Investor Reference Book

Post Q3 2018 Earnings Release

Last Updated January 7, 2019

Encompass Health®

Forward-Looking Statements

The information contained in this Investor Reference Book includes certain estimates, projections and other forward-looking information that reflect Encompass Health's current outlook, views and plans with respect to future events, including legislative and regulatory developments, strategy, capital expenditures, acquisition and other development activities, cyber security, dividend strategies, repurchases of securities, effective tax rates, financial performance, financial assumptions, business model, balance sheet and cash flow plans, disintermediation, and shareholder value-enhancing transactions. These estimates, projections and other forward-looking information are based on assumptions the Company believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance any estimates, projections or forward-looking information will be realized.

All such estimates, projections and forward-looking information speak only as of the date hereof. Encompass Health undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this Investor Reference Book as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2017, the Form 10-Q for the quarters ended March 31, 2018, June 30, 2018, and September 30, 2018, and in other documents Encompass Health previously filed with the SEC, many of which are beyond Encompass Health's control, that may cause actual events or results to differ materially from the views, beliefs, and estimates expressed herein.

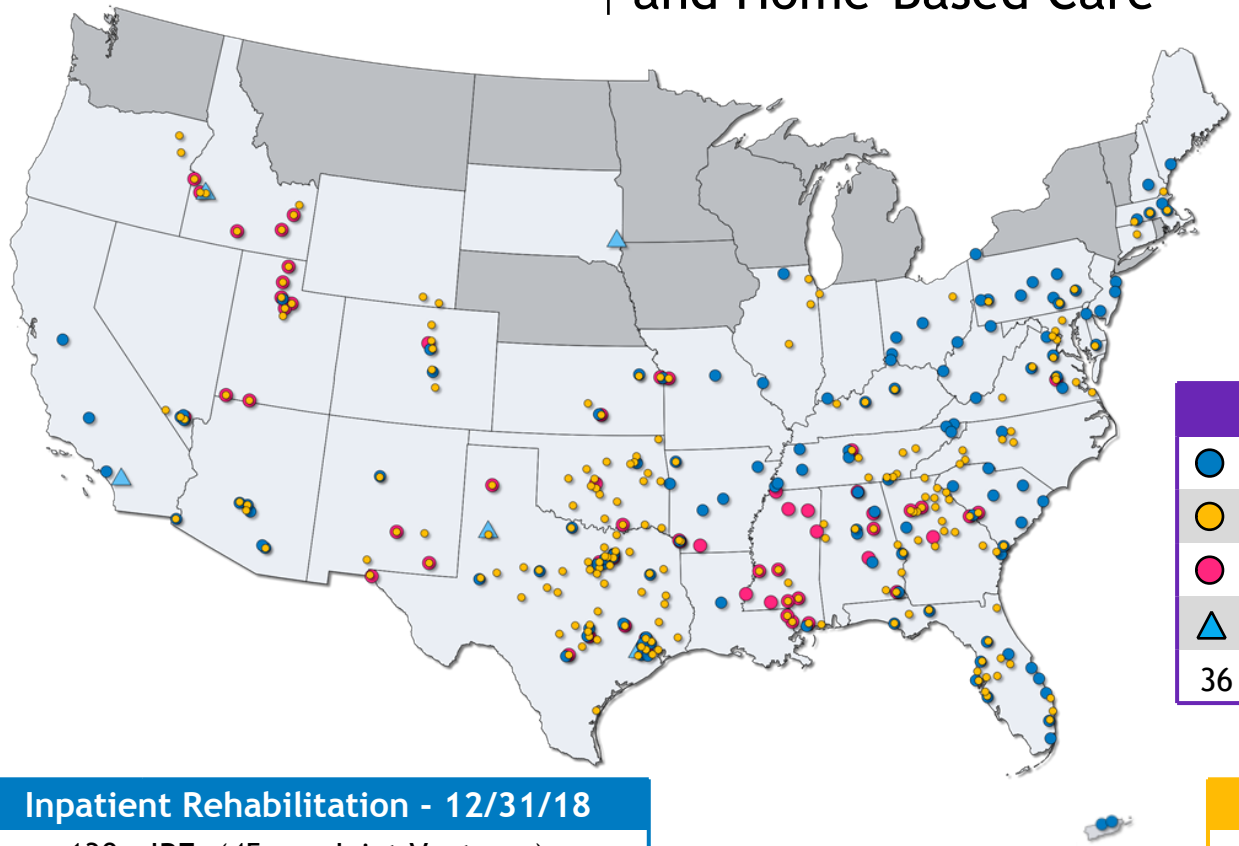
Note Regarding Presentation of Non-GAAP Financial Measures
The following Investor Reference Book includes certain "non-GAAP financial measures" as defined in Regulation G under the Securities Exchange Act of 1934, including Adjusted EBITDA, leverage ratios, adjusted earnings per share, and adjusted free cash flow. Schedules are attached that reconcile the non-GAAP financial measures included in the following Investor Reference Book to the most directly comparable financial measures calculated and presented in accordance with Generally Accepted Accounting Principles in the United States. The Company's Form 8-K, dated January 7, 2019, to which the following Investor Reference Book is attached as Exhibit 99.2, provides further explanation and disclosure regarding Encompass Health's use of non-GAAP financial measures and should be read in conjunction with this Investor Reference Book.

Table of Contents

Company Overview

Encompass Health is a leading provider of inpatient rehabilitation and home-based care committed to delivering high-quality, cost-effective, integrated care across the post-acute continuum.

Encompass Health | A Leading Provider of Inpatient Rehabilitation and Home-Based Care



Market Overlap - 12/31/18
81 of EHC's IRFs have an EHC home health location within the service area.*

Portfolio - 12/31/18	
Inpatient Rehabilitation Hospitals ("IRFs")	
Home Health Locations	
Hospice Locations	
5 Future IRFs**	
36 States and Puerto Rico	~40,400 Employees

Inpatient Rehabilitation - 12/31/18	
130	IRFs (45 are Joint Ventures)
32	States and Puerto Rico
~30,100	Employees
22%	of Licensed Beds†
30%	of Medicare Patients Served†
Key Statistics - Trailing 4 Quarters (09/30/18)	
178,258	Inpatient Discharges
~$3.3	Billion in Revenue

Largest Owner and Operator of IRFs

4th Largest Provider of Medicare-Certified Skilled Home Health Services

Home Health and Hospice - 12/31/18	
220	Home Health Locations
58	Hospice Locations
30	States
~10,300	Employees
Key Statistics - Trailing 4 Quarters (09/30/18)	
134,011	Home Health Admissions
6,799	Hospice Admissions
~$887	Million in Revenue

* Excluding markets that have home health licensure barriers ** Previously announced under development † Based on 2017 data
Note: One of the 130 IRFs and two of the 220 home health locations are nonconsolidated.
These locations are accounted for using the equity method of accounting.

Inpatient Rehabilitation Hospitals

114 of the Company's IRFs hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program.[1]

Major Services

- **Rehabilitation Physicians:** manage and treat medical conditions and oversee rehabilitation program
- **Rehabilitation Nurses:** provide personal care and oversee treatment plan for patients
- **Physical Therapists:** address physical function, mobility, strength, balance, and safety
- **Occupational Therapists:** promote independence through Activities of Daily Living ("ADLs")
- **Speech-Language Therapists:** address speech/voice functions, swallowing, memory/cognition, and language/communication
- **Case Managers:** coordinate care plan with physician, Care Transition Coordinators, caregivers and family
- **Post-Discharge Services:** outpatient therapy and home health

Refer to pages 111-115 for end notes.

Company Overview | Home Health and Hospice

Home Health Agencies

The Company offers evidence-based specialty programs related to: Post-Operative Care, Fall Prevention, Chronic Disease Management, and Transitional Care.



Major Services

- **Skilled Nurses:** comprehensively assess, teach, train, and manage care related to injury or illness
- **Home Health Aides:** provide personal care and assistance with Activities of Daily Living ("ADLs")
- **Physical Therapists:** address physical function, mobility, strength, balance, and safety
- **Occupational Therapists:** promote independence through training on self-management of ADLs
- **Speech-Language Therapists:** address speech/voice functions, swallowing, memory/cognition, and language/communication
- **Medical Social Workers:** provide assessment of social and emotional factors; assist with obtaining community resources

Hospice: provides services to terminally ill patients and their families to address patients' physical needs, including pain control and symptom management, and also provides emotional and spiritual support.

IRF Patient Mix

Referral Sources:

Acute Care Hospitals – **91%**
Physician Offices / Community – **7%**
Skilled Nursing Facilities – **2%**

Rehabilitation Impairment Category*		YTD-18	2017
RIC 01	Stroke	18.0%	18.0%
RIC 02/03	Brain dysfunction	10.2%	10.1%
RIC 04/05	Spinal cord dysfunction	3.9%	4.0%
RIC 06	Neurological conditions	21.0%	21.6%
RIC 07	Fracture of lower extremity	7.7%	7.9%
RIC 08	Replacement of lower extremity joint	3.9%	4.1%
RIC 09	Other orthopedic	9.0%	9.3%
RIC 10/11	Amputation	2.6%	2.6%
RIC 14	Cardiac	4.4%	4.3%
RIC 17/18	Major multiple trauma	5.2%	5.3%
RIC 20	Other disabling impairments	11.2%	10.0%
—	All other RICs	2.9%	2.8%

Average Age of the Company's IRF Patients:
All Patients = 71 Medicare FFS = 76

Admission to an IRF:

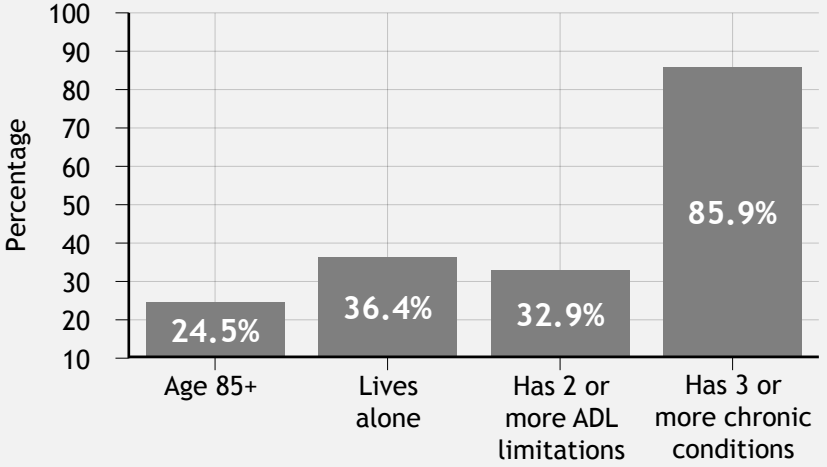
- Physicians and acute care hospital case managers are key decision makers.
- All IRF patients must meet reasonable and necessary criteria and must be admitted by a physician.
- All IRF patients must be medically stable and have potential to tolerate three hours of therapy per day (minimum).
- IRF patients receive 24-hour, 7 days a week nursing care.
- Average length of stay = 12.7 days

Home Health Patient Mix

Referral Sources:

Acute Care Hospitals – **35%**
Physician Offices / Community – **38%**
IRFs / LTCHs / SNFs – **27%**

Demographics of all Medicare Home Health Users**:



Average Age of the Company's Home Health Patients:
All Patients = 76 Medicare FFS = 77

Admission to home health:

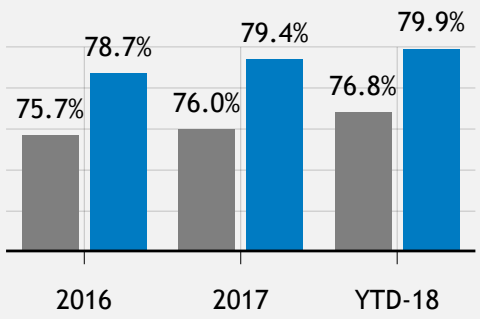
- For Medicare, a patient must be confined to the home and need skilled services.
- The patient must be under the care of a physician and receive services under a home health plan of care established and periodically reviewed by a physician.
- Medicare also requires a face-to-face encounter related to the primary reason the patient requires home health services with a physician or an allowed non-physician practitioner.

* Rehabilitation Impairment Categories (RICs) represent how the Company admitted the patient; BPCI (pages 61-62) uses Diagnostic-Related Groups (DRGs) which represent how the acute care hospital discharged the patient.
** Source: Avalere Health and Alliance for Home Health Quality and Innovation Home Health Chart Book 2018

High-Quality Care

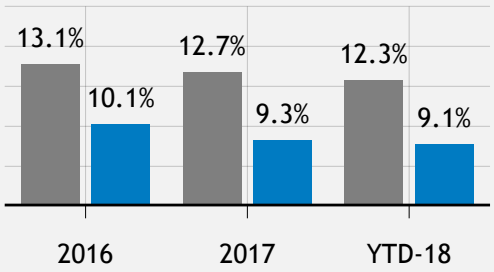
IRF Quality

Discharge to Community



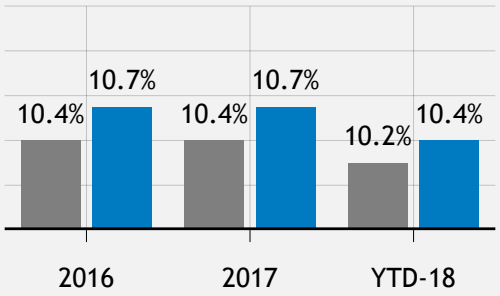
Percent of cases discharged to the community, including home or home with home health. Higher is better.

Discharge to Skilled Nursing



Percent of patients discharged to a skilled nursing facility. Lower is better.

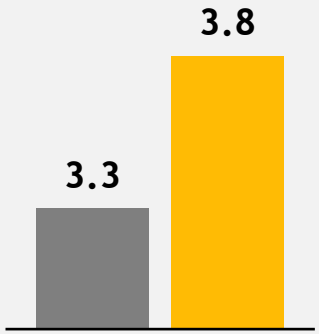
Discharge to Acute Hospital



Percent of patients discharged to an acute care hospital. Lower is better.

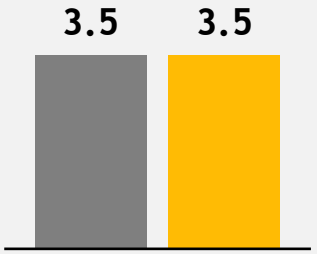
UDSMR[2] | Encompass Health

Home Health Quality



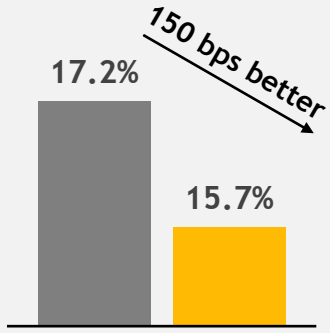
Quality of Care Star Ratings[3]

95% of our home health agencies are **3** Stars or higher;
55% are **4** Stars or higher



Patient Satisfaction Star Ratings[3]

90% of our home health agencies are **3** Stars or higher;
53% are **4** Stars or higher



30-Day Readmission Rate*

Percent of patients readmitted to an acute care hospital. Lower is better.

National Average | Encompass Health

Refer to pages 111-115 for end notes.
* Source for National Average: Avalere Health and Alliance for Home Health Quality and Innovation Home Health Chart Book 2018

Leading Position in Cost Effectiveness | Inpatient Rehabilitation

	#	Avg. Beds per IRF	Avg. Medicare Discharges per IRF[5]	Case Mix Index[6]	Avg. Est. Total Cost per Discharge for FY 2019	Avg. Est. Total Payment per Discharge for FY 2019
Encompass Health[4] =	126	67	951	1.28	$13,622	$20,315
Free-Standing = (Non-Encompass Health)	154	58	589	1.27	$18,107	$21,400
Hospital Units =	846	24	228	1.22	$21,483	$21,569
Total[7]	1,126	34	358	1.25	$18,388	$21,159

Medicare pays Encompass Health less per discharge, on average, and Encompass Health treats a higher acuity patient.

The Company differentiates itself by:

- *"Best Practices" clinical protocols*
- *Supply chain efficiencies*
- *Sophisticated management information systems*
- *Economies of scale*

The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration.[8]
Refer to pages 111-115 for end notes.

Low Cost Leader | Home Health

	2017 Episodes	Average Revenue per Episode†	Average Visits per Episode	Average Revenue per Visit (all payors)	Cost per Visit
Encompass Health	211,743	$2,998	17.9	$161	$75
Public Peer Average	283,366	$2,835	17.4*	$148*	$81*
Comparison to Peer Average		5.7%	2.9%	8.8%	(7.4)%

Average revenue per episode is 5.7% higher than the peer average due to higher acuity patient mix.

Cost per visit is 7.4% lower due to market density and operational efficiency:

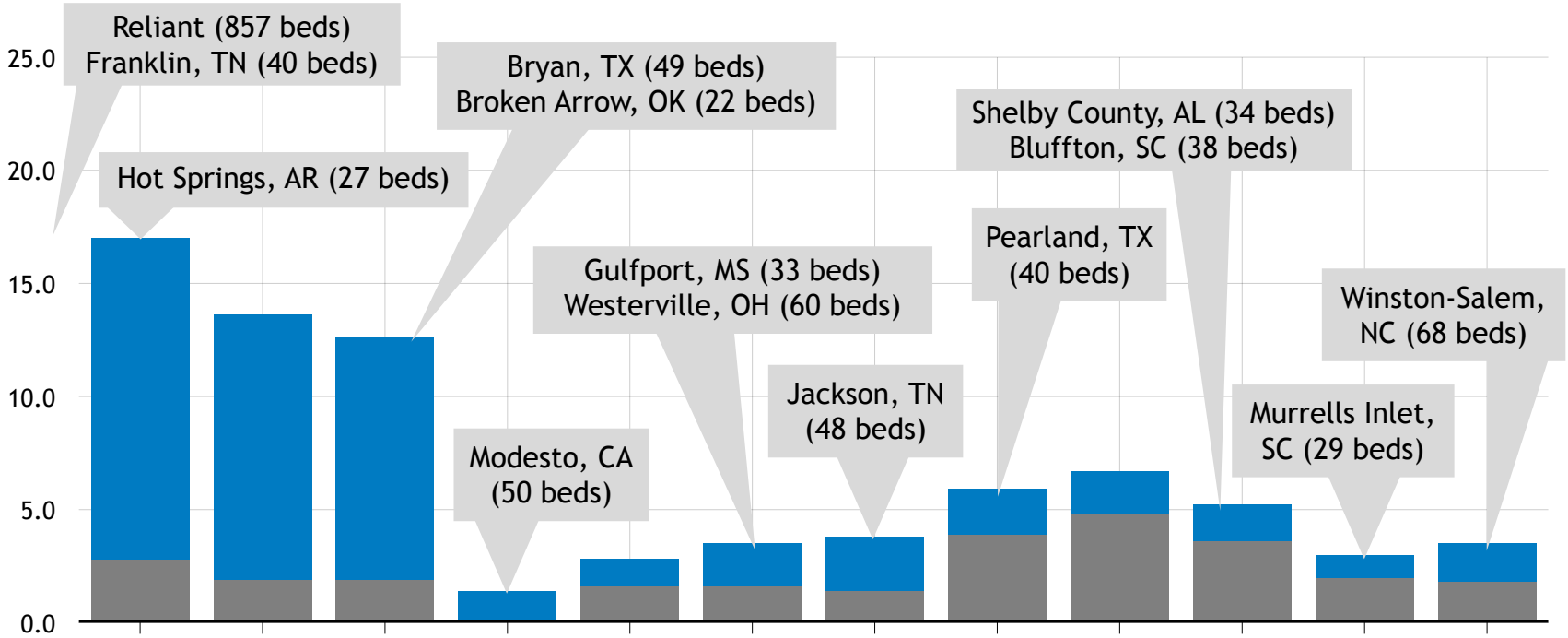
- *Caregiver optimization*
- *Optimization of HCHB*
- *Employee culture of excellence*
- *~75% of visits conducted by full-time staff*
- *Daily monitoring of productivity*

Public peer average represents 2017 data from publicly traded home health providers.

* Kindred did not report visit counts in 2017.

† Amounts do not reflect the impact of the new revenue recognition accounting standard discussed on page 36.

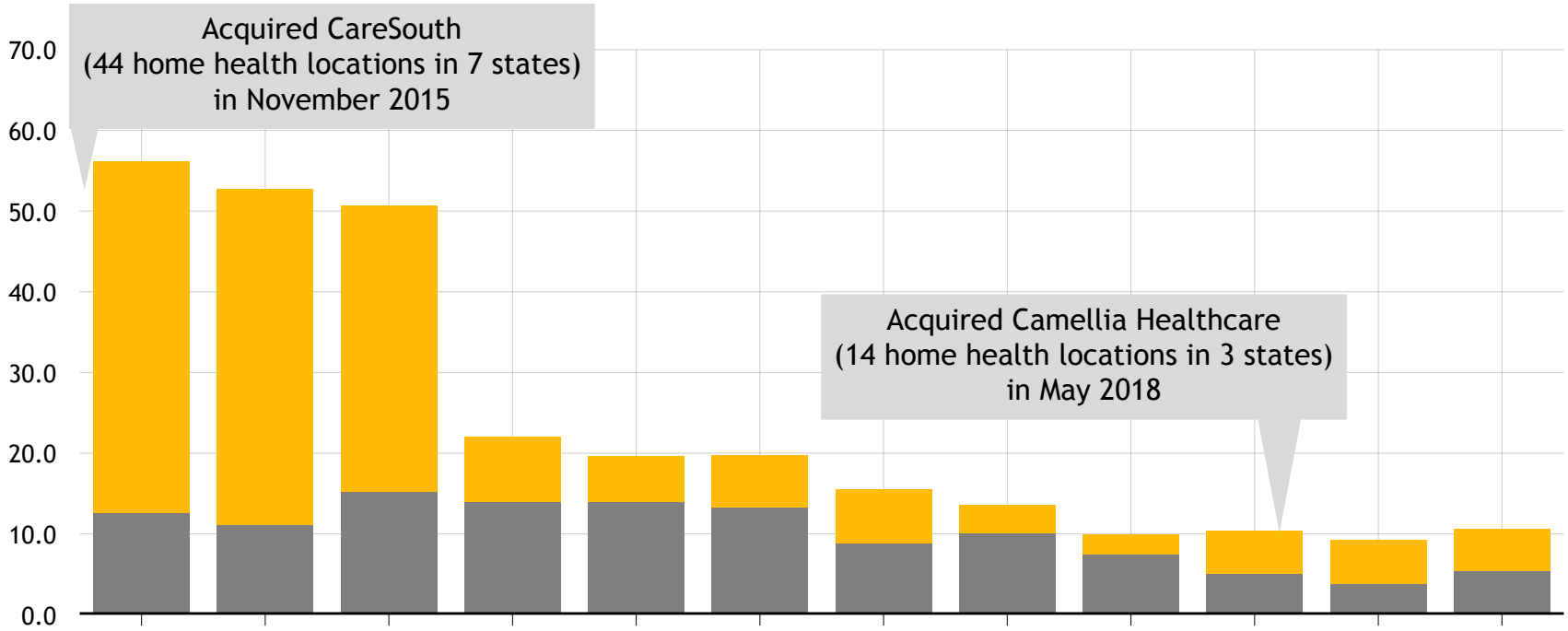
New-Store/Same-Store Growth | Inpatient Rehabilitation



Discharges	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Preliminary Q4 2018
New Store	14.2%	11.7%	10.7%	1.3%	1.2%	1.9%	2.4%	2.0%	1.9%	1.6%	1.0%	1.7%
Same Store*	2.8%	1.9%	1.9%	0.1%	1.6%	1.6%	1.4%	3.9%	4.8%	3.6%	2.0%	1.8%
Total by Qtr.	17.0%	13.6%	12.6%	1.4%	2.8%	3.5%	3.8%	5.9%	6.7%	5.2%	3.0%	3.5%
Total by Year				10.8%				4.0%				4.6%
Same-Store Year*				1.7%				1.8%				2.8%
Same-Store Year UDS**				(0.6)%				(0.5)%				

* Includes consolidated inpatient rehabilitation hospitals classified as same store during each period
** Data provided by UDSMR

New-Store/Same-Store Growth | Home Health

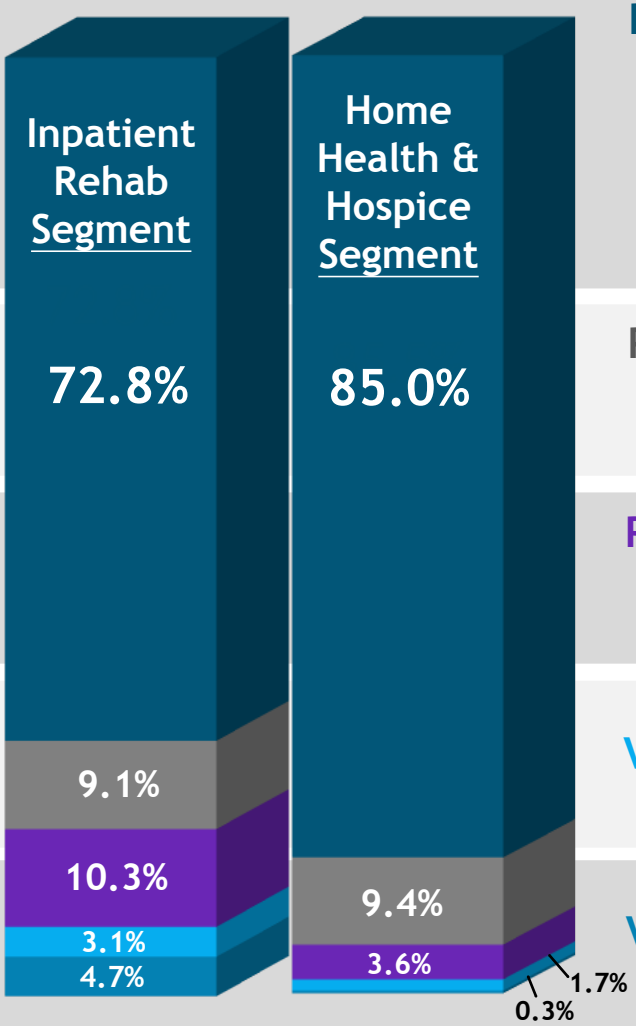


Admissions	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Preliminary Q4 2018
New Store	43.5%	41.6%	35.4%	8.1%	5.7%	6.4%	6.7%	3.5%	2.5%	5.3%	5.4%	5.2%
Same Store*	12.6%	11.1%	15.3%	14.0%	13.9%	13.3%	8.8%	10.1%	7.4%	5.1%	3.8%	5.4%
Total by Quarter	56.1%	52.7%	50.7%	22.1%	19.6%	19.7%	15.5%	13.6%	9.9%	10.4%	9.2%	10.6%
Total by Year				43.6%				17.0%				10.0%
Same-Store Year*				13.7%				11.4%				5.5%

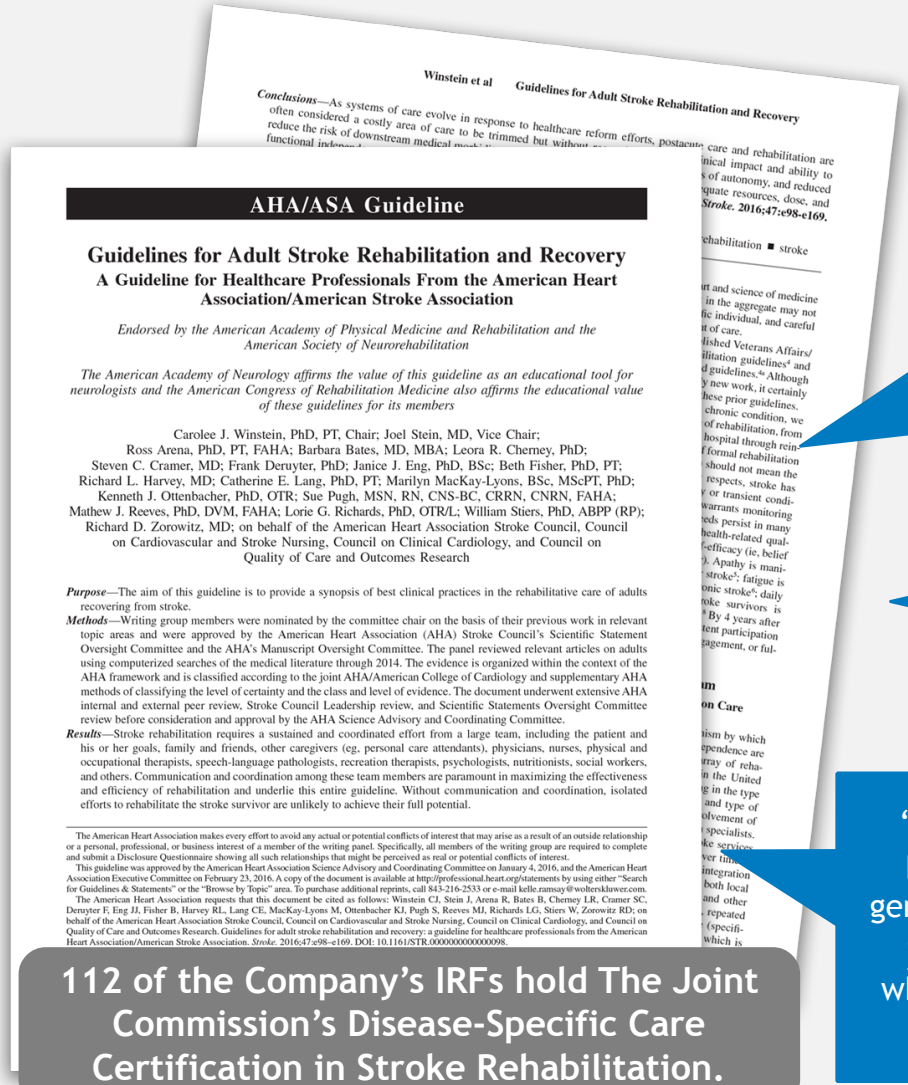
- In 2016, the Company acquired or opened 10 home health locations.
- In 2017, the Company acquired or opened 15 home health locations.
- In 2018, the Company acquired or opened 23 home health locations.

