

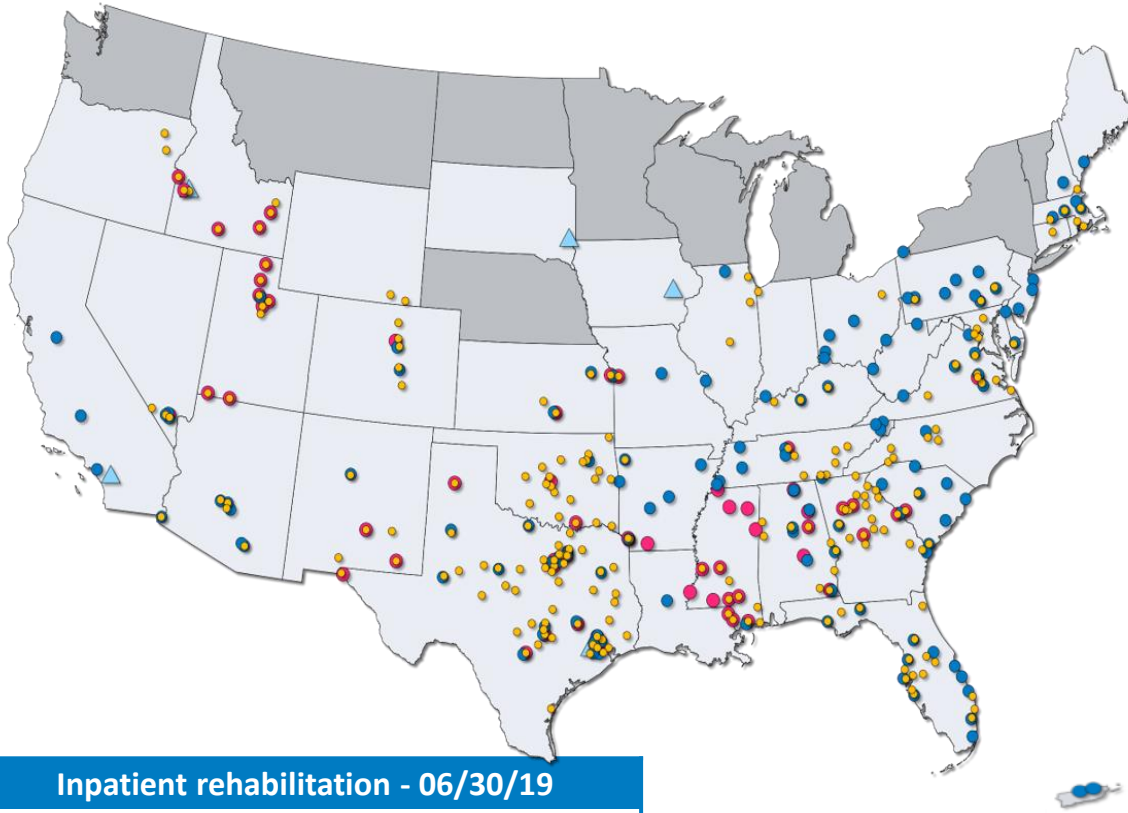


**Encompass Health Rehabilitation Hospital of Oregon
CN #679 Public Meeting
October 15, 2019**

Encompass Health is a national leader in integrated healthcare services offering both hospital-based and home-based patient care through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. The Company is committed to delivering high-quality, cost-effective, integrated care across the healthcare continuum.

Encompass Health

a leading provider of inpatient rehabilitation and home-based care



Portfolio as of June 30, 2019	
●	Inpatient rehabilitation hospitals ("IRFs")
●	Home health locations
●	Hospice locations
▲	5 Future IRFs**
37 States and Puerto Rico ~41,700 employees	

The 23 home health and 23 hospice locations acquired in the acquisition of Alacare on July 1, 2019 are excluded from these tables.

Inpatient rehabilitation - 06/30/19
131 IRFs (46 are joint ventures)
32 States and Puerto Rico
~30,800 Employees
23% of licensed beds [†]
31% of Medicare patients served [†]
Key statistics - trailing 4 quarters
182,016 Inpatient discharges
~\$3.4 Billion in revenue

Largest owner and operator of IRFs

4th Largest provider of Medicare-certified skilled home health services

Home health and hospice - 06/30/19
222 Home health locations
59 Hospice locations
31 States
~10,900 Employees
Key statistics - trailing 4 quarters
145,287 Home health admissions
8,786 Hospice admissions
~\$1.0 Billion in revenue

* Excluding markets that have home health licensure barriers ** Previously announced under development † Based on 2017 and 2018 data

Note: One of the 131 IRFs and two of the 222 home health locations are nonconsolidated.

These locations are accounted for using the equity method of accounting.



Inpatient rehabilitation hospitals

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



Comprehensive 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
- **Speech-language therapists:** address speech/voice functions, swallowing, memory/cognition, and language/communication
- **Respiratory therapists:** provide assessment and treatment of patients with both acute and chronic dysfunction of the cardiopulmonary system
- **Pharmacists:** oversee and manage medications to treat complex medical conditions pursuant to physician orders
- **Case managers:** coordinate care plan with physician, Care Transition Coordinators, caregivers and family
- **Post-discharge services:** outpatient therapy and transition to home health

Encompass Health: Patient Mix and Outcomes

Admission sources:

Acute care hospitals – 90%
 Physician offices / community – 8%
 Skilled nursing facilities – 2%

Rehabilitation impairment category

YTD-19

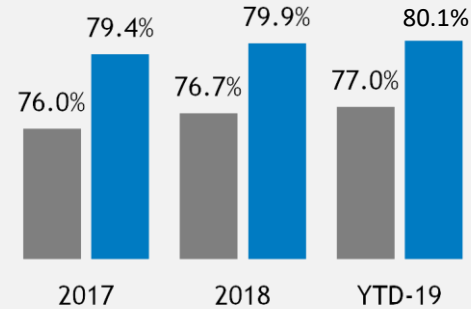
2018

Rehabilitation impairment category	YTD-19	2018
RIC 01 Stroke	18.5%	18.0%
RIC 02/03 Brain dysfunction	10.0%	10.3%
RIC 04/05 Spinal cord dysfunction	3.9%	3.8%
RIC 06 Neurological conditions	21.5%	21.0%
RIC 07 Fracture of lower extremity	7.4%	7.7%
RIC 08 Replacement of lower extremity joint	3.4%	3.9%
RIC 09 Other orthopedic	8.5%	9.0%
RIC 10/11 Amputation	2.7%	2.6%
RIC 14 Cardiac	4.5%	4.5%
RIC 17/18 Major multiple trauma	5.2%	5.3%
RIC 20 Other disabling impairments	11.3%	11.1%
— All other RICs	3.1%	2.8%

Average age of the Company's IRF patients:
 all patients = 71 Medicare FFS = 76

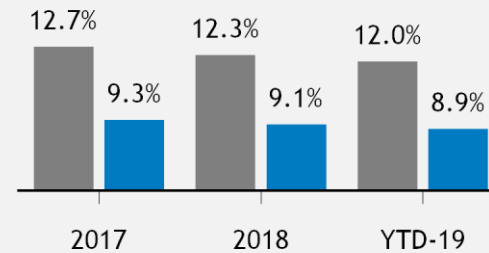
High-quality care:

Discharge to community



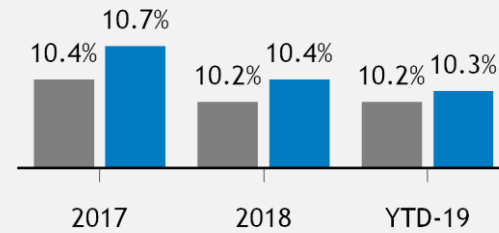
Percent of cases discharged to the community, including home or home with home health.
 Higher is better.

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

Encompass Health

Encompass Health: Leading position in cost effectiveness

	#	Avg. beds per IRF	Avg. Medicare discharges per IRF	Case mix index	Avg. est. total <u>cost</u> per discharge for FY 2019	Avg. est. total <u>payment</u> per discharge for FY 2019
Encompass Health =	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	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

Encompass Health : Leading the way with National Partnerships

Encompass Health's national sponsorship of AHA/ASA's Together to End Stroke promotes stroke awareness and recovery.



American Stroke Association.
A division of the American Heart Association.

