Investor Reference Book

Published: May 31, 2023

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 the business outlook and guidance, labor availability and costs, legislative and regulatory developments, addressable market, strategy, capital expenditures, acquisition and other development activities, such as the de novo pipeline, costs, growth and timelines, operational initiatives, dividend strategies, leverage, access to capital, financial performance, financial assumptions, business model, balance sheet and cash flow plans, and market share. 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, 2022 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, and adjusted free cash flow. Schedules are attached that reconcile the non-GAAP financial measures included in the 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 May 31, 2023, to which the Investor Reference Book is attached as Exhibit 99.1, provides further explanation and disclosure regarding Encompass Health's use of non-GAAP financial measures and should be read in conjunction with the Investor Reference Book.

Table of contents

Glossary of terms and abbreviations

Medicare

- Medicare refers to traditional Medicare / Medicare Fee-for-Service (FFS) programs.

Medicare Advantage ("MA")

- Medicare Advantage may also be referred to as Medicare Managed Care or Medicare Part C and refers to the private health plans contracted by Medicare as an alternative to traditional Medicare programs.

Return on Invested Capital ("ROIC")

- ROIC is measured using hospital-level EBIT (earnings before interest and taxes) and applying an assumed marginal tax rate, i.e., EBIT * (1 - marginal tax rate), divided by the hospital's average net assets for the same period.

Abbreviations

- Accountable Care Organization ("ACO")
- Bundled Payments for Care Improvement ("BPCI")
- Case Mix Group ("CMG")
- Centers for Medicare and Medicaid Services ("CMS")
- Certificate of Need ("CON")
- Comprehensive Care for Joint Replacement ("CJR")
- Home Health ("HH")
- Inpatient Rehabilitation Facility ("IRF")("hospital")
- Public Health Emergency ("PHE")
- Quality Reporting Program ("QRP")
- Real Estate Investment Trust ("REIT")
- Skilled Nursing Facility ("SNF")

Business Outlook

Business outlook | Strong and sustainable business fundamentals

Attractive healthcare sector

- Large addressable market indicated by low conversion rate of presumptively eligible inpatient rehabilitation patients
- Aging demographic driving increased demand for rehabilitation services
- Supply of licensed IRF beds increased only modestly over the past decade
- High acuity, nondiscretionary conditions treated
- Fragmented sector presents unit acquisition and joint venture opportunities
- Significant barriers to entry

Industry leading position

Encompass Health is uniquely positioned to grow the market and capture incremental share

- Largest provider of inpatient rehabilitation services
- Unparalleled clinical expertise for treating inpatient rehabilitation conditions with consistent delivery of high-quality, cost-effective care
- Enhanced utilization of technology (e.g., clinical, data analytics, and technology-enabled business processes)
- Economies related to scale and market density
- Ability to fund capacity expansions primarily with internally generated funds
- Management experience and depth
- Attractive financial returns on de novo and bed addition investments
- Successful long-standing acute care hospital joint venture strategy

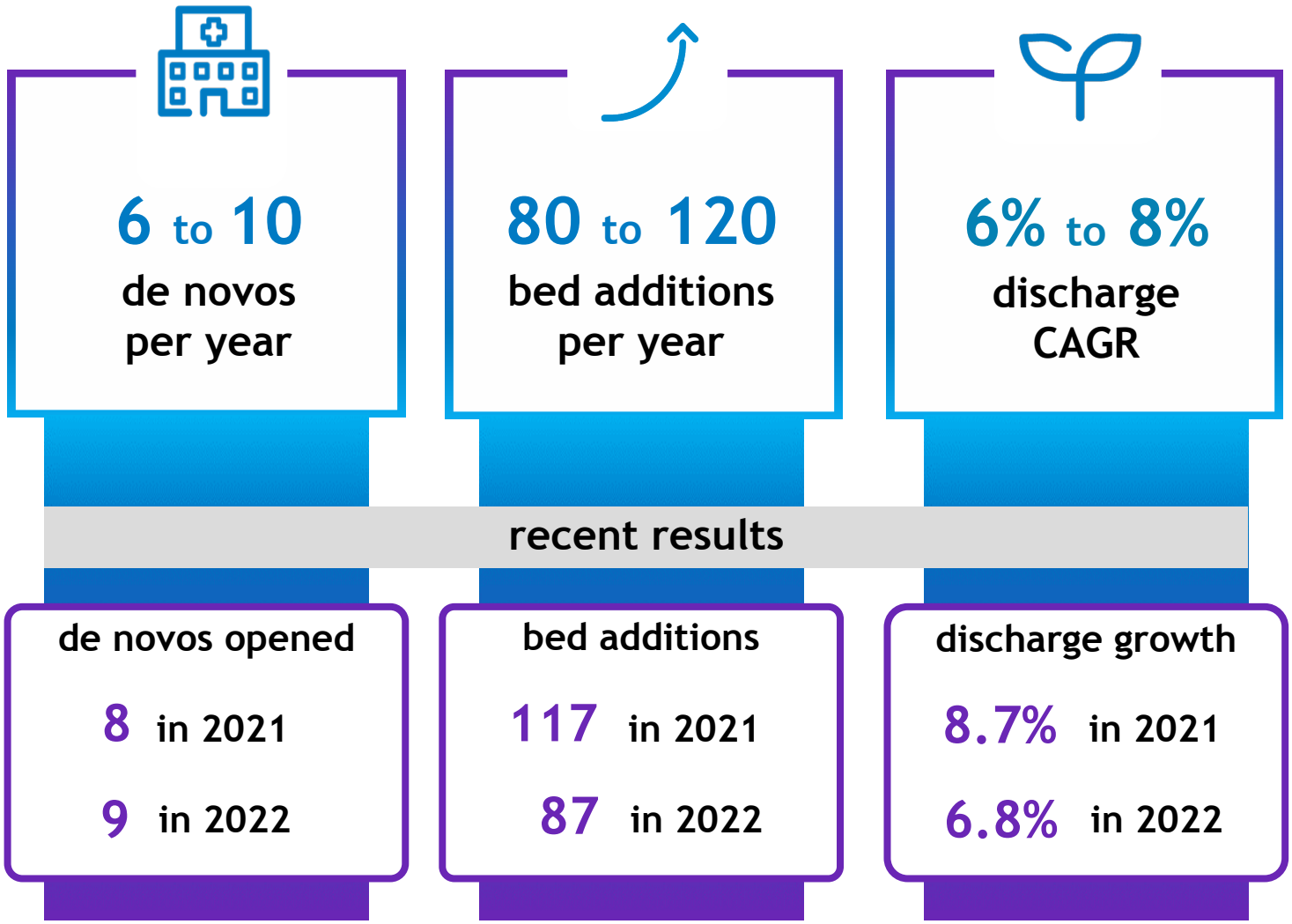
Real estate ownership

- Portfolio of 157 IRFs as of April 27, 2023
  - ✓ 120 owned and 37 leased
  - ✓ Owned real estate is not exposed to annual lease expense increases
  - ✓ Ability to customize building design to EHC specifications; promotes construction and operational efficiencies
  - ✓ Greater flexibility in managing hospital portfolio

Financial strength

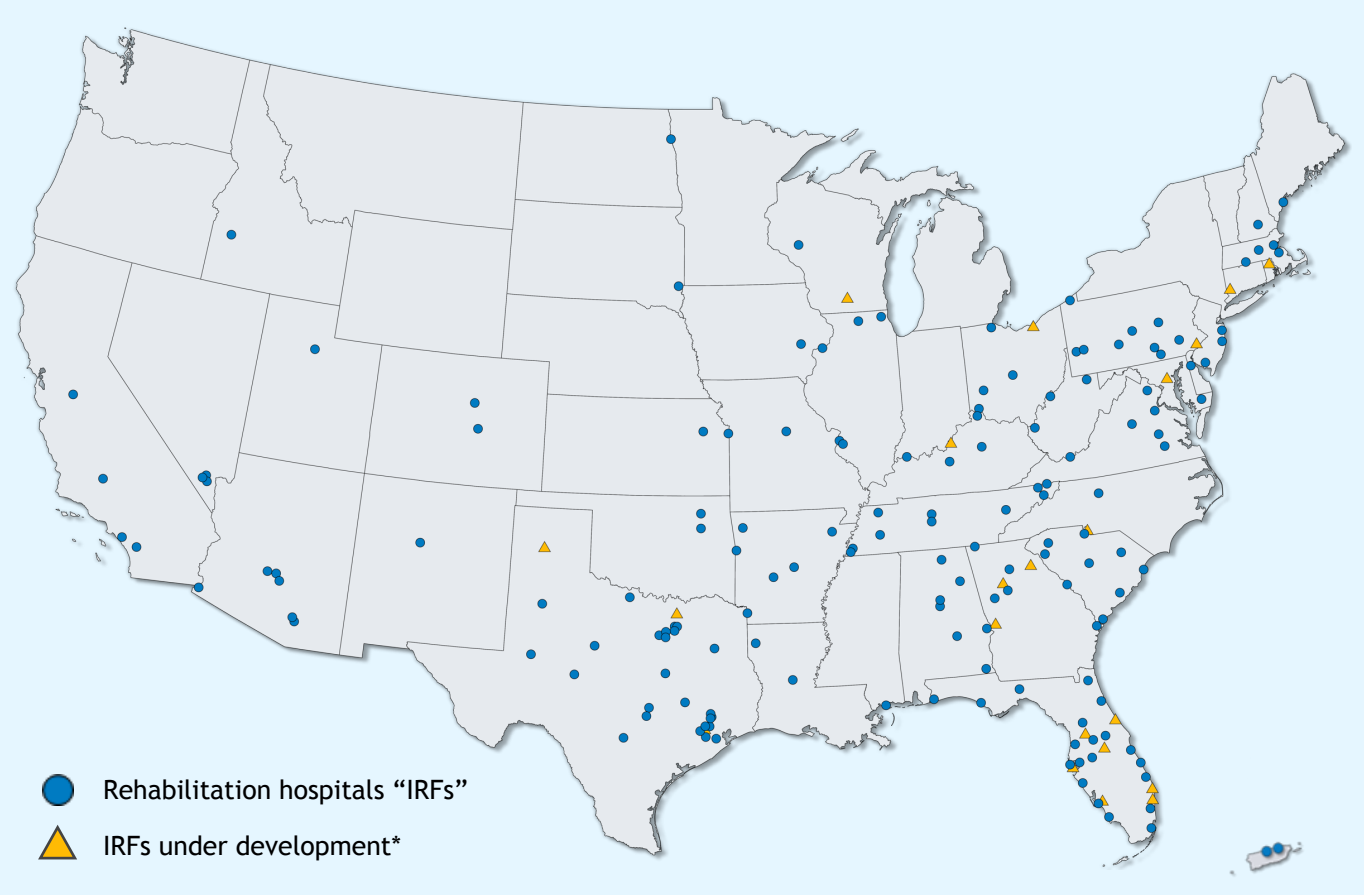
- Well-managed balance sheet and liquidity
  - ✓ No significant near-term maturities (credit agreement matures in 2027; bonds mature in 2025 and beyond)
  - ✓ $926 million available for borrowing on our $1 billion revolving credit facility (as of March 31, 2023)
- Substantial free cash flow generation
- Cash dividend paid on common stock since 2013

Business outlook | 2023 - 2027 Growth targets



Company Overview

Company overview | Largest owner and operator of IRFs



Recent expansion 2020 - 2022

21	de novo hospitals opened
321	beds added to existing hospitals
1,251	total beds added
12.0% increase in licensed beds	

2022 key statistics

~211,100	patient discharges
~$4.35	billion in revenue
6.8%	total discharge growth

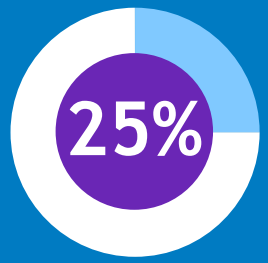
Modern Healthcare Best Places to Work 2022™

~35,000 employees

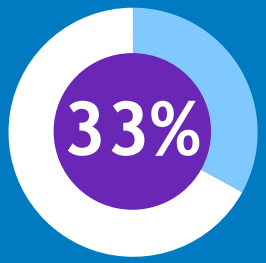
FORTUNE® "World's Most Admired Companies" 2022

*IRFs under development - previously announced under development as of April 27, 2023

Company overview | Largest owner and operator of IRFs



of all licensed beds†



of all Medicare patients served†

37
States & Puerto Rico

157
Inpatient rehabilitation hospitals

61
Operate as joint ventures with acute care hospitals

132
Hospitals hold one or more disease-specific certifications(1)

Clinical expertise in Joint Commission specialty accreditations*

Number of EHC hospitals with accreditation and EHC's % of all such accreditations

- Stroke rehabilitation accreditations - 132 EHC hospitals (~63%)
- Hip fracture rehabilitation accreditations - 59 EHC hospitals (~94%)
- Brain injury rehabilitation accreditations - 48 EHC hospitals (~76%)
- Amputee rehabilitation accreditations - 35 EHC hospitals (~80%)

† Based on 2021 and 2022 data.
Refer to pages 62-64 for end notes.

*Data as of May 15, 2023.

Inpatient rehabilitation hospitals

Encompass Health provides advanced therapy and nursing services to patients requiring intensive inpatient rehabilitative care.

Primary services include:

- Independent physician oversight of plan of care
- 24/7 nursing care
- Intensive multi-disciplinary therapy
- Extensive clinical support services

Company overview | Care delivery model

Independent physicians

Independent physicians manage and treat medical conditions as well as oversee the plan of care and medical rehabilitation program. Physician services include:

- Review and approve pre-admission screenings
- Develop an individualized overall plan of care
- At least three face-to-face rehabilitation physician visits per week
- Lead Team Conference
- Manage discharge planning (timing and destination)

Rehabilitation nursing

(CRRN, RN, LPN, LVN, CNA)

Onsite 24/7- assist patients by helping restore, maintain, and promote optimal health. Provide personal care including:

- Daily/ongoing care
- Medication dispensing
- Wound care
- Infection control
- Patient transfers from bed to wheelchair, bed to restroom, etc.