* Includes consolidated home health locations classified as same store during each period

Payors (Q3 2018)

Payor Source	% of Revenues	Payment Methodology
Medicare		**Prospective Payment System ("PPS")** - **IRF**: Paid per discharge by Case Mix Group ("CMG") - **Home Health**: Paid per 60-day episode of care by Home Health Resource Group • An episode is paid in two installments: 1) Request for Anticipated Payment 2) Final bill after episode is complete
Medicare Advantage		**Per Diem/Visit or CMG/Episodes** - Negotiated rate - Some are "tiered" for acuity/severity
Managed Care		**Per Diem/Visit or CMG/Episodes** - Negotiated rate - Some are "tiered" for acuity/severity
Medicaid		**Varies by state**
Other		**Variety of methodologies**

Independent Research Concludes IRFs are a Better Rehabilitation Option for Stroke Patients than SNFs



Winstein et al Guidelines for Adult Stroke Rehabilitation and Recovery

Conclusions—As systems of care evolve in response to healthcare reform efforts, postacute care and rehabilitation are often considered a costly area of care to be trimmed but without ... clinical impact and ability to reduce the risk of downstream medical ... of autonomy, and reduced functional ... quate resources, dose, and

Stroke. 2016;47:e98-e169.

rehabilitation ■ stroke

AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists and the American Congress of Rehabilitation Medicine also affirms the educational value of these guidelines for its members

Carolee J. Winstein, PhD, PT, Chair; Joel Stein, MD, Vice Chair; Ross Arena, PhD, PT, FAHA; Barbara Bates, MD, MBA; Leora R. Cherney, PhD; Steven C. Cramer, MD; Frank Deruyter, PhD; Janice J. Eng, PhD, BSc; Beth Fisher, PhD, PT; Richard L. Harvey, MD; Catherine E. Lang, PhD, PT; Marilyn MacKay-Lyons, BSc, MScPT, PhD; Kenneth J. Ottenbacher, PhD, OTR; Sue Pugh, MSN, RN, CNS-BC, CRRN, CNRN, FAHA; Mathew J. Reeves, PhD, DVM, FAHA; Lorie G. Richards, PhD, OTR/L; William Stiers, PhD, ABPP (RP); Richard D. Zorowitz, MD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research

Purpose—The aim of this guideline is to provide a synopsis of best clinical practices in the rehabilitative care of adults recovering from stroke.

Methods—Writing group members were nominated by the committee chair on the basis of their previous work in relevant topic areas and were approved by the American Heart Association (AHA) Stroke Council's Scientific Statement Oversight Committee and the AHA's Manuscript Oversight Committee. The panel reviewed relevant articles on adults using computerized searches of the medical literature through 2014. The evidence is organized within the context of the AHA framework and is classified according to the joint AHA/American College of Cardiology and supplementary AHA methods of classifying the level of certainty and the class and level of evidence. The document underwent extensive AHA internal and external peer review, Stroke Council Leadership review, and Scientific Statements Oversight Committee review before consideration and approval by the AHA Science Advisory and Coordinating Committee.

Results—Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers (eg, personal care attendants), physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This guideline was approved by the American Heart Association Science Advisory and Coordinating Committee on January 4, 2016, and the American Heart Association Executive Committee on February 23, 2016. A copy of the document is available at http://professional.heart.org/statements by using either "Search for Guidelines & Statements" or the "Browse by Topic" area. To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2016;47:e98–e169. DOI: 10.1161/STR.0000000000000098.

112 of the Company's IRFs hold The Joint Commission's Disease-Specific Care Certification in Stroke Rehabilitation.

"**Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility**. While in an inpatient rehabilitation facility, a patient participates in at least three hours of rehabilitation a day from physical therapists, occupational therapists, and speech therapists. Nurses are continuously available and doctors typically visit daily."*

"If the hospital suggests sending your loved one to a skilled nursing facility after a stroke, **advocate for the patient to go to an inpatient rehabilitation facility instead**…"*

"The studies that have compared outcomes in hospitalized stroke patients first discharged to an IRF, a SNF, or a nursing home have generally shown that **IRF patients have higher rates of return to community living and greater functional recovery**, whereas patients discharged to a SNF or a nursing home have higher rehospitalization rates and substantially poorer survival."**

* AHA/ASA press release, "Inpatient rehab recommended over nursing homes for stroke rehab," issued May 4, 2016 (newsroom.heart.org)

** "Guidelines for Adult Stroke Rehabilitation and Recovery," issued May 2016 (stroke.ahajournals.org)

Strong and Sustainable Business Fundamentals

Attractive Healthcare Sectors	• Favorable demographic trends driving increased demand • Nondiscretionary nature of many conditions treated • Highly fragmented post-acute sectors present acquisition and joint venture opportunities
Industry Leading Positions	• Largest provider of inpatient rehabilitation services • 4th largest provider of Medicare-certified skilled home health services • Top 25 provider of hospice services • Consistent delivery of high-quality, cost-effective, integrated facility-based and home-based care • Enhanced utilization of technology (e.g., clinical, data management, and technology-enabled business processes)
Cost-Effectiveness	• Effective labor management • Efficient supply chain • Economies related to scale and market density
Real Estate Ownership	• Portfolio of 130* IRFs as of December 31, 2018 ✓ 90 owned and 40 leased
Financial Strength	• Strong balance sheet and liquidity, no significant near-term maturities (credit agreement matures in 2022; bonds mature in 2023 and beyond) • Substantial free cash flow generation
Growth Opportunities	• Attractive organic growth opportunities in both segments • Flexible inpatient rehabilitation de novo and acquisition strategy • Home health and hospice platform with track record of growth through acquisitions

* Includes one nonconsolidated entity.

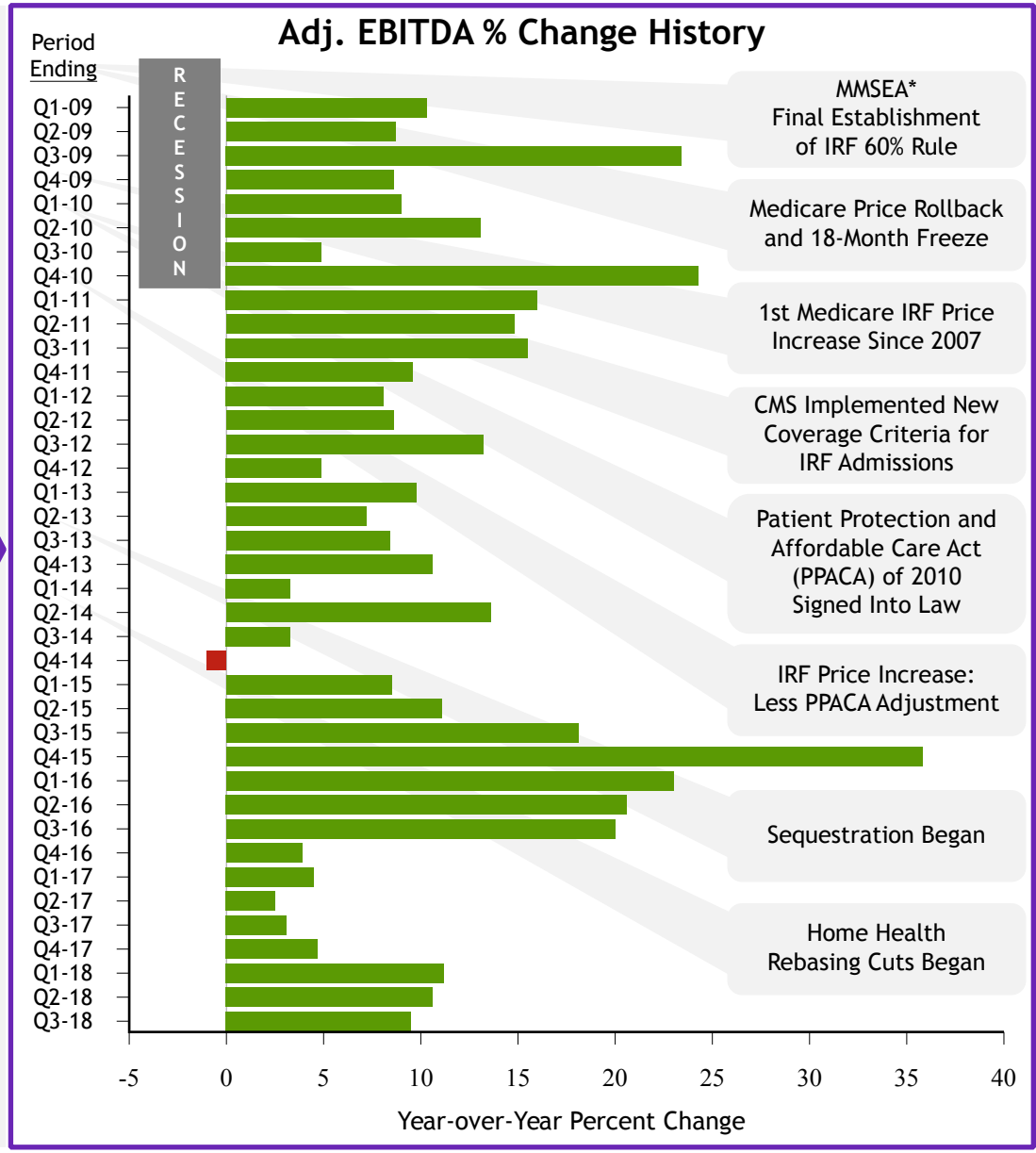
Proven Track Record

We have successfully managed through an economic recession, regulatory changes, sequestration, and Medicare payment freezes/cuts.

Beginning with 2009, we posted a year-over-year increase in Adjusted EBITDA in **38 of the last 39 quarters** despite these challenges.

The only exception was Q4 2014 when we opened four new hospitals (three de novo; one acquired) and incurred ~$6 million of start-up costs.

We will continue to adapt to the changing healthcare landscape by leveraging our position as a provider of high-quality outcomes delivered in a cost-effective manner.



* Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007

Investment Thesis and Strategy

Encompass Health's ability to adapt to changes, build strategic relationships, and consistently provide high-quality, cost-effective care positions the Company for success in the evolving healthcare industry.

Investment Thesis

Encompass Health is positioned to become the nation's leading provider of integrated post-acute services.

The healthcare industry is evolving toward integrated delivery models and value-based care. Providers must be able to adapt to changes, build strategic relationships across the healthcare continuum, and consistently provide high-quality, cost-effective care to be successful.

Change Agility	Demonstrated ability to adapt across economic cycles and in the face of numerous and significant regulatory and legislative changes
Strategic Relationships	Joint ventures with acute-care partners comprise one-third of IRF portfolio.
	Formed Post-Acute Innovation Center in collaboration with Cerner Corporation to develop enhanced tools to manage patients across the continuum of care
	Partnered with the American Heart Association/American Stroke Association to jointly work to elevate national and local awareness that stroke is treatable and beatable through rehabilitation and community support
Quality of Patient Outcomes	Outcomes in both operating segments exceed national industry standards.
Cost Effectiveness	Treatment of more medically complex patients at lower average costs than other post-acute providers through superior clinical protocols, economies of scale, and technology-enabled business processes
Growth	Both of the Company's segments benefit from favorable demographic trends and the nondiscretionary nature of many conditions treated.

Strategy

The Company's strategy is to expand its network of inpatient rehabilitation hospitals and home health and hospice locations, further strengthen its relationships with healthcare systems, provider networks, and payors in order to connect patient care across the healthcare continuum, and to deliver superior outcomes.

Elements of Strategy

Clinical Expertise and High-Quality Outcomes

Financial Resources

Advanced Technology

Sustained Growth

Post-Acute Solutions

Elements of Strategy

Clinical Expertise and High-Quality Outcomes	Institutional programs and advanced treatment protocols connect care and allow seamless transition of patients across the healthcare continuum
	Leverage technology to strengthen clinical data analytics
	Integration of care transition coordinators
	114 Encompass Health inpatient rehabilitation hospitals hold one or more disease-specific certifications, including 112 with stroke-specific certifications
	Outcomes in both operating segments exceed national industry standards (see page 9)
Financial Resources	Strong, well-capitalized balance sheet
	Free cash flow funds growth and shareholder distributions
Advanced Technology	Proprietary rehabilitation-specific clinical information system (known as "ACE-IT")
	Proprietary management reporting system (known as "Beacon")
	Optimization of Homecare Homebase
Sustained Growth	Highly fragmented sectors present acquisition and joint venture growth opportunities
	Technology-facilitated and data-driven sales processes
	Barriers to entry include capital investments, clinical expertise, regulatory compliance, and Certificate of Need (“CON”) requirements
Post-Acute Solutions	Predictive analytics used to enhance patient outcomes (e.g., ReACT; Sepsis Alert)
	Ongoing innovation with initiatives such as the Post-Acute Innovation Center
	Active participant in various alternative payment models

The Healthcare Landscape is Changing.

Current Post-Acute Providers

- *Medicare payments/regulations are site specific (e.g., 60% Rule, 3-Hour Rule, "preponderance" of one-to-one therapy).*

- Long-Term Acute Care Hospitals
- Inpatient Rehabilitation Hospitals
- Skilled Nursing Facilities
- Home Health

- ***Integrated Delivery Payment Models***
- ***Value-Based Payments***
- ***Site Neutrality***

Future Post-Acute Providers

- *Medicare payments/regulations will be outcome focused.*
- *Many existing regulations will become unnecessary.*

Facility-Based Post Acute Services

- Full range: low acuity → high acuity
- 24/7 nursing coverage
- Eliminates payment silos

Home-Based Post-Acute Services

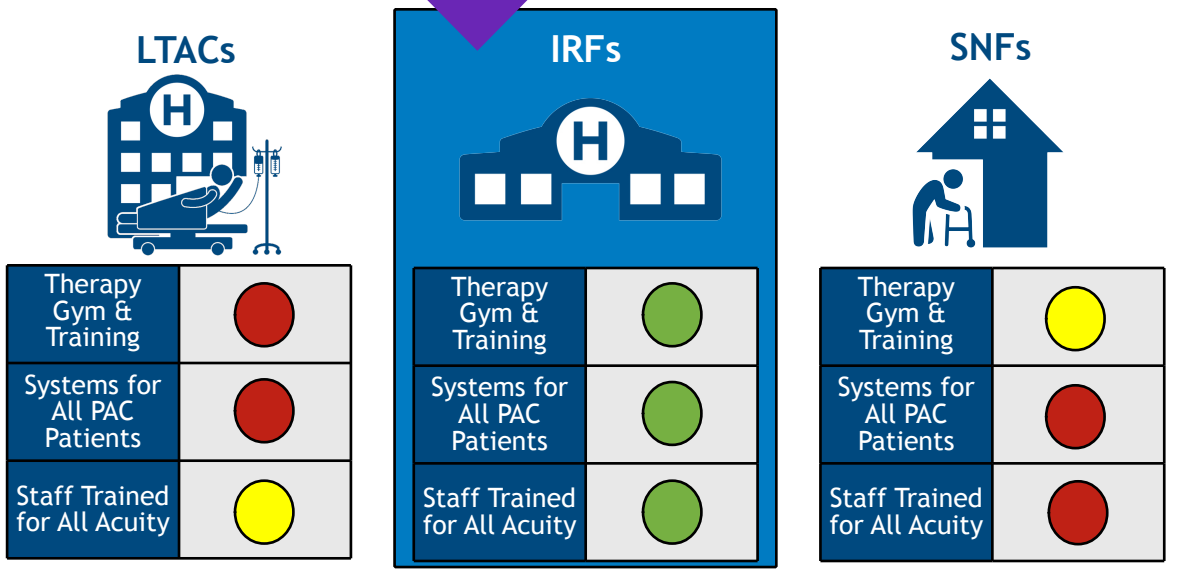
- More care in the home (lowest cost setting)
- Ability to care for high-acuity patients with multiple chronic conditions

- The healthcare industry is moving toward integrated delivery payment models, value-based purchasing, and site neutrality.
- To succeed, providers must adapt to changes in the regulatory and operating environments, build strategic relationships across the healthcare continuum, and consistently provide high-quality care at a cost-effective price.

The Company is Well-Positioned for the Progression Towards Site Neutrality as It Will be Able to Treat All Types of Post-Acute Patients by Leveraging Its Operational Expertise Across Its Network of Facility-Based and Home-Based Assets.

The Company's IRFs have the physical construct, clinical staffing, and operating expertise to "pivot from the center" to address the full spectrum of inpatient post-acute needs in a site neutral environment.

Present



Progression to Site Neutrality

Future

Post-Acute Inpatient Hospitals

Post-Acute Inpatient Spectrum

Higher Acuity — **Lower Acuity**

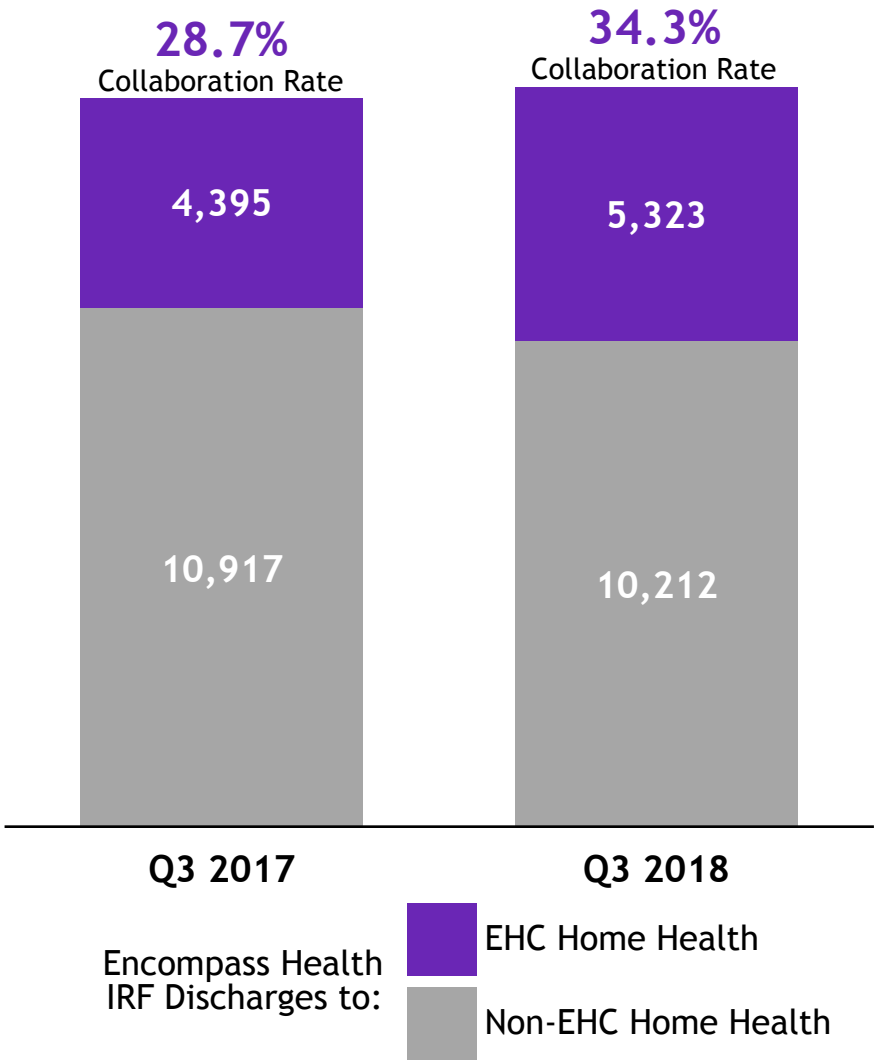
Home Health

Higher acuity patients will transition from post-acute inpatient hospitals to home health. Lower acuity patients will go directly to home health.

Clinical Collaboration - Overlap Markets*

Inpatient Rehabilitation-Home Health Clinical Collaboration (All Payors)

- The objectives of clinical collaboration are to improve patient experience and outcomes and to reduce the total cost of care across a post-acute episode.
  - Coordination between our IRFs and home health teams is resulting in lower discharges to skilled nursing facilities, higher discharges to home, and improved patient satisfaction.
- As of December 31, 2018, Encompass Health had 81 overlap markets* as compared to 76 overlap markets at December 31, 2017.
- The clinical collaboration rate with Encompass Health's inpatient rehabilitation hospitals increased by 560 basis points in Q3 2018 compared to Q3 2017.
- The clinical collaboration rate objective is 35% to 40% in the near term.

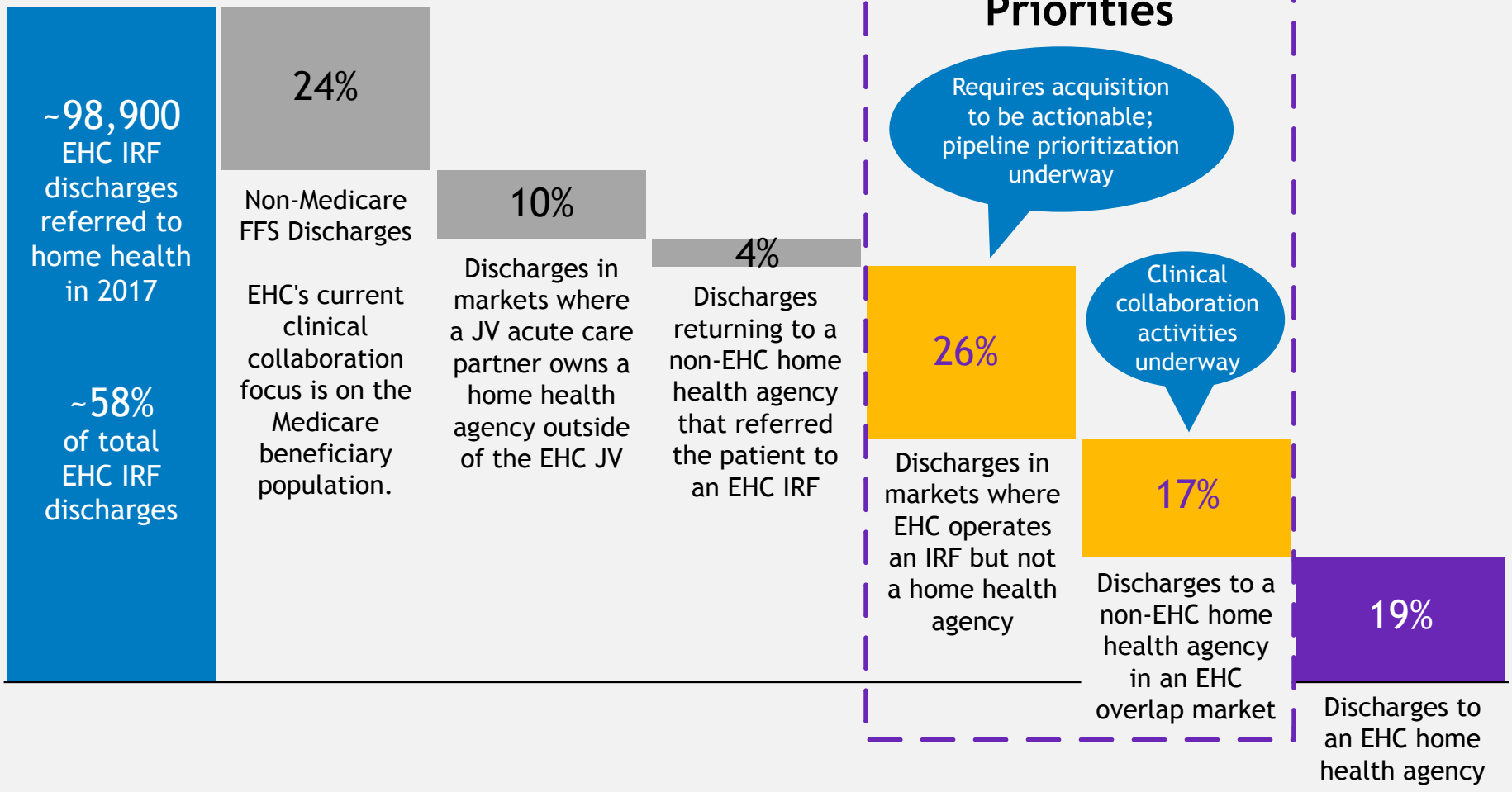


* Overlap markets have an Encompass Health IRF and an Encompass Health home health location within an approximate 30-mile radius, excluding markets that have home health licensure barriers. Home health locations in overlap markets are open for 12 months before inclusion in the clinical collaboration rate.

Clinical Collaboration - All Markets

To continue building its clinical collaboration platform, the Company will:

- focus on increasing its number of new overlap markets and building density in current overlap markets and
- use Care Transition Coordinators and TeamWorks best practices to enhance patient awareness and understanding of the value in clinical collaboration.