Together to End Stroke®

- 20 pilot markets for Go Red for Women luncheons (includes 43 EH hospitals)
- Point of Care/Life After Stroke Guide (English & Spanish versions)
- Highlighting Encompass Health patient stories on AHA/ASA national blog
- Future co-branded patient and caregiver support tools



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Encompass Health hospitals hold stroke-specific certifications from The Joint Commission



Inpatient Rehabilitation Hospital Patients

Admission Criteria

- Physicians, acute care hospital case managers, and therapists are key decision makers and partner with us to identify appropriate candidates for admission to an IRF level of care
- All IRF patients must meet medical necessity criteria and must be approved by a rehab physician.
- All IRF patients must be reasonably medically stable and have potential to participate in 3 hours of therapy 5 days per week (minimum).
- IRF patients receive 24-hour, 7 days a week rehabilitation nursing care.

Rehabilitation Hospitals: A Different Level of Service

Inpatient rehabilitation hospital	Nursing home
Average length of stay = 12.7 days	Average length of stay = 37.3 days
Requirements:	Requirements:
IRFs must also satisfy <u>regulatory/policy requirements for hospitals</u> , including Medicare hospital conditions of participation.	<u>No similar requirement</u> ; Nursing homes are regulated as nursing homes only
<u>All patients</u> must be admitted by a rehab physician.	<u>No similar requirement</u>
Rehab physicians must re-confirm each admission within 24 hours.	<u>No similar requirement</u>
<u>All patients</u> , regardless of diagnoses/condition, must demonstrate need and receive at least three hours of daily intensive therapy.	<u>No similar requirement</u>
All patients must see a rehabilitation physician “in person” <u>at least three times weekly</u> .	<u>No similar requirement</u> ; some SNF patients may go a week or longer without seeing a physician, and often a non-rehabilitation physician.
IRFs are required to provide <u>24 hour, 7 days per week</u> nursing care; many nurses are RNs and rehab nurses.	<u>No similar requirement</u>
IRFs are required to use a coordinated <u>interdisciplinary team</u> 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.	<u>No similar requirement</u> ; 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 <u>stringent admission/coverage policies</u> 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.

AHA/ASA Guidelines conclude IRFs are a better rehabilitation option for stroke patients than SNFs

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; Matthew 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 847-216-2533 or e-mail kelle.namuy@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.000000000000098.

Expert peer review of AHA Scientific Statements is conducted by the AHA Office of Science Operations. For more on AHA statements and guidelines development, visit <http://professional.heart.org/statements>. Select the "Guidelines & Statements" drop-down menu, then click "Publication Development."

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Stroke is available at <http://stroke.ahajournals.org>

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“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.”**

Encompass Health Cutting-Edge Clinical Rehabilitation Technology

Clinical technologies are invaluable tools in the therapy process and offer patients an exciting and enjoyable experience during their road to recovery. Encompass Health's Therapy Innovations Committee evaluates the most cutting-edge, innovative clinical technologies on the market today. The committee establishes and maintains technology standards for new hospitals and identifies best-in-class technologies for Disease Specific Certifications to support the gold star quality of care Encompass Health is known for. Some examples of these technologies are as follows:



The Vector Gait & Safety System®

Enables rehabilitative teams to increase patient mobility while preventing falls and reducing the risk of injury. From stroke and spinal cord injury to amputee and orthopedic injury, the Vector provides a customized gait training solution for patients of all levels. Leveraging dynamic body weight support, the Vector System allows patients to perform pre-gait activities, practice over-ground gait rehabilitation, and accomplish ADL training.



B.I.T.S. Bioness Integrated Therapy System®

Using a 50" touch screen monitor, BITS is designed to improve visual abilities for a wide range of patients with visually-related learning problems, strabismus, amblyopia, and traumatic brain injury. BITS offers 16 unique programs with customizable features designed to enhance outcomes for physical and occupational therapy patients.

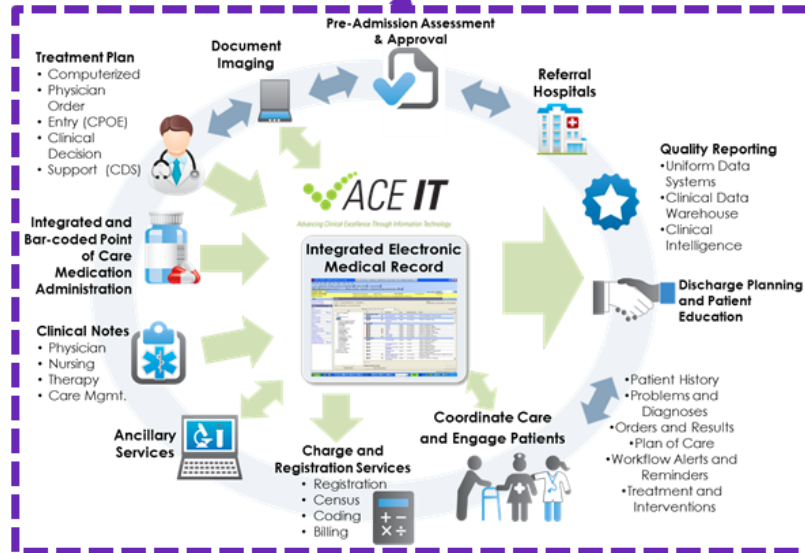
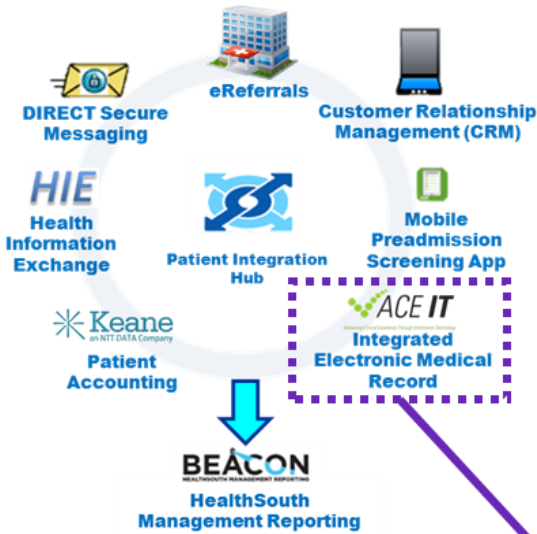


VitalStim®

For those who suffer from dysphagia, a common condition among stroke and brain injury survivors, this therapy greatly improves swallowing ability with electrical stimulation.

Encompass Health

Patient-centered technology allows for benchmarking & continual improvement



Proprietary EMR

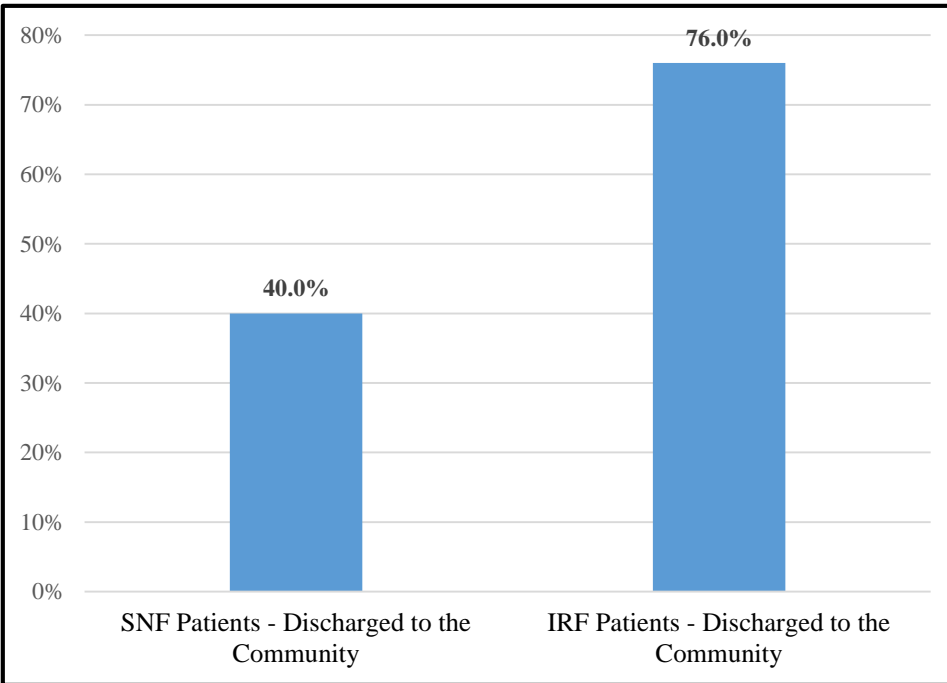
- ACE IT is a proprietary, rehabilitation-specific electronic medical records system that is fully implemented across our portfolio of hospitals
- Ability to interface with acute care hospitals and exchanges