Intensive multi-dimensional therapy

Patients generally receive at least 3 hours of therapy per day at least 5 days per week; by 2 or more therapy disciplines:

- **Physical therapists -** address physical function, mobility, strength, balance, and safety
- **Occupational therapists** - promote independence through activities of daily living
- **Speech-language therapists -** address speech/voice functions, swallowing, memory/cognition, and language/communication

Clinical support services

- **Case managers -** coordinate the care plan with the physician as well as the interdisciplinary team; serve as facilitators of Team Conference and work with patients, families and communities to ensure the patient has what is needed when they arrive home
- **Pharmacists** - reconcile medications at admission and discharge, dispense medications during patient stay and assist clinicians with pain management strategies
- **Respiratory therapists -** provide care and cardio-pulmonary medicine to patients with acute critical conditions and cardiac and pulmonary disease enabling them to tolerate intensive multi-disciplinary therapy
- **In-house dialysis** - offered at 64 Encompass hospitals as of March 31, 2023; further roll out will continue in 2023. Reduces disruption to therapy regimen and leads to increased patient satisfaction
- **Dietetics and nutrition services** - provide nutritional guidance and oversight with respect to each patient's dietary needs

Company overview | Our patients

Admissions

IRF admission criteria	At the time of admission, a patient must: • require the active and ongoing therapeutic intervention of multiple therapy disciplines • be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program • receive supervision by a physician through face-to-face visits at least three days a week
	At least 60% of patients must have at least one CMS-13 medical diagnosis or functional impairment
Average age of EHC patients	All payors = 71 years old
	Medicare FFS = 76 years old
EHC IRF admission sources	91% - acute care hospitals
	7% - physician offices / community
	2% - skilled nursing facilities

Patient mix

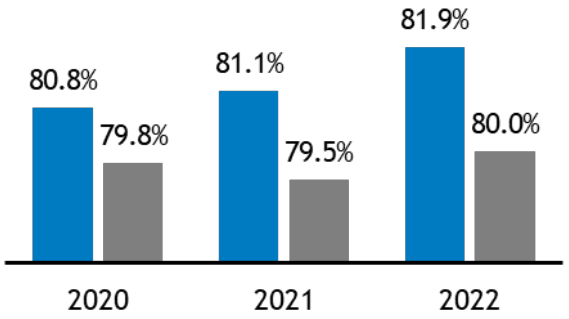
Rehabilitation impairment category ("RIC")		2022
RIC 01	Stroke	18.6 %
RIC 02/03	Brain dysfunction	11.2 %
RIC 04/05	Spinal cord dysfunction	4.0 %
RIC 06	Neurological conditions	21.7 %
RIC 07	Fracture of lower extremity	7.9 %
RIC 08	Replacement of lower extremity joint	3.0 %
RIC 09	Other orthopedic	6.9 %
RIC 10/11	Amputation	2.7 %
RIC 14	Cardiac	4.2 %
RIC 17/18	Major multiple trauma	5.9 %
RIC 20	Other disabling impairments	11.5 %
—	All other RICs	2.4 %

While 91% of EHC admissions come from acute care hospital discharges, only ~4% of nationwide acute care hospital discharges are admitted to an IRF.*

*Source: FORVIS reporting on 2021 Medicare claims data.

Company overview | High quality clinical results

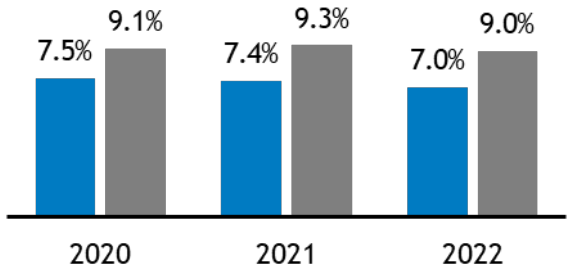
Discharge to Community



Higher is better

Percent of patients discharged to the community, including home or home with home health.

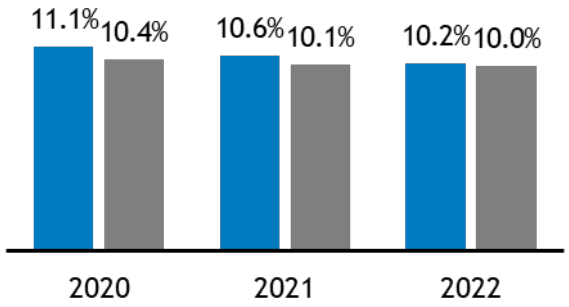
Discharge to SNF



Lower is better

Percent of patients discharged to a skilled nursing facility.

Discharge to Acute Care



Lower is better

Percent of patients discharged to an acute care hospital.

Encompass Health

UDSMR[(2)]

The above UDSMR measures include IRF units that are located within acute care hospitals.

Company overview | Leading position in cost effectiveness

	# of IRFs	Avg. beds per IRF	Avg. Medicare discharges per IRF[4]	Avg. est. total cost per discharge for FY 2024	Avg. est. total payment per discharge for FY 2024
Encompass Health[3] =	152	67	833	$16,627	$24,307
Free-standing = (Non-Encompass Health)	196	57	530	$22,351	$26,378
Hospital units =	779	24	196	$26,240	$27,027
Total[5]	1,127	36	340	$22,010	$25,952

Medicare FFS pays Encompass Health less per discharge, on average, in spite of comparable acuity

Encompass Health produces high-quality, cost-effective outcomes through:

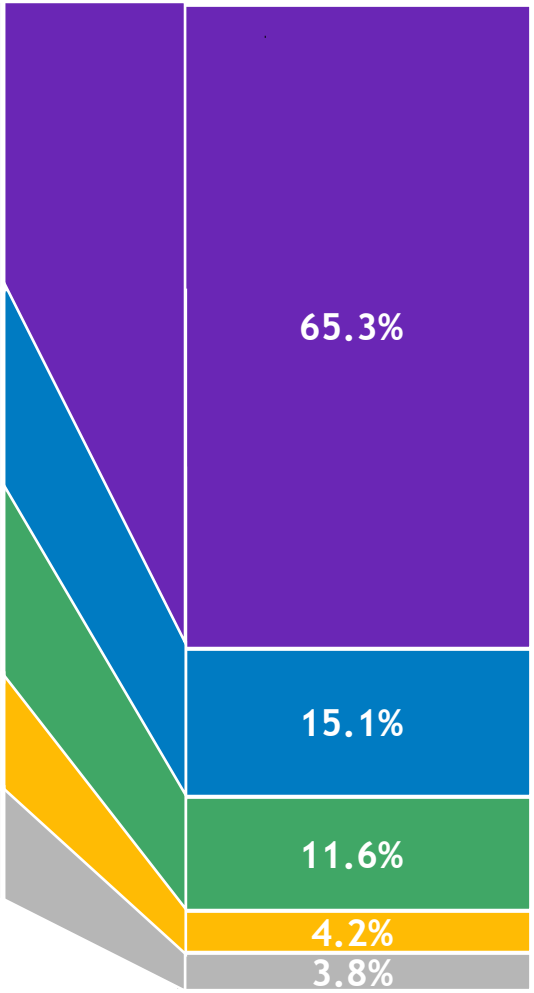
- *"Best Practices" clinical protocols*
- *Supply chain efficiencies*
- *Sophisticated management information systems*
- *Economies of scale*

- The average estimated total payment per discharge, as stated, does not reflect a 2% reduction for sequestration[6].

Refer to pages 62-64 for end notes.

Company overview | Payors and payment methods

Payor source	Payment methodology	% of 2022 Revenues
Medicare	**Prospective Payment System ("PPS")** - paid per discharge by Case Mix Group ("CMG")	65.3%
Medicare Advantage	**CMG or per diem** - Negotiated rate - Some are "tiered" for acuity/severity	15.1%
Managed Care	**Per diem or CMG** - Negotiated rate - Some are "tiered" for acuity/severity	11.6%
Medicaid	**Varies by state**	4.2%
Other	**Variety of methodologies**	3.8%



Disciplined approach to new store growth

Considerations for entering a new market:

- Market demographics and growth potential
- CON requirements (initial and for expansion)
- Presence of other inpatient rehabilitation services
- Acute care hospital presence and discharge patterns
- Geographic proximity to other Encompass hospitals
- Potential joint venture partners
- Major MA and Managed Care plans
- Clinical labor availability and costs
- Capital investment required (e.g., local market land and construction costs)

Typical development pipeline

Project category	Exploratory/ CA executed*	Active development	Annual openings
Number of projects	40 - 60	20 - 30	6 - 10

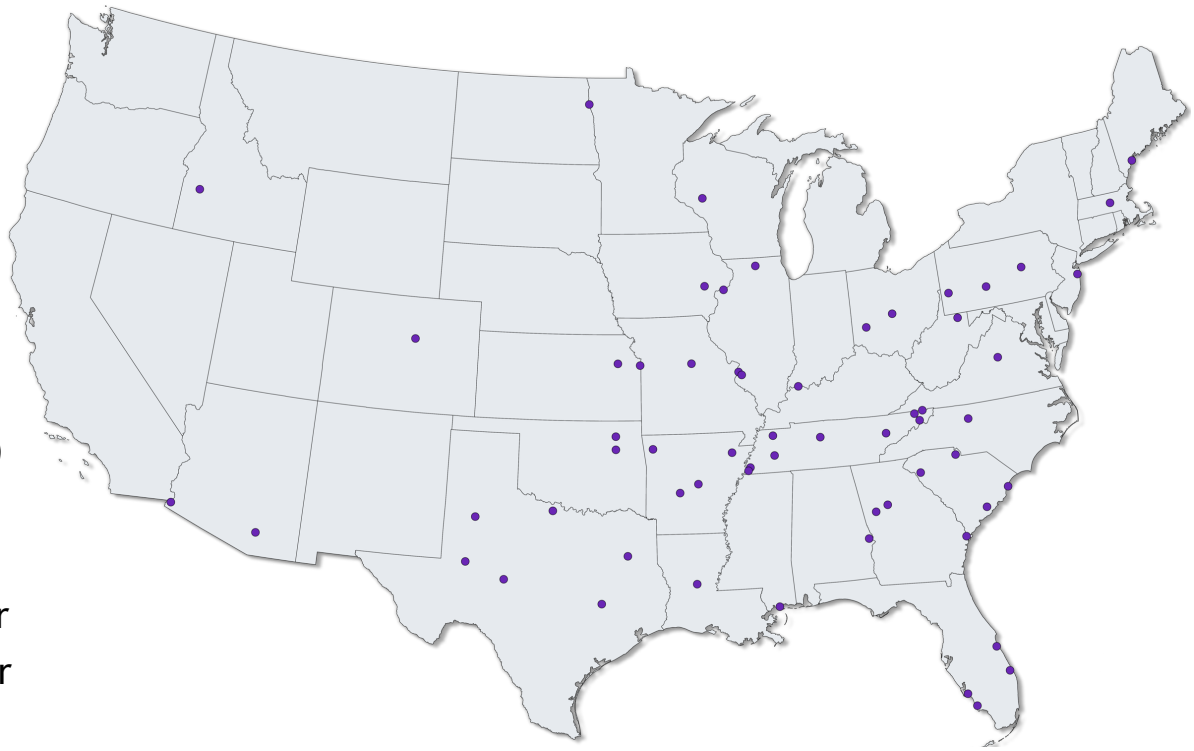
*CA = confidentiality agreement.

Company overview | Joint venture partnerships with acute care providers

The Company's joint ventures began in 1991 with Vanderbilt University Medical Center

61 joint venture hospitals in place with major healthcare systems including:

- Ascension St. John Hospital System
- Ballad Health
- Barnes-Jewish
- Cleveland Clinic Martin Health
- Geisinger Health System
- Lee Health subsidiary
- Monmouth Medical Center (RWJBarnabas Health)
- NCH Healthcare System (Naples, FL)
- Novant Health
- Piedmont Healthcare
- University of Virginia Medical Center
- Vanderbilt University Medical Center



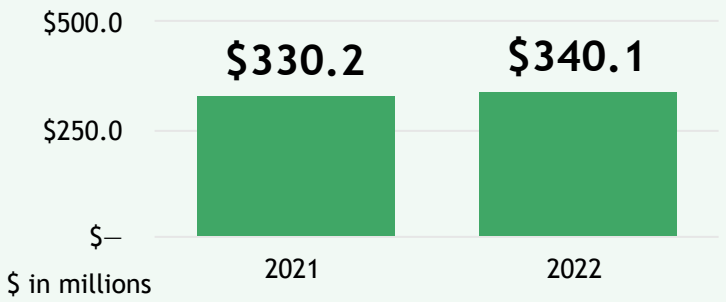
Joint ventures with acute care hospitals facilitate integrated care delivery

Company overview | Cash flow and liquidity

Adjusted Free Cash Flow*[7]

Able to fund our growth primarily through free cash flow (FCF)

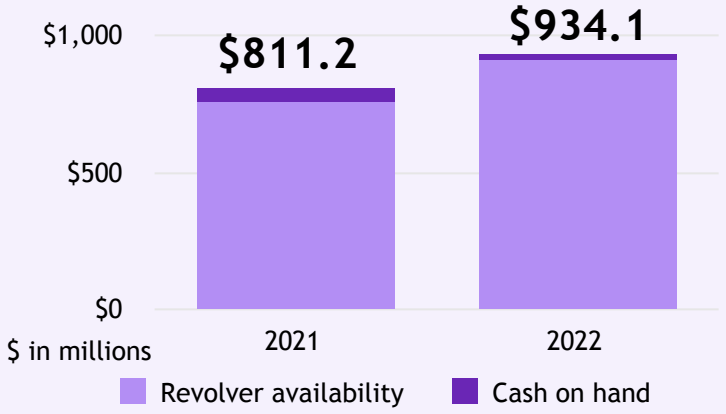
- De novos
- Bed additions
- Replacement IRFs
- FCF is after maintenance capex, before discretionary capex



Liquidity*

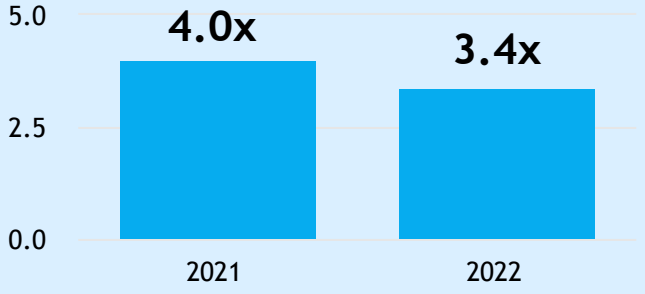
Ensure sufficient liquidity to meet the anticipated operating and strategic needs of the Company

- Liquidity - defined as cash on hand and revolver availability
- Credit facility - a diverse group of well-capitalized lenders in the senior credit facility



Leverage Ratio*

- Leverage ratio = Total Debt / LTM Adjusted EBITDA[8]
- Debt duration - limited near term refinancing risk
- Floating rate debt - very limited exposure

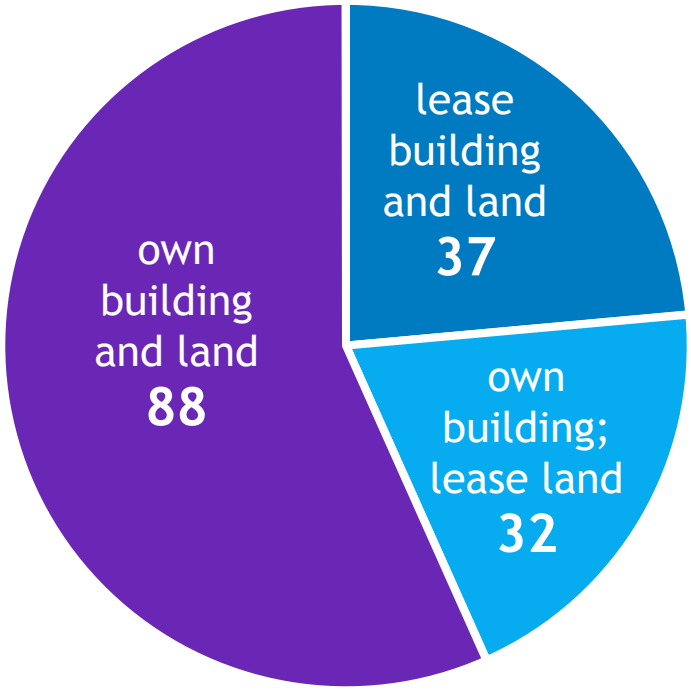


*Historical financial results reflect Enhabit Home Health and Hospice as discontinued operations.

