation decision we made in our Texas region. In April, we announced our plans to create a more efficient operating structure in the Fort Worth, Texas market by consolidating our three inpatient rehabilitation hospitals into two hospitals. Two of our hospitals were within nine miles of each other, with one of those being an owned facility with all semi-private beds in Downtown Fort Worth.

We have stopped admitting patients to this hospital and we'll officially close it in May. The remaining two hospitals, known as City View and Mid-Cities, had excess capacity that is sufficient to absorb the additional census from the closed Downtown Fort Worth hospital in the near-term. This belief in our ability to absorb the volume into two locations is validated by the fact that of our 600 employees across all three hospitals, less than 10 were displaced as a result of this market consolidation.

We currently plan to sell the building in Downtown Fort Worth and use the proceeds to fund a capacity expansion of approximately 30 beds at the City View hospital. We believe the consolidation of operations and construction of new private beds will contribute to improve financial performance and improved patient satisfaction in the market.

Now, moving to guidance, as a result of our strong start to the year, we are raising our full year guidance ranges as follows.

We're increasing net operating revenues from a range of $4.08 billion to $4.19 billion to a range of $4.11 billion to $4.21 billion. We're increasing the bottom and top ends of our adjusted EBITDA by $15 million to a range of $845 million to $865 million and we're increasing the bottom and top ends of our adjusted earnings per share by $0.05 per share to a range of $3.30 to $3.45 per share. These increased guidance ranges are inclusive of our planned acquisition of Camellia prior to June 1.

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

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

Thank you, Mark, and good morning, everyone. As Mark just outlined, Q1 represented a nice start to 2018, with strong operating results posted by both of our business segments and significant progress on several key strategic initiatives. Our Q1 consolidated revenue increased 9.3% owing to strong volume growth in both business segments as well as a significant reduction in IRF segment bad debt, which effective with the Q1 accounting change is now a component of revenue. Revenue growth was leveraged with labor management and expense efficiencies to drive an 11.2% increase in consolidating adjusted EBITDA for the quarter.

Adjusted EPS for Q1 increased approximately 33%, based primarily on higher adjusted EBITDA, lower interest expense stemming from our exercise of the early redemption option on our convertible subordinated notes in Q2 of 2017 and a lower effective tax rate resulting from income tax reform.

Our company continues to generate significant levels of free cash flow. Adjusted free cash flow of $170.2 million for Q1 increased 15.4% over the prior year period. The increase was attributable to a higher adjusted EBITDA and a working capital decrease primarily related to improved accounts receivable collections.

Adjusted free cash flow for Q1 also benefited from the timing of our federal income tax payments. We did not make a federal income tax payment in Q1. We anticipate making two federal income tax payments in Q2 and one each in Q3 and Q4. Our estimate for 2018 cash tax payments remains in a range of $105 million to $135 million. Free cash flow in Q1 was deployed to fund approximately $28 million in discretionary capital expenditures, $25 million in common dividends and the purchase of $65 million of shares in our Home Health and Hospice subsidiary held by members of the management team. The purchase of these rollover shares increased our ownership in the Home Health and Hospice subsidiary to 88.9%.

Our balance sheet remains strong with the leverage ratio at the end of Q1 at three times, down modestly from year end 2017. Given the level and composition of our debt capital, cash flow utilization for the balance of the year will be prioritized towards growth opportunities in both segments and continued shareholder distributions. The Camellia Healthcare transaction we previously announced is anticipated to close on or prior to June 1.

As noted on slide 5, this transaction has a purchase price of $135 million and will result in a federal tax benefit to be realized over an estimated 15-year period with an expected present value of $20 million to $25 million.

Moving now to the segment results, IRF segment revenue rose 8% on the strength of an 8.6% increase in inpatient revenue, partially offset by a decline in outpatient revenue associated with the closure of several hospital-based outpatient programs. Inpatient revenue growth was driven by both volume and pricing. Discharge growth was 6.7%, including same-store growth of 4.8%.

As Mark discussed in his comments, that heavy flu season and the timing of Passover and Easter contributed to Q1 volume growth. Revenue per discharge increased 1.7% in Q1 stemming from an increase in Medicare reimbursement rates and a year-over-year reduction in bad debt. Our revenue reserve related to bad debt in Q1 was 1.1% of IRF segment operating revenue as compared to 1.8% in Q1 2017.