Business Outlook, Including Guidance

(as of January 7, 2019)

2018 Highlights

GROWTH

- **Opened** or **acquired** 4 new IRFs (including 2 joint ventures)
  - 5 IRF projects underway as of December 31, 2018
- **Expanded** existing IRFs by 26 beds
- **Acquired** or **opened** 23 home health locations and 22 hospice locations

OPERATIONAL INITIATIVES

- **Completed** rebranding and name change (see page 40)
- **Enhanced** our use of predictive data analytics
  - **Deployed** rehabilitation-specific readmission model across all of our hospitals
  - **Began production** of 90-day post-acute readmission model that applies to all patients and settings
- **Increased** clinical collaboration between the Company's IRFs and home health locations
  - **Increased** the number of overlap markets to 81 (from 76 as of 12/31/17)
  - **Increased** the clinical collaboration rate to an estimated 34.9% (a 320 bps increase over Q4 2017)
- **Piloted** post-acute solutions
  - **Actively using** care management tools at our hospitals in Tyler, TX and Petersburg, VA
  - **Began utilizing** care navigators to follow a patient throughout an episode of care

CAPITAL STRUCTURE

- **Maintained** flexible balance sheet
  - **Reduced** leverage below 3.0x
- **Continued** shareholder distributions
  - **Paid** ~$101 million in cash dividends
  - **Raised** quarterly cash dividend per common share for the fifth straight year (from $0.25 to $0.27)

Priorities for 2019

GROWTH

- **Expand** portfolio of inpatient rehabilitation hospitals
  - Demographic trends driving **increased demand** for inpatient rehabilitation services
  - IRFs are **best positioned** to expand service offering in the progression towards site neutrality (see page 23)
  - Joint venture or wholly owned opportunities based on market-specific dynamics
  - **Increase capacity** at existing IRFs via bed additions
- **Expand** portfolio of home health and hospice locations
  - Demographic trends driving **increased demand** for skilled home health services and in-home hospice services
  - Home health **benefiting** from SNF disintermediation
  - **Continue** emphasis on:
    - ✓ **Increasing overlap** with the Company's inpatient rehabilitation hospitals
    - ✓ **Increasing market density** via acquisitions in existing and contiguous home health markets
  - Continue to **build scale** in hospice service line

OPERATIONAL INITIATIVES

CAPITAL STRUCTURE

Priorities for 2019

GROWTH

OPERATIONAL INITIATIVES

- **Continue** to increase clinical collaboration - see page 24 and 25
- **Build** stroke market share - see page 30
- **Continue** to develop and implement post-acute solutions - see page 31
- **Prepare** for transition to IRF CARE Tool payment system - see page 32
- **Prepare** for implementation of home health:
  - Patient-Driven Groupings Model ("PDGM") - see page 33
  - Review Choice Demonstration ("RCD") - see page 34

CAPITAL STRUCTURE

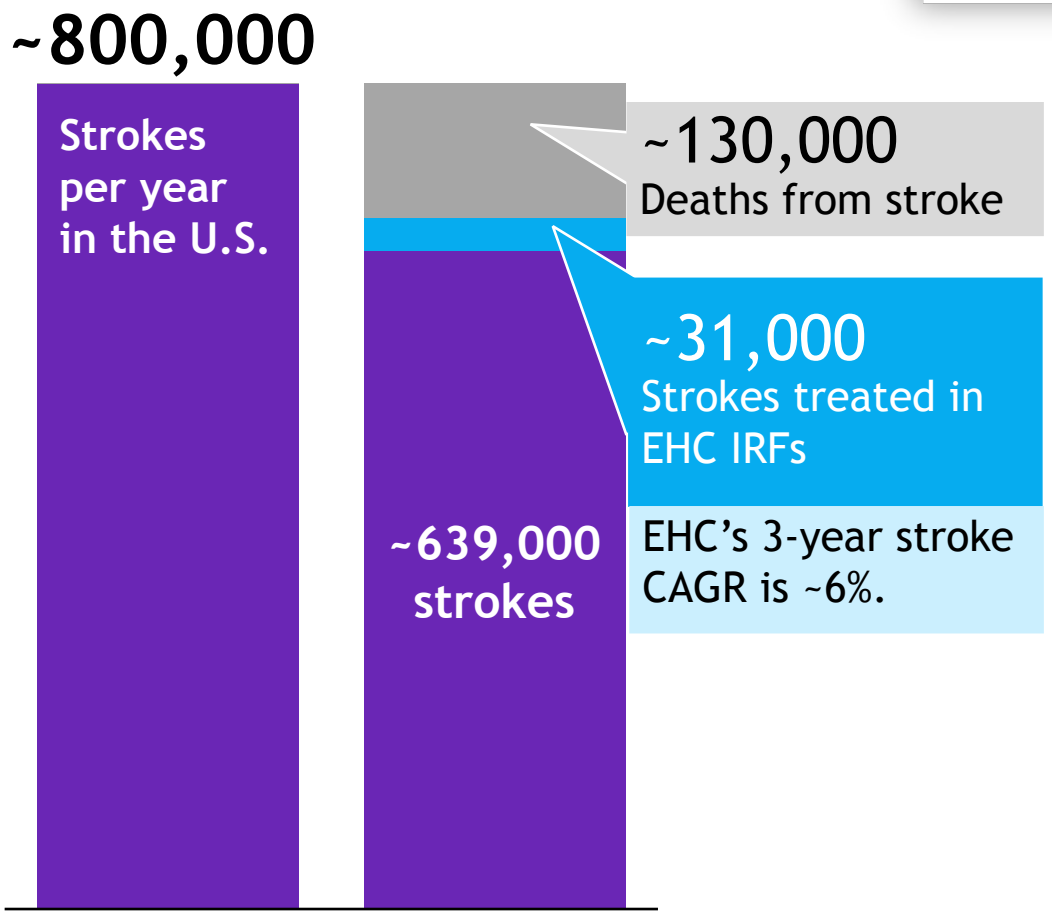
- **Maintain** real estate ownership and balance sheet flexibility
- Consider **opportunistic** refinancings
- **Continue** to augment returns from investments in operations with shareholder distributions

Building Stroke Market Share

Leveraging our:

- strategic partnership with the AHA/ASA
- clinical collaboration
- joint commission certifications

Encompass Health | American Heart Association | American Stroke Association



112 EHC IRFs hold stroke-specific certifications.

Continue to increase market share by focusing on IRF-eligible stroke patients going to SNFs and non-EHC IRFs

Stroke cases account for ~1/3 of EHC's Medicare Advantage volume.

Source: http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke-Stroke-statistics_UCM_310728_Article.jsp#

Post-Acute Solutions

Our post-acute solutions will leverage our clinical expertise, large post-acute datasets, EMR technologies, and strategic partnerships to drive improved patient outcomes and lower cost of care across the entire post-acute episode.

2018

- Modified and implemented Cerner's HealtheCare module; created a longitudinal patient record to manage patients across the post-acute continuum
  - piloting in Tyler, Texas
- Deployed ReAct in all of our hospitals
- Developed 90-day post-acute readmission prediction model
  - piloting in Tyler, Texas and Petersburg, Virginia
- Began utilizing care navigators to follow a patient throughout an episode of care

2019

- Refine 90-day post-acute readmission prediction model; deploy to additional EHC hospitals
- Design and implement post-acute care clinical decision support tools
- Design and implement quality reporting tool for building preferred provider networks
- Create a provider hub to automate market analysis tools for quality reporting across episodes
- Use Medalogix for home health care plan optimization and to reduce emergency room visits and hospital readmissions

Inpatient Rehabilitation: Transition to CARE Tool Payment System

Background

Elimination of FIM™ Functional Assessment items from IRF-PPS

- Effective October 1, 2019, CMS will replace the FIM™ functional assessment measures with the CARE Tool measures for reporting and payment purposes.
- This change will require CMS to make substantial changes to the CMGs, relative weights and average length of stay values for the IRF-PPS, likely impacting Medicare revenue per discharge for certain cases.

Transition to CARE Tool payment system

- Provide feedback to CMS on potential effects of care assessment measures on CMGs, relative weights and average length of stay
- Continue education of hospital staff on CARE Tool utilization, including documentation requirements
- Monitor FIM™ assessment to CARE Tool assessment comparative measures to ensure consistent representation of patients' functional status

Home Health: Patient Driven Groupings Model ("PDGM")

Background

Move to the Patient-Driven Groupings Model

- Effective January 1, 2020, PDGM will:
  - move from 60-day episodes for payment to 30-day payment periods;
  - rely more heavily on clinical characteristics; and
  - eliminate therapy service use thresholds in case-mix adjustments.
- To achieve budget neutrality, CMS assumed behavioral changes will offset a 6.4% reduction in the base rate.

Home Health PDGM Preparation Strategies

- Pursue legislative avenues to require CMS to use observed (vs. assumed) behavior changes to achieve budget neutrality
- Provide feedback to CMS on magnitude and timing of assumed behavioral changes.
- Ensure productivity levels are realized for full-time staff
- Optimize acuity-scaled care planning
- Maximize the economies generated by scale and density
- Utilize technology to drive incremental efficiencies

Home Health: Review Choice Demonstration ("RCD")*

State	Start Date	Company Locations
Illinois	To be determined	3
Ohio	To be determined	1
North Carolina	To be determined	6
Florida	To be determined	17
Texas	To be determined	52

Preparation

- Reviewed all documentation requirements
- Implemented system features to make electronic submission easier
- Continue to work with physicians to ensure consistency between their supporting documentation and our supporting documentation
- Add administrative resources as staggered implementation occurs
- Apply learnings from our Illinois locations that successfully navigated PCRD with an affirmation rate in excess of 90%

Overview

Following the pause of the Pre-Claim Review Demonstration ("PCRD") on April 1, 2017, CMS worked to revise PCRD to offer more flexibility and choice for providers. The proposed RCD will give providers in the demonstration states an initial choice of three options.

Three options

1. 100% pre-claim review
2. 100% postpayment review
3. Minimal postpayment review with a 25% payment reduction for all Medicare home health services

If a provider chooses 100% pre-claim or postpayment review (which applies to every episode of care) and reaches a 90% affirmation rate, it may elect to have only 5% of its claims spot checked to ensure continued compliance.

Timeline

The revised demonstration will likely begin in early 2019 (with at least 30 days' notice from CMS) and have a staggered implementation beginning with home health providers operating in Illinois, then expanding to Ohio and North Carolina, and later to Florida and Texas. CMS has the option to expand to other states in the Palmetto jurisdiction.

Duration

Five years

* On May 29, 2018, CMS announced its intention to restart PCRD as RCD.
Source: https://www.gpo.gov/fdsys/pkg/FR-2018-05-31/pdf/2018-11492.pdf

Guidance

2018 Updated Guidance		2019 Preliminary Guidance
Net Operating Revenues*		Net Operating Revenues
$4,260 million to $4,280 million		$4,500 million to $4,600 million
Adjusted EBITDA[9]		Adjusted EBITDA[9]
$890 million to $895 million		$925 million to $945 million
Adjusted Earnings per Share from Continuing Operations Attributable to Encompass Health[10]		Adjusted Earnings per Share from Continuing Operations Attributable to Encompass Health[10]
$3.62 to $3.66		$3.71 to $3.85

* See page 36 for discussion of the Company's adoption of a new revenue recognition accounting standard.

Refer to page 111-115 for end notes.

Impact of the New Revenue Recognition Accounting Standard

- During the first quarter of 2018, Encompass Health adopted a new accounting standard (ASC 606 - Revenue from Contracts with Customers) which clarifies the standard for recognizing revenue.
- The primary impact to the Company's financial reporting was that amounts it previously presented as provision for doubtful accounts became a component of net operating revenue (both segments impacted similarly).
  - This had the effect of reducing net operating revenues but was neutral to Adjusted EBITDA and adjusted EPS.
- The Company retrospectively adopted the new standard during Q1 2018, which means previously reported quarterly and full-year results for 2017 have been updated to reflect the requirements of the new standard.

Impact of the New Revenue Standard - Historical Periods

	As Historically Reported						As Currently Reported Under New Standard					
	Q4-17	Q3-17	Q2-17	Q1-17	FY 2017	FY 2016	Q4-17	Q3-17	Q2-17	Q1-17	FY 2017	FY 2016
Net operating revenue (millions)	$ 1,019.7	$ 995.6	$ 981.3	$ 974.8	$ 3,971.4	$ 3,707.2	$ 1,008.8	$ 981.6	$ 966.4	$ 957.1	$ 3,913.9	$ 3,642.6
Provision for doubtful accounts (millions)	9.7	12.6	13.7	16.4	52.4	61.2	—	—	—	—	—	—
Other operating expenses (millions)	139.5	137.6	130.5	129.1	536.7	492.1	138.3	136.2	129.3	127.8	531.6	488.7
Inpatient rehabilitation revenue/ discharge	17,871	17,896	17,823	18,131	17,929	17,577	17,693	17,654	17,557	17,812	17,679	17,265
IRF Segment - Prov. for doubtful accounts as a % of revenue	1.0%	1.4%	1.6%	1.8%	1.5%	1.9%	N/A	N/A	N/A	N/A	N/A	N/A
Home health revenue/episode	2,989	3,022	2,989	2,991	2,998	3,031	2,976	3,008	2,975	2,978	2,984	3,017
Adjusted EBITDA (millions)	208.2	204.6	209.5	200.8	823.1	793.6	No Change					
Adjusted EPS	0.70	0.66	0.71	0.70	2.76	2.67	No Change					

Impact of the New Revenue Standard - Current Period

	Pro Forma Under Previous Accounting Standard					As Currently Reported Under New Standard				
	Q4-18	Q3-18	Q2-18	Q1-18	YTD 2018	Q4-18	Q3-18	Q2-18	Q1-18	YTD 2018
Net operating revenue (millions)	$ —	$ 1,079.9	$ 1,079.5	$ 1,056.7	$ 3,216.1	$ —	$ 1,067.6	$ 1,067.7	$ 1,046.0	$ 3,181.3
Provision for doubtful accounts (millions)	—	12.3	11.8	10.7	34.8	—	—	—	—	—
Inpatient rehabilitation revenue/ discharge	—	18,276	18,196	18,297	18,256	—	18,051	17,987	18,114	18,051
IRF Segment - Prov. for doubtful accounts as a % of revenue	—%	1.3%	1.2%	1.1%	1.2%	—	N/A	N/A	N/A	N/A
Home health revenue/episode	—	3,006	2,982	2,937	2,976	—	2,995	2,968	2,934	2,966
Adjusted EBITDA (millions)	No Change					No Change				
Adjusted EPS	No Change					No Change				

2019 Guidance Considerations

Inpatient Rehabilitation

- Estimated 1.2% increase in Medicare pricing for Q1 through Q3 and estimated 2.4% increase for Q4 (see page 42)
  - Transition to CARE Tool may negatively impact Q4 pricing
- Salary increase of approx. 3.0%; benefits increase of approx. 6.0% to 8.0%
- Revenue reserve (formerly bad debt expense) of 1.4% to 1.6% of net operating revenues
- Panama City hospital expected to run at lower capacity in 2019
- Administrative costs related to transition to CARE Tool payment system

Home Health and Hospice

- Estimated 1.5% net Medicare pricing increase for CY 2019 (see page 42)
- Salary increase of approx. 3.0%; benefits increase of approx. 6.0% to 8.0%
- Inclusive of home health and hospice acquisitions in 2019
- Administrative costs related to the Review Choice Demonstration program and preparation for PDGM

Consolidated

- Investments of $3 million to $5 million in strategic initiatives, including post-acute solutions
- Diluted share count of ~100 million shares
- Tax rate of ~27%
- Adoption of new lease accounting standard is expected to result in a gross-up of fixed assets and corresponding liabilities of $300 million to $400 million and is not expected to have a material impact on our income statement or statement of cash flows.

Adjusted Free Cash Flow[(11)] Assumptions

Certain cash flow items (millions)	2018 Estimates	2019 Assumptions
• Cash interest expense, net of amortization of debt discounts and fees	~$144	$145 to $155
• Cash payments for taxes, net of refunds	~$116	$140 to $150
• Working capital and other	($0 to $20)	$30 to $50
• Maintenance CAPEX	~$150	$160 to $170
• Adjusted free cash flow	$480 to $505	$400 to $470

- Increased cash payments for taxes in 2019 primarily due to higher pre-tax income, as well as other changes in deferred tax assets; 2018 cash taxes benefited from utilization of federal overpayment in 2017.
- Working capital increase in 2019 due primarily to revenue growth
- Maintenance capital expenditures in 2019 are reflective of our expanding hospital portfolio.

Uses of Free Cash Flow

		2018 Estimates	2019 Assumptions
Growth in Core Business	IRF bed expansions	~$25	$40 to $50
	New IRFs		
	- De novos	~80	85 to 115
	- Acquisitions	—	opportunistic
	- Replacement IRFs and other	~25	90 to 110
	Home health and hospice acquisitions (includes Camellia in 2018)*	~143	50 to 100
		~$273	$265 to $375, excluding IRF acquisitions
Debt Reduction	Debt redemptions (borrowings), net	~$64	opportunistic
Shareholder Distributions	Cash dividends on common stock[12]	~101	~108
	Purchase of Home Health Holdings rollover shares (see page 69)	~65	TBD
	Common stock repurchases	—	opportunistic
		~$230	$TBD

Quarterly cash dividend currently set at $0.27 per common share[12]

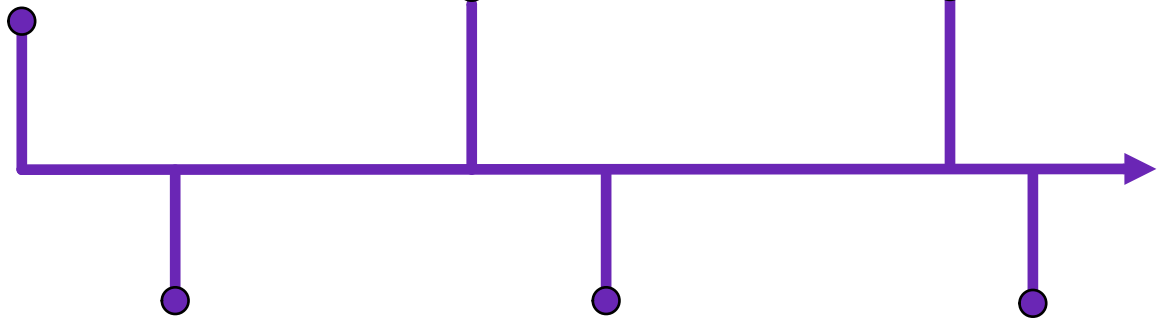
~$250 million authorization as of December 31, 2018[13]

* Net of assumed accounts payable and accrued expenses, the cash paid for the acquisition of Camellia was $129.7 million.

See the debt schedule on page 67. Refer to page 111-115 for end notes.

Rebranding and Name Change

The Company's rebranding and name change reinforce its existing strategy and position as an integrated provider of inpatient and home-based care.



JULY 2017
Announced planned name change

APRIL 2018
Phase 1 field asset conversions

OCT. 2018
Phase 3 field asset conversions

JAN. 2018
Legally changed name and stock ticker to Encompass Health Corporation (EHC)

JULY 2018
Phase 2 field asset conversions

JAN. 2019
Phase 4 field asset conversions; transition complete

Encompass Health

As of January 1, 2019, all of the Company's hospitals and home health and hospice locations have been transitioned to the Encompass Health brand.

	2017	2018	2019	Total
Operating expenses*	~$6 million	~$11 million	~$1 million	~$18 million
Capital expenditures	~$1 million	~$4 million	~$3 million	~$8 million
Total rebranding investment	~$7 million	~$15 million	~$4 million	~$26 million

*Included in corporate general and administrative expenses line item

Business Outlook: 2019 to 2021

	2019	2020	2021
Key Operational Initiatives	• Enhance clinical collaboration between the Company's IRFs and home health locations • Develop and implement post-acute solutions • Participate in alternative payment models • Implement changes to reimbursement models in both business segments		
Core Growth	• Same-store IRF growth • New-store IRF growth (de novos and acquisitions) • Same-store home health and hospice growth • New-store home health and hospice growth (acquisitions and de novos)		
Expansion of Service Offerings	• Consider acquisitions of other complementary businesses		
Strong Balance Sheet	• Maintain real estate ownership strategy and balance sheet flexibility		
Shareholder Distributions	• Quarterly cash dividends on common stock • Opportunistic common stock repurchases • Purchases of Home Health Holdings rollover shares		

Business Outlook 2019 to 2021: Revenue Assumptions

Volume (Includes New Stores)	Inpatient Rehabilitation* 3+% annual discharge growth			Home Health* 10+% annual admission growth		
Medicare Pricing *Amounts are approximations*	Approx. 73% of Segment Revenue			Approx. 85% of Segment Revenue		
	FY 2019 Q418-Q319 Final Rule	FY 2020 Q419-Q320[14] Estimate†	FY 2021 Q420-Q321 Estimate†	CY 2019 Q119-Q419 Final Rule	CY 2020 Q120-Q420[15]	CY 2021 Q121-Q421 Estimate†
Market basket update	2.9%	3.0%	3.0%	3.0%	1.5%	3.0%
Healthcare reform reduction	(0.75%)	-	-	-	-	-
Coding intensity reduction	-	-	-	-	-	-
Legislative changes to the rural add-on program[15]	-	-	-	(0.1%)	(0.2%)	(0.1%)
Change in outlier FDL** ratio	-	-	-	0.1%	-	-
Healthcare reform productivity adjustment	(0.8%)	(0.6%)	(0.6%)	(0.8%)	-	(0.6%)
Net market basket update	1.35%	2.4%	2.4%	2.2%	1.3%	2.3%
Change in wage index	(0.1%)	-	-	-	-	-
Change in CMG relative weights and average length of stay values	(0.1%)	-	-	-	-	-
Change in outlier threshold	(0.0%)	-	-	-	-	-
Impact from case mix re-weighting	-	-	-	(0.7%)	-	-
Estimated impact to Encompass Health[16]	1.2%			1.5%	(5.1%)[15]	
Medicare Advantage and Managed Care Pricing	Approx. 19% of Revenue			Approx. 13% of Revenue		
Expected Increases	2-4%	2-4%	2-4%	0-2%	0-2%	0-2%

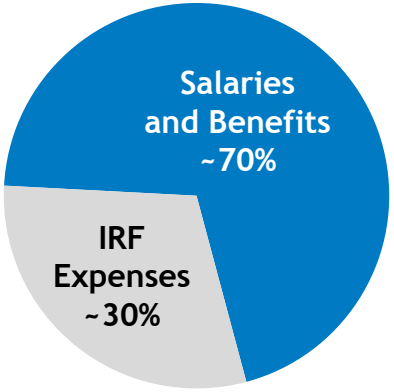
* Outpatient and hospice, which services accounted for 4.6% of total operating revenues for full-year 2017, are not included in the pricing assumptions.
** Fixed-dollar loss

† Estimates are based on current CMS and Congressional Budget Office projections which do not include potential changes from legislation or the CMS rule-making process.
Refer to pages 111-115 for end notes.

Business Outlook 2019 to 2021: Labor and Other Expense Assumptions

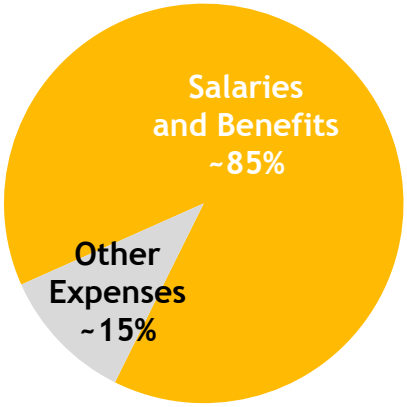
Inpatient Rehabilitation

Salaries and Benefits	2019	2020	2021
Salary increases	2.75-3.25%	2.75-3.25%	2.85-3.35%
Benefit costs increases	6-8%	5-10%	5-10%



% of Salaries and Benefits	
Salaries	~90%
Benefits	~10%

Home Health and Hospice



IRF Expenses

- Other operating expenses and supply costs tracking with inflation

Home Health and Hospice Expenses

- Other operating expenses and supply costs tracking with inflation

IRF-PPS Fiscal Year 2019 Final Rule: Key Provisions

Update to Payment Rates

The final rule will:

- Implement a **net 1.35%** market basket increase
  - 2.9% market basket increase
  - (75 bps) healthcare reform reduction
  - (80 bps) healthcare reform productivity reduction;
- Update case mix group relative weights and average length of stay values;
- Increase the outlier fixed loss threshold; and
- Revise the wage index values.

Quality Reporting and IRF Coverage Requirements

- CMS will remove National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716), beginning with the FY 2020 IRF QRP; and remove Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), beginning with the FY 2021 IRF QRP.
- CMS will begin to publicly displaying data on four assessment-based measures in CY 2020.
- CMS will make changes to certain IRF coverage requirements to increase flexibility and reduce burden.

Elimination of FIM™ Functional Assessment Items from IRF-PPS[14]

- Beginning October 1, 2019, CMS will remove the FIM™ functional assessment items from the IRF-PAI.
- CMS will replace the FIM™ measures with data items located in the Quality Indicators section of the IRF-PAI for payment purposes.
- This change will require CMS to make substantial changes to the CMGs, relative weights and average length of stay values for the IRF-PPS.

Company Observations

Pricing:

- *Net pricing impact to the Company expected to be an increase of ~1.2% for FY 2019 (see page 42)*

- *Because of its efficient cost structure, the Company receives very few outlier payments despite treating higher acuity patients (see page 92).*

FY 2020 FIM™ Changes[14]:

- *CMS will be proposing additional changes to the new CMGs, relative weights and average length of stay values in the FY 2020 IRF-PPS proposed notice of rulemaking.*
- *The Company will continue providing input to CMS on the development of the case-mix methodology changes.*

Source: https://www.federalregister.gov/documents/2018/08/06/2018-16517/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

Refer to pages 111-115 for end notes.

HH-PPS Calendar Year 2019 Final Rule: Key Provisions

Final Rule Update to 2019 Payment Rates

The final rule will:

- Implement a **net 2.2%** market basket **increase** (3.0% market basket less a 0.8% healthcare reform productivity reduction);
- Implement the rural add-on modifications as required by the Bipartisan Budget Act (BBA) of 2018; and
- Reduce the Outlier FDL ratio from 0.55 to 0.51.

New Quality Reporting Measures

- CMS will remove seven quality reporting measures from the CY 2021 HH Quality Reporting Program.
- CMS will refine the HH Value-Based Purchasing program by removing two OASIS-based measures, replacing three OASIS-based measures with two composite measures, and amending how the Total Performance Scores are calculated.

Patient-Driven Groupings Model (PDGM) for CY 2020[15]

- The final rule further refines the HH case-mix methodology for CY 2020 as required by Section 51001 of the BBA of 2018.
- PDGM will use 30-day payment periods
  - Relies more heavily on clinical characteristics and
  - Eliminates therapy service use thresholds currently used in case-mix adjustments
- To achieve budget neutrality, CMS assumed behavioral changes will offset a 6.4% reduction in the base rate.

Company Observations

Pricing:

- *Net pricing impact to the Company expected to be an increase of ~1.5% for CY 2019 (see page 42)*

Quality:

- *The Company will modify existing processes and systems to meet the changed requirements.*

Payment System[15]:

- *The Company will continue to engage with CMS, Congress, and other stakeholders to ensure any change to the underlying payment system maintains patient access to needed home health services.*

Source: https://www.federalregister.gov/documents/2018/11/13/2018-24145/medicare-and-medicaid-programs-cy-2019-home-health-prospective-payment-system-rate-update-and-cy
Refer to pages 111-115 for end notes.

IMPACT Act of 2014 - Enacted October 6, 2014

Company observations and considerations with respect to the IMPACT Act:

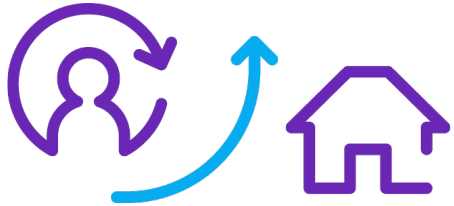
- It was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees' solicitation of post-acute payment reform ideas and proposals.
- It directs the United States Department of Health and Human Services ("HHS"), in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and resource use measures.
- Although the IMPACT Act does not specifically call for the implementation of a new post-acute payment system, the Company believes this act will lay the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided.
- It will create additional data reporting requirements for the Company's IRFs[17] and home health agencies. The precise details of these new reporting requirements, including timing and content, will be developed and implemented by the Centers for Medicare and Medicaid Services through the regulatory process the Company expects will take place over the next several years.
- While the Company cannot quantify the potential financial effect of the IMPACT Act on Encompass Health, the Company believes any post-acute payment system that is data driven and focuses on the needs and underlying medical conditions of post-acute patients will be positive for providers who offer high-quality, cost-effective care. Encompass Health believes it is doing just that and expects this act will be positive for the Company.
- However, it will likely take years for the quality data to be gathered, standardized patient assessment data to be assembled and disseminated, and potential payment policies to be developed, tested and promulgated. As the nation's largest owner and operator of inpatient rehabilitation hospitals, the Company looks forward to working with HHS, the Medicare Payment Advisory Commission and other healthcare stakeholders on these initiatives.

Source: https://www.govtrack.us/congress/bills/113/hr4994/text
Refer to pages 111-115 for end notes.

Growth

Encompass Health is a leader in serving the post-acute patient population and has multiple avenues available for sustained growth in both segments. Favorable demographic trends are driving increased demand.