Refer to pages 62-64 for end notes.

Company overview | Real estate holdings

Preference of ownership



6,285 (60%)	4,275 (40%)
licensed beds in non-CON states	licensed beds in CON states

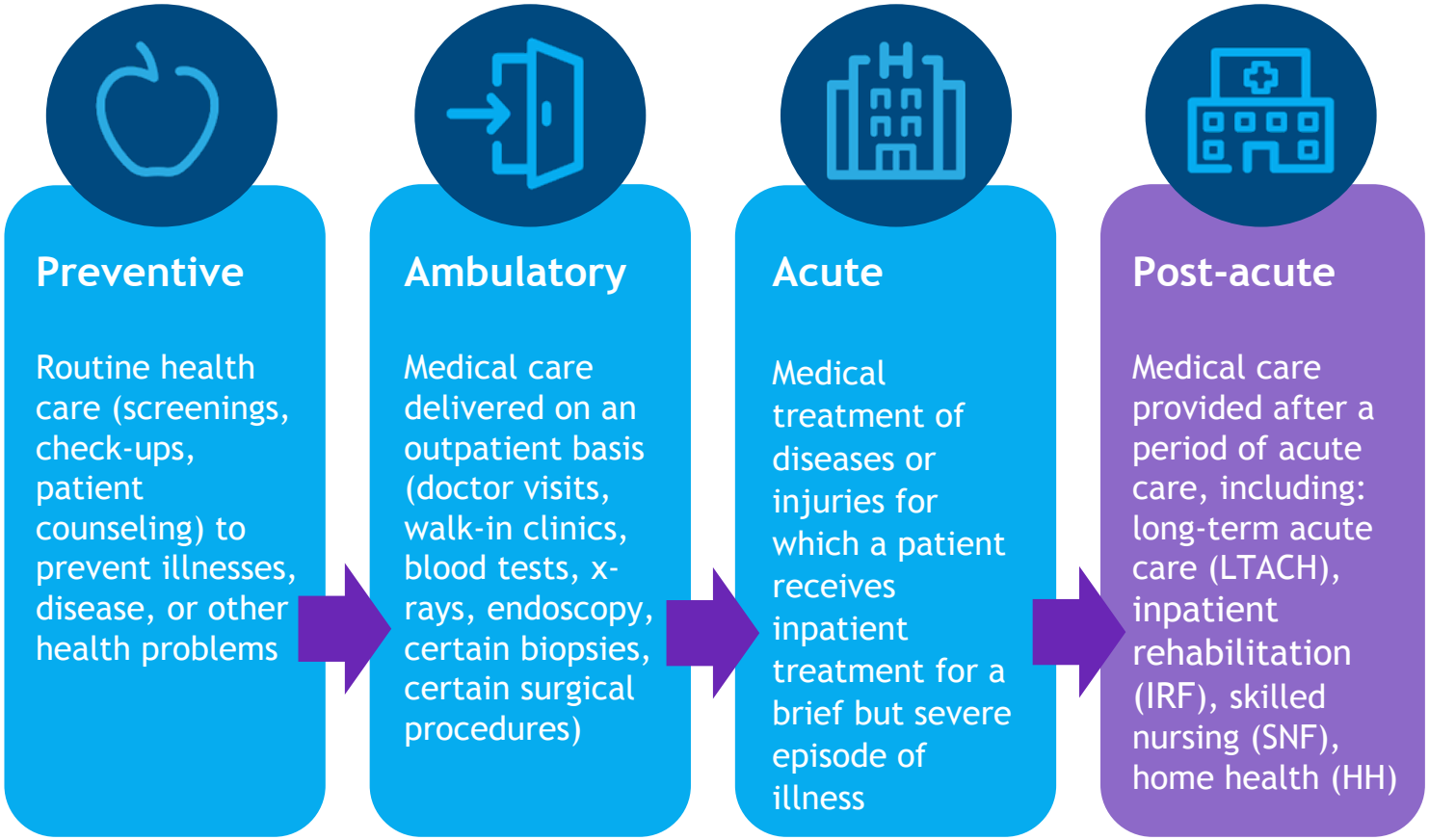
Own ~76% of IRF real estate

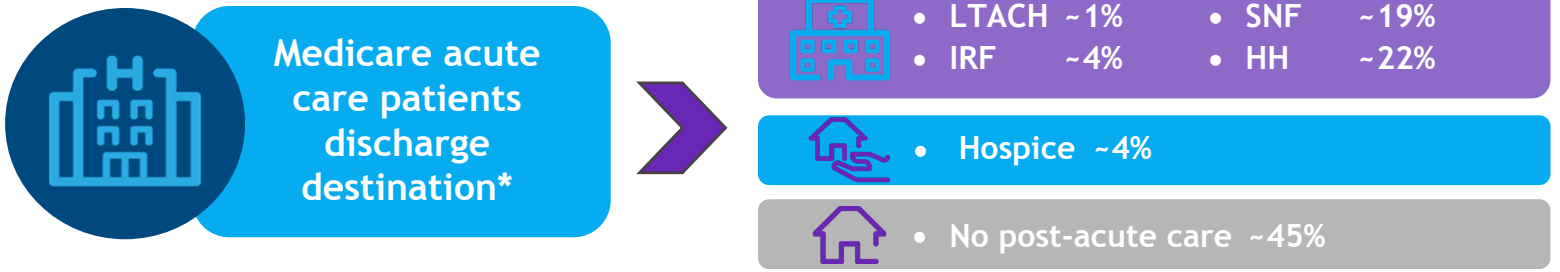
Rationale for real estate ownership

- Leases are effectively structured as long-term, fixed rate, non-prepayable debt with annual rent escalators
- Ownership providers greater flexibilty in managing real estate portfolio
- Presence of real estate on our balance sheet facilitates access to senior debt on attractive terms
- Specialty nature of our facilities contributes to relatively high cap rates from REITs
- We are better positioned than traditional financing sources to hold the residual risk in our properties

Industry Overview

Industry overview | Continuum of healthcare services



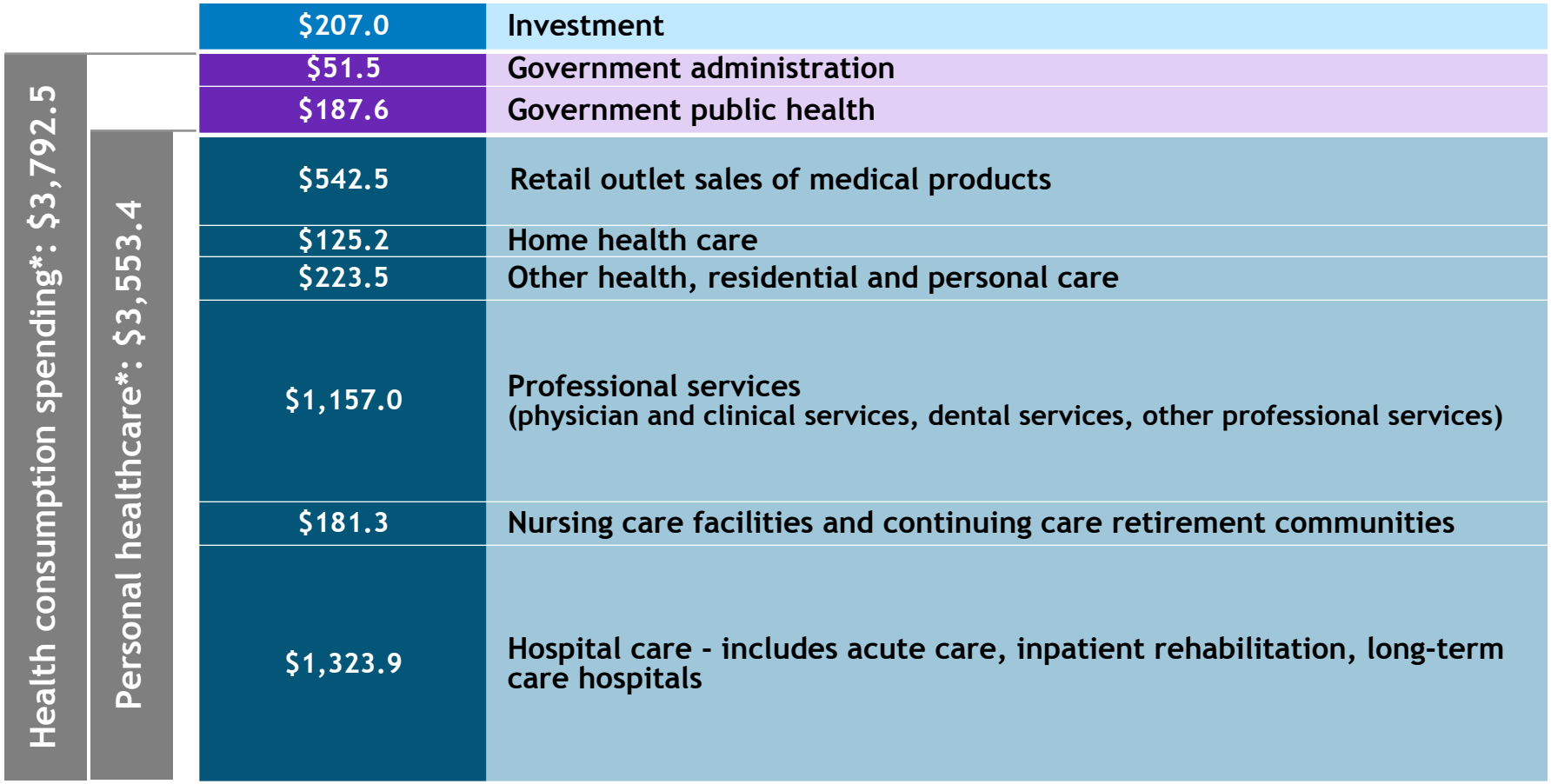


* Source: FORVIS reporting on 2021 Medicare claims data. Other discharge destinations (~5%) may include another acute care hospital, specialty hospital, or other destinations.

Industry overview | Total healthcare spending

National healthcare spending: $4.255 trillion in 2021

(in billions)



Healthcare consumption spending includes total spending on healthcare goods and services excluding investments. Investments include non-commercial research and academic investments (including the purchase of buildings and equipment for such research).

Source: Centers for Medicare & Medicaid Services, National Health Expenditure Data (Historical), Table 2 - 2021.
* Excludes Net Cost of Private Health Insurance of $255.7 billion.

Industry overview | Medicare 2021 spending

Total Medicare spending $839 billion	Medicare spending on inpatient rehabilitation $8.5 billion *(~1% of all Medicare spending)*

	% of Medicare spend	
$29B Skilled nursing	3%	Medicare Part A
$145B Inpatient hospital (includes IRF)	17%	
$74B Physician payments	9%	Medicare Part B
$65B Outpatient hospital	8%	
$17B Home health	2%	Medicare Parts A & B
$23B Hospice	3%	
$32B Other services	4%	
$350B Medicare managed care* **Medicare managed care / Medicare Advantage plans also pay for the services listed on this page*	42%	Medicare Part C
$104B Outpatient Rx	12%	Medicare Part D

Source: Centers for Medicare & Medicaid Services, Medicare Trustees' Report 2022 – page 12; and MedPAC, Medicare Payment Policy, March 2023 - pages 203, 237, 259 and 285.

Industry overview | Post-acute Medicare care services

	Inpatient rehabilitation hospital	Skilled nursing facility	Home health
Medicare spending ($ billions)	$8.5	$28.5	$16.9*
# of Discharges/Beneficiaries^	~379,000	~1,700,000	~3,000,000^
Average length of stay	12.9 days	34.5 days	N/A
# of Providers	~1,181	~14,700	~11,474
Facility ownership mix**	For-profit (37%) Non-profit (53%) Gov't (10%)	For-profit (72%) Non-profit (23%) Gov't (5%)	For-profit (88%) Non-profit (12%)
Freestanding vs. hospital based	Freestanding (28%) Hospital based (72%)	Freestanding (97%) Hospital based (3%)	Freestanding (87%) Hospital based (13%)
Rural vs. urban**	Urban (86%) Rural (14%)	Urban (73%) Rural (27%)	Urban (85%) Rural (15%)

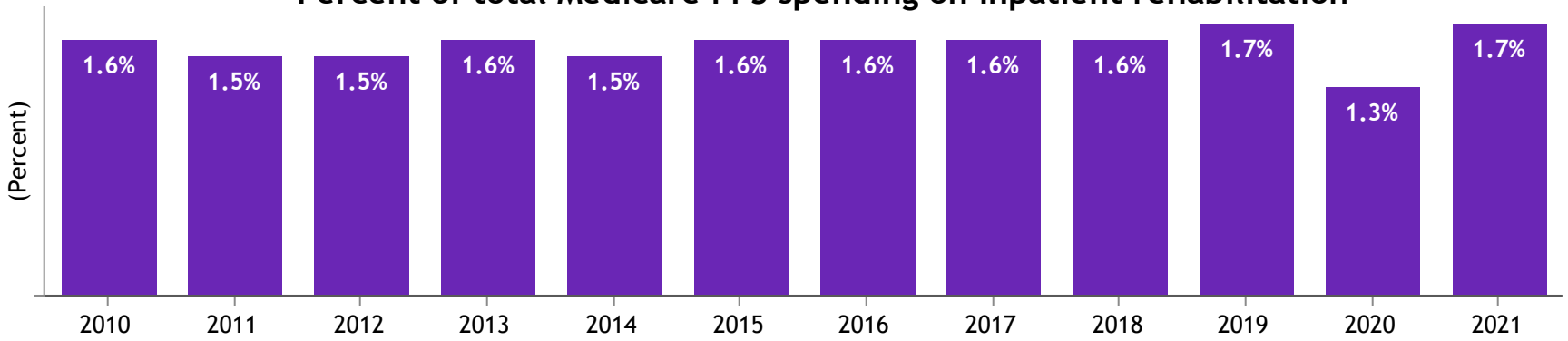
* Not all home health spending occurs as a post-acute service.
**Home health data represents freestanding agencies only.

Source: MedPAC, Medicare Payment Policy, March 2023 - pages 203, 208, 222, 237, 249, 259, 263 and 266; MedPAC, Health Care Spending and the Medicare Program, July 2022 - page 106.