As maybe seen on page 21 of the supplemental slides, new prepayment claims denials in Q1 were up modestly from the previous quarter, but down significantly from Q1 2017. As we have discussed on past calls, we attribute much of the reduction in ADR activity to the full implementation of TPE and to the transition of the MAC contract from Cahaba to Palmetto. We have also previously discussed that certain MACs have been denying claims based on what we believe to be an aggressive interpretation of CMS guidelines regarding required levels of therapy in the IRF setting.

We are pleased that in March of this year, CMS issued a clarification regarding these guidelines and we believe this contributed to the reduction in new prepayment claims denials during Q1. These recent positive results notwithstanding as can be seen in our guidance considerations on page 16 of the supplemental slides, our updated guidance assumes IRF segment bad debt for Q2 through Q4 consistent with those levels experienced in the first half of 2017. We still do not have enough experience with Palmetto or TPE to assess the sustainability of the bad debt levels realized over the past two quarters.

Additionally, Q1 was yet another quarter with little progress made on the substantial backlog of claims awaiting adjudication at the ALJ level. IRF segment adjusted EBITDA for Q1 rose 9% to $223.8 million as revenue growth was leveraged with labor management. SWB declined by 70 basis points to 50.5% of revenue in Q1 and labor productivity as measured by employees per occupied bed, or EPOB, improved to 3.35 from 3.39 in Q1 2017.

Moving to our Home Health and Hospice segment, Q1 revenue increased 14.7%, with 13.1% growth in home health and 31.4% growth in hospice. Home health revenue growth was again volume driven with admissions increasing 9.9%, including same-store admissions growth of 7.4%.

As Mark stated in his comments, please be reminded that home health admissions faced tough comparisons in the first half of 2018 owing to the improvement in the former CareSouth locations that occurred during the first half of 2017.

Approximately 20% of the same-store admission growth in Q1 was tied to clinical collaboration with our IRFs. And as Mark highlighted, we experienced a significant year-over-year increase in our clinical collaboration rate to 33.5% in Q1. Our home health revenue per episode for Q1 declined 1.5%. The decline was a result of the reduction in Medicare reimbursement rates and an approximate $4 million revenue reserve related to a ZPIC audit. ZPIC audits occur somewhat sporadically in the ordinary course of business and their scope and timing are difficult to predict.

Excluding the impact of the ZPIC reserve, revenue per episode would have increased by 0.7% as changes in patient mix more than offset the impact of the Medicare reimbursement reduction. Again, hospice revenue increased 31.4% in Q1 as ADC rose 31.7%, driven primarily by 36.8% increase in same-store admissions. We continue to seek opportunities to add scale to our hospice business line and the Camellia acquisition represents a nice step in this direction. Home Health and Hospice segment adjusted EBITDA for Q1 increased 40.2% to $33.5 million.

The ZPIC reserve in Q1 was fully offset by two items; prior period reconciliation payments related to managed care contracts and a decrease in incentive compensation accruals due to timing. Adjusted EBITDA growth in Q1 also resulted from a 100-basis point reduction in cost of services as a percent of revenue owing to further improvements in caregiver productivity and efficiency.

And now, operator, we'll open the line for questions.

## QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] Your first question is from Matt Larew, William Blair.

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

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

**<Q – Matt Larew – William Blair & Co. LLC>:** Hi, good morning, guys, and thanks for taking the question. First, I wanted to ask about the moving parts in terms of IRF growth. Obviously, flu impact, holiday impact, but this is really two straight quarters of very strong growth above the recent trend and I'm just wondering if you could break out if there are any particular patient types or local market dynamics that are driving such strong growth during the last two quarters?

**<A – Mark Tarr – Encompass Health Corp.>:** Hi, Matt. So, I'll give a couple of comments and ask Barb Jacobsmeyer to weigh in as well. As you know for the past several years, we've set a big focus on our neuro complement from a program standpoint. We continue to see nice progress in our neuro – both neuro and our stroke volume in virtually in all of our markets. We've had a number of hospitals. We're now over 100 hospitals have these drug certification from The Joint Commission, which really puts a nice strive from their sleeve relative to their ability to handle complex stroke cases. The overall growth was pretty consistent across the entire portfolio. We always have some markets that do better than others. But it was a broad spread across our portfolio.

With that, I'll ask Barb to give additional comments.

