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Encompass Health Corp. (EHC)

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Joanna Gajuk
Analyst, BofA Securities, Inc.

MANAGEMENT DISCUSSION SECTION

Joanna Gajuk
Analyst, BofA Securities, Inc.

Hi. Sounds like we are ready to start. Good morning, everyone. My name is Joanna Gajuk. I'm a Bank of America healthcare facilities and managed care analyst. Thank you so much for joining the conference and thanks for joining this session. So, it's my pleasure now to host the next 30 minutes with Encompass Health, who's the largest operator of inpatient rehab facilities in the US. And today, with us, we have Doug, who's going to introduce Brad. But Doug is the CFO of the company. And Brad, I guess, maybe you introduce yourself, too.

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

I'll introduce Brad very quickly, if I may, Joanna. First of all, good morning everyone. Thanks for your time and consideration this morning. Brad Kennedy is our Group President at Encompass Health. Brad started with Encompass Health 15 years ago. He was a physical therapist, but by the time he joined Encompass Health, he had risen to a hospital CEO. As Group President, Brad now oversees three of our eight geographical regions and is responsible for 60 of our 167 hospitals. So, very pleased to have Brad up here, a voice that perhaps many of you in this room don't get to hear from too often.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Great. Thank you so much. So, I guess, we'd go right into the Q&A.

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QUESTION AND ANSWER SECTION

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

The topic of the quarter was volumes in the quarter were very, very good. So, maybe walk us through how we should think about this translating to the rest of the year and going forward? I guess, you do have your long-term guidance for volumes, 6% to 8% organically. And how much, I guess, is coming from bed additions and de novos and such? And how we should think about this translating 2026 and forward?

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

A

Yeah. So for a period of time, we've had a long-range target of discharge growth of 6% to 8%. That is a multiyear CAGR, so we anticipate that there will be fluctuations from quarter to quarter based on things like what our comparable from the prior year is and also when new capacity is being added and the ramp up of that new capacity. Having said that, we've been pretty steady. For the last 11 quarters, we've had total discharge growth that exceeded 6%. And for the same 11 quarters, our same-store growth has exceeded 4%. We were very pleased with our growth in the first quarter, because we were up against a very difficult comp from last year.

Last year in the first quarter, our total discharge growth was 10%, and that was aided by two factors. First, and it does make a difference, is the first quarter of last year included an extra day because of leap year. And the second is the first quarter of 2024 ended on Easter Sunday. And we have observed historically is when you have the quarter end on a holiday, which is rare, but sometimes Easter comes into play, it has the effect of pulling forward discharges that might otherwise have occurred in the first week of the second quarter into the first quarter.

We continue to hold to that long-term discharge growth pattern. Again, it will fluctuate based on when capacity is coming on board. If you just do a comparison of 2025 to 2024, our capacity additions for this year are heavily weighted towards the back end of the year. We're opening up seven de novo hospitals in 2025, and five of those openings are occurring after September, whereas in 2024, we had many more of those openings occurring in the spring. But generally speaking, we would expect the breakdown between new store and same-store discharge growth to be about two-thirds same-store and the balance in new store.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

And talking about the new store, right, so you – recently you raised your targets in terms of the bed additions for this year and also the next two years. So, maybe you can remind the audience in terms of the economics, the returns you target for bed additions versus de novos.

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

A

Yeah. So, first, the real why in terms of why we increased the bed expansion activity is that our occupancy rate has been going up pretty rapidly. So, in the first quarter, our occupancy rate was at 78.8%, and that's the highest it has ever been. That was an increase of 210 basis points over an already high occupancy rate that was observed in the first quarter of 2024. It's important to note that we have been systematically increasing the

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theoretical occupancy rate of the company by increasing the portion of our overall portfolio that is comprised of private versus semi-private rooms.

As a point of comparison, if you go back as recently as the end of 2020, about 40% of our overall portfolio was comprised of private rooms and the balance was in semi-private rooms. And the breakdown between those two is important, because your occupancy level is always going to be higher if you've got more private rooms, and that is due to the fact that you don't have to account for issues of gender or germ compatibility.

It's also the case that just given the conditions that we're treating in our hospitals, a high percentage of our patients come to us with some form of cognitive impairment, and that can require patient isolation as well. As a result of really three initiatives, one is the fact that all of our de novo activity is comprised of private rooms – almost all of our bed expansion opportunity is comprised of private rooms. And when we are doing remodels of older hospitals, which have semi-private rooms, which was a convention as recently as 10 years ago, we try to take the opportunity to convert some of those into private rooms.