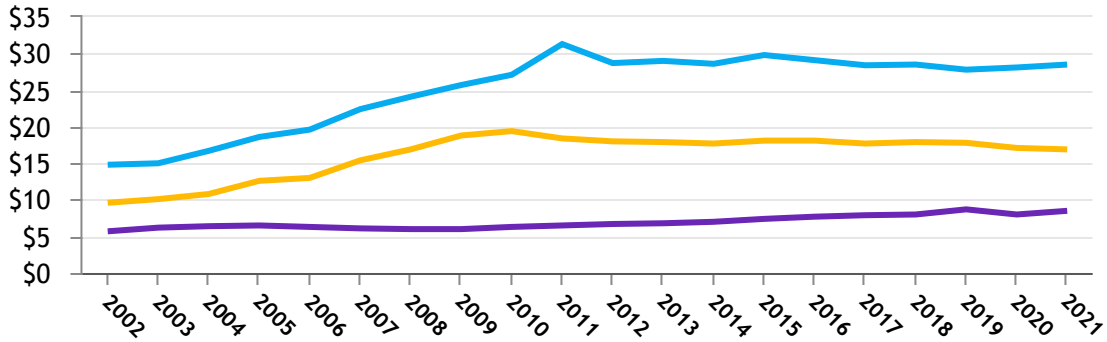
Industry overview | Medicare spending on post-acute services

Medicare spent ~ $54 billion on post-acute services in 2021 (IRF, SNF, HH)

Percent of total Medicare FFS spending on inpatient rehabilitation



Medicare spending on post-acute services



Post-Acute setting	2002 Spending	2021 Spending
Skilled nursing facilities	$14.8	$28.5
Home health agencies*	$9.6	$16.9
Inpatient rehabilitation hospitals	$5.7	$8.5

$ in billions

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

Source: MedPAC, Medicare Payment Policy, March 2023 - pages 203, 237 and 259 Centers for Medicare and Medicaid Services, Medicare Trustees' Report 2022 - page 12.

Industry overview | IRF qualifying conditions

CMS requires that 60% of an IRF's admissions must have at least one medical diagnosis or functional impairment from a list of 13 compliant conditions ("CMS-13").

CMS-13 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)

Other IRF qualification requirements at the time of a patient's admission

- ✓ Physician approval of preadmission screen and admission
- ✓ Patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy
- ✓ Patient can reasonably be expected to actively participate in, and benefit from, an intensive interdisciplinary rehabilitation therapy program of 3 hours of therapy a day, 5 days a week
- ✓ Requires supervision by a physician through face-to-face visits at least three days per week during the patient's stay to assess the patient both medically and functionally, as well as to modify the course of treatment as needed

Industry overview | Regulatory history 2009 - 2022

External Factors

IRF-specific regulatory updates

We have demonstrated the ability to adapt in the face of numerous and significant regulatory, legislative and operating environment changes.

2009	Global recession	75% Rule permanently changed to "60% Rule" with passage of "Medicare, Medicaid & SCHIP Extension Act of 2007" and paid for through a Medicare price rollback & 18-month freeze from 4/1/2008 to 9/30/2009
2010	Medicaid expansion due to the passing of the Patient Protection and Affordable Care Act (ACA) Medicare Advantage enrollment outpaces traditional Medicare enrollment growth	1) Passing of the ACA 2) CMS IRF Rule implemented new requirements for determining whether IRF claim is reasonable and necessary
2011		1) Budget Control Act generates automatic 2% reduction in Medicare payments beginning in 2013 (sequestration) 2) Medicare Shared Savings Program (MSSP) ACO begins
2012		IRF Quality Reporting Program (IRF QRP) requires IRF to report quality data with financial penalties for compliance issues
2013		IRF Quality Reporting Program (IRF QRP) requires IRF to report quality data with financial penalties for compliance issues
2014*		1) IMPACT Act directed CMS to create rules requiring the collection and reporting of standard patient assessment data 2) Original BPCI begins
2015*		CMS revised diagnosis codes that count toward 60% Rule

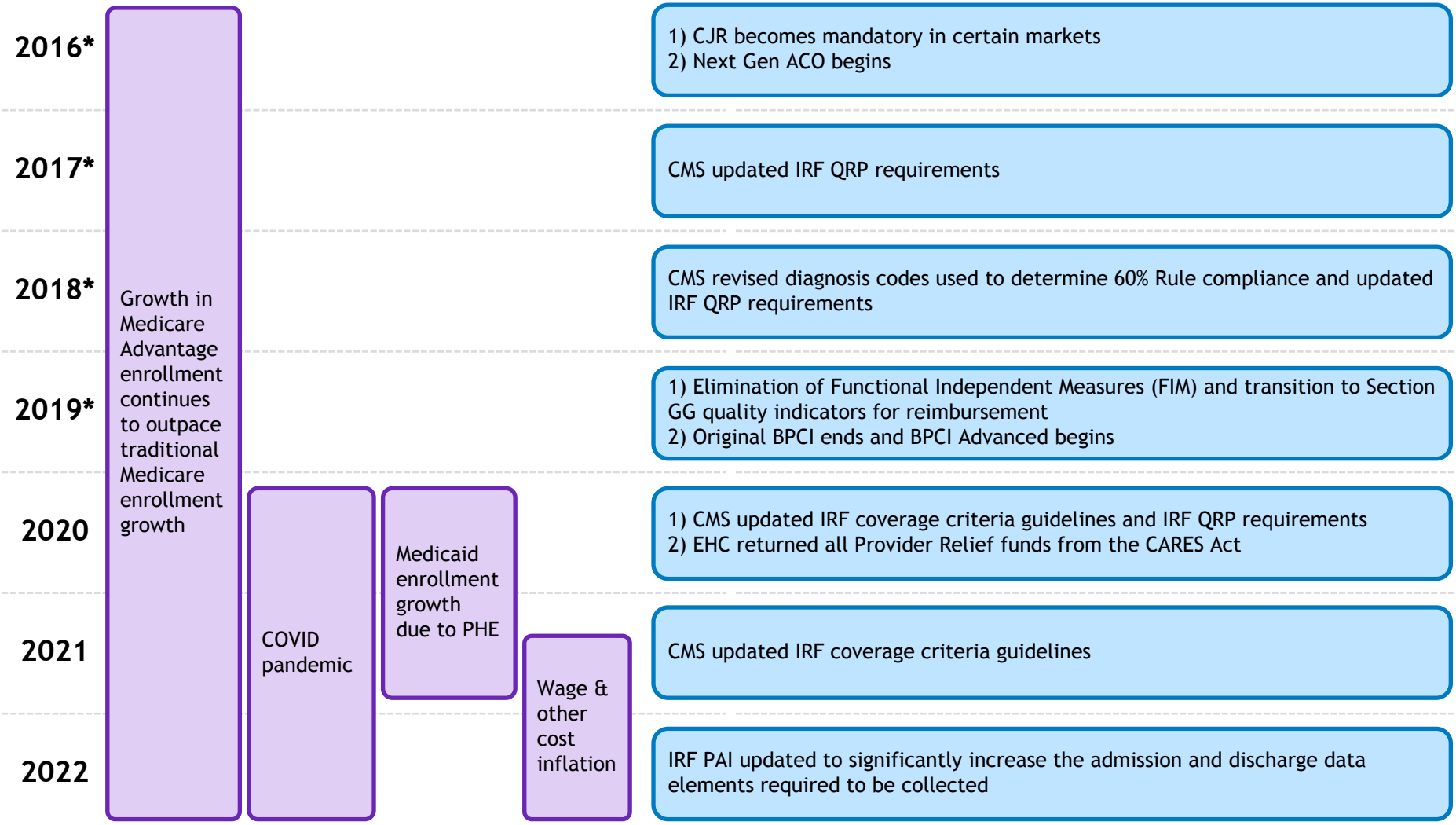
* Between 2014 and 2019, the CMS Innovation Center developed new voluntary and mandatory payment and service delivery models, in accodance with legislation, such as Bundled Payments for Care Improvement (BPCI), Accountable Care Organizations (ACO), and Comprehensive Care for Joint Replacement Model (CJR).

Industry overview | Regulatory history 2009 - 2022 (cont.)

External Factors

IRF-specific regulatory updates

We have demonstrated the ability to adapt in the face of numerous and significant regulatory, legislative and operating environment changes.



* Between 2014 and 2019, the CMS Innovation Center developed new voluntary and mandatory payment and service delivery models, in accodance with legislation, such as Bundled Payments for Care Improvement (BPCI), Accountable Care Organizations (ACO), and Comprehensive Care for Joint Replacement Model (CJR).

Growth

Growth | Our rationale for continued expansion of IRF capacity

Large, under penetrated and growing market

- ~13% estimated national conversion rate to IRF[9]
- Aging demographic (~5% population growth CAGR for our average age patient)
- Relatively static supply of licensed IRF beds for past decade
- SNF disintermediation opportunity
- Non-discretionary conditions

Significant barriers to entry and competitive advantages

- Clinical expertise
- Access to capital
- Economies of scale
- Regulatory and compliance knowledge and infrastructure
- Long history of successful acute care hospital joint ventures
- Relationships with referral sources and payors
- Nationally known and highly regarded brand

Attractive financial returns on de novos and bed additions

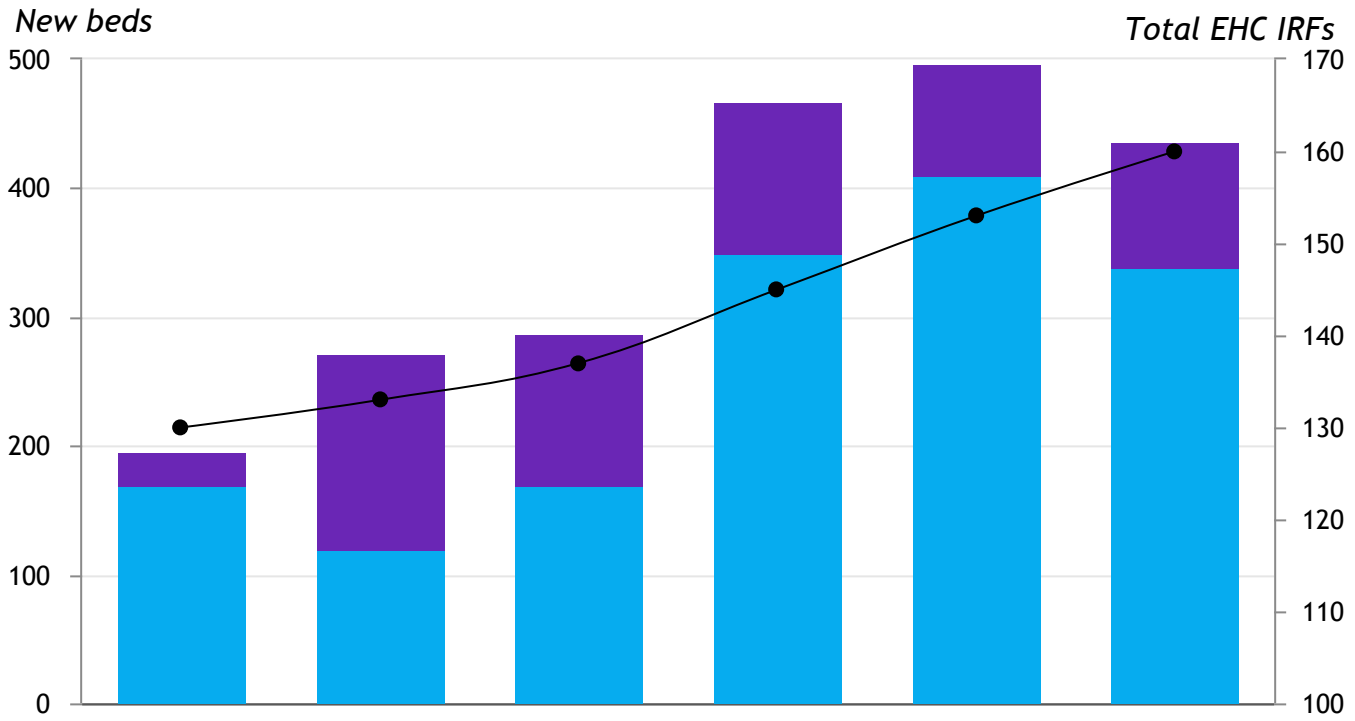
- Fuels revenue and EBITDA growth
- Accretive to ROIC
- Significant operating leverage in bed addition strategy
- Future period bed additions can increase de novo returns

Growth | IRF growth strategy

Wholly owned and joint ventures

Bed additions

De novos



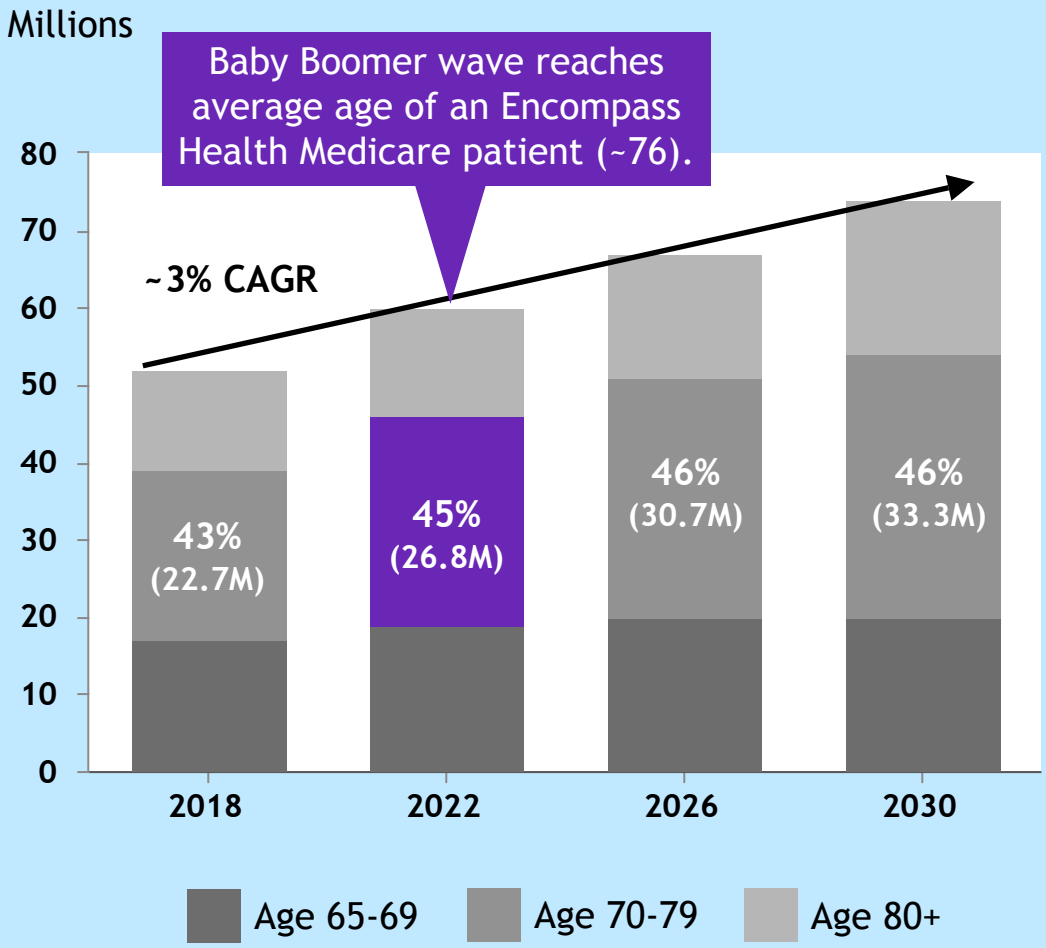
	2018	2019	2020	2021	2022	2023(P)
Bed additions	26	152	117	117	87	98
De novos (bed count)	169	120	170	350	410	339
De novos (new hospitals)	4	3	4	8	9	7
Total number of IRFs[10]	130	133	137	145	153	160
Total number of licensed beds[10]	8,966	9,249	9,505	9,924	10,356	10,774

Refer to pages 62-64 for end notes.