**<A – Barb Jacobsmeyer – Encompass Health Corp.>:** Yeah. So, the only thing that we spend a lot of time on, we've talked about this in the past, is going and really talking about the value proposition of the patients coming to IRF, when they looked -especially with when we looked at stroke patients in the past that we go to skilled, when you look at our ability to get patients home and keep them home, then when you're looking at that patient from a cost perspective have a 30-day, 60-day or 90-day, we can really show the value of coming to IRF and really reducing those readmission costs that come along with the high readmission rates that the SNFs have.

**<Q – Matt Larew – William Blair & Co. LLC>:** Okay. Thanks for that. And then just following up on the work you're doing with Cerner in the Tyler, Texas market, just curious if that increase of growth, the hip fracture patients is really taking market share or it's sort of an increased incidence in the market? And then what can we think about in terms of timing for expansion of that program more broadly? And then also additional pilot programs, potentially another patient types?

**<A – Barb Jacobsmeyer – Encompass Health Corp.>:** Yeah, we do know that it's taking market share. Those patients in the past were going to skilled facilities and again by the ability of showing that care navigator really managing that patient, helping to get all of them home, as Mark mentioned, only one has gone to acute. That has really helped to be able to show that that value again from a longer 90-day perspective, which is how the CJR model is, it's 90 days. So, it's definitely pulling those patients in the market that were in the past going to skilled facilities. And we do feel that that's something that we're now being able to collect this data on and really refine some of the analytics that we're using, so that we can replicate that in more markets.

**<A – Doug Coltharp – Encompass Health Corp.>:** I think in addition to replicating this particular model in other markets, the other thing we'll be doing is seeking to expand the scope of the patients that we're treating in Tyler and the level of services that we're providing in the area of being a post-acute patient navigator.

**<Q – Matt Larew – William Blair & Co. LLC>:** Okay. Thanks for taking the questions.

Operator: Your next question is from Kevin Ellich, Craig-Hallum.

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

**<A – Doug Coltharp – Encompass Health Corp.>:** Hey, Kevin.

**<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>:** Good morning. Hey, guys. So, first off, I wanted to touch on the M&A environment, given your decreasing leverage and strong cash flow, wondering if you could lay out your plans for capital allocation and especially given some of the transactions we've seen in the market?

**<A – Doug Coltharp – Encompass Health Corp.>:** Yeah. So, this is Doug. So, obviously, we're very excited about the Camellia Healthcare opportunity. That's a nice size transaction. It's one that we began working on in the latter part of last year and just based on a variety of issues, it took a little bit longer to get to the finish line. But we're really excited to have that come into the fold. And in terms of further acquisitions in Home Health and Hospice, our primary focus is going to be on successfully integrating the Camellia transaction because it is of a pretty good size.

We do believe we'll make additional acquisitions in Home Health and Hospice over the balance of the year. We've got line of sight into some smaller agency acquisitions, it would be more akin to those that we've done in recent years, again, with an emphasis on creating more overlap markets with our IRFs, more market density and adding hospice in those markets where we have a home health agency, but don't currently have a hospice presence.

There has obviously been a couple of significant transactions that have occurred over the last 12 months in the Home Health and Hospice space with the Kindred at Home assets and then announced this week, Curo. Those are larger assets and they come with a full price tag. And as we think about the appropriateness of our company, pursuing an acquisition of that size, we have to be mindful not only of the impact on balance sheet leverage, but just our ability to generate appropriate returns for our shareholders and the intended integration risk that comes along with those.

We do believe that there are any number, we've said this in prior calls, that there are any number of regional opportunities that exist out there in the Home Health and Hospice space that are kind of between the size of the Camellia transaction and transactions that are the size of the two that I just referenced and we will be an active participant in those processes or in preemptive discussions around those assets as those opportunities arise.

**<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>:** Hey, Doug, one quick one before I ask my question about the MACs, but Camellia, you expect it to close before June 1. How much contribution do you expect have you baked in your guidance for that closing?

**<A – Doug Coltharp – Encompass Health Corp.>:** We haven't broken out a particular number for a number of reasons. One is we don't own the asset yet. The second thing is what we do know is that even with the best of intentions and with parties working together closely in advance of the transaction closing for smooth integration that it's typical that you will see some erosion in the business in the period immediately following the closing of an acquisition and that you'll also incur some integration expenses in the first six months.

And then finally, you'll recall that our previous guidance assumptions had assumed that we would do somewhere between $50 million and $100 million in Home Health and Hospice agency acquisitions during 2018 with the mid-year convention. So, the overall impact for this year from the Camellia transaction is not expected to be so large that it's not already incorporated into the elevated guidance range.