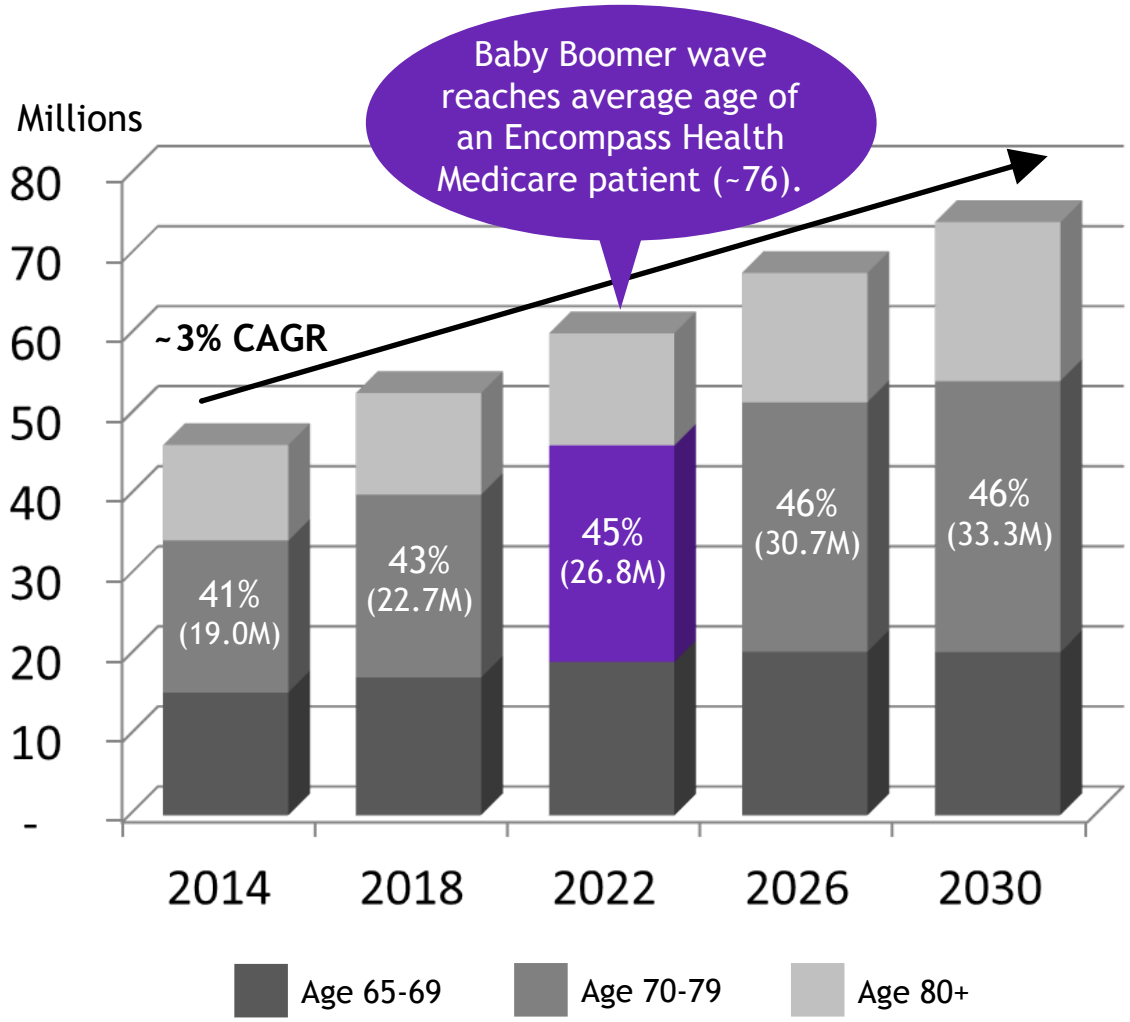
The Company Has Multiple Avenues Available for Sustained Growth in Both Segments



- **The Company continues to have excellent organic growth opportunities in inpatient rehabilitation, home health, and hospice.**
  - Track record of consistent market share gains
  - IRF organic growth supplemented by bed additions
  - Maturation of acquired home health locations
- **Target four to six new inpatient rehabilitation hospitals per year to complement organic growth**
  - De novos and acquisitions will allow entry into, and growth in, new markets.
  - Proven track record of success
- **Target $50 to $100 million per year toward home health and hospice acquisitions to complement organic growth**
  - Home health acquisitions and new-store growth prioritized in Encompass Health IRF markets without current overlap
  - Build additional scale in hospice via acquisitions and de novos

Both Segments Benefit from a Demographic Tailwind: Growth in the Medicare Beneficiary Population

Projected Population of Age 65+



- The growth rate of Medicare beneficiaries increased in 2011 to an approx. **3% CAGR** as "Baby Boomers" started turning age 65.
  - ~10,000 Baby Boomers turn 65 each day
- **The CAGR for the population in Encompass Health's average patient age range is ~5%.**

CAGR (Population Growth by Age)				
Age	2014 to 2018	2018 to 2022	2022 to 2026	2026 to 2030
65-69	2.8%	2.6%	1.6%	(0.1)%
70-74	4.9%	3.7%	2.5%	2.1%
75-79	4.0%	5.0%	4.9%	2.0%
80+	1.5%	2.4%	3.6%	5.2%
Total	**3.2%**	**3.3%**	**2.9%**	**2.2%**

Source: www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html

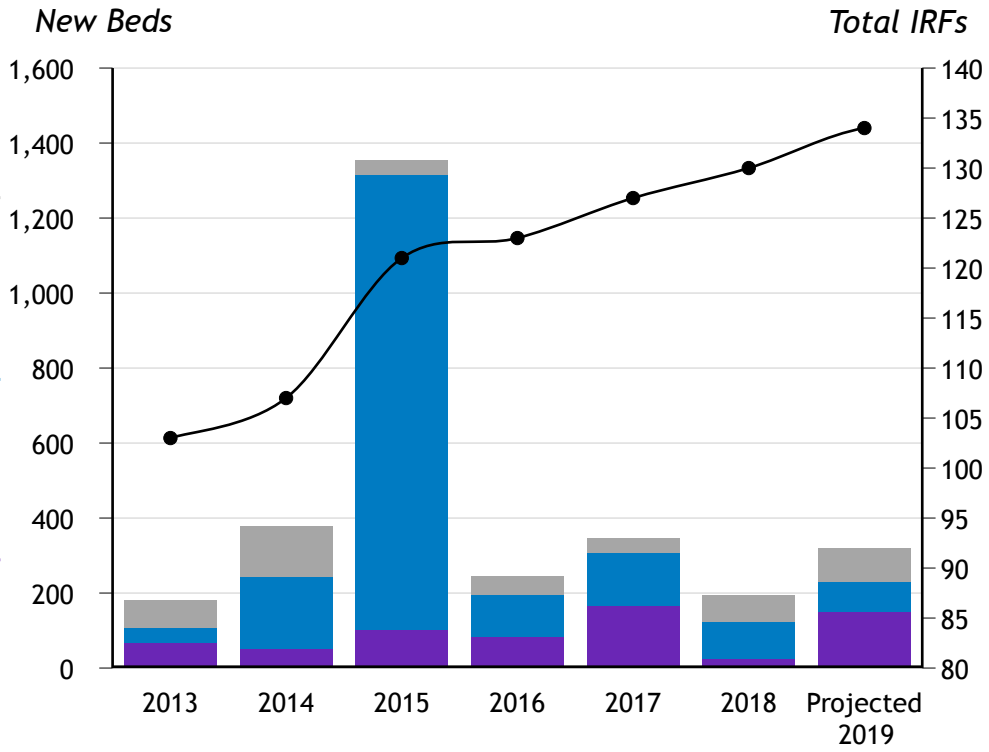
Multi-faceted Inpatient Rehabilitation Growth Strategy

Wholly Owned and Joint Ventures

De Novos

Acquisitions

Bed Expansions



% Increase in licensed beds		4%	18%	1%	4%	1%	3%
Total number of licensed beds	6,825	7,095	8,404	8,504*	8,851	8,966†	9,261‡
Total number of IRFs	103	107	121	123*	127	130†	134

* 2016 total number of licensed beds and total number of IRFs include the disposal of 61 beds at Beaumont, TX (sold June 2016) and 83 beds at Austin, TX (closed August 2016).
† 2018 total number of licensed beds and total number of IRFs include the consolidation of the Ft. Worth market (decrease of 60 beds) and the delicensure of 20 SNF beds at a Dallas IRF.
‡ Projected 2019 total number of licensed beds includes the delicensure of 25 SNF beds at Round Rock, TX.

2018 bed count increase

- *Shelby County, AL (34 beds)*
- *Bluffton, SC (38 beds)*
- *Murrells Inlet, SC (29 beds)*
- *Winston-Salem, NC (68 beds)*
- *Bed expansions (26 beds)*

2019 projected bed count increase

- *Lubbock, TX (40 beds)*
- *Boise, ID (40 beds)*
- *Katy, TX (40 beds)*
- *Murrieta, CA (50 beds)*
- *Bed expansions (~150 beds)*

Inpatient Rehabilitation Growth Pipeline

Disciplined Approach to New Store Growth
- $7.7 Billion Medicare IRF Market -

Considerations:

- Market demographics
- Presence of other IRFs
- Geographic proximity to other Company IRFs and home health locations
- Potential joint venture partners

Typical Development Pipeline

	Exploratory / CA Executed	Actively Working	Near-term Actionable
No. of Projects	30 - 40	10 - 12	4 - 6

Factors:

- Certificate of Need process/timeline
- Fair market valuation of contributed assets (joint ventures only)
- Partnership complexities

The Company's Value Proposition

✓	CAPEX to build free-standing IRF, freeing up space for medical/surgical beds in an acute care facility for a JV partner
✓	Enhance the position of the acute care hospital to meet quality requirements and effectively participate in alternative payment models
✓	Increased acute care hospital flow-through by taking appropriate higher acuity patients faster than other post-acute settings
✓	Clinical collaboration between the Company's IRFs and home health locations
✓	Proprietary rehabilitation-specific clinical information system ("ACE-IT") integrated with acute care hospitals' clinical information systems to facilitate patient transfers, reduce readmissions, and enhance outcomes
✓	Proprietary real-time performance management systems (care management, labor productivity, quality reporting, therapy analysis and expense management) to ensure appropriate clinical oversight and improve profitability
✓	Proven track record of efficient management of regulatory process (CON, licensure, occupancy, etc.)
✓	Experienced transaction/integration team
✓	National leader in post-acute policy activities
✓	TeamWorks approach to sales and marketing
✓	Supply chain efficiencies
✓	Medical leadership and clinical advisory boards

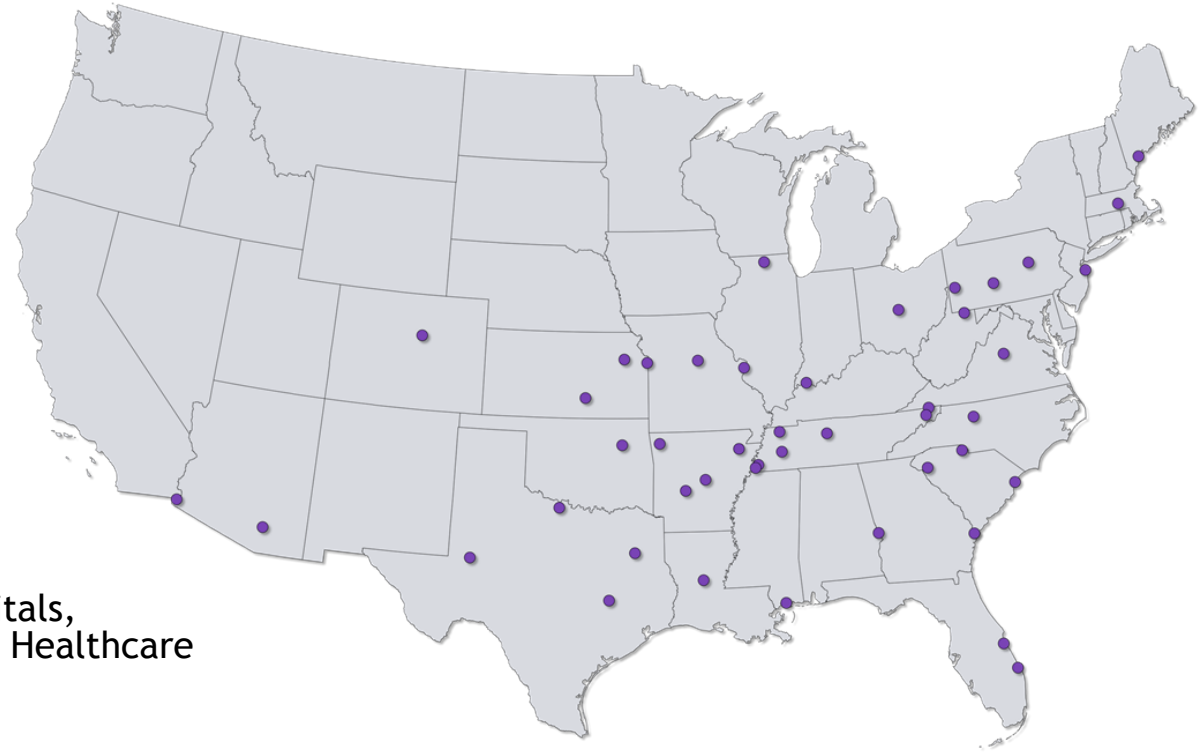
Source: MedPAC, Medicare Payment Policy, March 2018 - page 267
CA = confidentiality agreement

Inpatient Rehabilitation Acute Care Joint Venture Partnerships

- The Company's IRF joint ventures began in 1991 with Vanderbilt University Medical Center.
- The Company's joint venture acute care hospital partners own equity that ranges from 2.5% to 50%.
- 44 of 45 IRFs are consolidated joint ventures, with one accounted for under the equity method.

45* IRF joint venture hospitals in place with major healthcare systems such as:

- Barnes-Jewish
- University of Virginia Medical Center
- Vanderbilt University Medical Center
- Geisinger Health System
- Martin Health System
- Monmouth Medical Center (Barnabas Health)
- Yuma Regional Medical Center
- Mercy Health System
- Maine Medical Center
- Methodist Healthcare-Memphis Hospitals, a subsidiary of Methodist Le Bonheur Healthcare



Joint ventures with acute care hospitals establish a solid foundation for integrated delivery and alternative payment models.

* Excludes IRF joint venture hospitals that have been announced but were not operational as of December 31, 2018: Lubbock, TX; Boise, ID; and Dayton, OH (current wholly owned 50-bed IRF that will become a joint venture with Premier Health upon completion of a new 60-bed hospital).

De Novo IRFs and Acquisitions

Investment Considerations

- IRR objective of 13% (after tax)
- Joint venture capitalization
- Certificate of Need ("CON") costs, where applicable
- Clinical Information System ("CIS") installation costs
- Medicare certification for new hospitals (minimum of 30 patients treated for zero revenue)

5 **Previously Announced IRF Development Projects Underway**

4 **New States**
- Mississippi in 2017
- North Carolina in 2018
- Idaho in 2019
- South Dakota in 2020

	Location	Operations Date	Joint Venture?	# of New Beds			
				2017	2018	2019	2020
	De Novo IRFs:						
	Westerville, OH	Q2 2017	Yes	60			
	Jackson, TN*	Q3 2017	Yes	48			
	Pearland, TX	Q4 2017		40			
	Shelby County, AL	Q2 2018			34		
	Bluffton, SC	Q2 2018			38		
	Winston-Salem, NC	Q4 2018	Yes		68		
1	Lubbock, TX	Q2 2019	Yes			40	
2	Boise, ID	Q3 2019	Yes			40	
3	Katy, TX	Q4 2019				40	
4	Murrieta, CA	Q4 2019				50	
5	Sioux Falls, SD	2020					40
	Acquisitions:						
	Gulfport, MS	Q2 2017	Yes	33			
	Murrells Inlet, SC	Q3 2018	Yes		29		
	Bed Expansions, net**			166	26	~150	~100
				347	195	~320	~140

* Existing wholly owned, 40-bed IRF in Martin, TN became a joint venture in conjunction with this opening
** Net bed expansions in each year may change due to the timing of certain regulatory approvals and/or construction delays.

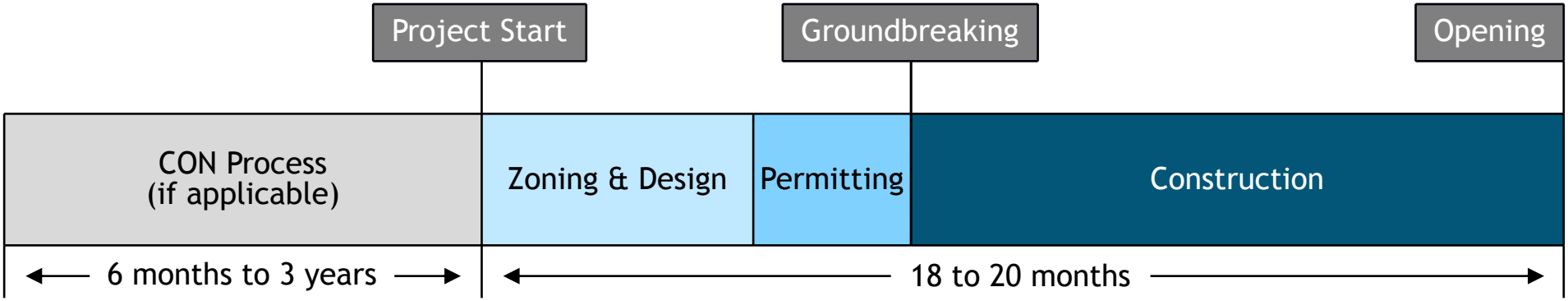
De Novo Costs and Timeline

- Prototype includes all private rooms
- Core infrastructure of building anticipates future expansion (accretive to financial returns)
- Factors that impact costs/timeline:
  - CON status
  - State regulatory requirements
  - Local planning and zoning approvals
  - Hospital-specific complexities

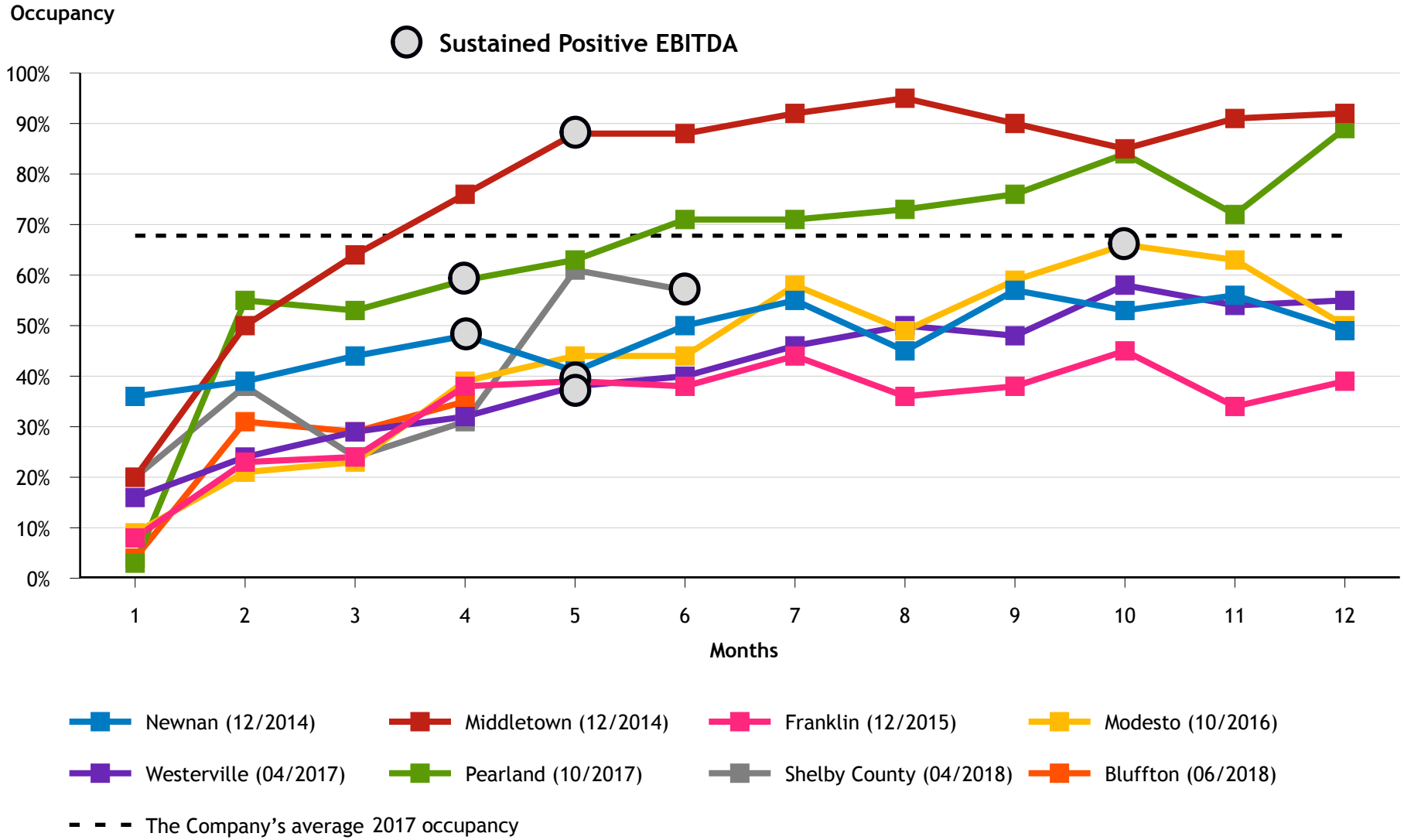
Capital Cost (millions)	Low	High
Construction, design, permitting, etc.	$17	$21
Land	2	3
Equipment (including CIS)	3	4
Range of a typical 40-50 bed IRF	**$22**	**$28**

Pre-Opening Expenses[18] (millions)	Low	High
Operating	$0.5	$1.0
Salaries, wages, benefits	0.4	1.0
	$0.9	**$2.0**

Illustrative Timeline



IRF De Novo Occupancy and EBITDA* Trends



* IRF EBITDA = earnings before interest, taxes, depreciation, and amortization directly attributable to the related hospital.

Multi-faceted Home Health and Hospice Growth Strategy

Organic Growth

- Strong demand due to cost effectiveness of home-based care and implementation of alternative payment models
- Strong organic growth from existing locations
- Located in markets with attractive demographics
  - Currently located in states that represent ~70% of total Medicare home health and hospice spend

Home Health Acquisitions and De Novos

- Highly fragmented market
- Prioritization of new IRF overlap markets
- Proven ability to consummate and integrate acquisitions
- Sustainable and replicable culture
- Implementation of best practices and technology

Clinical Collaboration

- Attractive partner due to quality of outcomes, data management, scale and market density, and willingness/ability to treat high acuity and/or chronic patients
- Plan of care coordination with the Company's IRFs
- Care Transition Coordinators serve as representatives in transitional care activities and strategic relationships with other healthcare providers

Hospice Acquisitions and De Novos

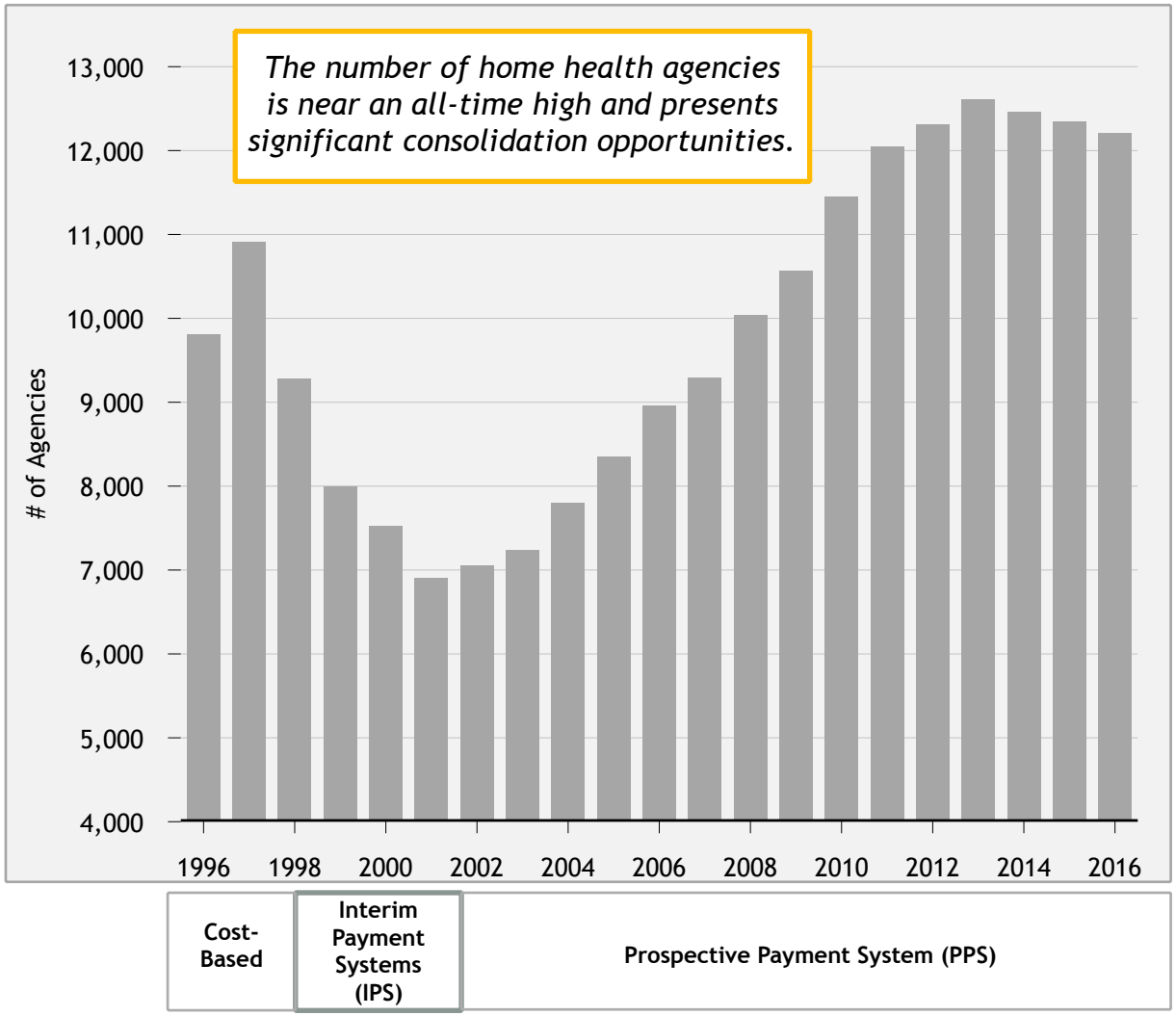
- Prioritization of existing home health markets
- Opportunity to build scale and leverage components of existing infrastructure

Home Health Growth Pipeline

- $18.1 billion Medicare home health market is highly fragmented with over 12,200 home health agencies.
- Approx. 93% of these have annual revenue of less than $5 million.
- Top 4 public companies represent approx. 20% of the Medicare market.
- The Company represents 3.5% of the Medicare home health market.

Prioritize acquisitions in Company IRF markets to enhance clinical collaboration

Number of Home Health Agencies Over Time



Source: MedPAC, Medicare Payment Policy - March 2018, page 246; March 2017, page 231; March 2016, page 214; March 2015, page 218; March 2014, page 221; March 2013, page 194; and March 2003, page 112; MedPAC - Healthcare spending and the Medicare program, June 2006, page 131; Medicare Claims Data

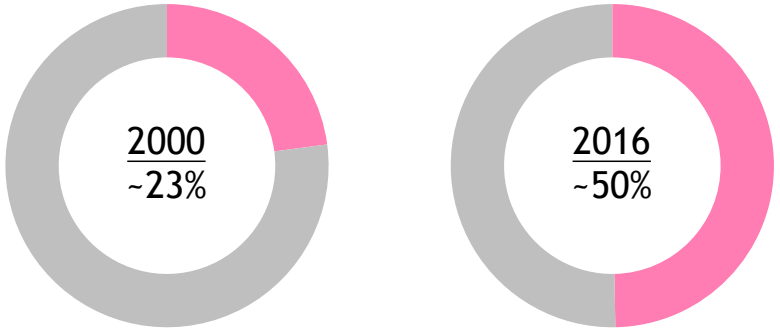
Hospice Growth Pipeline

- Medicare hospice market is approx. $17 billion.
- 1.4 million Medicare beneficiaries received hospice services from approx. 4,400 providers in 2016.
- Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services.
  - In 2016, only 50% of Medicare decedents utilized hospice services, and of those, more than 25% died in the first seven days of care, even though hospice care is intended for patients that physicians believe have 6 months or less to live.
  - On January 1, 2016, Medicare began paying for voluntary advance care planning conversations between a beneficiary and his or her physician.
- Annual Medicare spending on FFS decedents averages ~$34,500 per beneficiary — almost 4x higher than the average cost for beneficiaries who did not die during the year.
  - Roughly 25% of traditional Medicare spending for health care is for services provided to beneficiaries age 65 and older in their last year of life.

Acquisition Strategy for Hospice

- *Build additional scale*
- *Medicare focus*
- *Home-based service offering*
- *Strong clinical practice and clean compliance record*
- *Highly regarded market reputation*
- *Attractive geography and demographics*
- *Ability to leverage existing infrastructure*

% of Medicare Decedents Who Used Hospice



Source: MedPAC, Medicare Payment Policy, March 2018, pages 323, 325, 330 and 333; https://www.kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/

Alternative Payment Models

Most models remain in the early or pilot stage and results have been mixed. Both of our segments continue to participate in various APM initiatives.