Growth | IRF demand continues to grow

Demand continues to benefit from a demographic tailwind: growth in the Medicare beneficiary population

Projected population of age 65+



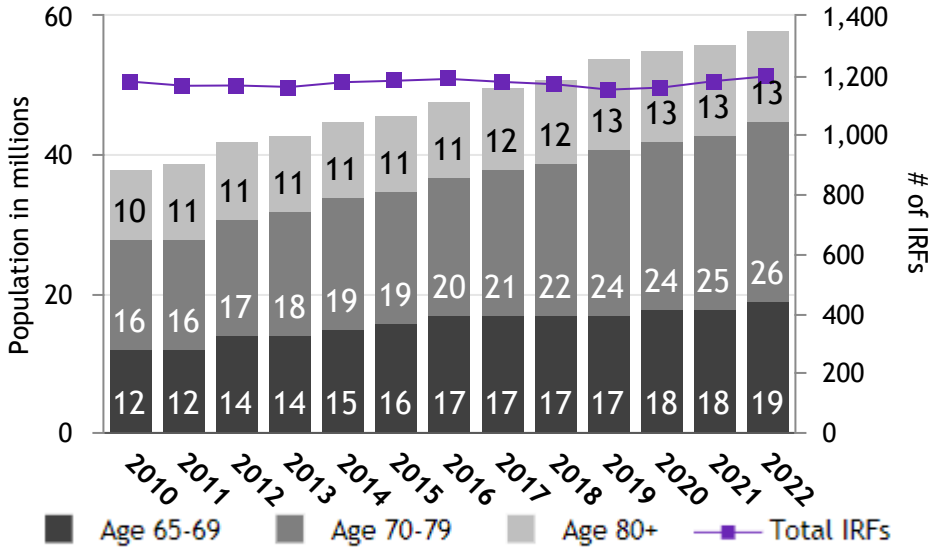
- The growth rate of Medicare beneficiaries increased to an ~3% CAGR in 2011, as "Baby Boomers" started turning age 65.
  - ~10,000 Baby Boomers turn 65 each day
- **The 4-year CAGR for the population in Encompass Health's average Medicare patient age range is ~5%.**

CAGR (population growth by age)		
Age	2018 to 2022	2022 to 2026
65-69	2.6%	1.6%
70-74	3.7%	2.5%
75-79	5.0%	4.9%
80+	2.4%	3.6%
Total	**3.3%**	**2.9%**

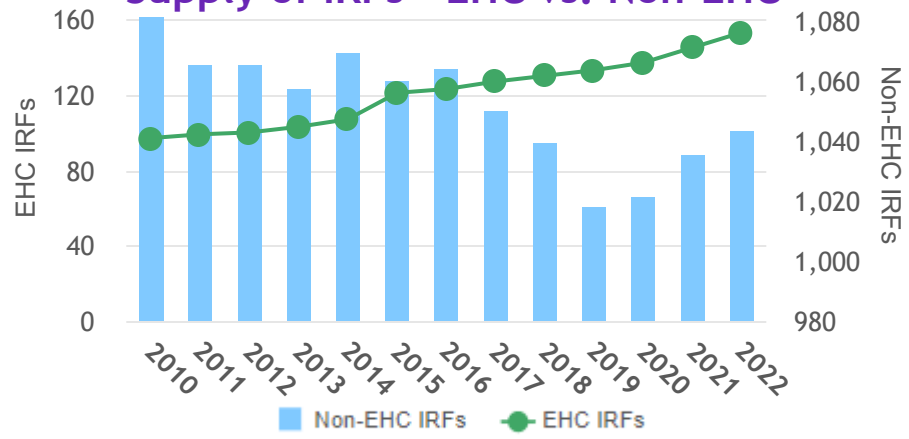
Source: https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html

Growth | IRF supply / demand imbalance continues to widen

IRF supply and demand



Supply of IRFs - EHC vs. Non-EHC



IRF supply has grown slightly since 2010:

- 1,179 IRFs in 2010
- 1,197 IRFs in 2022 (1.5% increase)

Challenges to entry include:

- high acuity patients requiring expert clinical services and skilled clinicians
- highly regulated industry
- establishment of referral and payor relationships
- significant capital investment

EHC has the scale, clinical and operational expertise, and access to capital to overcome these challenges. From 2016 to 2022, EHC:

- opened 33 de novo IRFs
- increased total beds from 8,404 to 10,356

Source: MedPAC, Medicare Payment Policy, 2023 - page 263, 2018 - page 277, 2014 - page 247; Provider Data Catalog (cms.gov) inpatient rehabilitation facilities_general information dataset; U.S. Census Bureau, Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2010 to July 1, 2019 and April 1, 2020 to July 1, 2022; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010-2018.

Growth | IRF conversion rate

IRF admission criteria

- At the time of admission, a patient must:
  - ✓ require the active and ongoing therapeutic intervention of multiple therapy disciplines
  - ✓ be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program
  - ✓ receive supervision by a physician through face-to-face visits at least three days a week
- At least 60% of patients must have at least one CMS-13 medical diagnosis or functional impairment

IRF conversion rate

- It is estimated that only ~13%[9] of acute care patients who are presumptively eligible for inpatient rehabilitation services (those with at least one CMS-13 medical diagnosis or condition) are admitted to an IRF

Reasons for low IRF conversion

- Low awareness of IRF vs. SNF care requirements for nursing coverage and therapy provision
- Lack of understanding of IRF value proposition
  - ✓ Quality of outcomes
  - ✓ Episodic versus per diem cost comparison
- Restrictive MA prescreening procedures/criteria
- Many markets have low IRF bed availability (sometimes attributable to CON requirements)

☆ EHC strategies are in place to address each of these

Growth | Medicare levels of service required - IRF vs. SNF

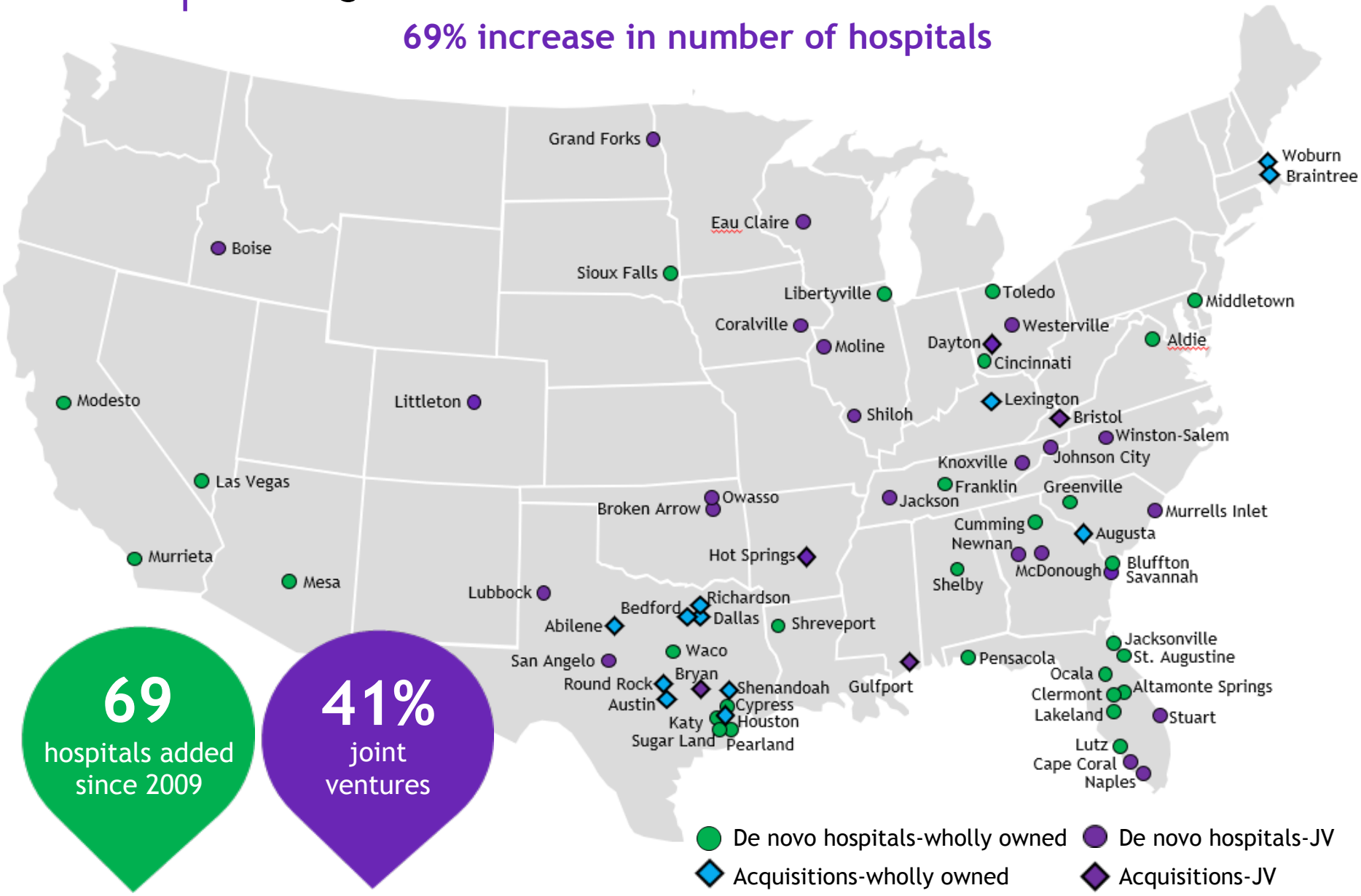
Industry averages			
		IRF	SNF
Quality metrics	FFS average length of stay	12.9 days	34.5 days
	Discharge to community rate	67.6%	43.5%

CMS requirements for IRFs vs. SNFs			
		IRF	SNF
Regulatory	Facility must satisfy regulatory and policy requirements for hospitals, including Medicare hospital conditions of participation	Yes	No
Patient care	At a minimum, face-to-face rehabilitation physician visits must occur no fewer than 3 times per week during the course of the patient's stay	Yes	No
	All patients must need and generally receive a minimum of three hours a day of intensive therapy, five days a week	Yes	No
	Nursing care is required 24 hours, 7 days a week by registered nurses	Yes	No
	A weekly team meeting, led by the physician and includes a rehabilitation nurse, a case manager, and a licensed therapist from each therapy discipline	Yes	No
Admission requirements	All patients must be admitted by a physician	Yes	No
	Stringent admission and coverage policies are required and carefully documented for each admission; further restricted in number and type of patients (e.g., 60% Rule)	Yes	No

Source: MedPAC, Medicare Payment Policy, March 2023 - pages 214, 222, 266 and 267.

Growth | Proven growth model since 2009

69% increase in number of hospitals



69
hospitals added since 2009

41%
joint ventures

Growth | Robust de novo development pipeline

21 De novos announced and underway* - total pipeline exceeds 50

Market considerations

- Demographics in and potential growth of local market
- State CON, licensure and other regulatory requirements
- Presence of other inpatient rehabilitation services
- Geographic proximity to other EHC hospitals
- Potential joint venture partners
- Volumes, patient mix and service lines of acute care hospitals
- Labor supply and costs
- Land and construction costs

Investment considerations

- Key metrics
  - Project NPV, IRR and ROIC
- Sensitivity analysis on key performance assumptions
- Comparison to analog EHC hospitals
- Potential for future expansion

Hospitals opened or under development

		Joint venture	Est. Opening Date	# of beds
De novo projects**				
	Eau Claire, WI	✓	2023	36
	Knoxville, TN	✓	2023	73
	Owasso, OK	✓	2023	40
	Clermont, FL		2023	50
1	Bowie, MD		2023	60
2	Columbus, GA	✓	2023	40
3	Prosper, TX		2023	40
4	Fitchburg, WI		2024	56
5	Kissimmee, FL		2024	50
6	Atlanta, GA	✓	2024	40
7	Johnston, RI		2024	50
8	Fort Mill, SC		2024	39
9	Louisville, KY	✓	2024	40
10	Houston, TX		2024	61
11	Lake Worth, FL		2025	50
12	Fort Myers, FL	✓	2025	60
13	Norristown, PA		2025	50
14	Wildwood, FL		2025	50
15	Athens, GA	✓	2025	40
16	St. Petersburg, FL		2025	50
17	Daytona Beach, FL		2025	50
18	Palm Beach Gardens, FL		2026	50
19	Strongsville, OH		2026	40
20	Amarillo, TX		2026	40
21	Danbury, CT		2026	40

**All dates are tentative and subject to change

*IRFs under development - previously announced under development as of April 27, 2023.