**<Q – Kevin Ellich – Craig-Hallum Capital Group LLC>:** Okay. That's helpful. And then I guess CMS issued some guidance around denials for a group versus individual therapy. Wondering and I might have

missed this if you commented in your prepared remarks, but what sort of impact do you expect and I guess are you seeing anything else on the horizon?

**<A – Doug Coltharp – Encompass Health Corp.>:** There was really only one MAC where we were having some issues around that specific basis for denial. And again that only came out I think about the third week in March, but right now it looks like it's having a positive impact on the flow of new denials from that specific MAC.

**<A – Mark Tarr – Encompass Health Corp.>:** I think it did help to add some clarity around the whole group versus individual therapy and [indiscernible] (32:02) of defining the propensity of therapy from a standpoint of individual versus group. But we do think it certainly seems to apply some additional clarity to the marketplace and how they evaluate this.

**<A – Doug Coltharp – Encompass Health Corp.>:** It's not going to have nearly the impact though just in terms of magnitude of either the Cahaba to Palmetto transition or the adoption of TPE.

Operator: And your next question is from Frank Morgan, RBC Capital Markets.

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

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

**<Q – Frank Morgan – RBC Capital Markets LLC>:** Good morning. Hey, I'll start out with a home health care question. Looking at how quickly that clinical collaboration rate has grown and I know at 33.5% today with a target of 35% to 40%. Do you have any thoughts about reassessing that goal or is there just sort of a geographic limit on the opportunity there? That would be my first question.

And then secondly, as you think about the – I think Camellia has less of an overlap opportunity. I'm just curious, will this in some way drive longer-term strategy to maybe layer in IRFs in those markets or should this we just think of that as being purely a home health care standalone market?

**<A – Mark Tarr – Encompass Health Corp.>:** Frank, it's Mark. I'll take your first question relative to the clinical collaboration. We are very pleased with the apparent impact from our TeamWorks initiative that we rolled out that was fully implemented by the fourth quarter of last year. You saw the increase of 460 basis points over prior year. We've said from a near-term standpoint, which was two years would be somewhere around the 35% to 40% which you've identified we're clearly closing in on. We said longer-term, if you look out more of a four-year timeframe, we think we can get it closer to 60%.

So, we'll take the next couple of quarters and we'll see where we stand and hopefully we'll continue to have this nice positive increase. Moving forward, we certainly expect that and then once we take the next couple of quarters to evaluate it, we will come back out with where we feel is an appropriate goal to measure.

**<A – Doug Coltharp – Encompass Health Corp.>:** And, Frank, this is Doug. I'll pick up on the second question. The Camellia transaction checks three really nice boxes for us. It does create an incremental IRF overlap market down in Gulfport, Mississippi. It creates further density in some of the home health markets in which we were already operating in or approximate to. And then importantly it adds scale to our hospice business. About 45% of the revenue base of Camellia is currently in the hospice space as well.

In terms of backfilling with IRFs, that can be a challenge to do in the State of Alabama because of the CON restrictions, although we were very pleased to have been able to open up a new facility in our home state this past quarter or early in the second quarter, I should say.

We do think we have as one of the markets that we're looking to expand our presence is Mississippi. So, there may be some opportunities, but we didn't acquire Camellia specifically with the objective of

backfilling some of those new home health markets within IRF. That will be done on an opportunistic basis.

Operator: Your next question is from Matthew Gillmor with Baird.

**<A – Mark Tarr – Encompass Health Corp.>:** Hey, Matthew.

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

**<Q – Matt Gillmor – Robert W. Baird & Co., Inc. (Broker)>:** Good morning, everybody. Good to speak to you again. I want to follow up on the pilot project with CHRISTUS and you provided some comments about how that could expand. But I guess more specifically, are there a number of markets you're targeting and sort of how many would an arrangement like this make sense within the portfolio? And then in addition to that as our way to kind of quantify how many hip fractures you think you could capture within the rest of the portfolio as you think about the broader opportunity?

**<A – Doug Coltharp – Encompass Health Corp.>:** I think it's too early to start assigning a number to how many hip fractures might be available to us. And I think that hip fractures are a convenient and appropriate place for us to start. But I really think that the upside is expanding this to other DRGs. In terms of the other markets that we can start piloting this or a similar project in, there are a lot of them, basically 127 of them. We're going to start really and most of the conversations that have taken into place are in those markets where we have a joint venture relationship already because we have peak interest with some of our joint venture partners earlier – or late last year with the announcement of the Post-Acute Innovation Center and then more recently with our public comments about the pilot that is underway with Trinity Mother Frances. We've had inbound calls [indiscernible] (36:48) can you talk to us about how you might be able to assist us.