Accountable Care Organizations ("ACOs")

As of January 2018, there were **619** MSSP and Next Generation ACOs serving **~11.9 million** Medicare beneficiaries.

Performance results so far have been **mixed.**

Medicare Shared Savings Program (MSSP)
(2018 - 561 ACOs / 10.5 million Medicare beneficiaries)

- Performance Year 5 (2017) results:
  - 284 of 472 ACOs (60%) held spending below their benchmark.
    - 125 of these ACOs reduced health costs compared to their benchmark, but did not meet the minimum savings threshold for shared savings.
  - 188 ACOs (40%) did not reduce costs compared to their benchmark.
  - Shared Savings Program ACOs generated total program savings of $1.1 billion or $314 million after adjusting for shared savings/loss payments.
- On December 21, 2018, CMS issued a Final Rule for the Shared Savings Program called "Pathways to Success." The new program contains two participation tracks that will start on July 1, 2019.
  - New BASIC track allows eligible ACOs to begin under a one-sided risk model and incrementally phases-in higher levels of risk that at the highest level will qualify as an Advanced "Alternative Payment Model" under the Quality Payment Program.
  - New ENHANCED track, based on the Shared Savings Program's existing Track 3, is intended to allow ACOs to take on higher levels of risk and possible shared-savings.
  - Current Track 1, Track 2, and Track 1+ Models will be discontinued.

Next Generation ACOs
(2018 - 58* ACOs / ~1.4 million Medicare beneficiaries)

- Initiative launched in January 2016 for ACOs that are experienced in coordinating care for populations of patients
- Allows providers to assume higher levels of financial risk and reward than are available under the MSSP
- Performance Year 2 (2017) results:
  - 32 out of 44 ACOs generated savings and received shared savings of $230 million.
  - Remaining 12 ACOs generated losses and were required to pay back $57 million to CMS.

Premier Patient Healthcare™

Premier CARE COMMUNITY

The Company serves as the exclusive preferred home health provider for two Premier ACOs. (~24,000 total covered lives in northern Texas and southern Oklahoma)

- EHC receives increased referrals for Medicare home health patients from the ACOs
- Eligible to receive a portion of the ACOs' shared savings
- Total shared savings achieved by both ACOs in 2017 was $6.0 million.
  - Met the minimum savings rate in one of the ACOs to participate in shared savings

Source: CMS/HHS press releases and public use files; MedPAC, Report to Congress, June 2018 - page 218
* Seven of the original 58 participating organizations have dropped out of the Next Generation ACO model since participants were announced in January 2018.

Bundled Payments

The Bundled Payments for Care Improvement (BPCI) initiative currently tests **four types of bundles** (i.e. "**Models**"):

Model 1

All acute patients (all DRGs)

- Concluded December 31, 2016 -

Models 2 & 3 have the most impact on post-acute providers.

Model 2*

Hospital plus post-acute period (selected DRGs)

Model 3*

Post acute only (selected DRGs)

Model 4*

Hospital plus readmissions (selected DRGs)

How the Retrospective Models Work

- The BPCI "convener" is responsible for bringing providers together to provide a continuum of services throughout an episode of care. The BPCI "awardee" is the entity that bears the financial risk and receives the shared savings from CMS.
- Each participating provider in the care sequence continues to receive its traditional reimbursement from Medicare.
- The sum of all payments made to each provider for selected DRGs is then retroactively reconciled to a target payment determined by CMS. Payment reconciliations are performed quarterly, typically with a 9- to 12-month lag.
- Payment reconciliations: If actual spending exceeds the target, the awardee is responsible for paying a portion of the difference to CMS. If actual spending is less than the target, the awardee keeps a portion of the savings.
- The convener can choose to partner with other providers in shared savings agreements and allocate the savings across the providers who participated in providing the continuum of care.
- Shared savings agreements must be reviewed and approved by the Center for Medicare and Medicaid Innovation.

* BPCI Models 2, 3, and 4 ended on September 30, 2018 and was replaced by the BPCI Advanced model which began on October 1, 2018 and runs through December 31, 2023. BPCI Advanced is a new voluntary episode payment model that will test a new iteration of bundled payments for 29 inpatient clinical episodes and 3 outpatient clinical episodes. For more information regarding BPCI Advanced, see https://innovation.cms.gov/initiatives/bpci-advanced.

Notes: Models 1, 2, and 3 are retrospective models; model 4 is a prospective model.
The convener and awardee can be, but may not be, the same entity.

The Company's Participation in BPCI Model 3* (2017)

Inpatient Rehabilitation			
BPCI Bundle	Participating IRFs	Bundle Length (in days)	% of the Company's Total Discharges
Stroke	3	60	0.11%
Simple Pneumonia	1	60	0.02%
Sepsis	1	60	0.01%
Double-lower extremity joint replacement	2	60	0.01%
Upper extremity joint replacement	1	60	<0.01%
Total	**8**		**0.16%**

Home Health			
BPCI Bundle	Bundled Arrangements	Bundle Length (in days)	% of the Company's Total Episodes
Major joint replacement of the lower extremity	19	90	0.77%
Spinal fusion (non-cervical)	7	60/90	0.06%
Sepsis	8	90	0.06%
Revision of the hip or knee	10	90	0.06%
Simple pneumonia and respiratory infections	6	90	0.05%
Major joint replacement of the upper extremity	8	60/90	0.05%
Urinary tract infection	2	90	0.03%
Other respiratory	15	90	0.03%
Chronic obstructive pulmonary disease	10	90	0.02%
Congestive heart failure	8	90	0.02%
All other episode types	35	30/60/90	0.13%
Total	**128****		**1.28%**

* BPCI Model 3 ended on September 30, 2018 and was replaced by the BPCI Advanced model which began on October 1, 2018 and runs through December 31, 2023. BPCI Advanced is a new voluntary episode payment model that will test a new iteration of bundled payments for 29 inpatient clinical episodes and 3 outpatient clinical episodes. EHC home health currently serves as a convener for two episode initiators.
For more information regarding BPCI Advanced, see https://innovation.cms.gov/initiatives/bpci-advanced.

** Represents a total of 72 locations participating in 128 bundled payment arrangements

Home Health Value-Based Purchasing Model

Over the long term, the Company believes it is well-positioned to benefit from a delivery system that rewards providers who are committed to providing high-quality care.

In the calendar year 2016 HH-PPS final rule, CMS finalized a Home Health Value-Based Purchasing ("HHVBP") Model that covers five performance years beginning January 1, 2016 and concluding on December 31, 2022.

Medicare-certified home health agencies that provide services in the following states will be required to participate in the model:	
1. Arizona	5
2. Florida	17
3. Iowa	—
4. Maryland	3
5. Massachusetts	4
6. Nebraska	—
7. North Carolina	6
8. Tennessee	9
9. Washington	—
Company Locations	44

~22% of the Company's home health Medicare revenue

Total Performance Scores (a numeric score ranging from 0 to 100 based on each agency's performance) will be calculated from the following set of measures* for Performance Year 2019:

- Two composite measures from existing Outcome and Assessment Information Set ("OASIS") data collection and three process measures submitted through the HHVBP portal
- Four outcome measures from existing OASIS data collection and two outcome measures from claims data
- Five HHCAHPS** consumer satisfaction measures

Performance Years		Calendar Year for Payment Adjustment	Maximum Payment Adjustment (-/+)
2016	1st Adjustment	2018†	3%
2017		2019‡	5%
2018		2020	6%
2019		2021	7%
2020		2022	8%

† Majority of EHC locations in the nine VBP states were acquired in late 2015 or 2016; EHC expects impact of ($0.3) million, or a (0.27%) payment adjustment to Medicare revenue in the nine VBP states, in 2018.

‡ EHC expects a neutral to slightly positive payment adjustment to Medicare revenue in the nine VBP states in 2019.

Source: https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model

* Per the CY 2019 HH Final Rule at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24145.pdf

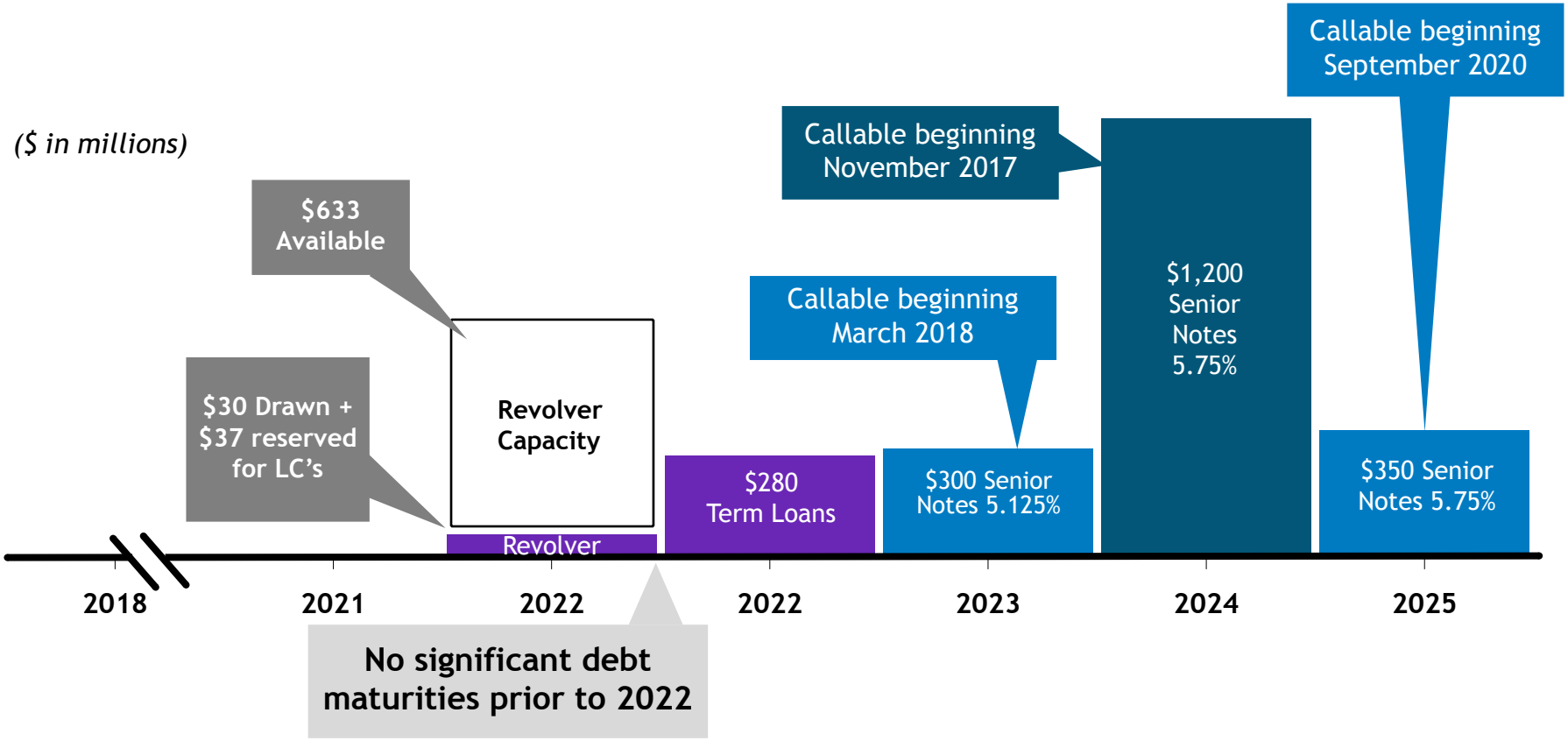
** Home Health Care Consumer Assessment of Healthcare Providers and Systems

Capital Structure

Encompass Health is positioned with a cost-efficient, flexible capital structure.

Debt Maturity Profile - Face Value

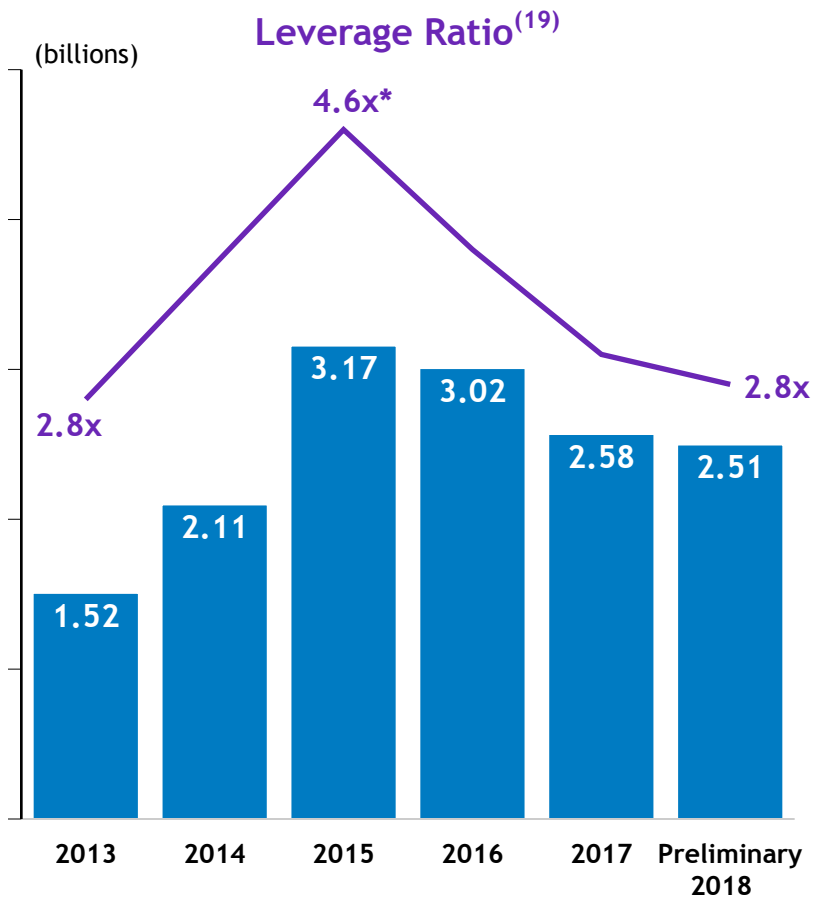
As of December 31, 2018*



* This chart does not include ~$263 million of capital lease obligations or ~$104 million of other notes payable. See the debt schedule on page 67.

Financial Leverage and Liquidity

Total Debt



* Increase in financial leverage at the end of 2015 due to the acquisition of Encompass Home Health and Hospice, Reliant Hospital Partners, and CareSouth Health System, Inc.

Liquidity

	Preliminary December 31, 2018	December 31, 2017
Cash Available	$ 52.5	$ 54.4
Revolver	$ 700.0	$ 700.0
Less:		
- Draws	(30.0)	(95.0)
- Letters of Credit	(37.4)	(35.4)
Available	$ 632.6	$ 569.6
Total Liquidity	$ 685.1	$ 624.0

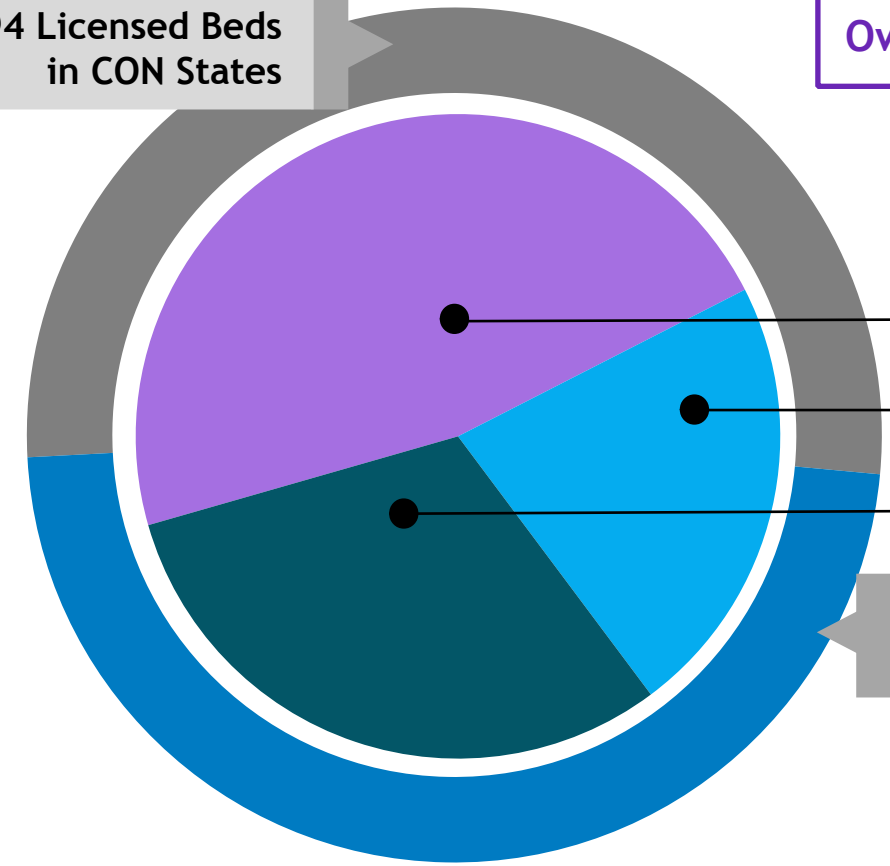
Credit Ratings

	S&P	Moody's
Corporate Rating	BB-	Ba3
Outlook	Stable	Stable
Revolver Rating	BB+	Baa3
Senior Notes Rating	B+	B1

Debt Schedule

($millions)	Preliminary December 31, 2018	December 31, 2017	Change in Debt vs. YE 2017
Advances under $700 million revolving credit facility, September 2022 - LIBOR +150bps	$ 30.0	$ 95.0	$ (65.0)
Term loan facility, September 2022 - LIBOR +150bps	280.1	294.7	(14.6)
Bonds Payable:			
5.125% Senior Notes due 2023	296.6	295.9	0.7
5.75% Senior Notes due 2024	1,194.7	1,193.9	0.8
5.75% Senior Notes due 2025	345.0	344.4	0.6
Other notes payable	104.4	82.3	22.1
Capital lease obligations	263.3	271.5	(8.2)
Long-term debt	**$ 2,514.1**	**$ 2,577.7**	$ (63.6)
Debt to Adjusted EBITDA	**2.8x**	**3.1x**	

IRF Real Estate Portfolio
130 Inpatient Rehabilitation Hospitals: 8,966 Licensed Beds



Own ~70% of IRF Real Estate

As of December 31, 2018

61	Own Building and Land
29	Own Building Only
40	Lease Building and Land

1 of the 130 IRFs is nonconsolidated. For that IRF, the Company owns the building only. The Company's licensed bed count does not include the 51 beds associated with the nonconsolidated IRF.

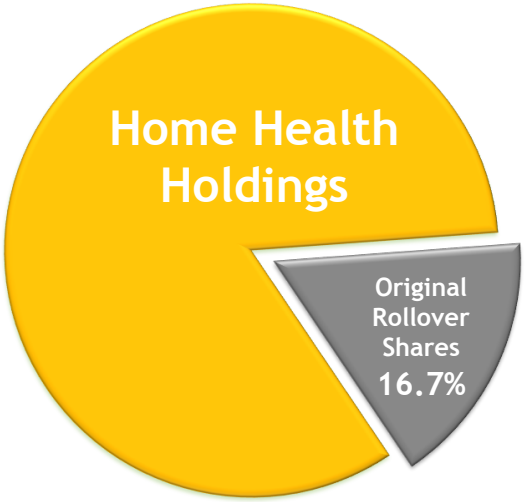
A CON is a regulatory requirement in some states and federal jurisdictions that require state authorization prior to proposed acquisitions, expansions, or construction of new hospitals.

Overview of Rollover Shares Held by Members of the Home Health and Hospice Management Team

Background

In connection with the 2014 acquisition of Encompass Home Health and Hospice:

- Certain members of that management team rolled a portion of their pre-acquisition equity into the post-acquisition entity ("Home Health Holdings") resulting in a 16.7% ownership interest (the "Rollover Shares").
- Home Health Holdings was capitalized with a promissory note to the parent company totaling ~$385 million (equal to 5.5x the segment's 2014 EBITDA). This was done to provide the opportunity for leveraged returns on the equity, thereby mimicking a private equity transaction structure.
- To the extent Home Health Holdings needs cash (e.g., acquisitions, capex, etc.), such amounts may be added to the principal amount of the note or via the creation of new notes. Cash generated from the operations of Home Health Holdings may be used to pay interest and principal on the note(s).
- In February 2018, each management investor exercised their rights to sell 1/3 of his or her Rollover Shares to EHC, representing ~5.6% of the outstanding common shares of Holdings. EHC settled the acquisition of those shares upon payment of ~$65 million, which decreased the ownership interest of the Rollover Shares to ~11.1%.

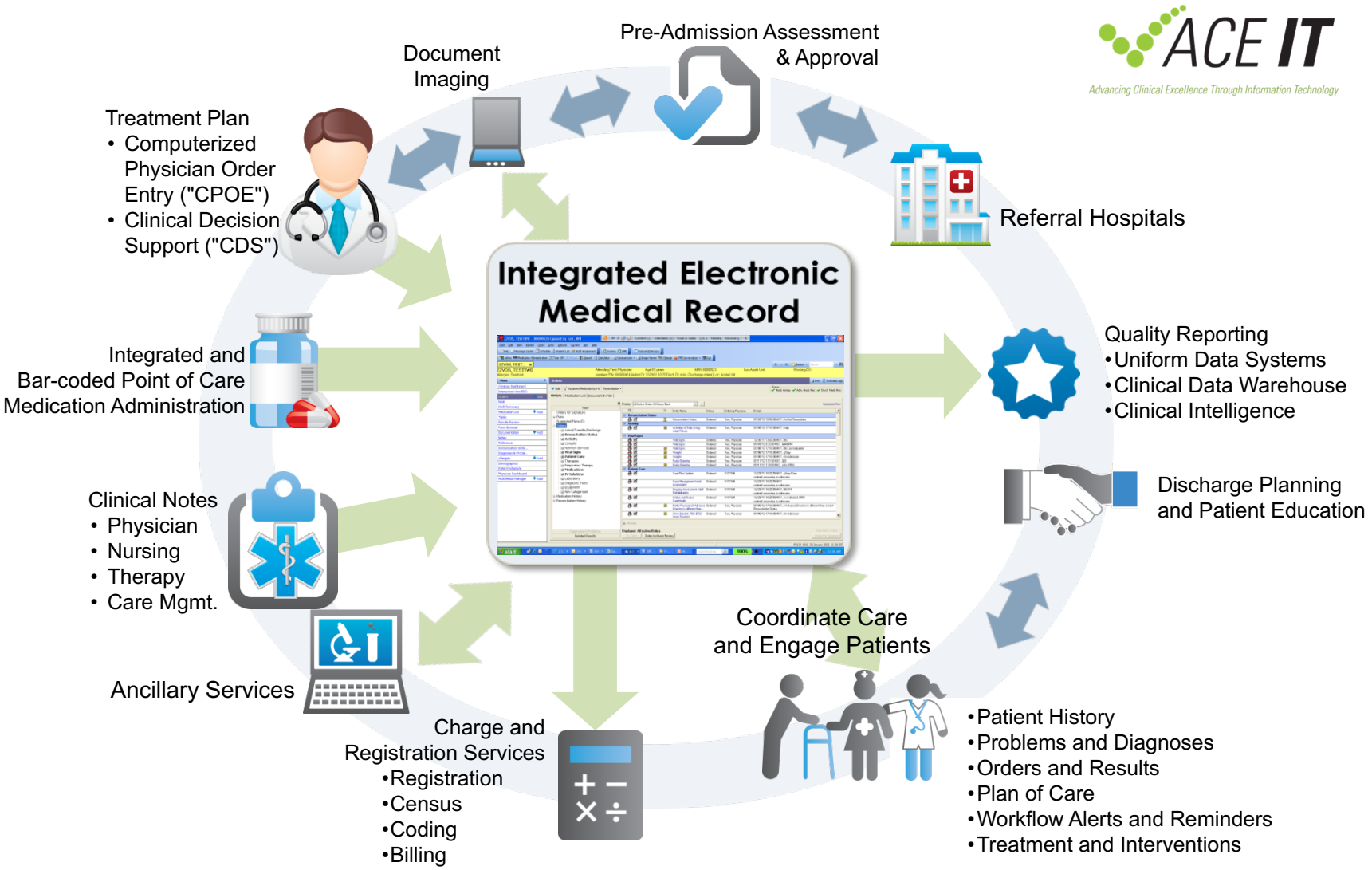


Options	**Holder** – The right (but not the obligation) to sell for cash up to 1/3 of the Rollover Shares to the parent after 1/1/18; 2/3 after 1/1/19; and all outstanding Rollover Shares after 1/1/20 **Company** – The right (but not the obligation) to purchase for cash all or any portion of the Rollover Shares after 1/1/20 upon 20 days prior written notice
Valuation	Fair value of the Rollover Shares is determined using the product of Home Health Holdings' EBITDA for the trailing 12-month period and a median market price multiple based on a basket of public home health companies and recent transactions, less the current balance of the intracompany note(s) to the parent. As of September 30, 2018, the value of the Rollover Shares was ~$208 million.

Information Technology

Encompass Health utilizes information technology to improve patient care and generate operating efficiencies.

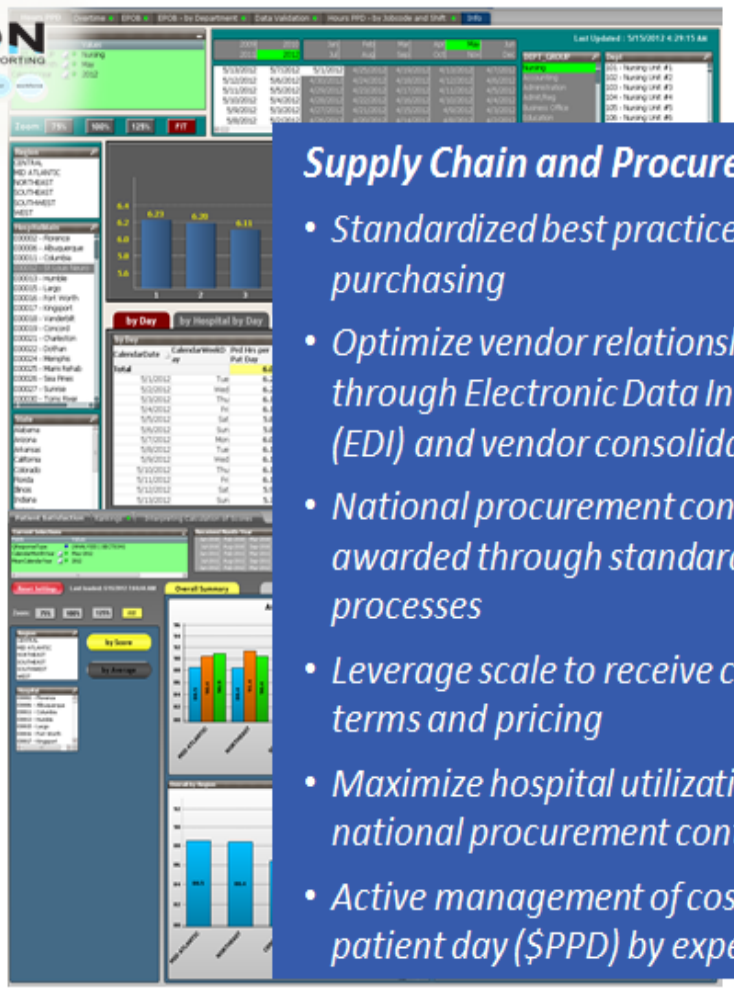
IRF Clinical Information System: Improved Patient Safety and Streamlined Operational Efficiencies



IRF Proprietary Management System: Beacon

Operations Management Tool

- Provides regional and hospital leadership near real-time data to run the business
- Benchmarking – side-by-side hospital comparison to promote best practices
- Quality
  - Key care indicators
  - Patient satisfaction
- Volume metrics – admissions, discharges, and daily census
- Labor productivity
- Other variable expenses
- Accounts receivable



Supply Chain and Procurement

- Standardized best practices and purchasing
- Optimize vendor relationships through Electronic Data Interchange (EDI) and vendor consolidation
- National procurement contracts awarded through standardized RFP processes
- Leverage scale to receive competitive terms and pricing
- Maximize hospital utilization of national procurement contracts
- Active management of cost per patient day ($PPD) by expense type

Home Health and Hospice Information System: Homecare Homebase

Homecare Homebase ("HCHB") was born out of the Company's operating model; HCHB is a leading IT platform provider in the home health and hospice industry.

homecare homebase

Optimization of capabilities in leading-edge technology embedded in culture, driving superior clinical, operational, and financial outcomes.