Proprietary Management System

- Proprietary operations management system that provides real-time data
- Benchmarking to promote best practices
- Capabilities include:
 - Clinical collaboration
 - Physician quality reporting
 - Acute Care Transfer (ReACT) & Readmission risk
 - Therapy outcomes
 - Quality and patient satisfaction reporting
 - Workforce and labor productivity
 - Sales and marketing analysis
 - Care management
 - Food and drug spend analysis
 - Market-by-market analysis
 - Claims analysis

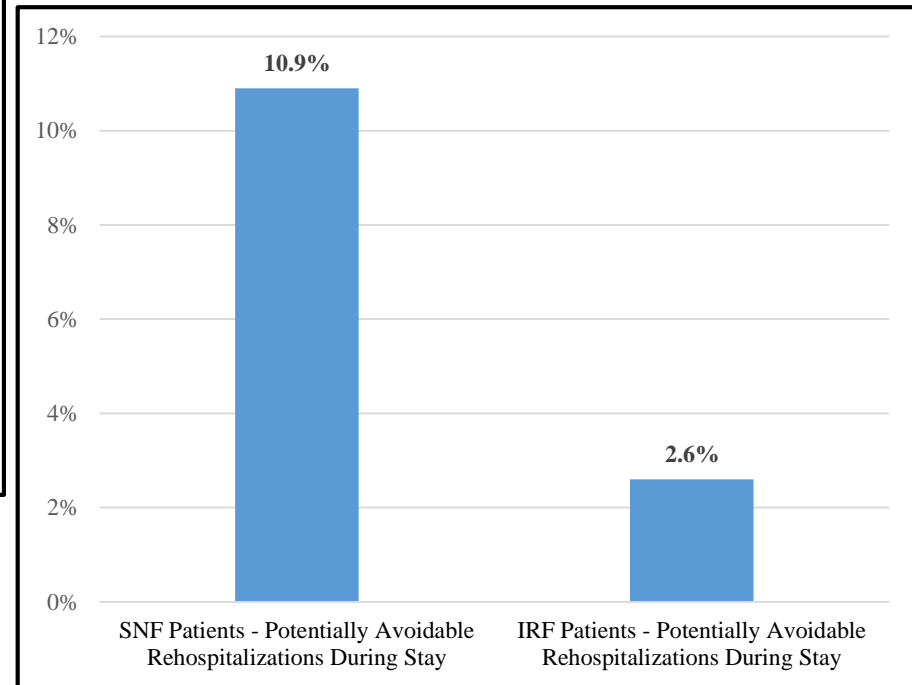
Rehabilitation Hospitals: Better Outcomes

Medicare Patients Discharged to the Community by Care Setting (2017)



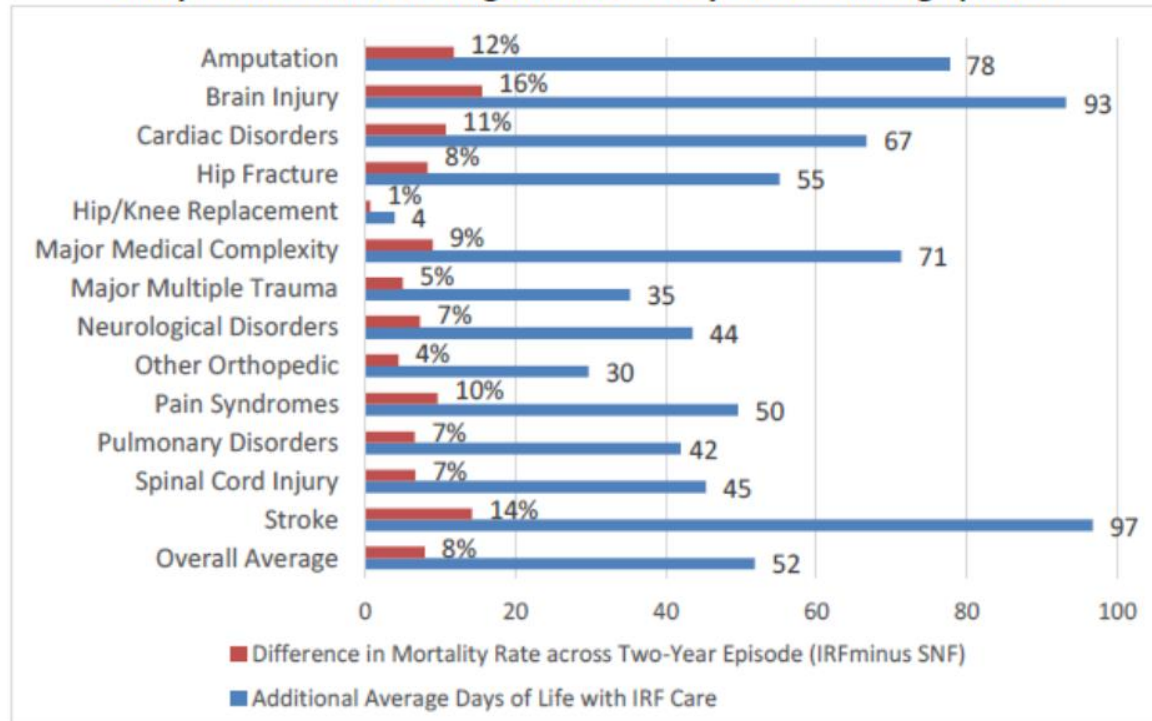
Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2019

Medicare Patients' Potentially Avoidable Rehospitalizations During the Patient Stay by Care Setting (2017)



Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2019

Matched IRF and SNF Patients: Difference in Mortality Rate¹ across Two-Year Study Period and Resulting Additional Days Alive³ During Episode*



*Difference in the mortality rate of matched IRF patients to matched SNF patients over the two-year study period. As a result of the lower mortality rate, additional average days of life represent the difference in the average episode length (after accounting for mortality) across groups (IRF average episode length in days minus SNF).

¹ Differences are statistically significant at $p < 0.0001$.

² Differences are statistically significant at $p < 0.0001$ with the exception of the number of readmissions per year, which are significant at $p < 0.01$ for five of the 13 conditions.

³ Differences are statistically significant at $p < 0.0001$ with the exception of major multiple trauma, which is significant at $p < 0.01$.

Source: Dobson | DaVanzo analysis of research identifiable 20% sample of Medicare beneficiaries, 2005-2009.