We are actively engaged in those discussions. We absolutely want to make sure that the things that we are doing in the existing pilot are working well and the early reads are very positive and then we can meet those expectations. So, I think it will be a little bit slow rolling at first and then it'll really build momentum as we determine that the protocols that we've established and the tools that we have built are replicable and scalable. I'd expect to see at least a couple of additional pilots announced before this year is out. And again I think that we'll go into 2019 with a lot more momentum around these initiatives.

**<A – Mark Tarr – Encompass Health Corp.>:** Matt, our experience in Tyler certainly supports our thoughts in terms of what we had hoped would be possible with Cerner. If you look at Cerner and our relationship, we've been now working with Cerner for almost seven years on our electronic medical record. They know our company very well. We know their systems very well. We think this partnership will allow us to create the data analytics and predictive modeling capabilities to really take it to the next level for us and apply things relative to marketplaces and make us a better partner both for existing partnerships as well as being attractive partner for new partnerships.

**<Q – Matt Gillmor – Robert W. Baird & Co., Inc. (Broker)>:** Got it. That's helpful. And one quick follow-up and I'm sorry if I missed these numbers. Doug, did you quantify what the impact from flu in the calendar shift was on the IRF volumes for the quarter?

**<A – Doug Coltharp – Encompass Health Corp.>:** We did not, but I will. So, we estimate that the flu volume is a little bit harder to predict, because really you've got two things. We've got patients who floated to our facilities who are diagnosed with the primary diagnosis being debility and those tend to be patients who landed in an acute care facility with a severe case of the flu and were so weakened by it that they then qualified for recovery in an IRF setting.

And then you've also got those patients that had absolutely no incidence of the flu, but that were discharged more quickly from an acute care hospital or were not retained in acute care hospitals' IRF unit because of capacity issues at those hospitals caused by the flu. We would estimate the range of volume

impact from flu-related factors to be about 100 basis points and 200 basis points for Q1 and then we'd describe another 50 basis points or 60 basis points to the timing of Easter and Passover.

Operator: Your next question is from A.J. Rice with Credit Suisse.

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

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

**<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>:** Hey, how are you guys?

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

**<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>:** First of all, [indiscernible] (39:37) ask a little bit about hospice. There seems to be a little more emphasis starting with Camellia deal in your commentary. I know with home health, there's a natural progression of discharges out of our bid to home health and there's a rehab orientation to some of your home health activities. I wouldn't think there's that many people coming out of the IRFs that are going into hospice. Do you just view that as an attractive standalone post-acute business to be involved in or give us a little bit more of your strategic thinking on why sort of the increasing emphasis on hospice?

**<A – Mark Tarr – Encompass Health Corp.>:** Yeah, A.J., it's Mark and I'll let Doug make some comments. We do see hospice as an attractive third arm to be involved with. We don't see a lot of clinical collaboration between our inpatient rehabilitation hospitals and hospice for the reasons that you stated. That's not something that we see the need for. But we do see it as a very nice additional standalone service line. There are certain synergies with the home health operations that we see particularly those that come in the back office. But we do think it represents another arm of growth for us moving forward.

**<A – Doug Coltharp – Encompass Health Corp.>:** And importantly, it's focused on serving the Medicare beneficiary population, which is the core of our business. And as we stated before, one of the things that we're very excited about as we look at growth opportunities for our two core business lines, IRF and Home Health over the foreseeable future is the demographic tailwind that's driving demand for those services. Well, that exists for hospice services as well and hospice has the further growth driver of kind of a societal shift, if you will, and also some fiscal pressures.

If you think about it right now, everybody knows the fact that approximately a third of total Medicare expenditures are expended during the last 30 days of the patient's life. And so to make meaningful progress on really bending the curve for healthcare expenditures, ultimately we're going to have to address that trend and hospice is an appropriate way to begin making inroads there.

If you look at some statistics out there right now, about 50% of the Medicare beneficiaries who expire in any particular year, expire well on the hospice benefit and because Medicare beneficiaries experience a relatively low degree of sudden death related to things like trauma from accidents and so forth, that percentage ought to be substantially higher. You couple that with the fact that approximately a third of the Medicare beneficiaries who avail themselves of the hospice benefit and then expire, expire within seven days of admission.