Clinical

- HCHB manages the entire patient workflow and provides field clinicians with access to patient records, diagnostic information, and notes from prior visits via a mobile application.
- Real-time, customized feedback and instructions provided on-site
- Enhances patient data capture and database management which aids in the development of algorithms that can improve the plan of care

Management and Operations

- Best-in-class data management and reporting ensures managers have access to relevant data needed to make correct decisions.
- Rules-based algorithms ensure accountability by escalating tasks and notifying management when processes are delayed.
- Seamless billing with processes in place to ensure claim completeness

Sales

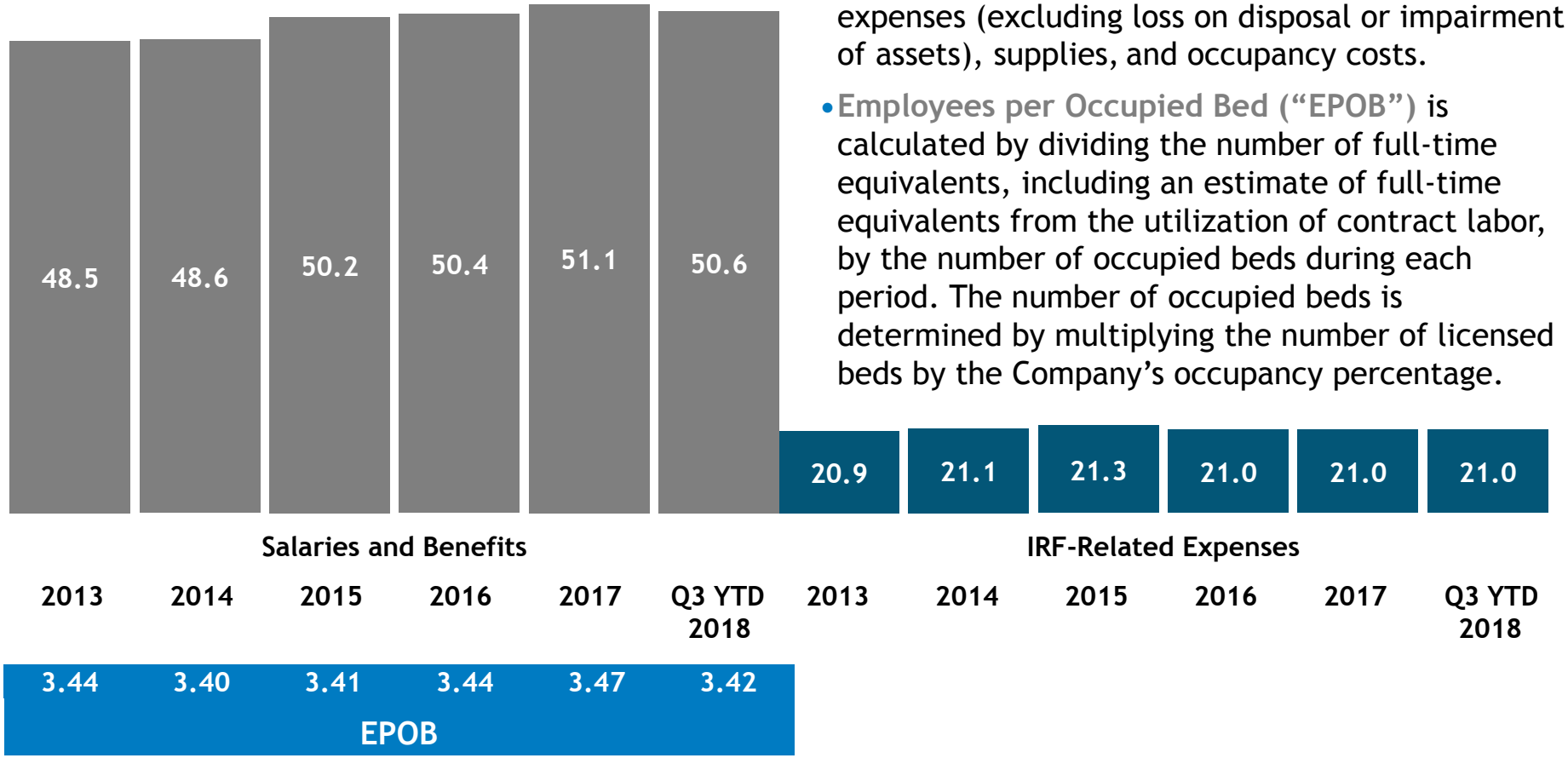
- Provides real-time market intelligence to sales area managers, allowing them to quickly identify the most valuable referral sources
- Specialty programs integrate individual physician protocols into HCHB.
  - Creates loyalty and incentives for physicians and facilities, generating additional future referrals
- Web-based portal allows referring physicians to easily monitor the care and progress of patients and to sign orders electronically.

Compliance

- Field clinicians are required to adhere to clinical protocols and physician orders, ensuring that proper regulatory and compliance procedures are followed.
- Internal branch-level audits completed three times a year
  - HCHB-generated outputs reviewed by management to identify any branches requiring additional oversight
- Compliance program also involves extensive internal training

Operational Metrics

IRF Operational Metrics: Expense Efficiencies



- **Salaries and Benefits** includes group medical costs and is impacted by staffing levels based on patient volumes.
- **IRF-related Expenses** includes other operating expenses (excluding loss on disposal or impairment of assets), supplies, and occupancy costs.
- **Employees per Occupied Bed ("EPOB")** is calculated by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by the Company's occupancy percentage.

Pre-Payment Claims Denials - Inpatient Rehabilitation Segment

Background

- For several years, under programs designated as "widespread probes," certain Medicare Administrative Contractors ("MACs") conducted pre-payment claim reviews and denied payment for certain diagnosis codes.
- Encompass Health appeals most denials. On claims it takes to an administrative law judge ("ALJ"), Encompass Health historically has experienced an approximate 70% success rate.
  - MACs identify medical documentation issues as a leading basis for denials.
  - Encompass Health's investment in clinical information systems and its medical services department has further improved its documentation and reduced technical denials.
- By statute, ALJ decisions are due within 90 days of a request for hearing, but appeals are taking years. HHS has implemented rule changes to address the backlog of appeals, but their effect is uncertain.
- In 2016, a federal court ordered HHS to eliminate the backlog by the end of CY 2020. HHS continues to object that it cannot clear the backlog in the timeframe established by the court. Although HHS remains bound by the order, the courts are considering how HHS will comply.
- All Medicare providers continue to experience delays resulting in a growing backlog.
  - Currently, ALJs are hearing Encompass Health appeals from claims denied up to eight years ago.
- CMS has implemented the Targeted Probe and Educate ("TPE") initiative. For more information regarding TPE, see https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html
- Effective February 2018, Palmetto GBA assumed responsibilities for Cahaba's MAC jurisdiction. See announcement from CMS at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/JurisdictionJAwardFactSheet-09082017.pdf

Encompass Health reserves pre-payment claim denials as a reduction of net operating revenues upon notice from a MAC a claim is under review.

Impact to Income Statement

Period	New Denials	Collections of Previously Denied Claims	Revenue Reserve for New Denials	Update of Reserve for Prior Denials
		(In Millions)		
Q3 2018	$0.7	$(1.3)	$0.2	$—
Q2 2018	1.8	(2.8)	0.5	—
Q1 2018	3.1	(6.8)	0.9	—
Q4 2017	0.7	(7.8)	0.2	—
Q3 2017	7.4	(6.2)	2.2	—
Q2 2017	16.5	(7.7)	4.9	—
Q1 2017	19.0	(5.9)	5.7	—
Q4 2016	17.8	(4.4)	5.4	0.5
Q3 2016	15.7	(8.5)	4.6	—
Q2 2016	18.7	(4.9)	4.6	—
Q1 2016	22.7	(8.4)	6.0	—
Q4 2015	22.5	(4.1)	5.6	(1.3)
Q3 2015	22.0	(4.1)	5.9	(1.1)

Impact to Balance Sheet

	Sept. 30, 2018	Dec. 31, 2017	Dec. 31, 2016
		(In Millions)	
Pre-payment claims denials	$ 158.2	$ 164.0	$ 159.7
Recorded reserves	(47.5)	(49.2)	(47.9)
Net accounts receivable from pre-payment claims denials	**$ 110.7**	**$ 114.8**	**$ 111.8**

Inpatient Rehabilitation Operational and Labor Metrics

	Q3 2018	Q2 2018	Q1 2018	Q4 2017	Q3 2017	Q2 2017	Q1 2017	Full Year 2017
				(In Millions)				
Net patient revenue-inpatient	$ 798.4	$ 809.6	$ 817.1	$ 776.9	$ 758.2	$ 751.5	$ 752.7	$ 3,039.3
Net patient revenue-outpatient and other revenues	27.2	25.0	23.2	25.5	25.3	26.1	25.1	102.0
Net operating revenues*	$ 825.6	$ 834.6	$ 840.3	$ 802.4	$ 783.5	$ 777.6	$ 777.8	$ 3,141.3
				(Actual Amounts)				
Discharges[20]	44,230	45,010	45,108	43,910	42,948	42,805	42,259	171,922
Net patient revenue per discharge*	$ 18,051	$ 17,987	$ 18,114	$ 17,693	$ 17,654	$ 17,556	$ 17,812	$ 17,678
Outpatient visits	119,006	131,041	127,308	131,787	138,689	153,415	152,454	576,345
Average length of stay	12.7	12.5	12.7	12.6	12.8	12.7	12.9	12.7
Occupancy %	68.9%	70.1%	71.9%	67.7%	68.2%	69.3%	71.0%	67.8%
# of licensed beds	8,888	8,848	8,831	8,851	8,748	8,641	8,528	8,851
Occupied beds	6,124	6,202	6,349	5,992	5,966	5,988	6,055	6,001
Full-time equivalents (FTEs)[21]	21,119	21,010	20,978	20,739	20,740	20,474	20,254	20,552
Contract labor	237	248	285	255	235	251	260	250
Total FTE and contract labor	21,356	21,258	21,263	20,994	20,975	20,725	20,514	20,802
EPOB[22]	3.49	3.43	3.35	3.50	3.52	3.46	3.39	3.47

* See page 36 for discussion of the Company's adoption of a new revenue recognition accounting standard.
Refer to pages 111-115 for end notes.

Home Health and Hospice Operational Metrics

	Q3 2018	Q2 2018	Q1 2018	Q4 2017	Q3 2017	Q2 2017	Q1 2017	Full Year 2017
				(In Millions)				
Net home health revenue	$ 209.2	$ 204.8	$ 185.3	$ 186.3	$ 180.3	$ 171.9	$ 163.9	$ 702.4
Net hospice revenue	32.8	28.3	20.4	20.1	17.8	16.9	15.4	70.2
Net operating revenues*	$ 242.0	$ 233.1	$ 205.7	$ 206.4	$ 198.1	$ 188.8	$ 179.3	$ 772.6
Home Health:				(Actual Amounts)				
Admissions[23]	34,364	34,026	33,855	31,766	31,471	30,823	30,810	124,870
Recertifications	28,733	28,089	25,229	25,479	24,396	22,568	20,546	92,989
Episodes	61,765	61,238	56,658	56,625	53,757	52,101	49,260	211,743
Average revenue per episode*	$ 2,995	$ 2,968	$ 2,934	$ 2,976	$ 3,008	$ 2,975	$ 2,978	$ 2,984
Episodic visits per episode	17.6	17.5	17.9	17.3	17.7	18.1	18.7	17.9
Total visits	1,259,055	1,240,490	1,174,950	1,124,268	1,101,109	1,095,225	1,070,356	4,390,958
Cost per visit	$ 77	$ 76	$ 75	$ 77	$ 76	$ 73	$ 75	$ 75
Hospice:								
Admissions[24]	2,054	1,797	1,593	1,355	1,273	1,114	1,128	4,870
Patient days	223,834	192,404	143,231	134,113	123,491	113,028	108,717	479,350
Revenue per day*	$ 147	$ 148	$ 142	$ 150	$ 145	$ 149	$ 141	$ 146

* See page 36 for discussion of the Company's adoption of a new revenue recognition accounting standard.
Refer to pages 111-115 for end notes.

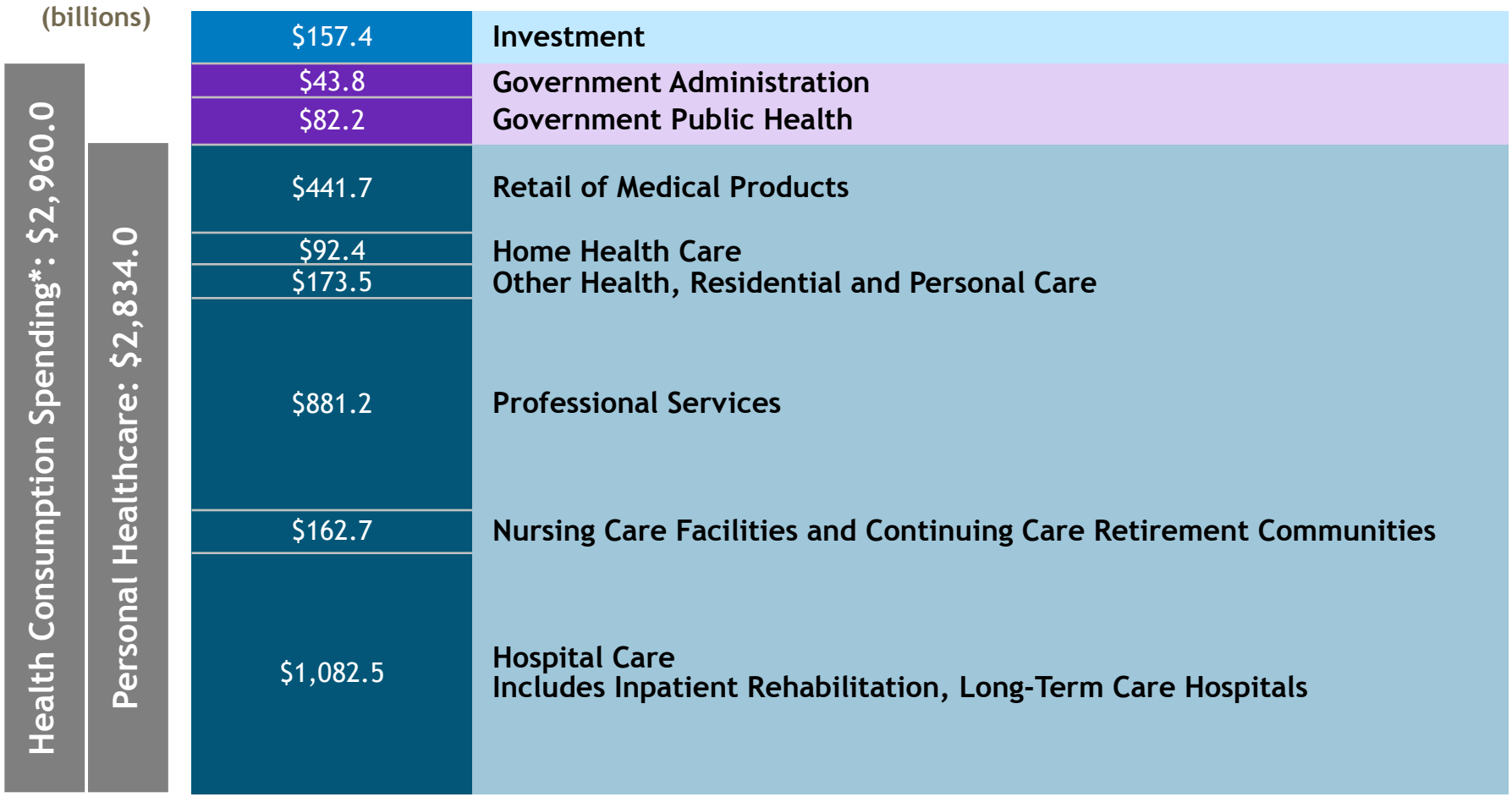
Payment Sources (Percent of Revenues)

	Inpatient Rehabilitation Segment		Home Health and Hospice Segment		Consolidated		
	Q3		Q3		Q3		Full Year
	2018	2017	2018	2017	2018	2017	2017
Medicare	72.8%	73.5%	85.0%	85.8%	75.4%	76.0%	76.0%
Medicare Advantage	9.1%	8.1%	9.4%	9.6%	9.2%	8.4%	8.6%
Managed care	10.3%	10.6%	3.6%	3.9%	8.8%	9.2%	9.3%
Medicaid	3.1%	3.3%	1.7%	0.5%	2.8%	2.7%	2.5%
Other third-party payors	1.4%	1.6%	—%	—%	1.1%	1.3%	1.3%
Workers' compensation	0.8%	0.9%	0.2%	—%	0.7%	0.7%	0.7%
Patients	0.6%	0.6%	—%	0.1%	0.5%	0.5%	0.5%
Other income	1.9%	1.4%	0.1%	0.1%	1.5%	1.2%	1.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Industry Structure

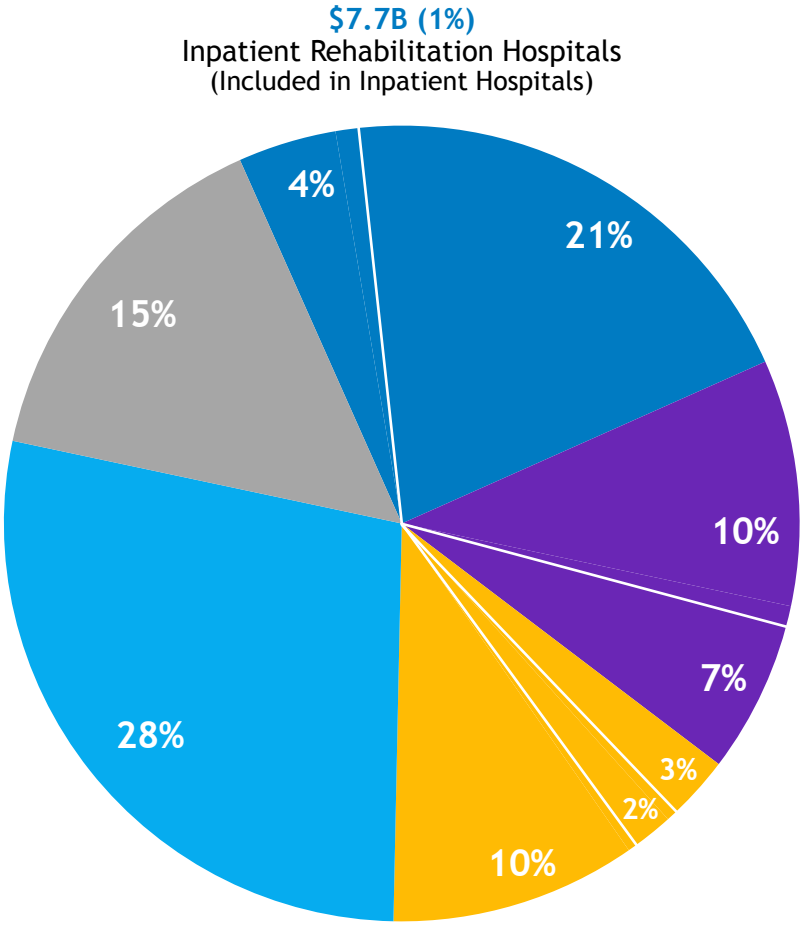
Overall Healthcare Spending

National Healthcare Spending: $3,337.2 billion in 2016



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Data (Historical), Table 2 - 2016
* Excludes Net Cost of Private Health Insurance of $219.8 billion.

Medicare 2016 Spending = $678.7 Billion



$ 29.1B	Skilled Nursing	Medicare Part A
$141.3B	Inpatient Hospital	
$69.9B	Physician Payments	Medicare Part B
$49.6B	Outpatient Hospital	
$18.1B	Home Health	Medicare Parts A&B
$16.8B	Hospice	
$65.8B	Other Services	
$188.6B	Medicare Managed Care	Medicare Part C
$99.5B	Outpatient Rx	Medicare Part D

Inpatient hospital includes spending for acute care hospitals along with inpatient rehabilitation and long-term acute care hospital services. In 2016, Medicare spent $7.7 billion and $5.1 billion, respectively for inpatient rehabilitation and long-term acute care hospital services.

Source: Centers for Medicare & Medicaid Services, Medicare Trustees' Report July 2017 - page 10; and MedPAC, Medicare Payment Policy, March 2018 - pages 205, 241, 267, 297, and 323

Continuum of Healthcare Services

Preventive
Routine health care (screenings, check-ups, patient counseling) to prevent illnesses, disease, or other health problems.

Home health and care management services to prevent or reduce acute admissions.

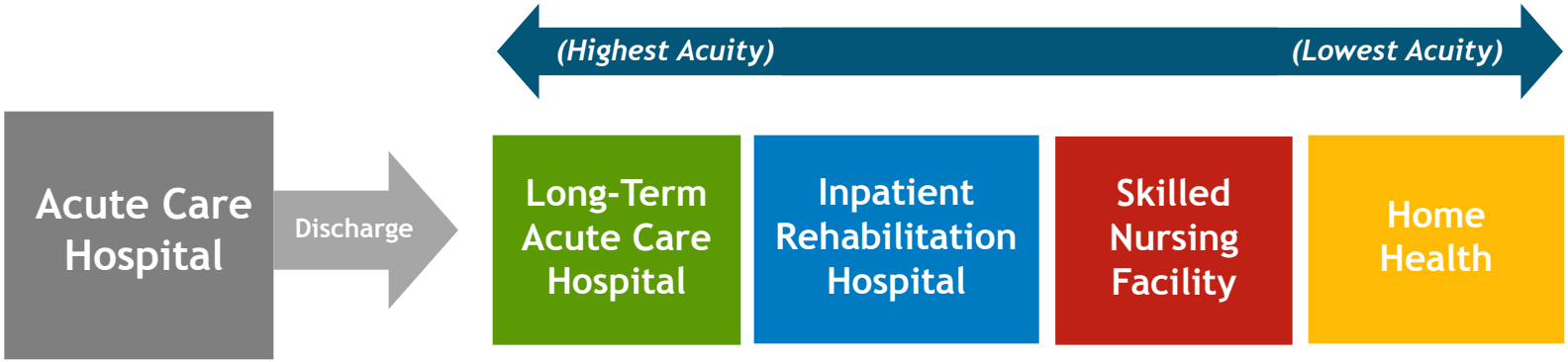
Ambulatory
Medical care delivered on an outpatient basis (blood tests, X-rays, endoscopy, certain biopsies, certain surgical procedures)

Acute
Medical treatment of diseases for which a patient is treated for a brief but severe episode of illness

Post-Acute
Medical care provided after a period of acute care (long-term acute care, **inpatient rehabilitation**, skilled nursing, **home health**)

Palliative
Medical care that is focused on providing relief from the symptoms and stress of a serious illness (**hospice**)

Post-Acute Care Services

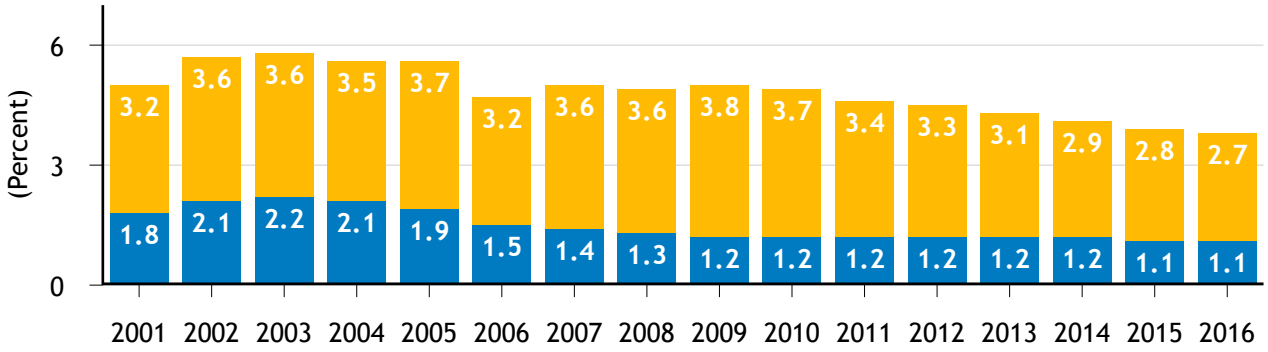


Medicare Spending (billions)	$5.1	$7.7	$29.1	$18.1*
# of Discharges	~126,000	~391,000	~2,300,000	~3,400,000
Length of Stay	26.8 days	12.7 days	38.4 days	N/A
# of Providers	~410	~1,200	~15,000	~12,200
Facility Ownership Mix**	For-Profit (79%) Non-Profit (17%) Gov't (4%)	For-Profit (32%) Non-Profit (57%) Gov't (11%)	For-Profit (70%) Non-Profit (24%) Gov't (6%)	For-Profit (88%) Non-Profit (12%)
Free-standing vs. Hospital Based	N/A	Free-Standing (23%) Hospital Based (77%)	Free-Standing (96%) Hospital Based (4%)	Free-Standing (85%) Hospital Based (15%)
Rural vs. Urban**	Urban (95%) Rural (5%)	Urban (86%) Rural (14%)	Urban (72%) Rural (28%)	Urban (83%) Rural (17%)

* Not all home health spending occurs as a post-acute service.
** Facility Ownership Mix / Rural vs. Urban - home health data represents freestanding agencies only.

Source: MedPAC, Medicare Payment Policy, March 2018 - pages 205, 210, 219, 226, 241, 258, 267, 277, 278, 297, 305, and 306; MedPAC, Health Care Spending and the Medicare Program, June 2017 - pages 121

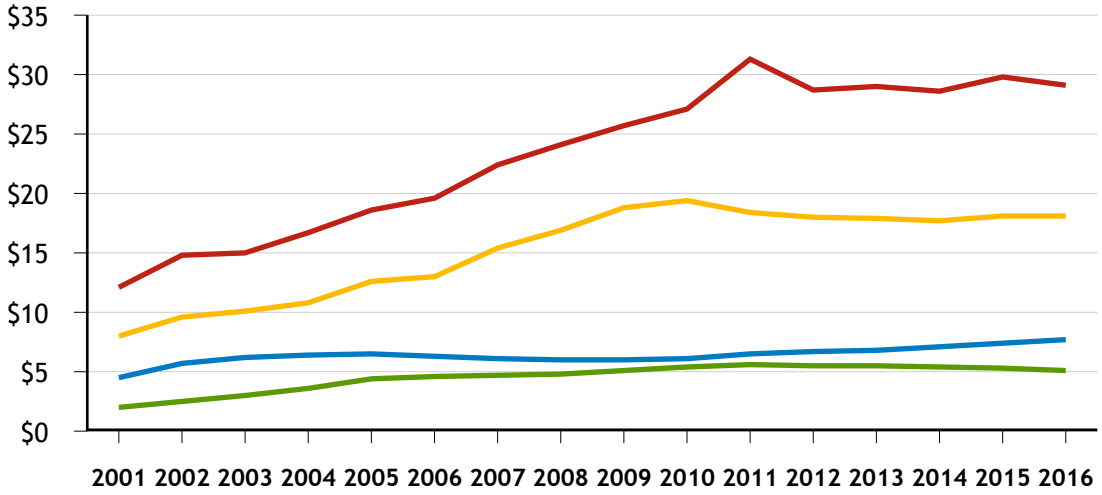
Medicare Spending on Post-Acute Services



Home health spending* (% of total Medicare spending)

Inpatient rehabilitation spending (% of total Medicare spending)

Total Medicare Spending on Post-Acute Services ~$60 billion in 2016



Post-Acute Settings	2016 Medicare Margin**	Projected 2018 Medicare Margin**
Skilled nursing facilities	11.4%	9.0%
Home health agencies*	15.5%	14.4%
Inpatient rehabilitation hospitals	13.0%	11.9%
Long-term acute care hospitals	4.1%	4.7%***

* Not all home health spending occurs as a post-acute service.

** 2016 Medicare Margin / Projected 2018 Medicare Margin - skilled nursing and home health data represents freestanding facilities and agencies only.

*** 2018 LTCH Projected Medicare Margin reflects margin estimates for full qualifying LTCH PPS cases only, not site-neutral rate cases.