We've lifted the percentage of our portfolio that is comprised of private beds at the end of the first quarter to 56%. So, a very substantial increase. Even with that, it's a high class problem at a 70% occupancy rate, and it's not evenly distributed across all of our hospitals. We identified some opportunities based on sustained growth that we've been realizing over several years to pull forward some bed expansions that were otherwise likely to occur in 2027 or 2028 into 2026, and that'll increase our overall capacity.

The returns on bed expansions are the highest return that we get on a deployment of capital. And that is because we are building into a market where the demand is already known, just justifying the bed expansion, to begin with. We are leveraging components of the fixed infrastructure and the administrative staff. We already have payer contracts and referral sources in place. So, it's not infrequent that we will see a return on a bed expansion with an IRR that is north of 30%. So, basically, we'll take all of those opportunities that we can get.

We've increased the targeted number of beds that we'll be adding to existing hospitals for each of 2026 and 2027 to about 120 each. And again, look forward to additional opportunities to be able to do that.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

And so, you said 30% on the beds, and could you compare it to de novos when you build completely new facility, how are the returns on those?

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

A

So, we look at the de novo returns a couple of ways. The first is that we want the ROIC by the end of year three of a de novo opening to exceed our weighted average cost of capital. When we're looking at the IRR on those, it's typically in the 12% to 15% range. And we've got a pretty good track record of being able to exceed those targets.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

Right. No, these are very attractive numbers, and I guess, explain why you're feeling strongly about the ability or the reason why you're going to accelerate, like you said, the bed expansions and such. So maybe, Brad, you can talk about – it sounds like you oversee a good chunk of the company. So, maybe kind of walk us through the

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plans in your regions in terms of the de novos and also maybe give us some examples of the success stories or how you're kind of looking at how, I guess, the strategy is playing in real life.

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.

A

Absolutely. So, I think what underpins this growth is the aging demographic, and we're experiencing those demographic tailwinds. One out of every five Americans will be over age 65 by the year 2030, and that's our cohort, over age 65. In fact, our average age patient is 77. So, we are experiencing those demographic tailwinds. Additionally, when we identify a market that has the possibility for de novo, we take a very data driven approach to our due diligence. We look at what the competitive landscape is, the demographics of the market, the divergence of the supply and the demand in that particular market, how fast the age 65-plus population is aging in that market. We look at the Medicare Advantage penetration. We look at labor costs, land costs, what potential construction costs would be. We even look at the proximity to an existing hospital. And I want to share our success stories with that strategy in my region.

We have used that strategy in several of our larger markets such as Houston, St. Louis, Atlanta, some of our markets in Florida. And even here in Las Vegas, we have three hospitals proximate to each other. And we realize some economies of scale with that situation, because we're able to share staff freely, we're able to share medical staff freely. But also, importantly, two of these strategies were implemented along with two major joint venture partners, BJC HealthCare in St. Louis, and Piedmont in Georgia. We aligned ourselves each other with – or each other's growth strategy, and we determined that we could expand to align with our joint venture partners' footprint, so there would be overlap. That's been very successful in both markets. In St. Louis, we started with one hospital in 2001. Since 2017, we've opened an additional hospital and two additional satellites. In Georgia, we are now up to seven operating JV hospitals with Piedmont and one is under construction.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

And I guess, maybe just touch a little bit more on that JV strategy, right? Is there also some numerical thought process there kind of the returns on a JV/non-JV? Because it sounds like there's some benefits [ph] – clear benefits that you JV for (00:10:45).

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.

A

There are. It's part of our due diligence when we are looking at a market, we look at how many acute care hospitals are in the market, what are the individual market shares for those acute care hospitals. We look at whether an acute care hospital has an in house inpatient rehabilitation unit. Is it operating well? Do they have opportunities with their length of stay in the acute care setting, readmission rate, things that we can help them with, because we are a very attractive partner for acute care hospitals for different reasons. And typically, they actually come to us.