Oregon Bed Need Methodology

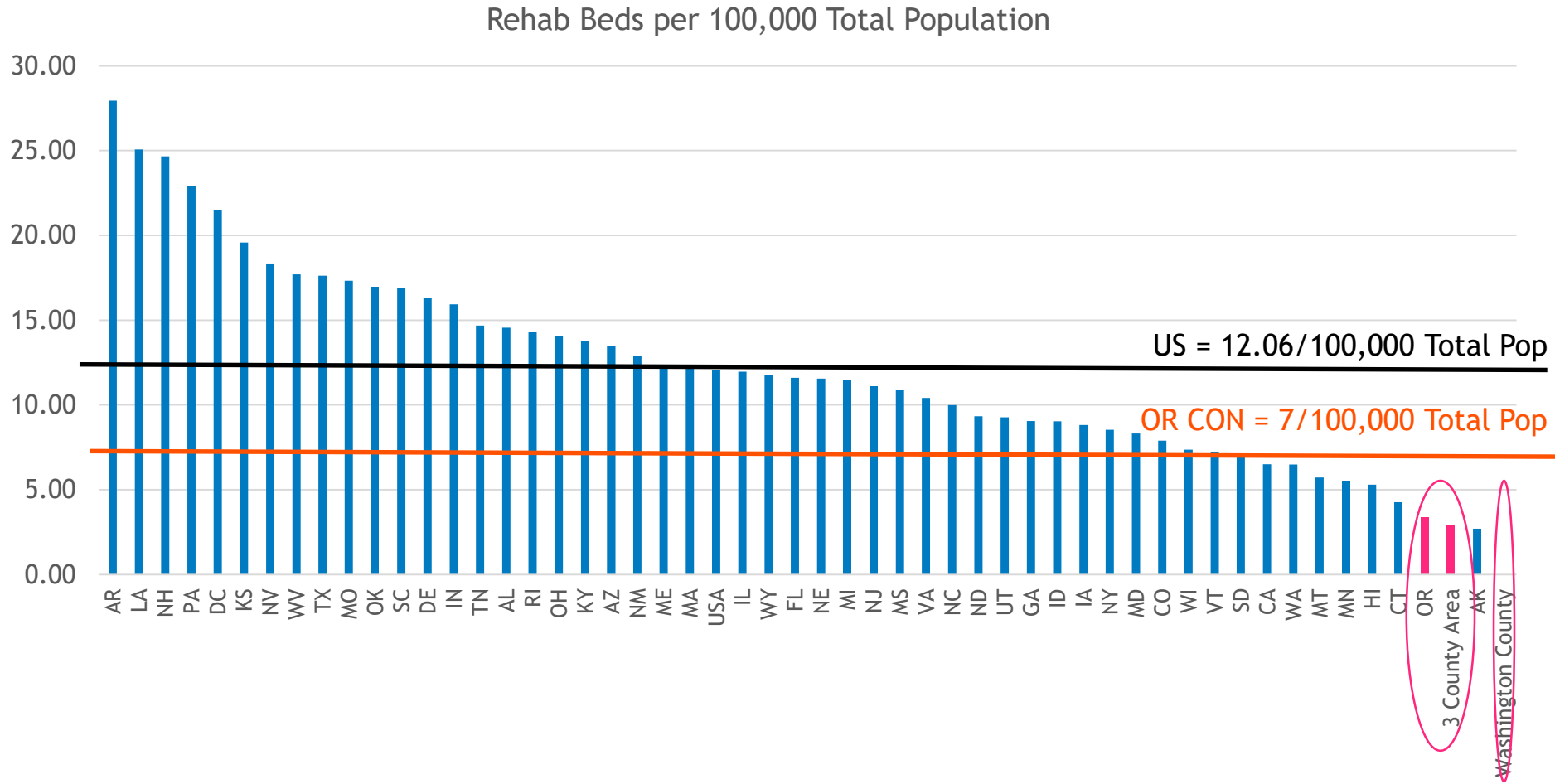
Division 645....directs applicants to:

- **Compute the rehabilitation needs of a population using 7 beds per 100,000 person standard as adjusted:**
- **Address specialty rehabilitation**
- **Address the special needs population at risk in the proposed area**
- **Address the sizes of population at risk in the proposed area**
- **Address the current and historic rates of hospitalization in Oregon for these groups**
- **Address the availability of existing IRF's**
- **Address accessibility of existing IRF's**
- **Address quality of existing IRF's**
- **Address levels of utilization of existing IRF services**

CON Application, p. 9

Bed Need Methodology

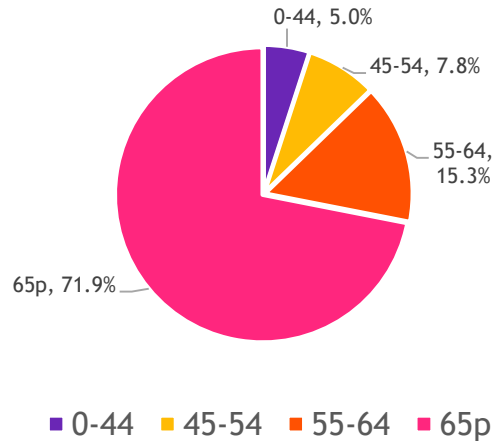
Oregon and the Service Area Currently Rank in the Bottom 10% of States on Rehab Beds per 100,000



Source: DHG Healthcare Analysis
Rehab Beds: Cost Reports, other market research
Population Source: Claritas - Pop-Facts Advanced 2019

IRF Services are Focused on Elderly Populations Where Need is Greatest

72% of IRF Patients are Age 65+



Medicare Clearly Focuses on Rehab Services for 65+ Complex Patient

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").

Population Segmentation

3 County Area- Population Segmentation Matters

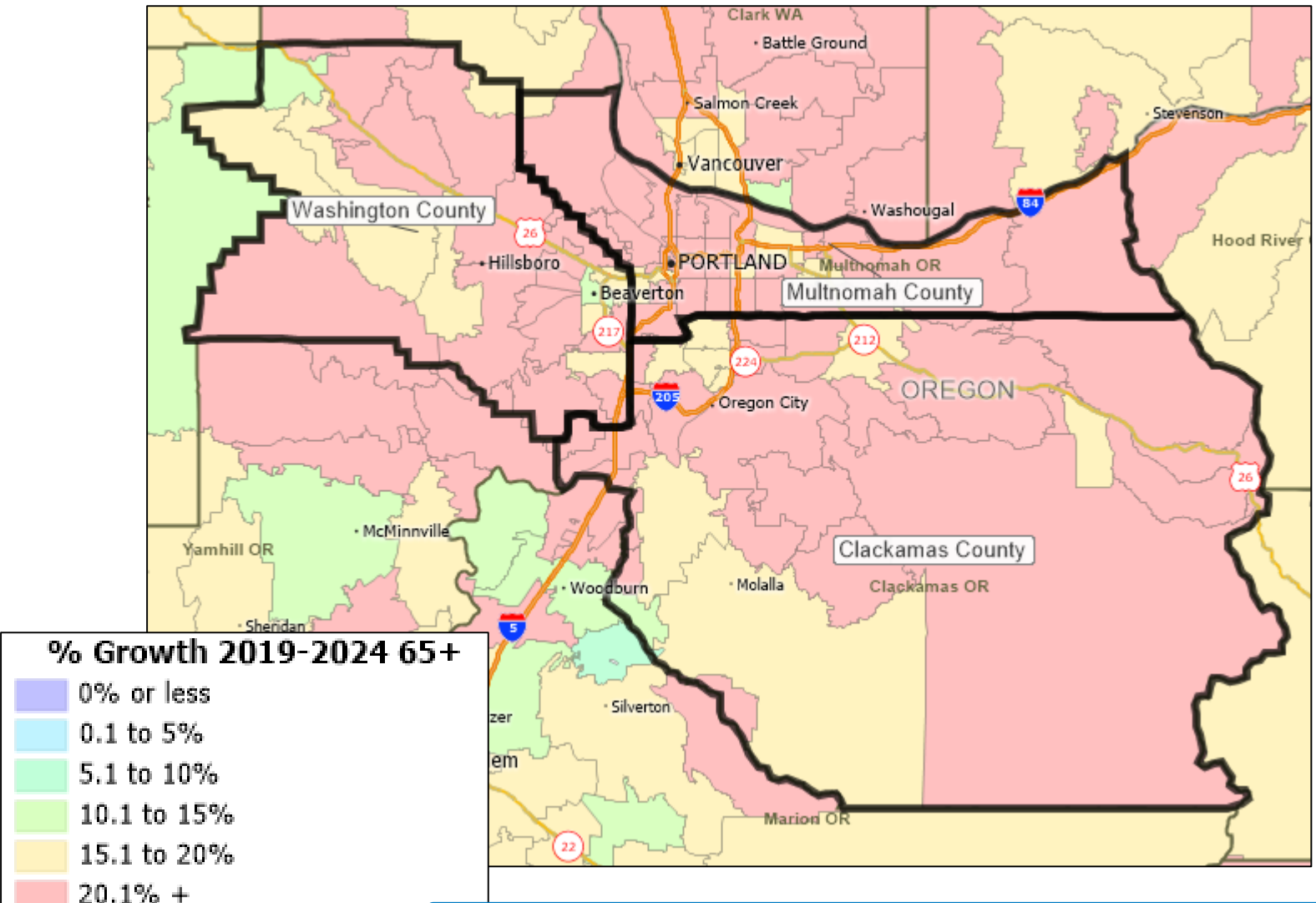
Washington County	Population		Change 2019-2024	
	2019	2024	Numeric	Percent
<65	521,957	544,658	22,701	4.35%
>65	82,404	101,350	18,946	22.99%
Total	604,361	646,008	41,647	6.89%
Clackamas & Multnomah Counties				
<65	1,051,422	1,086,794	35,372	3.36%
>65	191,375	234,777	43,402	22.68%
Total	1,242,797	1,321,571	78,774	6.34%
Oregon				
<65	3,464,158	3,567,592	103,434	2.99%
>65	759,054	901,773	142,719	18.80%
Total	4,223,212	4,469,365	246,153	5.83%

65+ Population is growing 5x faster than the under 65+ population

65+ Population is growing 7x faster than the under 65+ population

Population Segmentation

2019-2024 65+ Growth Rate Shows that the Elderly Population is Growing Dramatically Across the Service Area