We know it's a longer-term benefit than that would suggest that we're only now on a regular basis admitting folks to the hospice business line when all other means have been exhausted. All of those things we think are going to evolve over time and further drive demand. And because of the synergies Mark related, we think that that's a natural extension of our business.

It's also the case that as we mentioned before, April and her team have been very, very deliberate about studying the hospice business and making sure that we were developing the appropriate clinical and operational tools and characteristics to be able to be successful in that business. And if you look at the

growth indicators and the other metrics that I discussed during my comments regarding our hospice business, I think we're demonstrating that we have been able to adopt those successfully.

**<Q – A.J. Rice – Credit Suisse Securities (USA) LLC>:** Okay. That's great. And then just my follow-up question, when I look at your updated guidance, I'm thinking of a couple of things that happened. You've outperformed in the first quarter, at least relative to the Street estimates, I don't know how much relative to your internal estimates. You've got the Camellia deal and you also referenced how you're doing with the new MAC and that that may have implications for the rest of the year.

I guess, I'm looking because it doesn't seem like all of those are fully incorporated, the upside of those in the guidance. Is there offsets or you're assuming the discharge growth for example may have been a pull-forward from second quarter trend somewhat or is there other takes that we should be aware of that have balancing out the amount in which you've raised the guidance?

**<A – Doug Coltharp – Encompass Health Corp.>:** So, A.J., to start with, it's the end of the first quarter.

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

**<A – Doug Coltharp – Encompass Health Corp.>:** And it's almost unprecedented. There's only been one other time in our history where we ever raised guidance after the end of the first quarter. So, doing this is breaking a trend to some extent. As you can see from the guidance of considerations, specific to IRF segment bad debt, again because we don't have a long experience curve with either Palmetto or the adoption of TPE, we have made the assumption that Q2 through Q4 that bad debt snaps back to the level that we experienced in the first two quarters of 2017. Obviously, if it stays at certain levels, that would push us higher in the guidance range and provide some upside.

You may also recall that one of the assumptions that underlined our guidance initially and remains intact right now is that because we had such a favorable group medical experience in 2017 that that will be somewhat mean reverting and we're anticipating a higher increase in group medical expenses for 2018. That remains one of our guidance considerations.

And then finally, as I discussed earlier with regard to Camellia, one is the transaction has not closed yet. Two, it's going to happen relatively midyear. Three is, we would anticipate even though we're going to try to avoid it that there may be some temporary erosion in the business just as a result of the transaction taking place and we'll incur some integration expenses over the second half of the year. And then finally our previous guidance assumptions had already assumed $50 million to $100 million in the Home Health and Hospice agency acquisitions occurring in 2018 with the midyear convention.

Operator: Your next question is from John Ransom with Raymond James.

**<A – Mark Tarr – Encompass Health Corp.>:** Hey, good morning, John.

**<Q – John Ransom – Raymond James & Associates, Inc.>:** Hey, good morning.

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

**<Q – John Ransom – Raymond James & Associates, Inc.>:** Well, let me start out by saying that Matt and AJ asked my really smart questions. So, I'm down to the scraps. How is your health care cost trend in 1Q trending and do you have any updated comments? That's a pretty big wide range in your guidance consideration. So, how is that trending?

**<A – Doug Coltharp – Encompass Health Corp.>:** I think as we've discussed before, John, we only do an actuarial true-up of our group medical expenses on a semi-annual basis. So, it's hard to really establish a trend for the year just based on what we're seeing in Q1. It's also the case that you do see some timing issues through the course of the year around group medical expenses because of the utilization of deductibles and so forth. So, I guess the bottom line there is it's too early to tell and

therefore, we maintain those assumptions. We'll have a much better read as to how we think group medical is progressing when we get to the end of the second quarter.

**<Q – John Ransom – Raymond James & Associates, Inc.>:** Okay. Thanks. What do you explain, I mean, not just you, but across what we can look at publicly the acceleration in hospice volume over the past couple of years? Is it just the consciousness raising or is there something else going on? Is it better collaboration with home health? Is it market share gains by the [ph] for-profits (47:27), but what do you think is driving that?