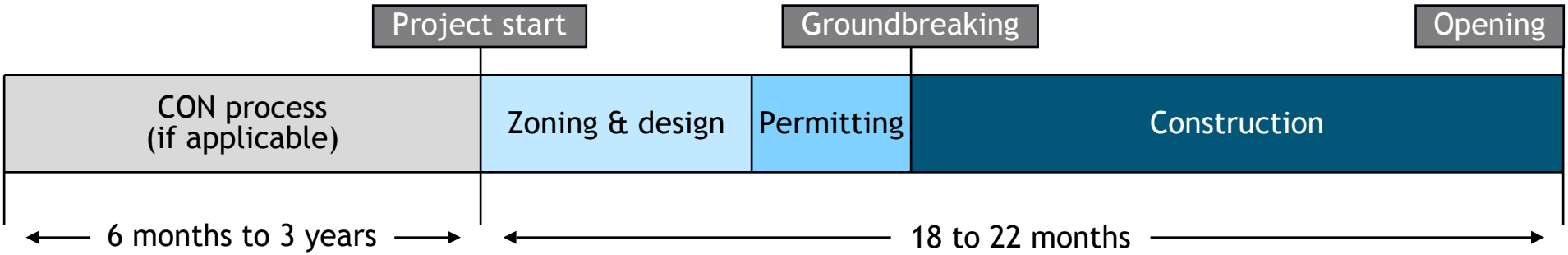
Growth | De novo costs and timeline

- Prototype hospital 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
  - Other location- or hospital-specific complexities

Capital cost (millions)	2022-2023*
Construction, design, permitting, etc.	$35.0
Land	5.5
Equipment (including CIS)	5.5
Cost of a typical 50-bed IRF	**$46.0**
Pre-opening and ramp up costs (millions)**	
Operating	$1.0
Salaries, wages, benefits	1.0
	$2.0

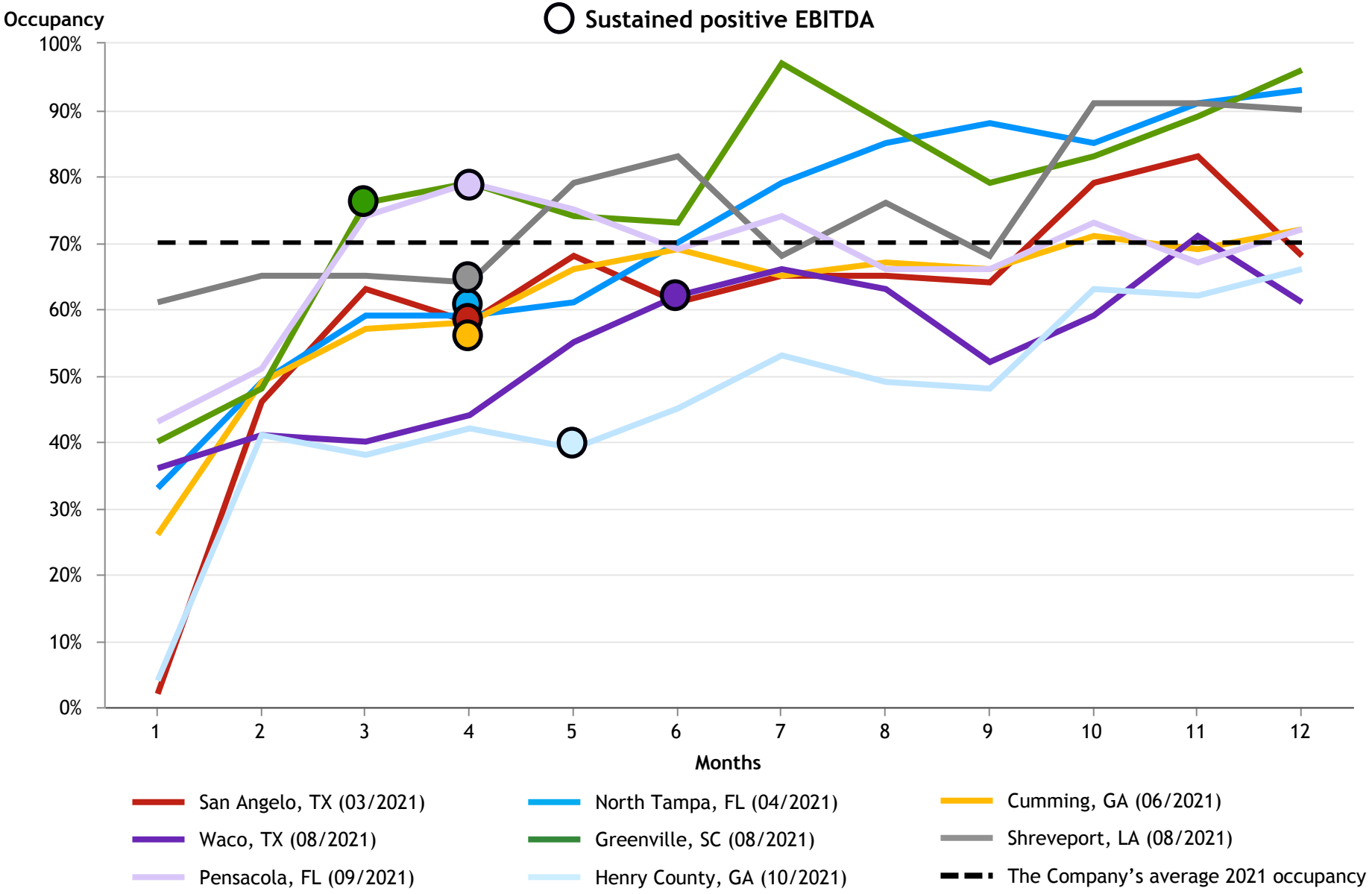
*Amounts are the average per hospital capital costs for 2022-2023 based on actual costs for EHC's 2022 50-bed hospitals and the projected costs for EHC's 2023 50-bed hospitals. The pricing for these projects is based on contracts established up to two years prior to hospital opening and may not fully represent inflationary pressures in the current market.

Illustrative timeline



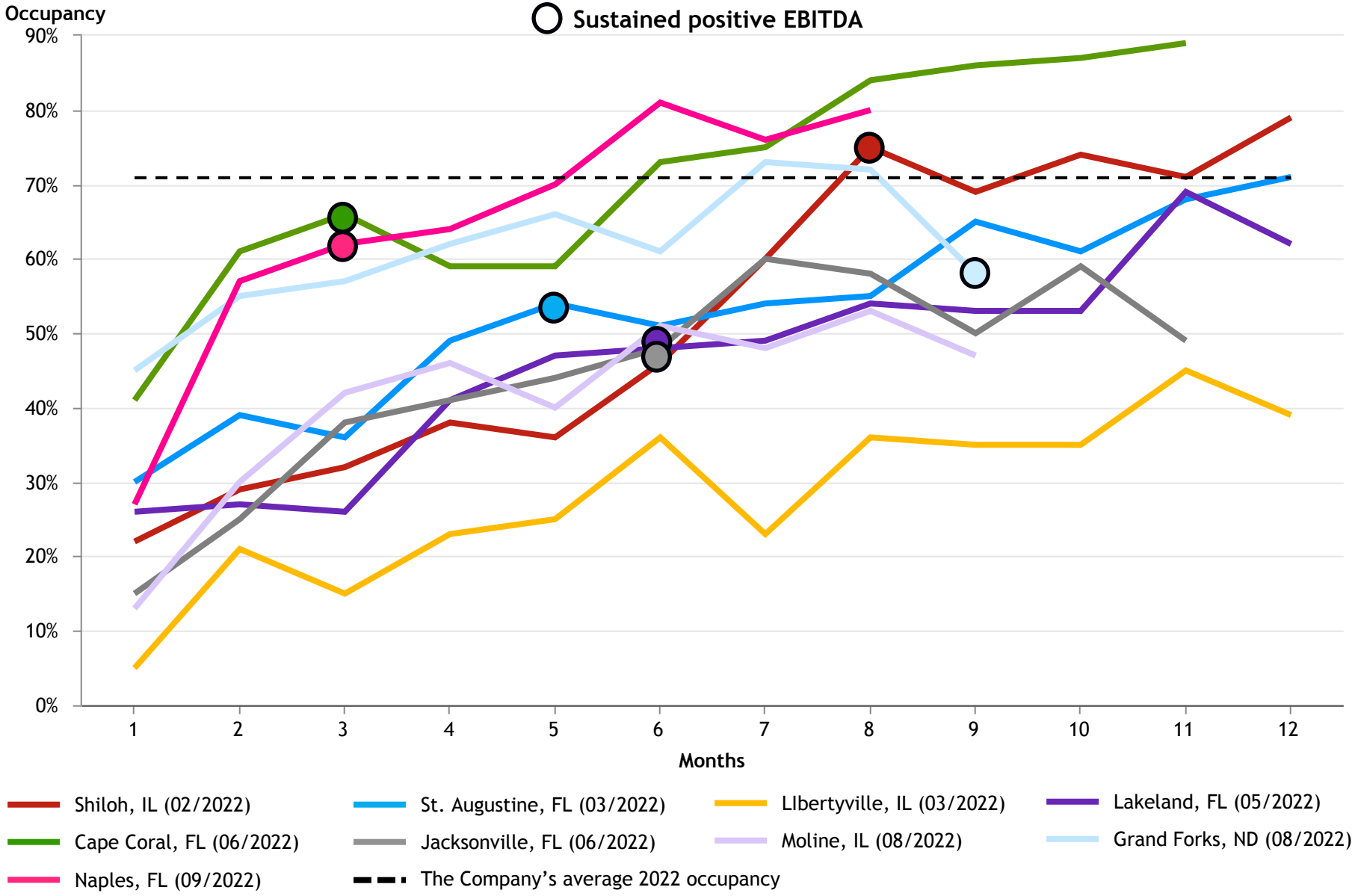
**Pre-opening expenses include expenses for pre-opening hires, training and other general operating costs incurred prior to the first patient's admission. The costs for this purpose is not inclusive of any revenues generated during the first month of operation.

Growth | De novo occupancy and EBITDA* trends - 2021



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

Growth | De novo occupancy and EBITDA* trends - 2022



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

Growth | Bed additions

Proven ability to enter new markets and boost returns with subsequent bed additions

52 Hospitals built since 2009

Of the newly constructed hospitals built 2009 to 2020:

- 52% have added beds
- 23% have had beds added more than once

Location	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023(P)
Mesa, AZ	40	40	60	60	60	60	60	60	60	60	70	70	70	70	70
Aldie, VA		40	40	40	40	55	55	60	60	60	60	60	60	60	60
Houston, TX			40	40	40	60	60	60	60	60	60	60	60	60	60
Ocala, FL				40	40	50	50	60	60	60	70	80	80	80	80
Littleton, CO					40	40	40	40	40	40	40	60	60	60	60
Stuart, FL					34	34	44	44	54	54	64	80	80	80	80
Altamonte Springs, FL						50	50	50	50	60	60	70	70	70	70
Newnan, GA						50	50	50	50	50	50	60	60	60	60
Middletown, DE						34	34	34	37	37	37	40	40	40	50
Pearland, TX									40	40	40	60	60	60	60
Murrells Inlet, SC										29	75	75	75	75	75
Lubbock, TX											40	40	66	66	66
Katy, TX											40	40	40	60	60
North Tampa, FL													50	50	71
Waco, TX													40	40	61

Data as of April 27, 2023.

Operational Initiatives

Operational initiatives | Summary

Build market share in high acuity, IRF appropriate conditions

- Utilize extensive database on IRF eligible patients to continuously refine clinical protocols and improve patient outcomes

Develop and implement post-acute solutions, clinical initiatives and operational best practices

- Clinical innovation model
- Internally and co-developed solutions
- Incorporate data analytics
- Continuous collaboration across our hospitals

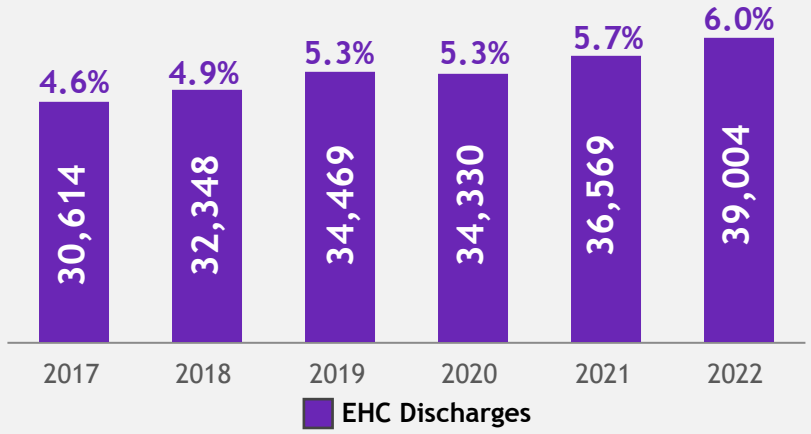
Evaluate and implement therapy and clinical technologies

- Technologies developed in-house or with vendors
- Includes:
  - state-of-the-art therapy technology used by clinicians in the treatment of patients
  - automation and technology used by the patient and the patient's caregivers to improve the patient's non-therapy experience

Operational initiatives | Build market share in high acuity conditions

Increase stroke patient market share through education and awareness

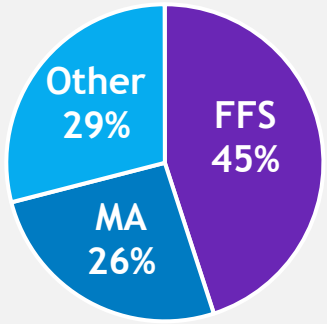
Stroke Market Share*



Stroke as a % of Payor Discharges (2022)

% of Total Discharges	18.5%
% of Medicare FFS Discharges	13.7%
% of Medicare Advantage Discharges	31.9%

EHC Stroke 2022 Payor Mix



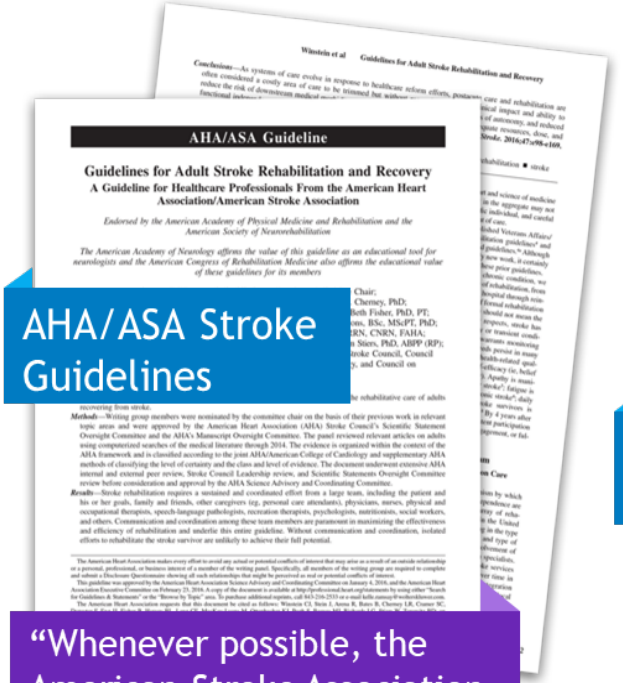
Partnership with the American Stroke Association - Highlights from 2022

- We developed and launched three **Stroke Support Group Lesson modules**, helping to support and inform group leaders with preset discussion topics and resources. Our module topics are Personality Changes After Stroke; Post-Stroke Depression; and Post-Stroke Pain. In total for the year, the **lesson module webpage was viewed over 12,000 times.**
- **Go Red for Women luncheons** were officially back to the ballroom after two years of digital experiences. We **reached over 3,000 attendees** with important information on how to prevent, treat and beat a stroke.
- Our **Life After Stroke guide and Simply Good cookbook** continue to perform well. This year alone, we had over 56,000 copies ordered or downloaded, bringing lifetime orders and downloads to just shy of 228,000 copies!
- Almost 50 Encompass Health staff are actively engaging with their local association teams by serving on **event volunteer committees, local Boards of Directors and on national committees.**

*Stroke market share = EHC stroke discharges / total stroke survivors.