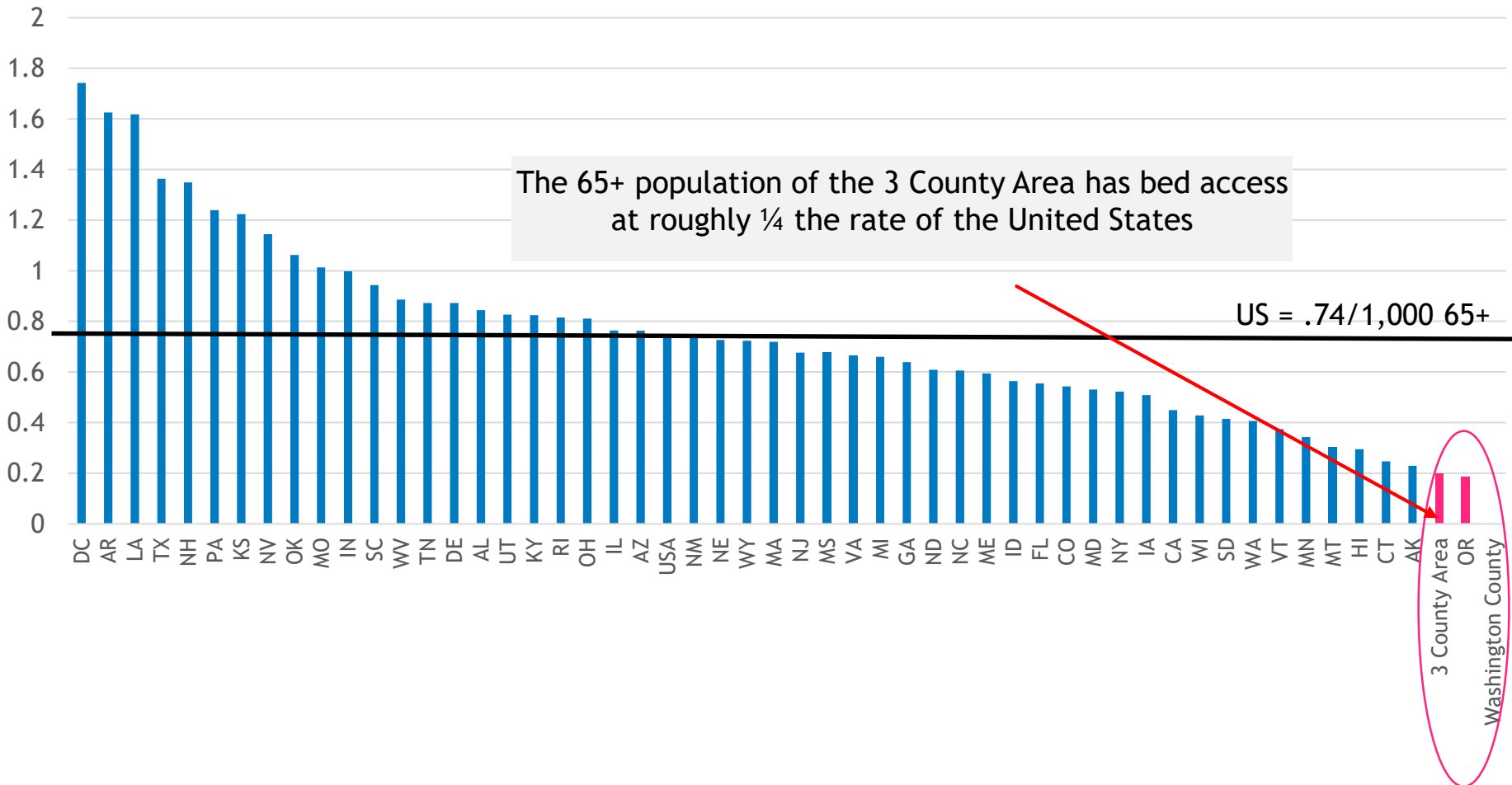


Population Source: Claritas - Pop-Facts Advanced 2019

Population Segmentation

Oregon and the Service Area Rank at the Bottom of the US in Beds per 1000 for the 65+ Population

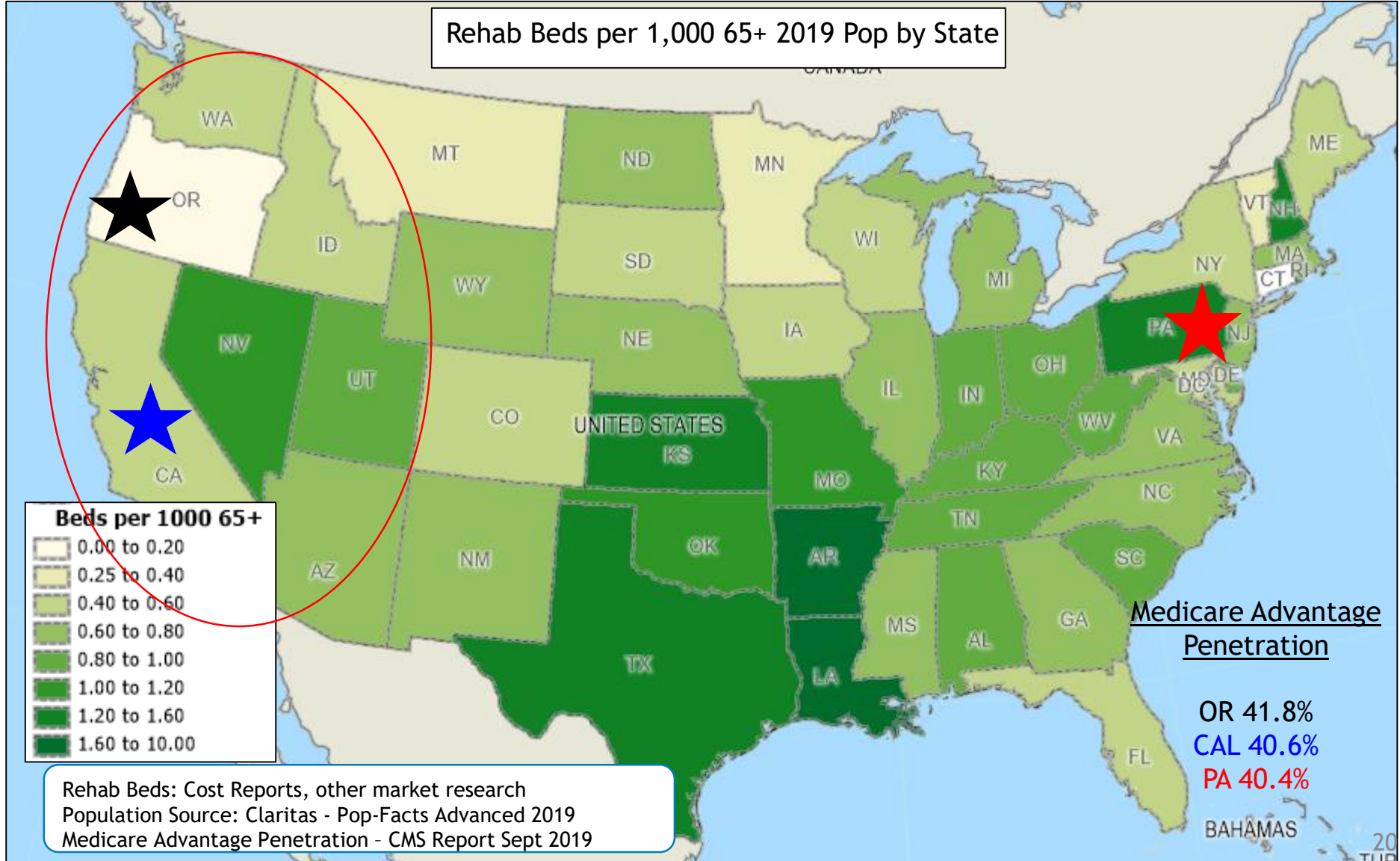
Rehab Beds per 1,000 65+



Source: DHG Healthcare Analysis
 Rehab Beds: Cost Reports, other market research
 Population Source: Claritas - Pop-Facts Advanced 2019