**<A – Mark Tarr – Encompass Health Corp.>:** John, it's Mark. I am going to ask April for her thoughts on this too, but just overall I think that the societal acceptance of hospice is continuing to increase. More and more people are wanting to spend their end of life days at home and not in an institutional hospital setting all hooked up to tubes and wires and they want to be able to make their own decisions as they move towards end of life. So, I think people are starting to realize that this is a possibility and once again it's just societal acceptance is increasing with time.

April, you want to give your thoughts on that?

**<A – April Anthony – Encompass Health Corp.>:** Yeah. The other thing I would add to that is just of course the growing demographic that we've talked about is just creating ways that's coming our direction. And then finally, I would say the awareness not only just broadly at a consumer level, but particularly the awareness with Medicare Advantage plans, with ACOs of the value of understanding when a patient is appropriate for hospice, so that you can address those very high cost end of life costs that Doug mentioned earlier, it seems that as we have more ACOs, more Medicare Advantage plans, they are informing consumers that you don't have to simply rely on broad-based consumer awareness of service.

**<Q – John Ransom – Raymond James & Associates, Inc.>:** Okay. That makes sense. Two more quick ones from me. Doug, what do you think the breakpoint is on multiples? What level of EBITDA does the multiple jump from something [indiscernible] (49:00) – or, excuse me, Encompass would consider reasonable to the 11 times to 13 times numbers?

**<A – Doug Coltharp – Encompass Health Corp.>:** You mean in terms of acquisition opportunities?

**<Q – John Ransom – Raymond James & Associates, Inc.>:** Yeah. Like where can you buy where you're not having to pay these crazy multiples?

**<A – Doug Coltharp – Encompass Health Corp.>:** Well, I think it's situational specific. I think what we've seen is on the larger properties where there are more aggressive options and where you're drawing in players like the managed care companies, those are going to be aggressive options where the multiples run very high. I think on some of the more regional players where we're creating overlap opportunities with IRFs, where we're creating more market density and so forth, I think we can justify somewhat higher multiples. We have demonstrated consistently throughout the past that we are very disciplined acquirers of businesses and we'll continue to exhibit that trait going forward.

Operator: Your next question is from Kevin Fischbeck, Bank of America.

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

**<Q – Kevin Fischbeck – Bank of America Merrill Lynch>:** Hey, good morning. So, I guess I wanted to ask a little bit about the – just the adjustments you're making on the home health side. You mentioned that you're making adjustments to reduce the number of visits per episode. And I wanted to understand exactly how you're going about doing that and whether this was in any way trying to prepare for what may be coming down the line as far as the new grouping model?

**<A – Mark Tarr – Encompass Health Corp.>:** Kevin, I'm going to ask April to weigh in on that.

**<A – April Anthony – Encompass Health Corp.>:** Yeah. Kevin, I don't think that there is anything necessarily systemic to those alterations. I think it's a continued effort that we have across the organization of really challenging our clinical staff to ensure that they're bringing value in every single encounter that they have with patient, that they're never letting themselves succumb to kind of being a professional visitor to the patient, that they're always really focusing on what can I do to advance clinical outcomes to the patient. And I think just like having that continued focus [indiscernible] (51:00) among our full clinical staff, we're seeing them in fact create efficiencies.

We also see a little bit of shift in our patient mix as a contributor as well. And so, different types of patients have different volume demands. And so, as we see patient mix shift, that can have a little bit of an impact. But, I would say the primary impact is simply that that clinical awareness and that challenging of our clinical staff to say, boy, make sure that you are finding that greatest efficiency and we can't fully know exactly what the future models are going to look like yet at this stage. What we know is to bring the highest value in the shortest amount of time at the least cost is going to be a winning philosophy.

And so, everything that we've done for years has focused around those core tenets of bring value, do it cost effectively, get the patient back to their full rehab potential as quickly as possible. And so I think it's just a continued progression of strategies that have been in place for a long time.

**<Q – Kevin Fischbeck – Bank of America Merrill Lynch>:** So, I guess how much more do you think opportunity there is in doing this and then just to clarify, when you say shifting mix in patients, what exactly are you seeing?

**<A – April Anthony – Encompass Health Corp.>:** Well, so if we see more patients that have higher chronic care needs, they may have higher volume of care than patients that are coming out of their IRF setting, who are really in a bridge situation where they're trying to bridge back to transitional care home. We may find those IRF patient discharges to be more intense on the front-end, but shorter in duration with less overall intensity across the 60-day episode.