Source: MedPAC, Medicare Payment Policy, March 2018 – pages 205, 206, 227, 241, 242, 267, 268, 269, 297, 298, and 299; MedPAC, Health Care Spending and the Medicare Program, June 2017 – page 112

Different Levels of Services

Inpatient Rehabilitation Hospital		Nursing Home	
Average length of stay	**= 12.7 days**	**Average length of stay**	**= 38.4 days**
Discharge to community	**= 76.9%**	**Discharge to community**	**= 39.5%**
Requirements:		**Requirements:**	
IRFs must also satisfy regulatory/policy requirements for hospitals, including Medicare hospital conditions of participation.		No similar requirement; Nursing homes are regulated as nursing homes only	
All patients must be admitted by a rehab physician.		No similar requirement	
Rehab physicians must re-confirm each admission within 24 hours.		No similar requirement	
All patients, regardless of diagnoses/condition, must demonstrate need and receive at least three hours of daily intensive therapy.		No similar requirement	
All patients must see a rehabilitation physician "in person" at least three times weekly.		No similar requirement; some SNF patients may go a week or longer without seeing a physician, and often a non-rehabilitation physician.	
IRFs are required to provide 24 hour, 7 days per week nursing care; many nurses are RNs and rehab nurses.		No similar requirement	
IRFs are required to use a coordinated interdisciplinary team approach led by a rehab physician; includes a rehab nurse, a case manager, and a licensed therapist from each therapy discipline who must meet weekly to evaluate/discuss each patient's case.		No similar requirement; Nursing homes are not required to provide care on a interdisciplinary basis and are not required to hold regular meetings for each patient.	
IRFs are required to follow stringent admission/coverage policies and must carefully document justification for each admission; further restricted in number/type of patients (60% Rule).		Nursing homes have comparatively few policies governing the number or types of patients they treat.	

Source: MedPAC, Medicare Payment Policy, March 2018 - pages 215, 219, 226, 278, and 280

Supply of IRFs is Relatively Stable

Type of IRF	Share of Medicare Discharges 2016	2004	2006	2008	2010	2013	2014	2015	2016	Average Annual Change 2006-2013	Average Annual Change 2013-2016
All IRFs	100%	1,221	1,225	1,202	1,179	1,161	1,177	1,182	1,188	-0.8%	0.8%
Urban	93	1,024	1,018	1,001	981	977	1,013	1,020	1,026	-0.6	1.6
Rural	7	197	207	201	198	184	164	162	162	-1.7	-4.2
Freestanding	50	217	217	221	233	243	251	262	273	1.6	4.0
Hospital based	50	1,004	1,008	981	946	918	926	920	915	-1.3	-0.1
Nonprofit	41	768	758	738	729	677	681	681	676	-1.6	—
For profit	52	292	299	291	294	322	338	352	370	1.1	4.7
Government	7	161	168	173	156	155	149	138	133	-1.1	-5.0

Source: MedPAC, Medicare Payment Policy, March 2018 - page 277

Inpatient Rehabilitation Sector Margins

	Share of Medicare Discharges	Margins								
Type of IRF	2016	2004	2006	2008	2010	2012	2013	2014	2015	2016
All IRFs	100%	16.7%	12.5%	9.4%	8.6%	11.2%	11.5%	12.4%	13.8%	13.0%
Urban	93	17.0	12.8	9.6	9.0	11.6	11.9	12.8	14.2	13.2
Rural	7	13.2	10.0	6.9	4.7	6.5	6.0	6.2	8.3	9.5
Freestanding	50	24.7	17.5	18.2	21.4	23.9	24.7	25.3	26.7	25.5
Hospital based	50	12.2	9.9	3.9	-0.5	0.7	-0.1	0.9	1.9	1.2
Nonprofit	41	12.8	11.0	5.3	2.1	2.1	1.1	2.0	3.5	2.0
For profit	52	24.4	16.3	16.9	19.6	22.9	23.4	23.8	24.8	23.9
Government	7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of beds										
1 to 10	2	3.7	-3.6	-4.9	-10.3	-6.9	-11.2	-10.8	-7.1	-10.3
11 to 24	22	10.5	7.3	1.2	-3.3	-1.2	-0.8	-0.2	-0.4	0.3
25 to 64	48	18.3	13.7	10.1	10.6	12.3	13.2	14.2	15.8	14.6
65 or more	28	21.5	17.8	17.3	17.5	21.0	20.0	20.7	22.9	22.0

Source: MedPAC, Medicare Payment Policy, March 2018 - page 285

Inpatient Rehabilitation Standardized Comparison of Costs

Type of IRF	Median Standardized Cost Per Discharge
All IRFs	$15,494
Hospital based	16,406
Freestanding	11,796
Nonprofit	16,311
For profit	13,315
Government	17,813
Urban	15,185
Rural	17,914
Number of beds	
1 to 10	18,588
11 to 24	16,408
25 to 64	14,239
65 or more	12,103

Median standardized costs per discharge are lower for freestanding IRFs and larger facilities.

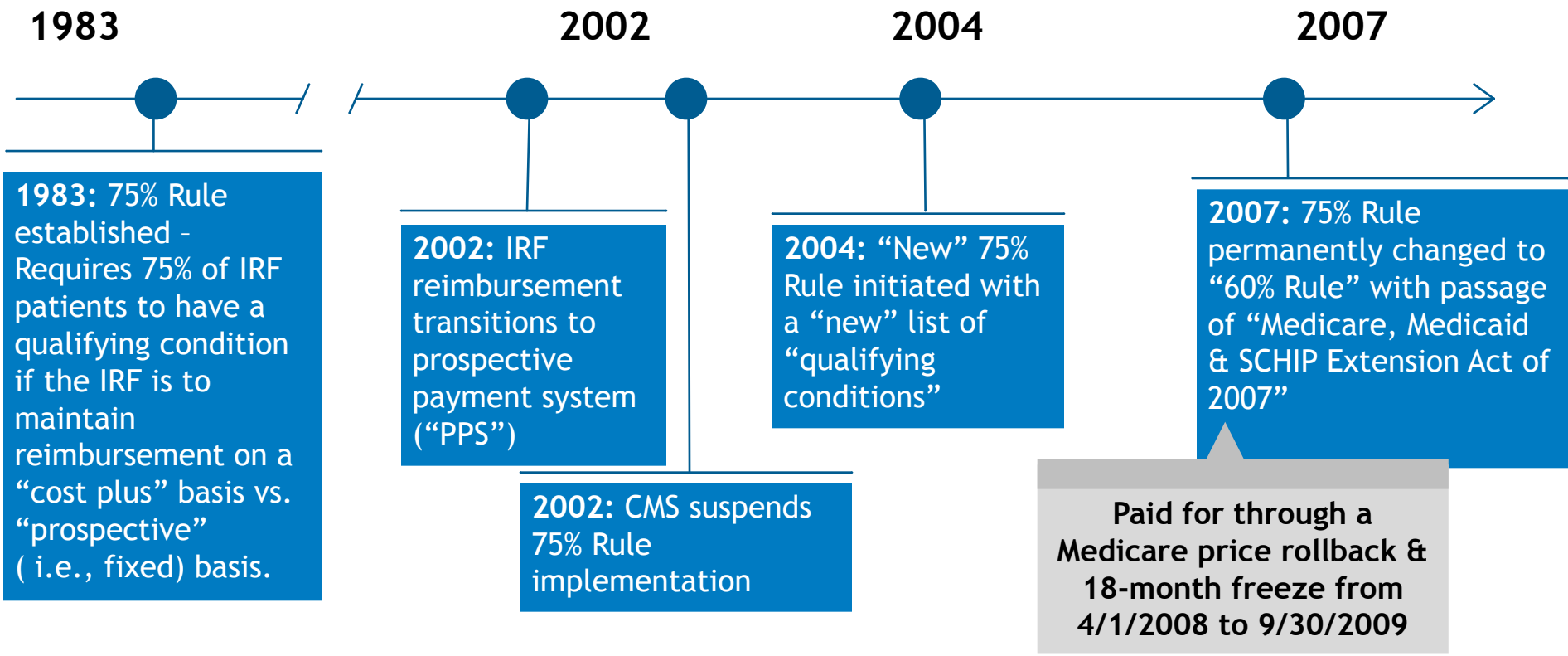
High margin IRFs (both hospital-based and freestanding) are concentrated in the low-cost quartile of standardized costs.

Characteristic	Quartile: Low Cost	Quartile: High Cost
Percent:		
Hospital based	38%	94%
Freestanding	62	6
Nonprofit	31	62
For profit	66	20
Government	3	17
Urban	94	80
Rural	6	20
Median Medicare Margin:		
All	28.4%	-22.1%
Hospital based	23.4	-22.1
Freestanding	31.0	-23.1
Median:		
Number of beds	48	18
Occupancy rate	72%	53%
Median costs per discharge:		
All	$11,490	$19,873
Hospital based	12,158	19,860
Freestanding	10,854	20,417

Source: MedPAC, Medicare Payment Policy, March 2018 - page 286 and 287

“60% Rule”: Medicare Regulation for IRFs

The 60% Rule requires at least 60% of all patients admitted must have at least one medical diagnosis or functional impairment from a list of 13 compliant conditions (a.k.a. “compliant conditions” or “CMS-13”).



IRF Qualifying Conditions

Original Qualifying Conditions

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorder
7. Multiple trauma
8. Congenital deformity
9. Burns
10. Polyarthritis (includes "joint replacement")

Became

Current Qualifying Conditions

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorder
7. Multiple trauma
8. Congenital deformity
9. Burns
10. Osteoarthritis (after less intensive setting)
11. Rheumatoid arthritis (after less intensive setting)
12. Joint replacement
    - Bilateral
    - Age ≥ 85
    - Body Mass Index >50
13. Systemic vasculidities (after less-intensive setting)

Since the implementation of the 60% Rule in 2007, the relative number of lower extremity fractures and lower extremity joint replacements treated in the Company's IRFs has declined significantly.

	% of the Company's Medicare Discharges						
Lower Extremity:	2005	2007	2009	2011	2013	2015	2017
Fractures (RIC 07)	13.1%	14.8%	13.6%	11.6%	10.2%	9.8%	8.9%
Joint Replacements (RIC 08)	17.9%	11.8%	9.0%	7.6%	6.7%	5.5%	3.7%

Inpatient Rehabilitation Outlier Payments[7]

More Efficient Less

IRF Deciles	# of IRFs			Total Outlier Payments				Avg Outlier Payment per Discharge		
	Encompass Health	Non-Encompass Health	Total	Encompass Health	Non-Encompass Health	Total	%	Encompass Health	Non-Encompass Health	Total
90-100	—	112	112	$ —	$ 134,977,428	$ 134,977,428	52.7%	N/A	$ 3,072	$ 3,072
80-90	2	110	112	$ 705,836	$ 46,878,724	$ 47,584,560	18.6%	$ 1,373	$ 1,316	$ 1,317
70-80	1	112	113	$ 237,706	$ 27,515,884	$ 27,753,590	10.8%	$ 113	$ 895	$ 845
60-70	5	108	113	$ 815,666	$ 16,985,379	$ 17,801,045	7.0%	$ 170	$ 525	$ 480
50-60	7	106	113	$ 715,301	$ 10,810,889	$ 11,526,190	4.5%	$ 96	$ 416	$ 345
40-50	9	104	113	$ 546,134	$ 6,900,730	$ 7,446,864	2.9%	$ 54	$ 274	$ 212
30-40	19	94	113	$ 810,929	$ 3,917,683	$ 4,728,612	1.9%	$ 45	$ 144	$ 105
20-30	29	84	113	$ 755,957	$ 2,168,627	$ 2,924,584	1.1%	$ 31	$ 113	$ 67
10-20	27	85	112	$ 308,975	$ 871,995	$ 1,180,970	0.5%	$ 12	$ 42	$ 26
0-10	27	85	112	$ 39,483	$ 61,960	$ 101,443	—%	$ 1	$ 3	$ 2
Totals	126	1,000	1,126	$ 4,935,987	$ 251,089,299	$ 256,025,286	100.0%			

Outlier Observations:

- 10% of IRFs receive 53% of the outlier payments; none of the 10% are Encompass Health IRFs.
- The Company receives 1.9% of the IRF outlier payments despite treating approx. 30% of the Medicare patients/discharges.
- As a result of outlier payments, CMS pays the Company approx. $845 less per discharge than other providers.
- Capping the IRF industry outlier payments at 10% of each IRF's total Medicare payments could save Medicare approx. $651 million over 10 years.

Refer to pages 111-115 for end notes.

Segment Operating Results

Inpatient Rehabilitation Segment Adjusted EBITDA

(In Millions)	Q3 2018	Q2 2018	Q1 2018	Q4 2017	Q3 2017	Q2 2017	Q1 2017	Full Year 2017
Net operating revenues:								
Inpatient	$ 798.4	$ 809.6	$ 817.1	$ 776.9	$ 758.2	$ 751.5	$ 752.7	$ 3,039.3
Outpatient and other	27.2	25.0	23.2	25.5	25.3	26.1	25.1	102.0
Total segment revenue*	825.6	834.6	840.3	802.4	783.5	777.6	777.8	3,141.3
Operating expenses:								
Salaries and benefits	(423.6)	(416.5)	(424.2)	(408.1)	(403.2)	(394.3)	(398.2)	(1,603.8)
% of revenue	51.3%	49.9%	50.5%	50.9%	51.5%	50.7%	51.2%	51.1%
Other operating expenses[(a)]	(124.3)	(126.9)	(122.9)	(120.4)	(117.4)	(112.9)	(111.8)	(462.5)
Supplies	(33.6)	(34.7)	(35.9)	(35.1)	(33.1)	(33.8)	(33.7)	(135.7)
Occupancy costs	(15.9)	(16.0)	(15.5)	(15.6)	(15.7)	(15.5)	(15.1)	(61.9)
	(173.8)	(177.6)	(174.3)	(171.1)	(166.2)	(162.2)	(160.6)	(660.1)
% of revenue	21.1%	21.3%	20.7%	21.3%	21.2%	20.9%	20.6%	21.0%
Equity in nonconsolidated affiliates	1.9	1.6	2.0	1.7	1.9	1.8	1.9	7.3
Other income[(b)]	1.8	1.2	0.5	1.2	1.0	0.9	1.0	4.1
Noncontrolling interests[(c)]	(19.0)	(19.8)	(20.5)	(19.0)	(16.7)	(15.4)	(16.5)	(67.6)
Segment Adjusted EBITDA	**$ 212.9**	**$ 223.5**	**$ 223.8**	**$ 207.1**	**$ 200.3**	**$ 208.4**	**$ 205.4**	**$ 821.2**

	In arriving at Adjusted EBITDA, the following was excluded:								
(a)	(Gain) loss on disposal of assets	$ (1.0)	$ 2.4	$ 0.8	$ 1.3	$ 3.1	$ 0.8	$ (0.4)	$ 4.8
(b)	Change in fair market value of equity securities[(25)]	$ 0.1	$ 0.4	$ 0.6	$ —	$ —	$ —	$ —	$ —
(c)	Tax reform impact on noncontrolling interests[(26)]	$ —	$ —	$ —	$ 0.5	$ —	$ —	$ —	$ 0.5

Reconciliations to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* See page 36 for discussion of the Company's adoption of a new revenue recognition accounting standard.

Home Health and Hospice Segment Adjusted EBITDA

(In Millions)	Q3 2018	Q2 2018	Q1 2018	Q4 2017	Q3 2017	Q2 2017	Q1 2017	Full Year 2017
Net operating revenues:								
Home health revenue	$ 209.2	$ 204.8	$ 185.3	$ 186.3	$ 180.3	$ 171.9	$ 163.9	$ 702.4
Hospice revenue	32.8	28.3	20.4	20.1	17.8	16.9	15.4	70.2
Total segment revenue*	242.0	233.1	205.7	206.4	198.1	188.8	179.3	772.6
Operating expenses[a]								
Cost of services	(114.6)	(109.1)	(98.6)	(96.0)	(92.1)	(87.5)	(87.7)	(363.3)
% of revenue	47.4%	46.8%	47.9%	46.5%	46.5%	46.3%	48.9%	47.0%
Support and overhead costs	(82.4)	(80.8)	(72.0)	(73.8)	(68.9)	(67.7)	(66.8)	(277.2)
% of revenue	34.0%	34.7%	35.0%	35.8%	34.8%	35.9%	37.3%	35.9%
	(197.0)	(189.9)	(170.6)	(169.8)	(161.0)	(155.2)	(154.5)	(640.5)
% of revenue	81.4%	81.5%	82.9%	82.3%	81.3%	82.2%	86.2%	82.9%
Other income	—	0.5	—	—	—	—	—	—
Equity in net income of nonconsolidated affiliates	0.2	0.4	0.3	0.1	0.2	0.2	0.2	0.7
Noncontrolling interests[b]	(2.0)	(2.5)	(1.9)	(2.3)	(2.5)	(1.0)	(1.1)	(6.9)
Segment Adjusted EBITDA	**$ 43.2**	**$ 41.6**	**$ 33.5**	**$ 34.4**	**$ 34.8**	**$ 32.8**	**$ 23.9**	**$ 125.9**
In arriving at Adjusted EBITDA, the following was excluded:								
(a) Gain on disposal of assets	$ —	$ —	$ —	$ —	$ (0.1)	$ —	$ (0.1)	$ (0.2)
(b) SARs mark-to-market impact on noncontrolling interests[27]	$ (0.3)	$ (0.9)	$ (1.0)	$ —	$ —	$ —	$ —	$ —
(b) Tax reform impact on noncontrolling interests[26]	$ —	$ —	$ —	$ 4.1	$ —	$ —	$ —	$ 4.1

Reconciliations to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* See page 36 for discussion of the Company's adoption of a new revenue recognition accounting standard.

Segment Operating Results

(In Millions)	Q3 2018 IRF	Q3 2018 Home Health and Hospice	Q3 2018 Reclasses	Q3 2018 Consolidated	Q3 2017 IRF	Q3 2017 Home Health and Hospice	Q3 2017 Reclasses	Q3 2017 Consolidated
Net operating revenues	$ 825.6	$ 242.0	$ —	$ 1,067.6	$ 783.5	$ 198.1	$ —	$ 981.6
Operating Expenses:								
Inpatient Rehabilitation:								
Salaries and benefits	(423.6)	—	(168.7)	(592.3)	(403.2)	—	(138.9)	(542.1)
Other operating expenses[a]	(124.3)	—	(19.6)	(143.9)	(117.4)	—	(15.8)	(133.2)
Supplies	(33.6)	—	(5.0)	(38.6)	(33.1)	—	(3.4)	(36.5)
Occupancy	(15.9)	—	(3.7)	(19.6)	(15.7)	—	(2.9)	(18.6)
Home Health and Hospice:								
Cost of services sold (excluding depreciation and amortization)	—	(114.6)	114.6	—	—	(92.1)	92.1	—
Support and overhead costs	—	(82.4)	82.4	—	—	(68.9)	68.9	—
	(597.4)	(197.0)	—	(794.4)	(569.4)	(161.0)	—	(730.4)
Other income[b]	1.8	—	—	1.8	1.0	—	—	1.0
Equity in net income of nonconsolidated affiliates	1.9	0.2	—	2.1	1.9	0.2	—	2.1
Noncontrolling interests[c]	(19.0)	(2.0)	—	(21.0)	(16.7)	(2.5)	—	(19.2)
Segment Adjusted EBITDA	**$ 212.9**	**$ 43.2**	**$ —**	**256.1**	**$ 200.3**	**$ 34.8**	**$ —**	**235.1**
General and administrative expenses[d]				(31.8)				(30.5)
Adjusted EBITDA				**$ 224.3**				**$ 204.6**
In arriving at Adjusted EBITDA, the following were excluded:								
(a) (Gain) loss on disposal of assets	$ (1.0)	$ —	$ —	$ (1.0)	$ 3.1	$ (0.1)	$ —	$ 3.0
(b) Change in fair market value of equity securities[25]	$ 0.1	$ —	$ —	$ 0.1	$ —	$ —	$ —	$ —
(c) SARs mark-to-market impact on noncontrolling interests[27]	$ —	$ (0.3)	$ —	$ (0.3)	$ —	$ —	$ —	$ —
(d) Stock-based compensation	$ —	$ —	$ —	$ 18.1	$ —	$ —	$ —	$ 9.2

Segment Operating Results

(In Millions)	Nine Months Ended September 30, 2018 IRF	Home Health and Hospice	Reclasses	Consolidated	Nine Months Ended September 30, 2017 IRF	Home Health and Hospice	Reclasses	Consolidated
Net operating revenues	$ 2,500.5	$ 680.8	$ —	$ 3,181.3	$ 2,338.9	$ 566.2	$ —	$ 2,905.1
Operating Expenses:								
Inpatient Rehabilitation:								
Salaries and benefits	(1,264.3)	—	(476.4)	(1,740.7)	(1,195.7)	—	(404.3)	(1,600.0)
Other operating expenses[a]	(374.1)	—	(57.2)	(431.3)	(342.1)	—	(47.9)	(390.0)
Supplies	(104.2)	—	(13.6)	(117.8)	(100.6)	—	(10.0)	(110.6)
Occupancy	(47.4)	—	(10.3)	(57.7)	(46.3)	—	(8.5)	(54.8)
Home Health and Hospice:								
Cost of services sold (excluding depreciation and amortization)	—	(322.3)	322.3	—	—	(267.3)	267.3	—
Support and overhead costs	—	(235.2)	235.2	—	—	(203.4)	203.4	—
	(1,790.0)	(557.5)	—	(2,347.5)	(1,684.7)	(470.7)	—	(2,155.4)
Other income[b]	3.5	0.5	—	4.0	2.9	—	—	2.9
Equity in net income of nonconsolidated affiliates	5.5	0.9	—	6.4	5.6	0.6	—	6.2
Noncontrolling interests[c]	(59.3)	(6.4)	—	(65.7)	(48.6)	(4.6)	—	(53.2)
Segment Adjusted EBITDA	**$ 660.2**	**$ 118.3**	**$ —**	**778.5**	**$ 614.1**	**$ 91.5**	**$ —**	**705.6**
General and administrative expenses[d][e]				(99.3)				(90.7)
Adjusted EBITDA				**$ 679.2**				**$ 614.9**
In arriving at Adjusted EBITDA, the following were excluded:								
(a) Loss (gain) on disposal of assets	$ 2.2	$ —	$ —	$ 2.2	$ 3.5	$ (0.2)	$ —	$ 3.3
(b) Change in fair market value of equity securities[25]	$ 1.1	$ —	$ —	$ 1.1	$ —	$ —	$ —	$ —
(c) SARs mark-to-market impact on noncontrolling interests[27]	$ —	$ (2.2)	$ —	$ (2.2)	$ —	$ —	$ —	$ —
(d) Stock-based compensation	$ —	$ —	$ —	$ 65.6	$ —	$ —	$ —	$ 37.9
(e) Transaction costs	$ —	$ —	$ —	$ 1.0	$ —	$ —	$ —	$ —

Segment Operating Results

(In Millions)	Year Ended December 31, 2017			
	IRF	Home Health and Hospice	Reclasses	Consolidated
Net operating revenues	$ 3,141.3	$ 772.6	$ —	$ 3,913.9
Operating Expenses:				
Inpatient Rehabilitation:				
Salaries and benefits	(1,603.8)	—	(550.8)	(2,154.6)
Other operating expenses[a]	(462.5)	—	(64.5)	(527.0)
Supplies	(135.7)	—	(13.6)	(149.3)
Occupancy	(61.9)	—	(11.6)	(73.5)
Home Health and Hospice:				
Cost of services sold (excluding depreciation and amortization)	—	(363.3)	363.3	—
Support and overhead costs	—	(277.2)	277.2	—
	(2,263.9)	(640.5)	—	(2,904.4)
Other income	4.1	—	—	4.1
Equity in net income of nonconsolidated affiliates	7.3	0.7	—	8.0
Noncontrolling interest[b]	(67.6)	(6.9)	—	(74.5)
Segment Adjusted EBITDA	**$ 821.2**	**$ 125.9**	**$ —**	**947.1**
General and administrative expenses[c]				(124.0)
Adjusted EBITDA				**$ 823.1**

In arriving at Adjusted EBITDA, the following were excluded:				
(a) Loss (gain) on disposal of assets	$ 4.8	$ (0.2)	$ —	$ 4.6
(b) Tax reform impact on noncontrolling interests[26]	$ 0.5	$ 4.1	$ —	$ 4.6
(c) Stock-based compensation	$ —	$ —	$ —	$ 47.7

Reconciliations to GAAP and Share Information

Reconciliation of Net Income to Adjusted EBITDA[9]

(in millions, except per share data)	2018 Q1 Total	2018 Q1 Per Share	2018 Q2 Total	2018 Q2 Per Share	2018 Q3 Total	2018 Q3 Per Share	2018 9 Months Total	2018 9 Months Per Share
Net Income	$ 105.2		$ 113.2		$ 109.3		$ 327.7	
Loss (income) from disc ops, net of tax, attributable to Encompass Health	0.5		(0.2)		0.1		0.4	
Net income attributable to noncontrolling interests	(21.4)		(21.4)		(20.7)		(63.5)	
Income from continuing operations attributable to Encompass Health*	84.3	$ 0.85	91.6	$ 0.92	88.7	$ 0.89	264.6	$ 2.65
Provision for income tax expense	30.0		29.3		30.2		89.5	
Interest expense and amortization of debt discounts and fees	35.6		37.7		37.3		110.6	
Depreciation and amortization	45.9		49.7		51.2		146.8	
Net noncash loss (gain) on disposal of assets	0.8		2.4		(1.0)		2.2	
Stock-based compensation expense	26.1		21.4		18.1		65.6	
Transaction costs	1.0		—		—		1.0	
SARs mark-to-market impact on noncontrolling interests[27]	(1.0)		(0.9)		(0.3)		(2.2)	
Change in fair market value of equity securities[25]	0.6		0.4		0.1		1.1	
Adjusted EBITDA	$ 223.3		$ 231.6		$ 224.3		$ 679.2	
Weighted average common shares outstanding:								
Basic		97.8		97.9		98.0		97.9
Diluted		99.4		99.6		100.0		99.7

* Per share amounts for each period presented are based on diluted weighted-average shares outstanding.
Refer to pages 111-115 for end notes.

Reconciliation of Net Income to Adjusted EBITDA[9]

(in millions, except per share data)	2017 Q1 Total	2017 Q1 Per Share	2017 Q2 Total	2017 Q2 Per Share	2017 Q3 Total	2017 Q3 Per Share	2017 Q4 Total	2017 Q4 Per Share	2017 Full Year Total	2017 Full Year Per Share
Net Income	$ 84.4		$ 79.4		$ 85.1		$ 86.5		$ 335.4	
Loss (income) from disc ops, net of tax, attributable to Encompass Health	0.3		(0.2)		0.1		0.2		0.4	
Net income attributable to noncontrolling interests	(17.6)		(16.4)		(19.2)		(25.9)		(79.1)	
Income from continuing operations attributable to Encompass Health*	67.1	$ 0.70	62.8	$ 0.66	66.0	$ 0.67	60.8	$ 0.61	256.7	$ 2.69
Provision for income tax expense	39.7		28.6		43.1		49.2		160.6	
Interest expense and amortization of debt discounts and fees	41.3		40.4		36.8		35.9		154.4	
Depreciation and amortization	45.2		45.8		46.2		46.6		183.8	
Loss on early extinguishment of debt[28]	—		10.4		0.3		—		10.7	
Net noncash (gain) loss on disposal of assets	(0.5)		0.8		3.0		1.3		4.6	
Stock-based compensation expense	8.0		20.7		9.2		9.8		47.7	
Tax reform impact on noncontrolling interests[26]	—		—		—		4.6		4.6	
Adjusted EBITDA	$ 200.8		$ 209.5		$ 204.6		$ 208.2		$ 823.1	
Weighted average common shares outstanding:										
Basic		88.8		90.3		97.8		97.6		93.7
Diluted		99.0		98.9		99.0		99.2		99.3

* Per share amounts for each period presented are based on diluted weighted-average shares outstanding.
Refer to pages 111-115 for end notes.