Population Segmentation

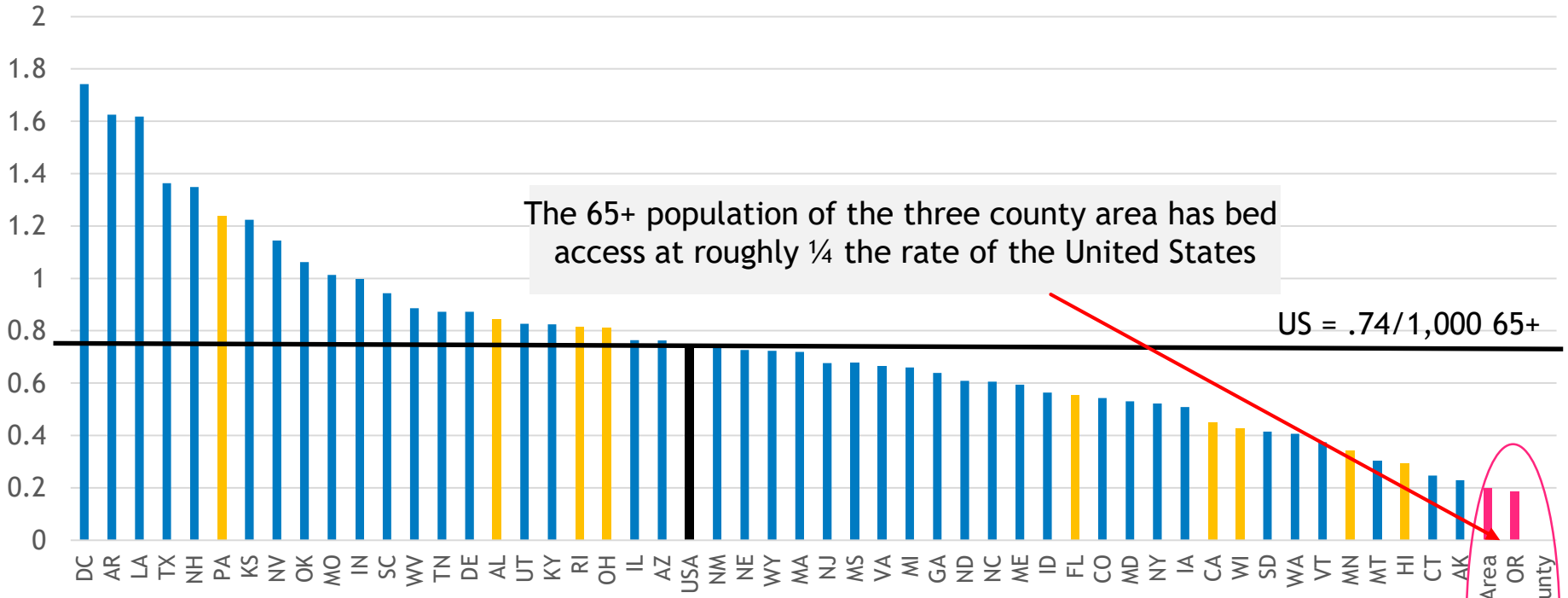
Access to Rehab Beds for the 65+ Population is Lowest in Oregon than any Other State



Population Segmentation

Oregon and the Service Area Rank at the Bottom of the US in Beds per 1000 for the 65+ Population

Rehab Beds per 1,000 65+

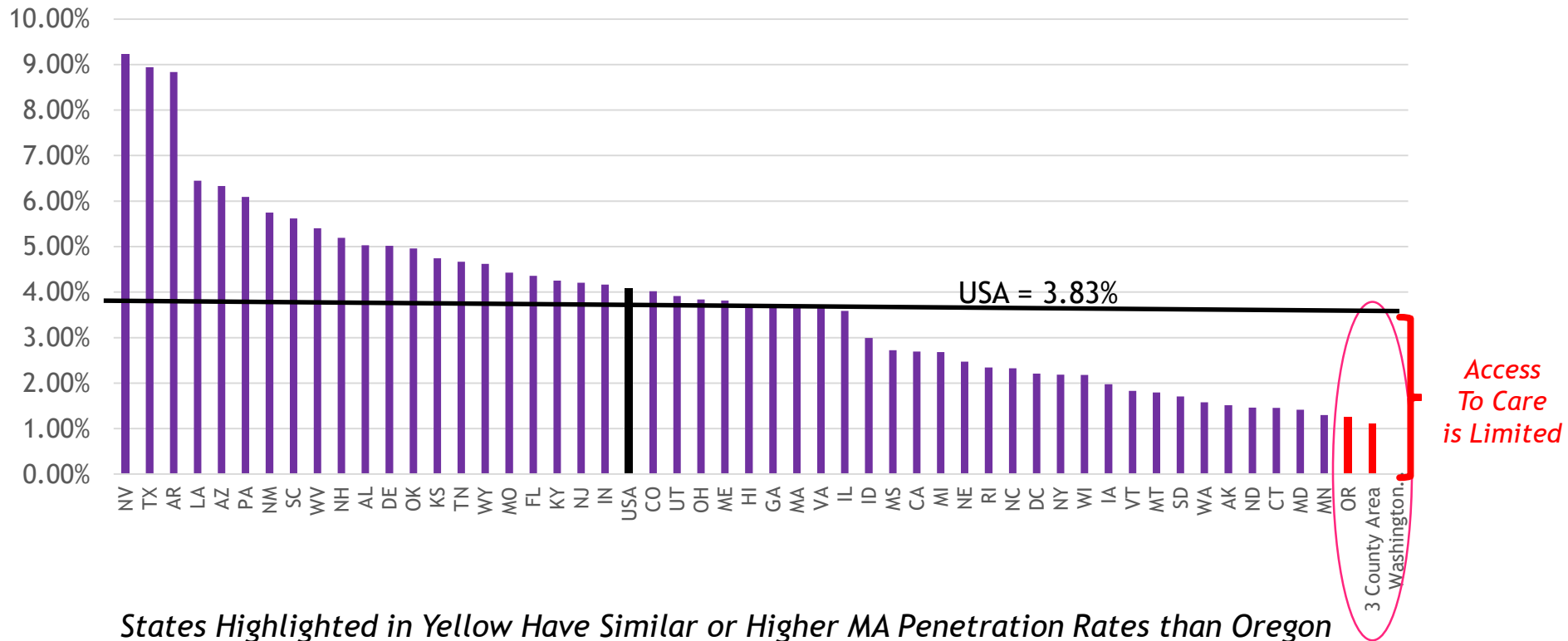


States identified in yellow all have Medicare Advantage penetration rates similar or greater than Oregon (40%+).

Source: DHG Healthcare Analysis
 Rehab Beds: Cost Reports, other market research
 Population Source: Claritas - Pop-Facts Advanced 2019