One reason may be they want to add IRF to augment their continuity of care, and they need a partner to help them do that. Another reason may be that they are operating an in house inpatient rehabilitation unit. It's either not operating well or they need that space for another service line. And so, they come to us to help them roll those beds out. We absorb the beds and roll them out into a freestanding hospital. So, JV partners are about 40% of our book of business, and we have a very robust pipeline. And in any typical moment, about 50% of our pipeline consists of potential JV partnerships. So, we see that as an upside.

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

A

From pure financial return, there's not a very distinct difference between a JV and a wholly-owned hospital, but there two are – or two advantages that a JV structure brings to the table. One is, as Brad mentioned, most frequently when we're doing a JV, we're having them contribute a unit that's housed within their acute care hospital into a new freestanding IRF. And so, that gives us an immediately boost in the out of the ground ADC or average daily census. And so, the ramp-up tends to be a bit faster in the joint venture opportunities.

The second is we get a management fee. And so, on our portion of the capital, you're adding a spread that is typically 3% to 5% revenue in the form of a management fee, which we think we earn and we believe that our joint venture partners would agree with that, but it does help from a pure financial perspective boost the return.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

And I guess, we started this conversation, you mentioned the occupancy rate was so high, but also the inside your payer mix, right, the Medicare mix was very high. So, maybe you can talk about this a little bit. Is this something that is sustainable? I mean, you mentioned, Brad, the aging demographics and such. So, should we just expect kind of this continue or there's something else that happened in this quarter that was unusual that drove that 76%, I think, of Medicare [ph] payers mix (00:13:24)?

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

A

Actually, it was 67%.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

67%. Oh, I flipped it.

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

A

Yeah. So, what Joanna is referencing is in the first quarter of 2025, our traditional Medicare discharges grew faster than Medicare Advantage. And that is not something we had observed since early in 2022. In the periods preceding this, Medicare Advantage discharges have been growing faster than Medicare fee for service, although both of them had been progressing at a very nice CAGR. As a matter of fact, if you take the period from 2020 to the end of 2024, our discharge growth CAGR for Medicare fee for service was north of 7% and was right at about 9% for Medicare Advantage. So, seeing nice growth in both of those payer mixes.

We didn't take any kind of different strategic approach in the first quarter that led to that change in the relative discharge growth rates. And one quarter does not a trend to make. We think there remain very good growth opportunities within both of those payer classes. And so, we'll continue to observe that over time.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

So, maybe to that end, you can talk about your strategy with Medicare Advantage plans, right. So, you've done a pretty good job increasing that payer mix, right, because historically it was sort of underpenetrated, so to speak. And it sounds like maybe there's still a little bit more room. And also, to that end, can you talk about your

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contracting strategy? It sounds like, you did pretty good job on closing the gap in the rate. So, can you kind of remind us where you are? And is there more, I guess you can do with Medicare Advantage plans?

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

A

Sure. Maybe I'll start with a few of the numbers that underline that discussion. I'm going to hand it over to Brad really to talk about the strategy, because he's one of the folks that's out there on the front line, dealing with this on a regular basis. So, to Joanna's point, we've made a lot of progress with regard to our Medicare Advantage book of business. If you roll back the clock to as recently as 2018, Medicare Advantage in terms of our payer mix would have comprised just under 9% of our overall discharge base and it's closer to 17% now. Some of that is just a result of enrollment trends within the Medicare beneficiary population, but much of it has been a deliberate effort of us getting out and meeting with the plans and underscoring our value proposition, particularly around complex medical conditions like treating stroke and neurological disorders.

It is also the case that if you went back to really the initial adoption or the tick-up in the adoption rate of Medicare Advantage, which would have been on the heels of the introduction of the Affordable Care Act in, say, 2011, that we started with a very significant gap in terms of reimbursement rates between fee for service and Medicare Advantage. It was north of 25%. At the end of the first quarter of 2025, it was less than 2%. And so, we have been doing two things in conjunction as part of our contracting. We have been moving our contracts from being paid on a per diem basis to being paid on an episodic basis. And we now have more than 90% of our contracted Medicare Advantage revenues paid on an episodic basis. And as we've been doing that, we've been tying those episodic rates to the Medicare fee for service rates.

Now, frequently, when we're initially flipping a contract over to episodic, we'll require – or it'll require us offering a discount. And then either based on quality measures being achieved or just the passage of time or sometimes both, that discount narrows. I'm going to ask Brad to talk specifically about some of the components of our value proposition.

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.