Reconciliation of Segment Adjusted EBITDA to Income from Continuing Operations Before Income Tax Expense

	Three Months Ended September 30,		Nine Months Ended September 30,		Year Ended December 31,
	2018	2017	2018	2017	2017
	(In Millions)				
Total segment Adjusted EBITDA	**$ 256.1**	**$ 235.1**	**$ 778.5**	**$ 705.6**	**$ 947.1**
General and administrative expenses	(49.9)	(39.7)	(165.9)	(128.6)	(171.7)
Depreciation and amortization	(51.2)	(46.2)	(146.8)	(137.2)	(183.8)
Gain (loss) on disposal of assets	1.0	(3.0)	(2.2)	(3.3)	(4.6)
Loss on early extinguishment of debt	—	(0.3)	—	(10.7)	(10.7)
Interest expense and amortization of debt discounts and fees	(37.3)	(36.8)	(110.6)	(118.5)	(154.4)
Net income attributable to noncontrolling interests	20.7	19.2	63.5	53.2	79.1
SARs mark-to-market impact on noncontrolling interests[27]	0.3	—	2.2	—	—
Change in fair market value of equity securities[25]	(0.1)	—	(1.1)	—	—
Tax reform impact on noncontrolling interests[26]	—	—	—	—	(4.6)
Income from continuing operations before income tax expense	**$ 139.6**	**$ 128.3**	**$ 417.6**	**$ 360.5**	**$ 496.4**

Adjusted EPS[10] - Q3 2018

	For the Three Months Ended September 30, 2018				
		Adjustments			
	As Reported	Mark-to-Market Adjustment for Stock Compensation Expense	Income Tax Adjustments	Change in Fair Market Value of Equity Securities[25]	As Adjusted
	(In Millions, Except Per Share Amounts)				
Adjusted EBITDA	**$ 224.3**	**$ —**	**$ —**	**$ —**	**$ 224.3**
Depreciation and amortization	(51.2)	—	—	—	(51.2)
Interest expense and amortization of debt discounts and fees	(37.3)	—	—	—	(37.3)
Stock-based compensation	(18.1)	4.2	—	—	(13.9)
Gain on disposal of assets	1.0	—	—	—	1.0
SARs mark-to-market impact on noncontrolling interests[27]	0.3	(0.3)	—	—	—
Change in fair market value of equity securities[25]	(0.1)	—	—	0.1	—
Income from continuing operations before income tax expense	118.9	3.9	—	0.1	122.9
Provision for income tax expense	(30.2)	(1.1)	(0.7)	—	(32.0)
Income from continuing operations attributable to Encompass Health	**$ 88.7**	**$ 2.8**	**$ (0.7)**	**$ 0.1**	**$ 90.9**
Add: Interest, amortization, and loss on extinguishment of convertible debt, net of tax	—				—
Numerator for diluted earnings per share	**$ 88.7**				**$ 90.9**
Diluted earnings per share from continuing operations, as reported*	**$ 0.89**	**$ 0.03**	**$ (0.01)**	**$ —**	**$ 0.91**
Diluted shares used in calculation	**100.0**				

Reconciliation to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* Adjusted EPS may not sum across due to rounding.

Adjusted EPS[(10)] - Q3 2017

	For the Three Months Ended September 30, 2017				
		Adjustments			
	As Reported	Mark-to-Market Adjustment on Stock Compensation Expense	Loss on Early Extinguishment of Debt	Income Tax Adjustments	As Adjusted
	(In Millions, Except Per Share Amounts)				
Adjusted EBITDA	**$ 204.6**	**$ —**	**$ —**	**$ —**	**$ 204.6**
Depreciation and amortization	(46.2)	—	—	—	(46.2)
Loss on early extinguishment of debt	(0.3)	—	0.3	—	—
Interest expense and amortization of debt discounts and fees	(36.8)	—	—	—	(36.8)
Stock-based compensation	(9.2)	(1.0)	—	—	(10.2)
Loss on disposal of assets	(3.0)	—	—	—	(3.0)
Income from continuing operations before income tax expense	109.1	(1.0)	0.3	—	108.4
Provision for income tax expense	(43.1)	0.4	(0.1)	(0.4)	(43.2)
Income from continuing operations attributable to Encompass Health	**$ 66.0**	**$ (0.6)**	**$ 0.2**	**$ (0.4)**	**$ 65.2**
Add: Interest, amortization, and loss on extinguishment of convertible debt, net of tax	—				—
Numerator for diluted earnings per share	**$ 66.0**				**$ 65.2**
Diluted earnings per share from continuing operations, as reported*	**$ 0.67**	**$ (0.01)**	**$ —**	**$ —**	**$ 0.66**
Diluted shares used in calculation	**99.0**				

Reconciliation to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* Adjusted EPS may not sum across due to rounding.

Adjusted EPS[10] - YTD 2018

	For the Nine Months Ended September 30, 2018					
		Adjustments				
	As Reported	Mark-to-Market Adjustment for Stock Compensation Expense	Income Tax Adjustments	Transaction Costs	Change in Fair Market Value of Equity Securities[25]	As Adjusted
	(In Millions, Except Per Share Amounts)					
Adjusted EBITDA	**$ 679.2**	**$ —**	**$ —**	**$ —**	**$ —**	**$ 679.2**
Depreciation and amortization	(146.8)	—	—	—	—	(146.8)
Interest expense and amortization of debt discounts and fees	(110.6)	—	—	—	—	(110.6)
Stock-based compensation	(65.6)	26.6	—	—	—	(39.0)
Loss on disposal of assets	(2.2)	—	—	—	—	(2.2)
Transaction costs	(1.0)	—	—	1.0	—	—
SARs mark-to-market impact on noncontrolling interests[27]	2.2	(2.2)	—	—	—	—
Change in fair market value of equity securities[25]	(1.1)	—	—	—	1.1	—
Income from continuing operations before income tax expense	354.1	24.4	—	1.0	1.1	380.6
Provision for income tax expense	(89.5)	(6.8)	(1.4)	(0.3)	(0.3)	(98.3)
Income from continuing operations attributable to Encompass Health	**$ 264.6**	**$ 17.6**	**$ (1.4)**	**$ 0.7**	**$ 0.8**	**$ 282.3**
Add: Interest, amortization, and loss on extinguishment of convertible debt, net of tax	—					—
Numerator for diluted earnings per share	**$ 264.6**					**$ 282.3**
Diluted earnings per share from continuing operations, as reported*	**$ 2.65**	**$ 0.18**	**$ (0.01)**	**$ 0.01**	**$ 0.01**	**$ 2.83**
Diluted shares used in calculation	**99.7**					

Reconciliation to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* Adjusted EPS may not sum across due to rounding.

Adjusted EPS[10] - YTD 2017

	For the Nine Months Ended September 30, 2017				
		Adjustments			
	As Reported	Mark-to-Market Adjustment for Stock Compensation Expense[27]	Loss on Early Extinguishment of Debt	Income Tax Adjustments	As Adjusted
	(In Millions, Except Per Share Amounts)				
Adjusted EBITDA	**$ 614.9**	**$ —**	**$ —**	**$ —**	**$ 614.9**
Depreciation and amortization	(137.2)	—	—	—	(137.2)
Loss on early extinguishment of debt[28]	(10.7)	—	0.3	—	(10.4)
Interest expense and amortization of debt discounts and fees	(118.5)	—	—	—	(118.5)
Stock-based compensation	(37.9)	13.9	—	—	(24.0)
Loss on disposal of assets	(3.3)	—	—	—	(3.3)
Income from continuing operations before income tax expense	307.3	13.9	0.3	—	321.5
Provision for income tax expense	(111.4)	(5.6)	(0.1)	(10.4)	(127.5)
Income from continuing operations attributable to Encompass Health	**$ 195.9**	**$ 8.3**	**$ 0.2**	**$ (10.4)**	**$ 194.0**
Add: Interest, amortization, and loss on extinguishment of convertible debt, net of tax	10.8				10.8
Numerator for diluted earnings per share	**$ 206.7**				**$ 204.8**
Diluted earnings per share from continuing operations, as reported*	**$ 2.08**	**$ 0.08**	**$ —**	**$ (0.10)**	**$ 2.07**
Diluted shares used in calculation	**99.1**				

Reconciliation to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* Adjusted EPS may not sum across due to rounding.

Adjusted EPS[10] - 2017

	For the Year Ended December 31, 2017					
		Adjustments				
	As Reported	Mark-to-Market Adjustment for Stock Compensation Expense[27]	Tax Reform Impact[26]	Loss on Early Extinguishment of Debt[28]	Income Tax Adjustments[29]	As Adjusted
	(In Millions, Except Per Share Amounts)					
Adjusted EBITDA	**$ 823.1**	**$ —**	**$ —**	**$ —**	**$ —**	**$ 823.1**
Depreciation and amortization	(183.8)	—	—	—	—	(183.8)
Loss on early extinguishment of debt[28]	(10.7)	—	—	0.3	—	(10.4)
Interest expense and amortization of debt discounts and fees	(154.4)	—	—	—	—	(154.4)
Stock-based compensation	(47.7)	13.3	—	—	—	(34.4)
Loss on disposal of assets	(4.6)	—	—	—	—	(4.6)
Tax reform impact of noncontrolling interests[26]	(4.6)	—	4.6	—	—	—
Income from continuing operations before income tax expense	417.3	13.3	4.6	0.3	—	435.5
Provision for income tax expense	(160.6)	(5.3)	1.2	(0.1)	(7.7)	(172.5)
Income from continuing operations attributable to Encompass Health	**$ 256.7**	**$ 8.0**	**$ 5.8**	**$ 0.2**	**$ (7.7)**	**$ 263.0**
Add: Interest, amortization, and loss on extinguishment of convertible debt, net of tax	10.8					10.8
Numerator for diluted earnings per share	**$ 267.5**					**$ 273.8**
Diluted earnings per share from continuing operations, as reported*	**$ 2.69**	**$ 0.08**	**$ 0.06**	**$ —**	**$ (0.08)**	**$ 2.76**
Diluted shares used in calculation	**99.3**					

Reconciliation to GAAP provided on pages 99-109. Refer to pages 111-115 for end notes.
* Adjusted EPS may not sum across due to rounding.

Adjusted Free Cash Flow History[11]

(In Millions)	Q3 2018	Q3 2017	9 Months 2018	9 Months 2017	Full Year 2017	Full Year 2016
Net cash provided by operating activities	$ 198.5	$ 174.9	$ 584.0	$ 506.9	$ 658.3	$ 634.4
Impact of discontinued operations	0.1	0.1	0.7	0.7	0.6	0.7
Net cash provided by operating activities of continuing operations	198.6	175.0	584.7	507.6	658.9	635.1
Capital expenditures for maintenance	(33.2)	(37.6)	(105.3)	(92.1)	(138.3)	(104.2)
Distributions paid to noncontrolling interests of consolidated affiliates	(21.3)	(14.2)	(56.5)	(38.3)	(51.9)	(64.9)
Items non-indicative of ongoing operating performance:						
Cash paid for professional fees – accounting, tax, and legal	–	–	–	–	–	1.9
Transaction costs and related assumed liabilities	(0.7)	–	(2.4)	–	–	0.8
Net premium on bond issuance/repayment	–	–	–	–	–	5.8
Cash paid for SARs exercise	–	–	4.3	–	–	–
Adjusted free cash flow	**$ 143.4**	**$ 123.2**	**$ 424.8**	**$ 377.2**	**$ 468.7**	**$ 474.5**
Cash dividends on common stock[12]	**$ 24.5**	**$ 23.5**	**$ 74.4**	**$ 67.0**	**$ 91.5**	**$ 83.8**

Information regarding investing and financing categories of the statement of cash flows for the periods presented can be found on Encompass Health's website in the Earnings Releases for those periods.

Net Cash Provided by Operating Activities Reconciled to Adjusted EBITDA

(In Millions)	Q3 2018	Q3 2017	9 Months 2018	9 Months 2017	Full Year 2017	Full Year 2016	Full Year 2015	Full Year 2014	Full Year 2013
Net cash provided by operating activities	$ 198.5	$ 174.9	$ 584.0	$ 506.9	$ 658.3	$ 640.2	$ 505.9	$ 458.9	$ 477.8
Professional fees — accounting, tax, and legal	—	—	—	—	—	1.9	3.0	9.3	9.5
Interest expense and amortization of debt discounts and fees	37.3	36.8	110.6	118.5	154.4	172.1	142.9	109.2	100.4
Equity in net income of nonconsolidated affiliates	2.1	2.1	6.4	6.2	8.0	9.8	8.7	10.7	11.2
Net income attributable to noncontrolling interests in continuing operations	(20.7)	(19.2)	(63.5)	(53.2)	(79.1)	(70.5)	(69.7)	(59.7)	(57.8)
Amortization of debt-related items	(1.0)	(1.0)	(3.0)	(7.7)	(8.7)	(13.8)	(14.3)	(12.7)	(5.0)
Distributions from nonconsolidated affiliates	(2.0)	(2.2)	(5.5)	(6.6)	(8.6)	(8.5)	(7.7)	(12.6)	(11.4)
Current portion of income tax expense	34.6	36.0	97.5	60.1	85.0	31.0	14.8	13.3	6.3
Change in assets and liabilities	(24.8)	(23.5)	(47.1)	(11.2)	7.4	30.1	82.7	48.8	17.1
Tax reform impact on noncontrolling interests[26]	—	—	—	—	4.6	—	—	—	—
Cash used in operating activities of discontinued operations	0.1	0.1	0.7	0.7	0.6	0.7	0.7	1.2	1.9
Transaction costs	—	—	1.0	—	—	—	12.3	9.3	—
SARS mark-to-market impact on noncontrolling interests[27]	(0.3)	—	(2.2)	—	—	—	—	—	—
Change in fair market value of equity securities[25]	0.1	—	1.1	—	—	—	—	—	—
Other	0.4	0.6	(0.8)	1.2	1.2	0.6	3.2	1.9	1.6
Adjusted EBITDA	$ 224.3	$ 204.6	$ 679.2	$ 614.9	$ 823.1	$ 793.6	$ 682.5	$ 577.6	$ 551.6

Information regarding investing and financing categories of the statement of cash flows for the periods presented can be found on Encompass Health's website in the Earnings Releases for those periods.

Share Information

	Weighted Average for the Period						
	Q3		9 Months		Full Year		
	2018	2017	2018	2017	2017	2016	2015
Basic shares outstanding[30]	98.0	97.8	97.9	92.3	93.7	89.1	89.4
Convertible perpetual preferred stock[31]	—	—	—	—	—	—	1.0
Convertible senior subordinated notes[30]	—	—	—	5.4	4.0	8.5	8.3
Restricted stock awards, dilutive stock options, restricted stock units, and common stock warrants[32]	2.0	1.2	1.8	1.4	1.6	1.9	2.3
Diluted shares outstanding	100.0	99.0	99.7	99.1	99.3	99.5	101.0

	End of Period						
	Q3		9 Months		Full Year		
(Millions)	2018	2017	2018	2017	2017	2016	2015
Basic shares outstanding[30]	98.0	97.6	98.0	97.6	97.6	88.3	89.3

End Notes

End Notes

(1) Under this program, Joint Commission accredited organizations, like the Company's IRFs, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates the Company's commitment to excellence in providing disease-specific care.

(2) Data compares Encompass Health IRFs to IRFs comprising the Uniform Data System for Medical Rehabilitation ("UDSMR"), a division of UB Foundation Activities, Inc., a data gathering and analysis organization for the rehabilitation industry which represents approximately 80% of the industry, including Encompass Health sites. Data is adjusted by applying Encompass Health IRF case-mix to non-Encompass Health UDS IRFs.

(3) Source: https://data.medicare.gov/data/home-health-compare. Data on this page was published in October 2018 and reflects OASIS and HHCAHPS Survey data collected from April 2017 through March 2018 and claims-based data collected from January 2017 through December 2017.

(4) The 126 for Encompass Health excludes the inpatient rehabilitation hospitals at Novant Health Rehabilitation Hospital, an affiliate of Encompass Health (opened October 2018), Encompass Health Rehabilitation Hospital of Hilton Head (opened June 2018), Encompass Health Rehabilitation Hospital of Shelby County (opened April 2018), and Encompass Health Rehabilitation Hospital of Pearland (opened October 2017). The 126 does include HealthSouth Rehabilitation Hospital of Fort Worth, which closed in May 2018.

(5) In 2017, the Company averaged 1,386 total Medicare and non-Medicare discharges per IRF in its then 123 consolidated IRFs that were open the full year.

(6) Case Mix Index (CMI) from the rate-setting file is adjusted for short-stay transfer cases. The Company's unadjusted CMI for 2017 was 1.36 versus 1.34 for the industry as measured by UDSMR.

(7) Source: FY 2019 CMS Final Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2016/2017) or in the case of new IRFs, the June 2018 CMS Provider of Service File.

a. All data provided was filtered and compiled from the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2019 IRF Final Rule Rate Setting File found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/FY2019_datafiles_final.zip. The data presented was developed entirely by CMS and is based on its definitions which are different in form and substance from the criteria Encompass Health uses for external reporting purposes. Because CMS does not provide its detailed methodology, Encompass Health is not able to reconstruct the CMS projections or the calculation.

b. The CMS file contains data for each of the 1,126 inpatient rehabilitation facilities used to estimate the policy updates for the FY 2019 IRF-PPS Final Rule. Most of the data represents historical information from the CMS fiscal year 2017 period and may or may not reflect the same Encompass Health hospitals in operation today. The data presented was separated into three categories: Freestanding, Units, and Encompass Health. Encompass Health is a subset of Freestanding and the Total.

(8) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.

(9) Adjusted EBITDA is a non-GAAP financial measure. The Company's leverage ratio (total consolidated debt to Adjusted EBITDA for the trailing four quarters) is, likewise, a non-GAAP measure. Management and some members of the investment community utilize Adjusted EBITDA as a financial measure and the leverage ratio as a liquidity measure on an ongoing basis. These measures are not recognized in accordance with GAAP and should not be viewed as an alternative to GAAP measures of performance or liquidity. In evaluating Adjusted EBITDA, the reader should be aware that in the future the Company may incur expenses similar to the adjustments set forth. Further explanation and disclosure relating to Adjusted EBITDA are included in the Company's Form 8-K, dated January 7, 2019, to which this Investor Reference Book is attached as Exhibit 99.2.

End Notes, con't.

(10) The Company is providing adjusted earnings per share from continuing operations attributable to Encompass Health ("adjusted earnings per share"), which is a non-GAAP measure. The Company believes the presentation of adjusted earnings per share provides useful additional information to investors because it provides better comparability of ongoing operating performance to prior periods given that it excludes the impact of government, class action, and related settlements, professional fees - accounting, tax, and legal, mark-to-market adjustments for stock appreciation rights, gains or losses related to hedging and equity instruments, loss on early extinguishment of debt, adjustments to its income tax provision (such as valuation allowance adjustments and settlements of income tax claims), items related to corporate and facility restructurings, and certain other items deemed to be non-indicative of ongoing operating performance. It is reasonable to expect that one or more of these excluded items will occur in future periods, but the amounts recognized can vary significantly from period to period and may not directly relate to the Company's ongoing operating performance. Accordingly, they can complicate comparisons of the Company's results of operations across periods and comparisons of the Company's results to those of other healthcare companies. Adjusted earnings per share should not be considered as a measure of financial performance under generally accepted accounting principles in the United States as the items excluded from it are significant components in understanding and assessing financial performance. Because adjusted earnings per share is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, it may not be comparable as presented to other similarly titled measures of other companies. Further explanation and disclosure relating to adjusted EPS are included in the Company's Form 8-K, dated January 7, 2019, to which this Investor Reference Book is attached as Exhibit 99.2.

(11) Definition of adjusted free cash flow, which is a non-GAAP measure, is net cash provided by operating activities of continuing operations minus capital expenditures for maintenance, dividends paid on preferred stock, distributions to noncontrolling interests, and certain other items deemed to be non-indicative of ongoing operating performance, including government, class action, and related settlements and transaction costs. Common stock dividends are not included in the calculation of adjusted free cash flow. Because this measure is not determined in accordance with GAAP and is susceptible to varying calculations, it may not be comparable to other similarly titled measures presented by other companies. Further explanation and disclosure relating to adjusted free cash flow are included in the Company's Form 8-K, dated January 7, 2019, to which this Investor Reference Book is attached as Exhibit 99.2.

(12) On July 21, 2016, the board of directors approved a $0.01 per share, or 4.3%, increase to the quarterly cash dividend on the Company's common stock, bringing the quarterly cash dividend to $0.24 per common share. On July 20, 2017, the board of directors approved a $0.01 per share, or 4.2%, increase to the quarterly cash dividend on the Company's common stock, bringing the quarterly cash dividend to $0.25 per common share. On July 24, 2018, the board of directors approved a $0.02 per share, or 8.0%, increase to the quarterly cash dividend on the Company's common stock, bringing the quarterly cash dividend to $0.27 per common share.

(13) On October 28, 2013, the Company announced its board of directors authorized the repurchase of up to $200 million of its common stock. On February 14, 2014, the Company's board approved an increase in this common stock repurchase authorization from $200 million to $250 million. As of June 30, 2018, the remaining repurchase authorization was approximately $58 million. On July 24, 2018, the Company's board approved resetting the aggregate common stock repurchase authorization to $250 million. As of December 31, 2018, the remaining repurchase authorization was $250 million.

(14) Beginning in FY 2020, CMS will no longer utilize the functional assessment items contained in the FIM™ instrument as part of the IRF Patient Assessment Instrument. This will affect patients' classification into case-mix groupings and length-of-stay values under the IRF-PPS. CMS will be further modifying the case-mix groupings, length-of-stay values and other definitions in the FY 2020 Notice of Proposed Rulemaking after incorporating a second year of data in its regression modeling. At present, we are unable to determine the impact the changes to the case-mix classification system starting in FY 2020 would have on Medicare payments beginning October 1, 2019.

End Notes, con't.

(15) The Bipartisan Budget Act ("BBA") of 2018, signed into law on February 9, 2018, provides for a home health market basket update of 1.5% for CY 2020 and the elimination of any productivity adjustment to the market basket for that year. It also provides for the extension of the rural add-on adjustment through 2022, albeit declining in amount along the way. Additionally, it requires that a new case mix payment model be introduced in 2020 that would be based on a 30-day unit of service, not include therapy thresholds as a component of the system, and be implemented in a budget neutral manner. On October 31, 2018, CMS released its Notice of Final Rulemaking for CY 2019, which finalizes significant changes to the HH-PPS that would be effective on or after January 1, 2020. These changes would include the implementation of a new home health payment system, called the Patient-Driven Groupings Model ("PDGM"), as mandated by the BBA of 2018 discussed above. The PDGM would use 30-day payment periods and rely more heavily on clinical characteristics and other patient information (such as principal diagnosis, functional level, referral source, and timing), rather than the current therapy service-use thresholds, to set payments. It is too early to assess the potential effect of PDGM on our business in 2020. The details of the rule are likely to change before the rule goes into effect. We cannot at this time assess potential changes to our patient mix between now and 2020. Current projections do not account for actions we may take to adapt to the rule. To achieve budget neutrality, CMS assumed behavioral changes will offset a 6.4% reduction in the base rate. Based on 2017 data, and assuming no change in the foregoing and other factors, which are subject to potentially significant change, we estimate an approximate 5.1% incremental reduction in Medicare payments assuming the PDGM is implemented on a budget neutral basis. We are unable to assess the likelihood or effect of these potential behavioral changes.

(16) The Company estimates the expected impact of each rule utilizing, among other things, the acuity of its patients over the 8-month (home health segment) to 12-month (inpatient rehabilitation segment) period prior to each rule's release and incorporates other adjustments included in each rule. These estimates are prior to the impact of sequestration.

(17) Quality reporting requirements and potential penalties were enabled for IRFs as part of the Healthcare Reform Bill (PPACA). The IMPACT Act of 2014 requires additional quality and clinical data reporting for IRFs to be subject to the original 2% penalty.

(18) Pre-opening expenses include expenses for training new employees on the clinical information system, which vary based on the timing of the first admission.

(19) The leverage ratio is based on trailing four quarters of Adjusted EBITDA.

(20) Represents discharges from 128 consolidated hospitals in Q3 2018; 127 consolidated hospitals in Q2 2018; 126 consolidated hospitals in Q1 2018 and Q4 2017; 125 consolidated hospitals in Q3 2017; 124 consolidated hospitals in Q2 2017; and 122 consolidated hospitals in Q1 2017

(21) Full-time equivalents included in the table represent Encompass Health employees who participate in or support the operations of our hospitals and include an estimate of full-time equivalents related to contract labor.

(22) Employees per occupied bed, or "EPOB," is calculated by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by the Company's occupancy percentage.

(23) Represents home health admissions from 214 consolidated locations in Q3 2018; 213 consolidated locations in Q2 2018; 196 consolidated locations in Q1 2018; 198 consolidated locations in Q4 2017; 196 consolidated locations in Q3 2017; and 191 consolidated locations in Q2 2017 and Q1 2017

(24) Represents hospice admissions from 57 locations in Q3 2018 and Q2 2018; 38 locations in Q1 2018; 37 locations in Q4 2017, Q3 2017 and Q2 2017; and 35 locations in Q1 2017

(25) During the first quarter of 2018, the Company adopted Accounting Standards Update No. 2016-01, "Financial Instruments - Overall (Topic 825): Recognition and Measurement of Financial Assets and Liabilities," and began recognizing mark-to-market gains and losses associated with available-for-sale securities through net income instead of accumulated other comprehensive income.

End Notes, con't.

(26) The application of the lower income tax rate that resulted from the Tax Cuts and Jobs Act to the Company's net deferred tax assets resulted in a net $1.2 million increase in tax expense in Q4 2017. Application of the new tax rate to the Company's joint venture entities' deferred tax liabilities resulted in a net reduction in tax expense in Q4 2017. The Company's joint venture partners' share of this net tax benefit was $4.6 million, which resulted in an increase in noncontrolling interest expense in Q4 2017.

(27) In connection with the acquisition of Encompass Home Health & Hospice, the Company granted stock appreciation rights based on the fair value of the common stock of HealthSouth Home Health Holdings, Inc. to certain members of Encompass Home Health & Hospice management. The fair value of Holdings' common stock is the amount by which the product of the trailing 12-month adjusted EBITDA for Holdings and the median market EBITDA multiple based on a basket of public home health companies and certain public home health acquisition transactions exceeds the initial fair value assigned to the Holdings' stock. The fair value also takes into consideration the balance of the intercompany note in place and the net debt of Holdings. The fair value of these SARs will vary from period to period primarily based on the performance of the Company's home health and hospice segment and the change in the median market multiple. Half of the SARs vest of January 1, 2019, and the other half vest on January 1, 2020. Once vested, they are exercisable until they expire on December 31, 2024 or in connection with termination of employment. As of September 30, 2018, the fair value of the SARs was approximately $75 million.

(28) The interest and amortization and the loss on early extinguishment of debt related to the convertible senior subordinated notes must be added to income from continuing operations when calculating diluted earnings per share because the debt was assumed to have been converted at the beginning of the period, and the applicable shares were included in the diluted share count.

(29) New guidance in ASU 2016-09, "Improvements to Employee Share-Based Payment Accounting," requires entities to record all of the tax effects related to share-based payment at settlement (or expiration) through the income statement. Historically, the Company recorded such tax effects to equity.

(30) In November 2013, the Company closed separate, privately negotiated exchanges in which it issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of its 6.5% Series A Convertible Perpetual Preferred Stock. The Company recorded ~$249 million as debt and ~$71 million as equity. In May 2017, the Company provided notice of its intent to redeem all $320 million of outstanding convertible notes. In lieu of receiving the redemption price, the holders had the right to convert their notes into shares of the Company's common stock at a conversion rate of 27.2221 shares per $1,000 principal amount of Notes, which rate was increased by a make-whole premium. In the aggregate, holders of $319.4 million in principal elected to convert, which resulted in the Company issuing 8,895,483 shares of common stock (approximately 8.6 million shares were previously included in the diluted share count). The remaining $0.6 million of principal was redeemed by cash payment.

(31) In March 2006, the Company completed the sale of 400,000 shares of its 6.5% Series A Convertible Perpetual Preferred Stock. In Q4 2013, the Company exchanged $320 million of newly issued 2.0% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of its outstanding preferred stock. In April 2015, the Company exercised its rights to force conversion of all outstanding shares of its preferred stock. On the conversion date, each outstanding share of preferred stock was converted into 33.9905 shares of common stock, resulting in the issuance of 3,271,415 shares of common stock.

(32) The agreement to settle the Company's class action securities litigation received final court approval in January 2007. The 5.0 million shares of common stock and warrants to purchase ~8.2 million shares of common stock at a strike price of $41.40 (expired January 17, 2017) related to this settlement were issued on September 30, 2009. The 5.0 million common shares are included in the basic outstanding shares. The warrants were not included in the diluted share count prior to 2015 because the strike price had historically been above the market price. In full-year 2016, zero shares related to the warrants were included in the diluted share count due to antidilution based on the stock price.