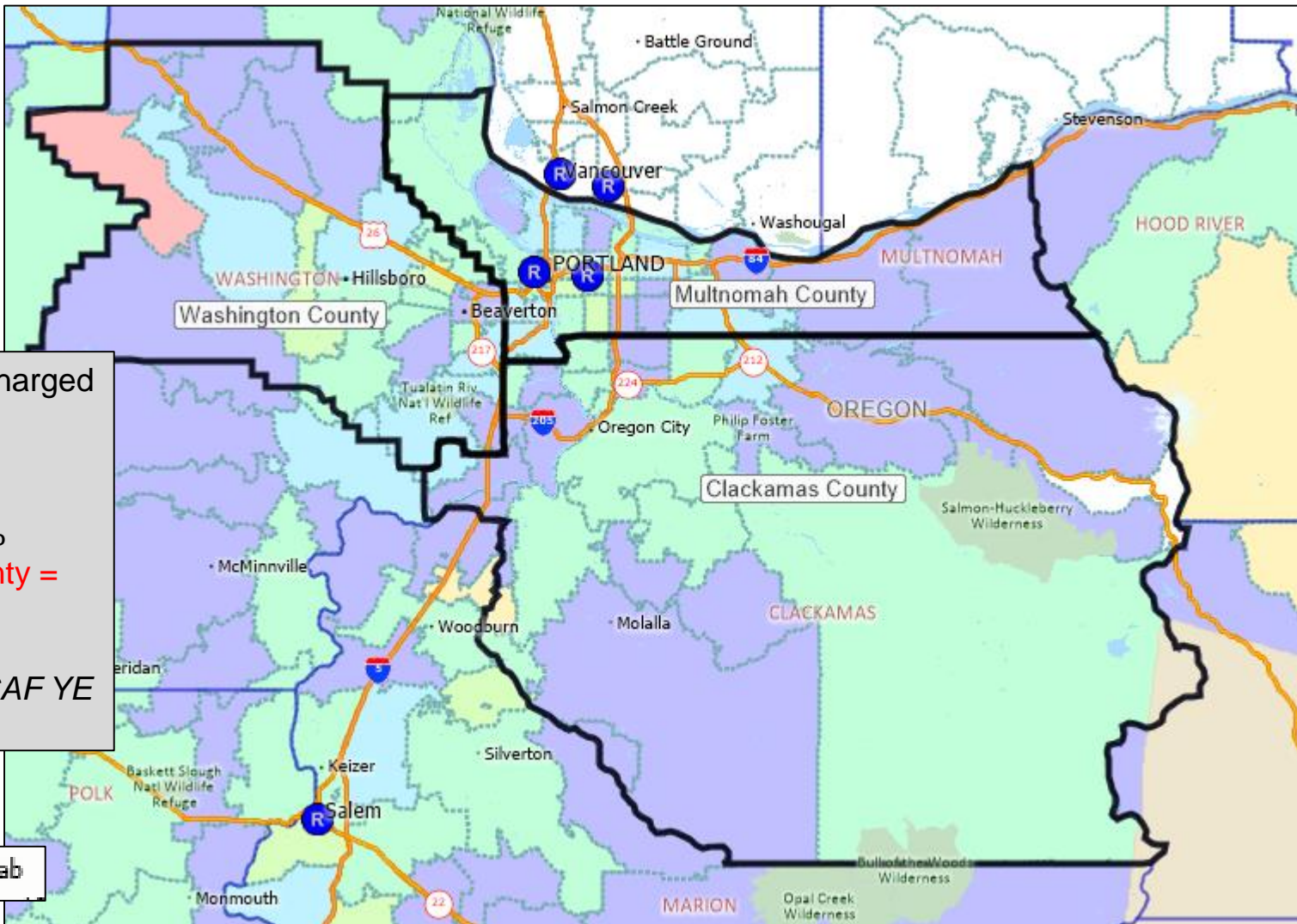
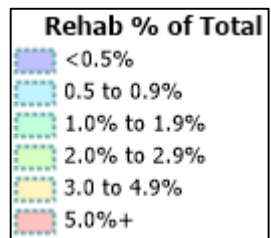
By Other Common National Utilization Benchmarks this Area is Underserved with Rehab Services

Medicare Conversion Rate to Rehab (Medicare Rehab Discharges/Medicare Acute Discharges)



States Highlighted in Yellow Have Similar or Higher MA Penetration Rates than Oregon

Low Utilization of Rehab is Evident Across the Service Area



Acute Patients Discharged to Rehab

USA = 3.83%
State = 1.14%
Washington County = 0.99%

Source: Medicare SAF YE 2018Q3.

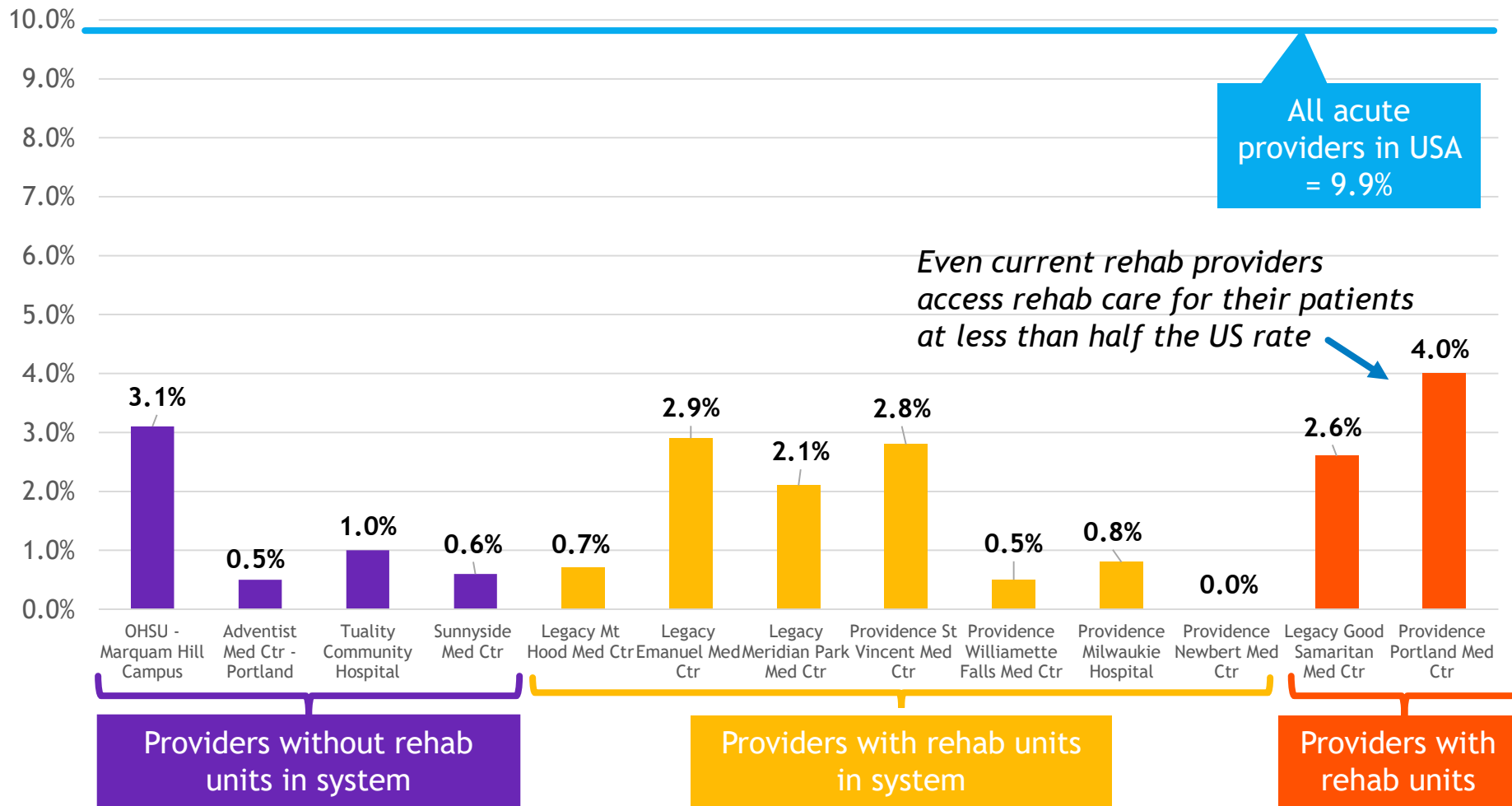
Acute Care/Rehab

Discharge Source: Medicare Standard Analytical IP File YE 2018Q3. Shows acute discharges with a discharge status of rehab as a % of total. Acute discharges exclude LTAC hospitals, rehab hospitals and rehab DPUs. Product lines excluded: alcohol and drug abuse, neonatology, normal newborns, OB, psych and rehab.

Access to Appropriate Services

Access and Availability of Rehab Beds Impacts Utilization of Rehab

2016 % of Potentially Rehab Appropriate Patients Discharged to Inpatient Rehabilitation by Provider



Top 20 Largest Counties in US with no Rehab Beds

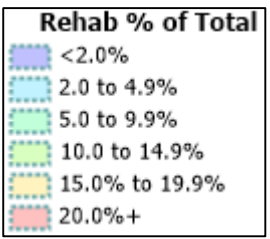
	County	2019 Total Pop
1	San Mateo County, CA	779,473
2	Washington County, OR	604,361
3	Anne Arundel County, MD	579,979
4	Union County, NJ	569,042
5	Plymouth County, MA	519,639
6	Prince William County, VA	470,275
7	Pinal County, AZ	446,877
8	Dakota County, MN	427,370
9	Clackamas County, OR	421,801
10	Anoka County, MN	356,540
11	Lake County, FL	356,209
12	Larimer County, CO	353,332
13	Douglas County, CO	345,373
14	Somerset County, NJ	337,300
15	Howard County, MD	327,701
16	Lexington County, SC	296,997
17	Gloucester County, NJ	292,869
18	Clayton County, GA	292,252
19	Ottawa County, MI	291,072
20	Thurston County, WA	287,858

Source: DHG Healthcare Analysis
 Rehab Beds: Cost Reports, other market research
 Population Source: Claritas - Pop-Facts Advanced 2019

To the Patient...it Matters

Lack of access is clearly impacting the patients that need rehab services most. Stroke patients in Washington and surrounding counties receive rehab services at roughly half the rate of the US.