Take a chronic hypertension patient that's dealing with the multiplicity of co-morbid issues surrounding that and you will find that that patient's going to need three or so visits a week for the entirety of their 60-day episode versus that IRF patient may need three visits a week for four or five weeks. And so, we'll see as those patient types shift, that's when we'll see that shift in what we call mix of patients that we're bringing in.

As far as, will the trend continue, I would say it's just a matter of continuing to challenge ourselves to use alternatives to visits. We also find the ability to interject high risk phone calls in certain situations as visit replacement tool. That's another program that helped us to do that. And so I do think there is some continued runway for improved visit per episode as we really look for the most efficient way to deliver care not only with the most efficient caregiver, but with the most efficient caregiving method.

**<Q – Kevin Fischbeck – Bank of America Merrill Lynch>:** Okay. Thanks.

Operator: Your next question is from Dana Hambly with Stephens.

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

**<Q – Dana Hambly – Stephens, Inc.>:** Good morning. Thanks for getting me in. My question is actually on the personal care or private duty business, which to-date you have largely stayed away from while your peers have been adding to that line. So, what's your view on that industry? And does the new benefit that will allow Medicare Advantage to pay for those services starting next year kind of alter your view of that business?

**<A – April Anthony – Encompass Health Corp.>:** So, this is April. I think the – our belief is that that's a tough business to run. We've had experiences over our 20-year history at different points in time where we've acquired businesses that have small segments that look like that. We think it's a challenging

business to say the least and really that it's very much about having the right local leadership and the right local control. And as a result, we've really just found that utilizing partnerships across our network and finding the best player that we can have as effective outcome for the patient through a partnership relationship as we can through an ownership relationship.

That being said, as the Medicare Advantage plan benefit evolves and changes, we could certainly find that that could be something that down the road could gain interest for us. But I would say in the foreseeable future, we do not anticipate expanding into that area in any meaningful way. We may certainly pick up an acquisition here or there that continues to have pieces that include that service line, but that would not be a major acquisition that we would pursue in the foreseeable future.

**<Q – Dana Hambly – Stephens, Inc.>:** Thank you.

Operator: [Operator Instructions] Your next question is from Frank Morgan, RBC Capital Markets.

**<A – Mark Tarr – Encompass Health Corp.>:** Welcome back, Frank.

**<Q – Frank Morgan – RBC Capital Markets LLC>:** Yeah, just had a shopping list question here. I think I calculated that you're – on the home health care side, episodic growth was about 15% in total and I wanted to make sure that was aggregate and – but my question was, what is the same-store number if that's not the same-store number, would be number one, and what's the recertification rate that goes with that?

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

**<A – April Anthony – Encompass Health Corp.>:** Sure. Frank, if you look at slide 32 in the supplemental information, I think it'll break it down for you pretty clearly as well as trends where it's been over time. So, the total same-store growth in the home health division, 9.9% and 7.4% of that was coming from the same-store category.

**<A – Doug Coltharp – Encompass Health Corp.>:** And, Frank, from an episode perspective, episodes were up 15% as you suggested and the same-store component of that was 12.7% and that is on slide 9 of the supplemental slides.

**<Q – Frank Morgan – RBC Capital Markets LLC>:** Okay, thanks. Just one final question, obviously, you all have done a great job managing productivity with a strong volume growth, but just curious, other people talk so much about labor as an issue. Just any color around your two segments of business on what you're seeing in terms of availability of labor and what are the pressures on the labor market overall and if there are any regional, how much regional variation there is? Thanks.

**<A – Mark Tarr – Encompass Health Corp.>:** Yeah, Frank, it's Mark. I mean clearly and you've heard us talk in past calls in terms of everything that we've done to try to stay in front of the labor issues, whether it's evaluating benefits or clinical education and putting a lot of emphasis on the onboarding process with our staff. I would say if you look at it across the board right now, our turnover rates are at or below certainly industry standards. We've had a lot of luck particularly on the therapy side. I would say if we have an area that continues to see increased pressure, it's on the nursing side. We continue to once again track below the industry average on turnover. It's not impacting our ability to grow either one of our business lines right now.

But that keeps our attention on every single day and we try to do our best to increase employee engagement and retention and use every tool that we have to retain our good staff and be a great place to be attractive for new nurses and therapists coming into the workforce.

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

Operator: Thank you. I would now like to turn the call back over to Crissy Carlisle for closing remarks.

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

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

Operator: This concludes Encompass Health's first quarter 2018 earnings conference call. You may now disconnect.