Operational initiatives | Build market share in high acuity conditions

Independent research concludes IRFs are a better rehabilitation option for stroke patients compared to SNFs

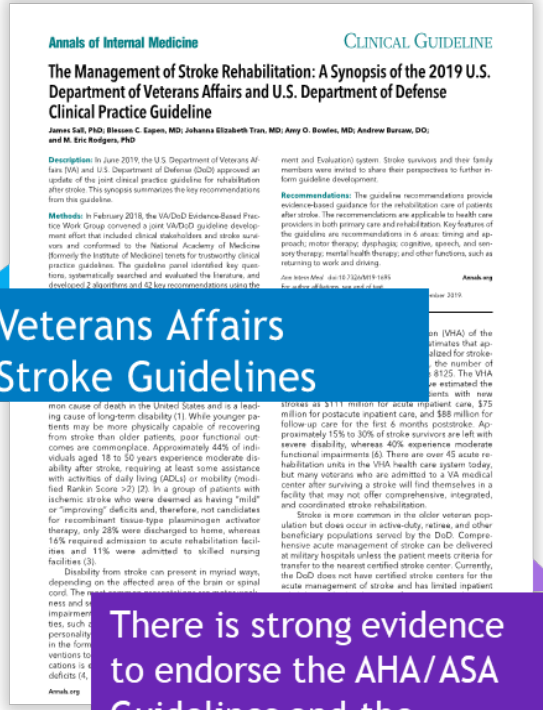

AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery

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

AHA/ASA Stroke Guidelines

"Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility."*

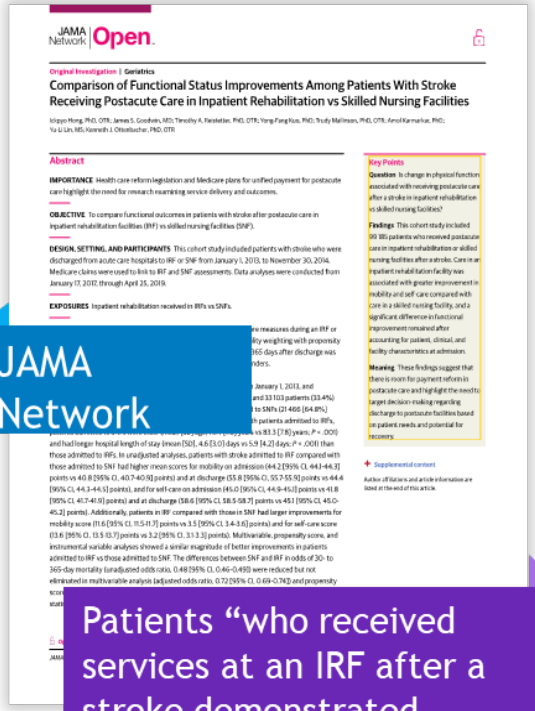

Annals of Internal Medicine

CLINICAL GUIDELINE

The Management of Stroke Rehabilitation: A Synopsis of the 2019 U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline

Veterans Affairs Stroke Guidelines

There is strong evidence to endorse the AHA/ASA Guidelines and the need for an organized, multidisciplinary approach found at an Inpatient Rehabilitation Facility.


JAMA Network Open.

Comparison of Functional Status Improvements Among Patients With Stroke Receiving Postacute Care in Inpatient Rehabilitation vs Skilled Nursing Facilities

JAMA Network

Patients "who received services at an IRF after a stroke demonstrated greater improvement in mobility and self care compared with patients who received inpatient rehabilitation at a SNF."**

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

**"The Management of Stroke Rehabilitation" issued December 2019 (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756256?resultClick=1).

Operational initiatives | Build market share in high acuity conditions

Implement in-house dialysis service through Tablo system

Historically, dialysis has been provided by third-party vendors either onsite or offsite.

- In 2022, patients receiving hemodialysis represented 5.1% of Encompass Health's patient population

With the Tablo system, we are providing onsite dialysis to our patients and recognize several benefits:

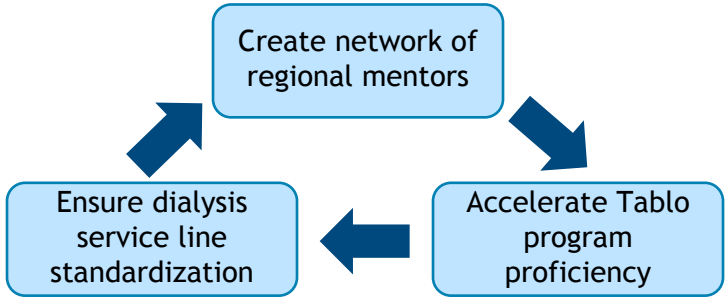
- Patients now receive uninterrupted therapy and dialysis treatment in one location
- Usage has lowered our cost of treatment and improved patient satisfaction
  - ✓ National average treatment cost of $600 vs. Tablo of $300
  - ✓ We have seen a 90 basis point reduction in discharge to acute and an increase in therapy intensity for those hospitals using Tablo for at least one year

! As of March 31, 2023, we had Tablo capabilities in 64 of our hospitals, with further implementation planned for 2023.

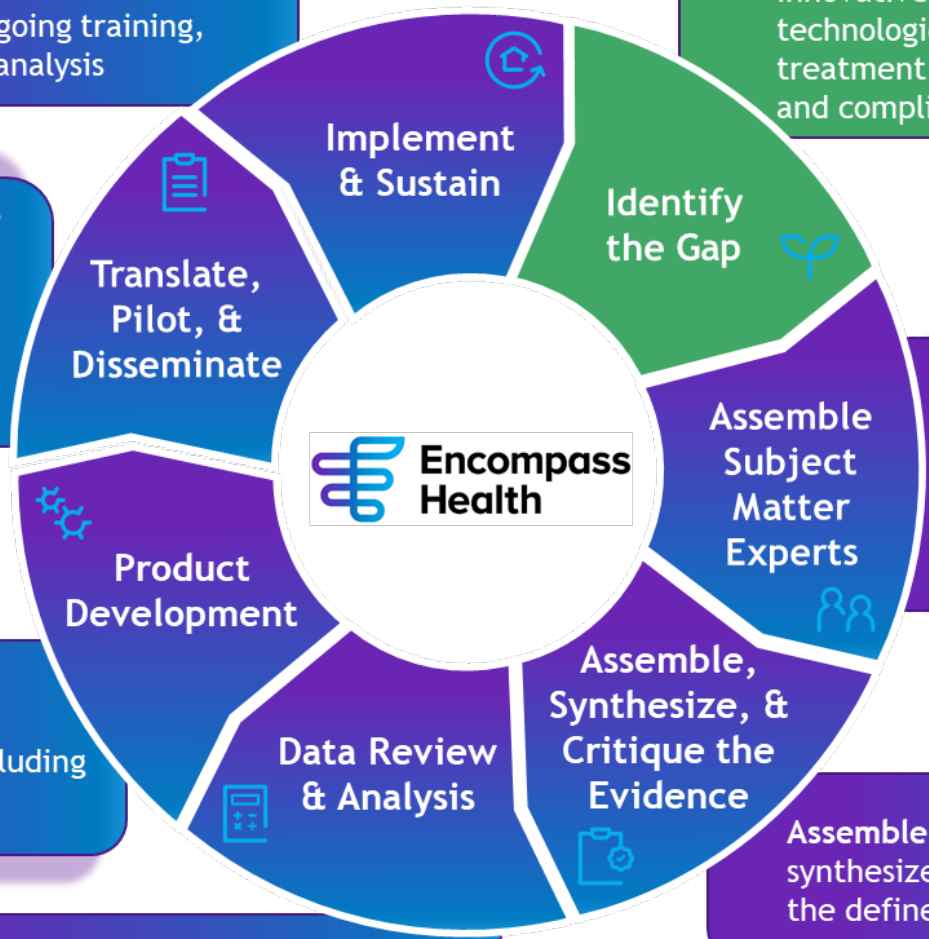
Photo: Tablo Hemodialysis System

Our first Tablo Center of Excellence Program is at Encompass Health Rehabilitation Hospital of Las Vegas

Framework for Tablo Center of Excellence Program



Operational initiatives | Post-acute clinical innovation model



Identify a gap or need and potential innovative solution in therapy services, technologies or processes to improve treatment protocols, patient quality and compliance

Assemble subject matter experts across the organization from multiple disciplines & departments with an expertise in the defined gap

Assemble evidence and science, and synthesize and critique its impact to the defined gap

Review and analyze data to determine the baseline of the gap and define key performance indicators (KPIs) and goals

Develop the product or innovative solution and necessary deliverables including procedures, training, etc.

Pilot or test the innovative solution with a subset of hospitals, review the data from the pilot locations, modify and pilot again as needed

Implement & sustain the innovative solution, including ongoing training, modification, & data analysis

Operational initiatives | Post-acute solutions

Our goals are to optimize our predictive tools and to use our extensive clinical database to further improve patient outcomes

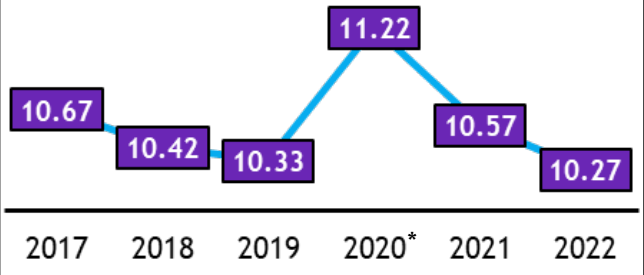
Encompass Health REACT™

Trademarked system developed in 2015 to predict a patient's risk of being transferred back to an acute care hospital.

40 clinical variables are considered in the risk analysis with risk levels assigned to each patient. High risk levels generate action items for the clinical staff to intervene and evaluate the patient.

The Company's performance since the system was fully implemented in 2017 is shown below.

Acute Care Transfer Rate**



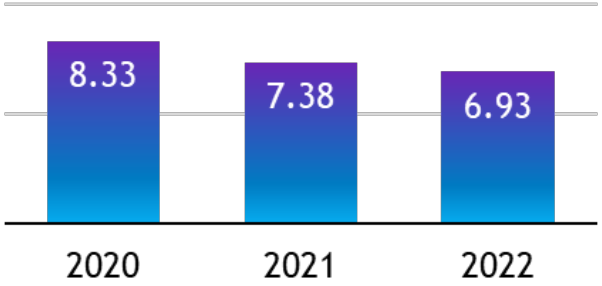
Fall Risk Model

Initiated in November 2021 to provide clinicians a near-real-time evaluation of each patient's fall risk.

50 clinical elements are considered and patients are assigned risk levels. Fall prevention strategies and workflows are created and assigned based on risk assessment.

The Company began implementation in 2021 with an enterprise wide year of utilization in 2022.

Fall Rate***



Innovation Center

The Readmission Prediction Model was initiated in October 2020. A patient's probability of readmission to an acute care hospital post IRF discharge is assessed based on diagnoses, medications, lab results, vitals and other patient information.

The Innovation Center's ongoing strategy includes:

- Regular updating of models to stay ahead of model degradation and to incorporate advances in AI
- Improve ease of learning and adoption by standardizing categories for all models and optimizing training resources for onboarding and continuing education

*Reflects COVID impact. **Acute care transfer rate = acute care transfers / total number of discharges.
***Fall rate = number of patient falls / 1,000 patient days.

Operational initiatives | Post-acute solutions

"ReACT" and Readmission prevention

- Developed predictive models to identify patients at risk for transfer and readmission to acute-care hospitals
- Implemented intervention strategies as part of the plan of care and notify home health provider of risk prior to discharge

Infection control

- Standardized and improved infection control practices across the Company. These practices and oversight provided clinicians with tools to successfully navigate the COVID-19 pandemic.
- Applied evidence-based decision making

Sepsis/SIRS alert

- Implemented an evidenced-based predictive model to identify patients at-risk for sepsis or Systemic Inflammatory Response Syndrome (“SIRS”)
- Applied intervention strategies as part of the plan of care

Medication reconciliation

- Implemented a multidisciplinary reconciliation process using the Company's EMR upon admission and discharge

Reduce opioid use

- Implemented a multidisciplinary approach to improve pain management, including non-pharmacologic treatment of pain and vigilant opioid stewardship

Reduce readmissions & improve outcomes

Operational initiatives | Therapy and clinical technologies

Therapy Technology

The therapy innovations committee reviews and recommends state of the art technology for our hospitals to ensure our therapy teams have the equipment and the training to provide the best care

(recent implementations are shown below)

Ambu aScope

Swallowing study technology that is portable with a disposable scope eliminating the labor intensive cleaning process with previous technologies

BITS

A multidisciplinary therapy solution used for balance, cognitive and visuo-motor therapy

Vector

Robotic trolleys using dynamic body weight support to promote faster recovery, over-ground gait rehabilitation and activities of daily living

BURT

A highly dexterous robotic arm manipulator for upper-extremity rehabilitation training

Clinical Technology

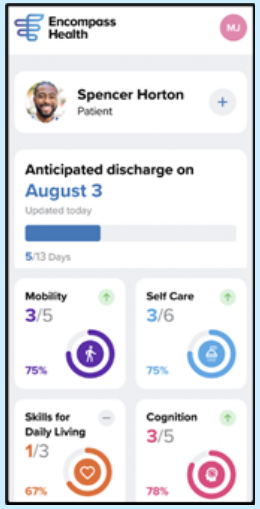
As our employees engage with patients and their families outside of therapy sessions, automation and technology is available for a better patient experience

(recent implementations are shown below)

MyEncompass Health

The MyEncompass Health caregiver application is a patient experience application designed to promote early, ongoing engagement of the patient and their family or caregivers by communicating real-time progress toward their goals and an overview of their care plan in a secure manner.

The application is integrated with ACE IT (our clinical information system) for real-time updates to the patient's information.



CBORD food service management technology provides the hospital an electronic meal ordering and preparation system with standardized meal plans plus a point-of-sale system for cafeteria operations. The system interfaces with ACE IT to provide accurate and timely diet information, including nutritional data for blood sugar management and malnutrition status.

eCafé

Operational initiatives | Culture of collaboration and emphasis on best practices

Collaboration among our 157 hospital teams supports continuous learning and deployment of best practices

Standardization across all hospitals

- Care management
- Comfort, Professionalism, & Respect (CPR - Heart of the Patient Experience)
- Pre-admission & admission process
- Clinical documentation
- Credentialing
- Career ladders for nursing, therapy and case management
- Contracting
- Therapy practice guidelines
- Medication management & reconciliation
- Clinical education offerings for staff
- Policies & procedures
- Quality reporting program
- Predictive models

Value of collaboration and networking across hospitals

- Strategic development as market dynamics change
- TJC Disease Specific Certification through shared program development tools
- Leadership mentoring among leaders within the same organization
- Lessons learned that impact metrics related to quality, employees and financial measures