A

Sure. So one major difference between Medicare Advantage and fee for service is that Medicare Advantage requires pre-authorization for our services. So, there is a difference. Our conversion from referral to admission for Medicare Advantage is less than fee for service Medicare. But we see that as upside, because most of these pre-authorization decisions are made regionally or locally. So, our hospital operators frequently meet with representatives from the Medicare Advantage plans to discuss our value proposition. So, most Medicare Advantage plans, as Doug mentioned, now pay us a capitated rate. They also pay acute care hospitals a capitated rate. So, they are aiming to control the episodic cost of care, and that's where we can help them.

The major inflation factor for increasing episodic cost of care is a readmission back to acute care. Because of our value proposition, because of our clinical initiatives, such as predictive analytics that help us identify patients who are at high risk for readmission, our evidence-based clinical protocols to take care of high acuity patients, and our therapy – advanced technology to take care of those stroke, brain injury, neurological condition patients, our message is resonating. And in the last quarter, we saw our MA stroke mix increase by 20 basis points. So, we feel there's continued upside. We continue to educate the Medicare Advantage plans.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

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So would you say, right, because based on just the nationwide penetration, MA is maybe 53%, 54%?

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.
A

In our markets, it's 54%.

Joanna Gajuk
Analyst, BofA Securities, Inc.
Q

Okay. So, are you there [ph] or (00:18:48) there's more, I guess, even on the penetration with MA to go for you guys specifically?

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

I think there's a lot more upside, to get back to something that Brad mentioned, and that is the conversion rate. So, we look across payer classes at the percentage of referrals within a payer class that ultimately get converted into an admission. And even with the tremendous progress that we've made with Medicare Advantage, predominantly based on restrictive pre-authorization procedures, our conversion ratio for Medicare Advantage is about half what it is for fee for service. And there's no reason when we look at the underlying patient base why that distinction should occur. So, it's hand-to-hand combat. We are armed with very good results for the patients that we are treating, and we're making progress along the way, but it represents significant opportunity for us.

Joanna Gajuk
Analyst, BofA Securities, Inc.
Q

Great. And also topic of today is health plans complaining about high utilization and higher trend. So because of that – and I guess it's not really maybe today, but through this year and the last two years really. So, are you seeing more denials from MA plans because of that, as in like they try to manage the cost better? Or is it the reverse, where maybe you're a beneficiary of it as a – to your point, Doug, in terms of your solution, maybe some of the cost [ph] run (00:20:07) issue that they have with inpatient?

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

It varies from plan to plan. Overall, it's been pretty steady. As I said, it's really hand-to-hand combat. Brad mentioned the fact that many of the decisions – all of the large national plans operate on a very decentralized basis, and that's fine with us. And it just means that in each one of our geographies and each one of our marketplaces, we have to observe on a regular basis what's happening within those plans and take concerted efforts to address any areas where we feel there's not an understanding of the value proposition that we bring to the table, or where there are unnecessary pre-authorization requirements that are really impeding upon the Medicare beneficiaries' choice for where they should receive their care.

Joanna Gajuk
Analyst, BofA Securities, Inc.
Q

Right. So you're not seeing any increase in terms of denials...?

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

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No, I think it's getting modestly better. We'd like to see it move faster. And I think if you go back and if you look at the Medicare Advantage update in 2024 that came out of CMS, it was some very specific language about the utilization differentials between Medicare Advantage and Medicare fee for service, and they were really getting called out on that. We'd like to see some additional teeth behind that. We carry our own experience to the halls of CMS on a regular basis just to keep them informed about what we're observing in the field, because we're the largest player in this space.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

Right. And I guess maybe shifting the gears a little bit to the fee for service. In DC, a lot of discussions, right, there are lot of different topics. At least, you guys are not exposed to Medicaid discussions. But as you know, there's talk of fraud and abuse and going after that. Is there any risk in your head that somehow IRF's going to be there in terms of just part of some cuts to Medicare spending at some point? Because obviously, [ph] MedPAC (00:22:00) has been going out with this report every year and flagging that Medicare margins for IRFs are pretty high relative to, say, like hospitals. So, do you view this as a risk that at some point something might happen from CMS or Congress, I guess?