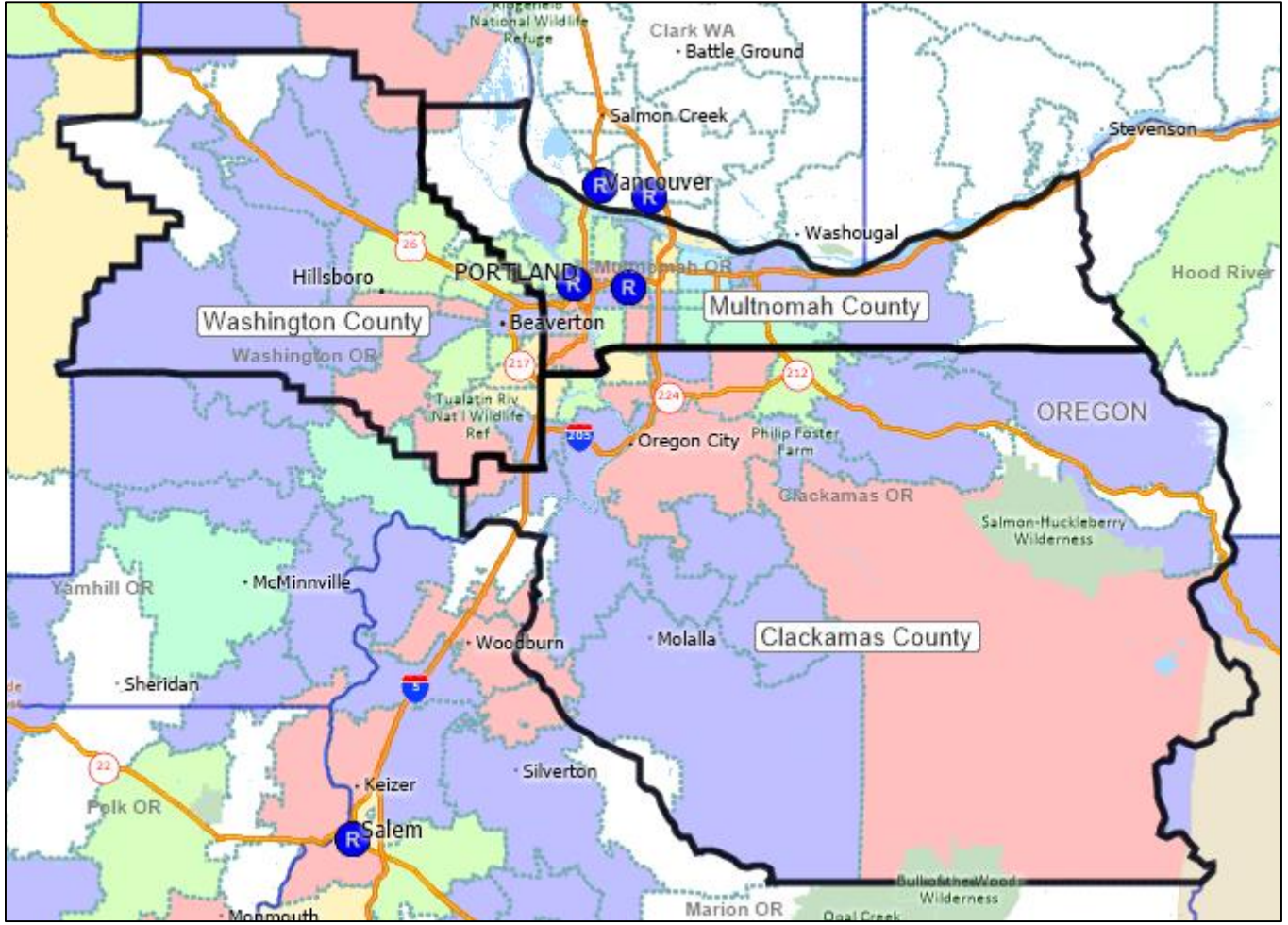
Access Issues - Stroke (DRGs 64, 65, 66)



Stroke Patients Discharged to Rehab

USA = 19.98%
 State = 11.84%
**Washington = 11.76%
 County**

Source: Medicare SAF YE 2018Q3.



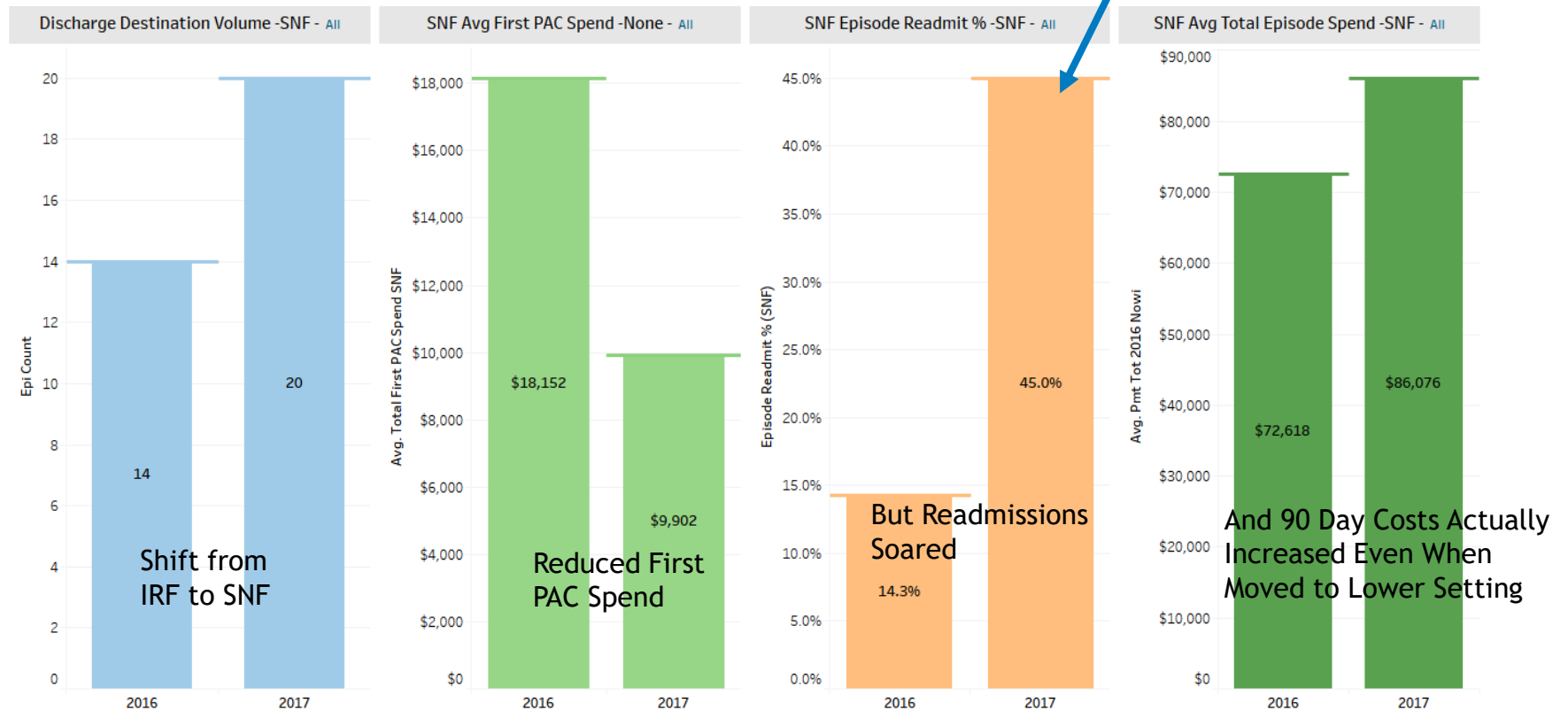
R Acute Care/Rehab

Discharge Source: Medicare Standard Analytical IP File YE 2018Q3. Shows stroke discharges with a discharge status of rehab as a % of total. Acute discharges exclude LTAC hospitals, rehab hospitals and rehab DPUs. Product lines excluded: alcohol and drug abuse, neonatology, normal newborns, OB, psych and rehab.

The Complex Patient is Best Served in IRF - One Example

Medicare data indicates that readmitted patients “spend” in 90 days almost 2x the patients with no readmission. A stroke patient, for instance, costs \$24,603 without a readmission and increases to \$47,865 with a readmission.

Cardiac Valve



(1) Source: Medicare Public Use Datasets, 2016-2017, analyzed by DHG Healthcare for Cardiac Valve DRG's for One Major Health System
(2) Source: Encompass Health provided study of Medicare data including case mix and average costs and average payment