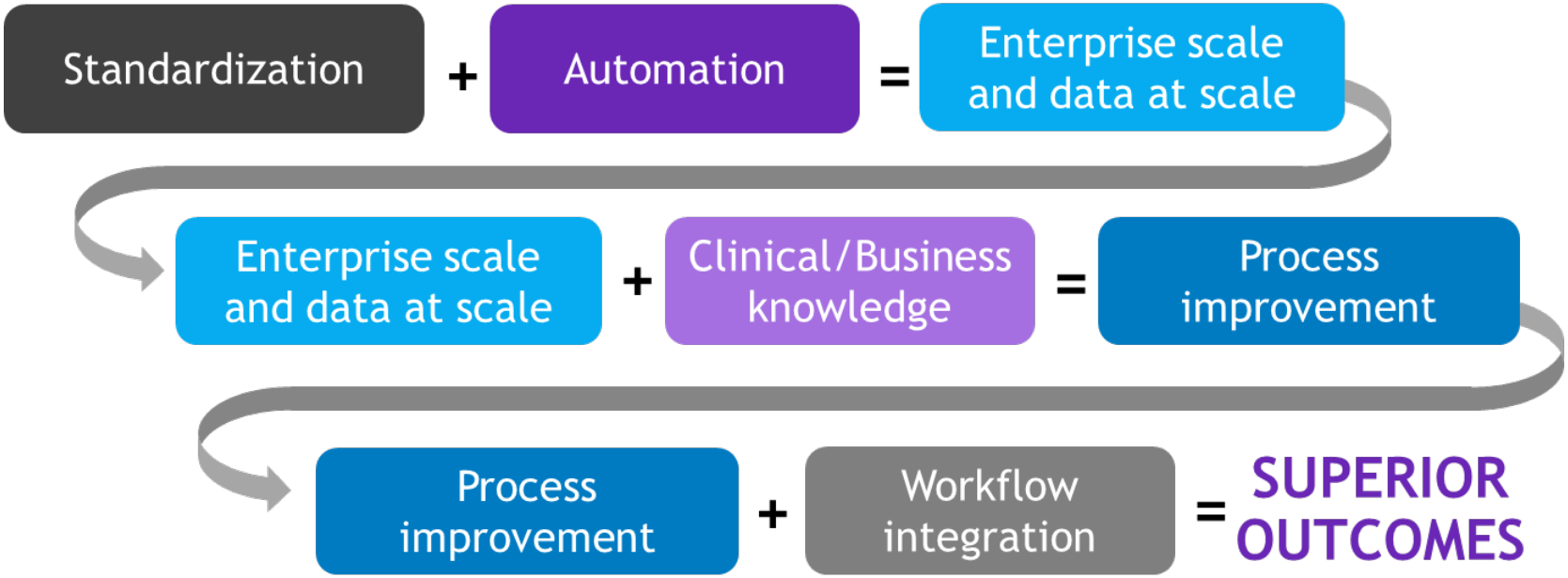
Information Technology

Information technology | Investment thesis and strategy

Our digital health strategy is based on leveraging our:

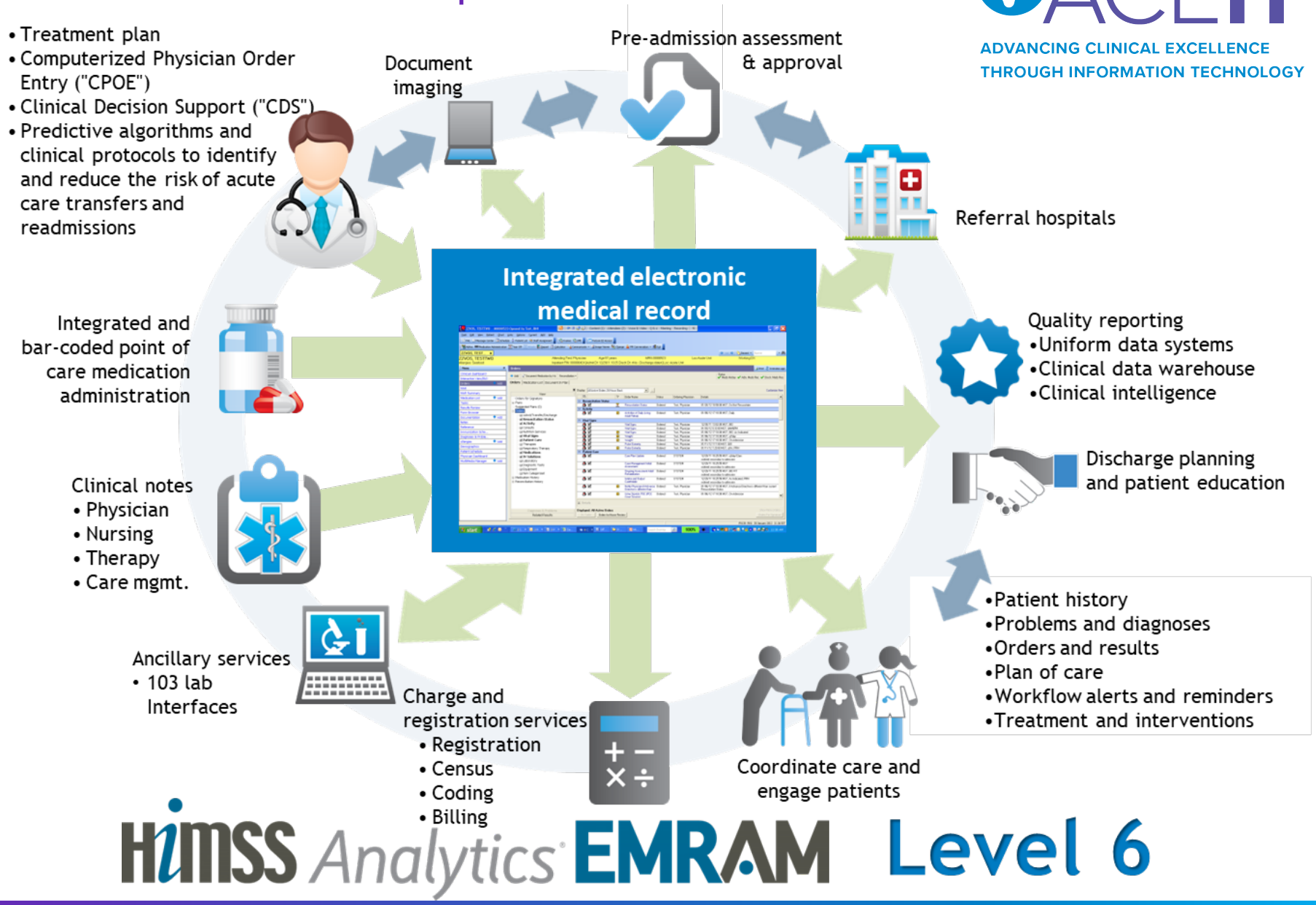
- clinical expertise
- exceptionally large post-acute datasets
- business and technology partners (e.g., Oracle Cerner)
- and our proven capabilities in
  - enterprise EMR technologies
  - data integration
  - data analytics and predictive analytics

to drive value-based performance across the continuum for our patients, our partners and our payors.



Information technology | Clinical information system

ACEIT
ADVANCING CLINICAL EXCELLENCE THROUGH INFORMATION TECHNOLOGY



HIMSS Analytics EMRAM Level 6

Information technology | Beacon management reporting

Standardize the process, then automate it

Enterprise scalability + Proprietary large patient datasets + Clinical and business knowledge = Continuous improvement

BEACON Proprietary Management System

- Proprietary operations management system that provides real-time data
- Benchmarking to promote best practices
- Capabilities include:
  - Clinical coordination
  - Physician quality reporting
  - Readmission risk
  - Therapy outcomes analysis
  - Quality and patient satisfaction reporting
  - Workforce and labor productivity
  - Sales and marketing analysis
  - Care management
  - Food and drug spend analysis
  - Ability to run market-by-market analysis and reports
  - Accounts Receivable analysis

MyEncompass Health caregiver application

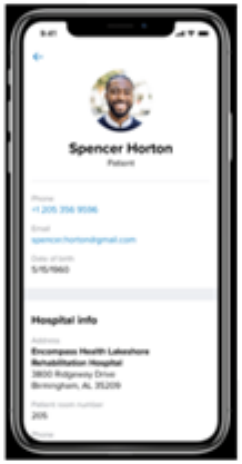
The app shows a patient's real-time progress toward their goals and an overview of their care plan in a secure manner. Information in the app is regularly updated by interfacing with our clinical documentation system specific to the patient's goals and outcomes.

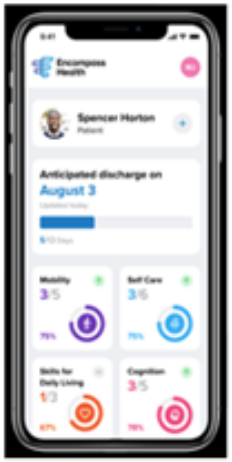
TRACK

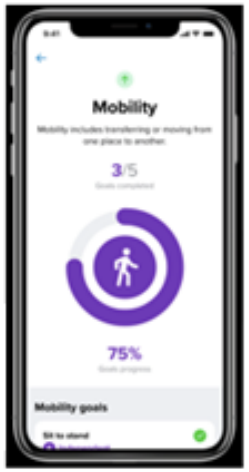
- Follow the patient's stay at our hospital as they make progress toward established goals.
- Track goals established by the patient and the hospital interdisciplinary care team, including mobility, self-care, cognition and behavior, and daily living skills such as meal preparation and medication management.
- See anticipated discharge date / plan for discharge

SHARE

- Invite others to follow along as the patient progresses in their rehabilitation stay
- The patient and those who are granted access to app will have access up to 14 days after discharge







Reconciliations to GAAP

Reconciliation

Net cash provided by operating activities to Adjusted EBITDA[8]

($ in millions)	For the Year Ended December 31, 2022	2021
Net cash provided by operating activities	$ 705.8	$ 715.8
Interest expense and amortization of debt discounts and fees	175.7	164.3
(Loss) gain on sale of investments, excluding impairments	(15.5)	3.8
Equity in net income of nonconsolidated affiliates	2.9	3.4
Net income attributable to noncontrolling interests in continuing operations	(93.6)	(103.2)
Amortization of debt-related items	(9.7)	(7.8)
Distributions from nonconsolidated affiliates	(4.0)	(2.6)
Current portion of income tax expense	72.2	84.5
Change in assets and liabilities	30.4	109.9
Cash provided by operating activities of discontinued operations	(52.3)	(151.1)
Change in fair market value of equity securities	7.4	(0.6)
Adjusted EBITDA	$ 819.3	$ 816.4

The leverage ratio for 2021 stated in terms of the most comparable GAAP measurement would be Debt to Net cash provided by operating activities: 4.6x

The leverage ratio for 2022 stated in terms of the most comparable GAAP measurement would be Debt to Net cash provided by operating activities: 3.9x

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.

Refer to pages 62-64 for end notes.

Reconciliation | Net income to Adjusted EBITDA[8]

($ in millions)	For the Year Ended December 31, 2022	2021
Net income	$ 365.9	$ 517.2
Income from discontinued operations, net of tax, attributable to Encompass Health	(15.2)	(114.1)
Net income attributable to noncontrolling interests included in continuing operations	(93.6)	(103.2)
Provision for income tax expense	100.1	101.9
Interest expense and amortization of debt discounts and fees	175.7	164.3
Depreciation and amortization	243.6	219.6
Loss on early extinguishment of debt [11][12]	1.4	1.0
Loss on disposal or impairment of assets	4.8	1.2
Stock-based compensation	29.2	29.1
Change in fair market value of equity securities	7.4	(0.6)
Adjusted EBITDA	$ 819.3	$ 816.4

Refer to pages 62-64 for end notes.

Reconciliation

Net cash provided by operating activities to adjusted free cash flow[7]

($ in millions)	For the Year Ended December 31, 2022	2021
Net cash provided by operating activities	$ 705.8	$ 715.8
Impact of discontinued operations	(52.3)	(151.1)
Net cash provided by operating activities of continuing operations	653.5	564.7
Capital expenditures for maintenance	(238.4)	(133.4)
Distributions paid to noncontrolling interests of consolidated affiliates	(96.6)	(101.1)
Items not indicative of ongoing operating performance:		
Transaction costs and related liabilities	21.6	—
Adjusted free cash flow	**$ 340.1**	**$ 330.2**

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.

Refer to pages 62-64 for end notes.

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"), part of Netsmart, a data gathering and analysis tool 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) The 152 IRFs shown for Encompass excludes Altru Rehabilitation Hospital (opened August 2, 2022); Patricia Neal Rehabilitation Hospital (opened March 7, 2023); Rehabilitation Hospital of Western Wisconsin (opened March 7, 2023); Ascension St. John Rehabilitation Hospital, an affiliate of Encompass Health - Owasso (opened March 21, 2023); Encompass Health Rehabilitation Hospital of Clermont (opened April 18, 2023) and Wesley Rehabilitation Hospital, an affiliate of Encompass Health (closed March 2022).

(4) In 2022, the Company averaged 1,397 total Medicare & Non-Medicare discharges per IRF in its then 143 consolidated IRFs that were open the full year.

(5) Source: FY 2024 CMS Proposed Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2020/2021/2022) or in the case of new IRFs, the Q4 2022 CMS Provider of Service File.

- All data provided was filtered and compiled from the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2024 IRF Proposed Rule Rate Setting File found at: https://www.cms.gov/files/zip/fy-2024-irf-pps-data-files-nprm.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.
- The CMS file contains data for each of the 1,127 inpatient rehabilitation facilities used to estimate the policy updates for the FY 2024 IRF-PPS Proposed Rule. Most of the data represents historical information from the CMS fiscal year 2020 and 2021 periods and may or may not reflect the same Encompass Health hospitals in operation today. The total was reduced by one to reflect the closure of Wesley Rehabilitation Hospital, an affiliate of Encompass Health (closed March 2022).

(6) 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. The CARES Act temporarily suspended the automatic 2% sequestration reduction for the period from May 1 through December 31, 2020. The 2021 Budget Act extended the sequestration suspension through March 31, 2021. An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, signed into law on April 14, 2021, extended the suspension period to December 31, 2021. The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims extending the suspension through March 31, 2022, a payment adjustment of 1% from April 1 to June 30, 2022, and full 2% sequestration beginning July 1, 2022.

(7) 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. 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 May 31, 2023, to which this Investor Reference Book is attached as Exhibit 99.1.*

(8) 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 May 31, 2023, to which this Investor Reference Book is attached as Exhibit 99.1.*

(9) The conversion rate of inpatient rehabilitation eligible patients is based on patients who are discharged from acute-care hospitals with one or more of 13 specified medical conditions that CMS ties to IRF eligibility based on Medicare fee-for-service data, which is the only publicly available data on the subject.

End notes, continued

(10) 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 de-licensure of 20 SNF beds at a Dallas IRF. 2019 total number of licensed beds includes the de-licensure of 25 SNF beds at Round Rock, TX, the de-licensure of 5 beds at an IRF in Newburgh, IN, the de-licensure of 10 beds in Western Hills, WV, and the consolidation of Yuma (increase of 51 beds). 2020 total number of licensed beds includes the de-licensure of 31 beds at an IRF in Woburn, MA. 2021 total number of licensed beds includes the de-licensure of 48 beds in Erie, PA. 2022 total number of IRFs and licensed beds includes the closure of the Wesley hospital (decrease of 65 beds). Projected 2023 licensed beds includes a de-licensure of 19 beds.

(11) In the second quarter of 2021, the Company redeemed a total of $200 million of 5.125% Senior Notes due 2023 ($100 million in April and $100 million in June). The redemptions were completed at 100% of par using cash on hand and drawings under the Company's revolving credit facility. As a result of the redemptions, the Company recorded a $1.0 million loss on early extinguishment of debt in the second quarter of 2021.

(12) In the first quarter of 2022, the Company redeemed the remaining $100 million of its 5.125% Senior Notes due 2023. The redemption was completed at 100% of par using drawings under the Company's revolving credit facility. As a result of the redemption, the Company recorded a $0.3 million loss on early extinguishment of debt in the first quarter of 2022. In the second quarter of 2022, the Company redeemed approximately $236 million of its term loan due 2024 and fully repaid the $250 million outstanding balance on its revolving credit facility. The redemption was completed using proceeds which were dividended from Enhabit. As a result of the redemption, the Company recorded a $1.1 million loss on early extinguishment of debt in the second quarter of 2022.