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

A

We don't know that there are any flashing red lights or even yellow lights. If you think about it, IRF is a relatively small segment of the overall Medicare program. We make up less than 2% of the overall expenditures on an annual basis, and it's not as if that level has been rising at an alarming rate, which would signal some kind of attempted fraud or abuse. It's also the case that we are subject to numerous and frequent audits already that are authorized and administered by CMS. We talk about TPE, Targeted Probe and Educate, which goes on, on a regular basis. We've got Review Choice Demonstration that is underway in the state of Alabama. There are more audits with more acronyms that I could go through.

So, a high percentage of our claims are audited on either a prepayment or a post-payment basis every year, and we prevail at very high rates. Our overall bad debt expense tends to hover right around 2%. And on any comparative basis, that's very favorable. We put a big emphasis on compliance. The fact that so much of our documentation is automated through the clinical information system that we first began developing and investing in, in 2011 is a big advantage in that regard.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

Right. And the one item, right, that CMS – I guess it must have been already a couple of years ago – been considering around the transfer policy for home health transfer policy, and they haven't really come back to this idea. So, do you think this is kind of like off-the-shelf or it might come back at some point?

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

A

Well, you never say never, right? It's like one of those recurring characters in a Halloween horror movie and so forth. You think it's been killed several times and it tends to raise its head. But there's been absolutely no discussion of this topic at all in the last two years. And even its initial level of discussion, I think, was substantially overplayed. So, I think it was back in 2023 of the proposed rule, there was simply a request for comments from the industry, not a suggestion that it was going to be incorporated into the rule in coming years. Those comments were provided by participants in the industry, including us. When the final rule came out later that fall, there was

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absolutely no mention of the home health transfer policy, and we've gone now two rulemaking cycles without any further mention of it.

We hear nothing about it in the halls of Congress or in our frequent discussions with CMS. So, obviously, we're cognizant of the fact that it is one of the issues that are on the table, as are so many that have been brought up as a potential threat to the industry and never materialized. I mean, go back and think about, oh, my goodness, you're going to go from a 60% required CMS 13 compliance to a 75%; there's going to be a site neutral payment, all of these things come up. The fact is, and Brad alluded to this earlier, the underlying demand for the patients that are treated in the IRF setting is only growing, and those patients cannot be treated in many different settings. So, somebody has got to be there to treat those patients.

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.

A

And to tag on to that, only 14% of presumptively eligible IRF patients actually make it to IRF in the United States. That means that there's a large portion of IRF-appropriate patients that are going to other settings, but they could be better served in IRF. So, we know that there is a total addressable market that is not currently reflected in the current penetrated market.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

I guess we have a few minutes, so there's two topics I want to hit on. So, another one in DC around tariffs, because I'm thinking like what else could be, I guess, impactful to you, because again like reconciliation bill doesn't seem like there's anything in there, but maybe walk us through your thought process around the supply expenses, and if we get there, right, and there's some increase in costs, how you're thinking about this? And is there any mitigation strategy you might have been considering, if that was to happen?

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

A

Yeah. So with regard to the threat of tariffs – and the story [ph] literally (00:26:30) changes from hour to hour for all of us, right? There are two areas that we really focused on. One is because we're adding so much capacity in the form of de novo construction and bed expansions as well, do we see anything immediately that is pressuring the cost of that construction? And again, to provide a basis, we have been running for the last several years at cost of roughly $1.2 million per bed for de novo construction. We do a little bit better than that on bed expansions because, again, you're leveraging components of fixed infrastructure. So, those tend to run about $800,000 to $850,000 per bed.

In terms of the activity that is underway right now, which really covers 2025 and 2026, we're not seeing any upward pressures. And I had a discussion just last Friday with our Head of Design and Construction. We had four projects that were put out for final bids. We had had a preliminary bid. They moved forward in our approval process internally and we put them out for final bid. Two were de novos, and these are for projects beyond 2026. And two were bed expansions. And all four of those bids came back at or below the preliminary bids.

So, we're not seeing upward pressure on building materials right now, and we're actually seeing the benefits of some slacking demand amongst general contractors and subcontractors, which is increasing capacity and influencing price. So, the answer there is, for the foreseeable future, we're not seeing any pressure on building supply costs or construction costs from the tariffs.

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The second area that we look at are our variable supplies. When a patient is in our facility, we're responsible for feeding them every day and also for all of our medical supplies, including we are responsible for administering and covering the pharmaceuticals that our patients are on. And that's not insignificant, because, on average, a patient in one of our facilities is on nine different medications. And thus far, we have not identified any upward pressures. We worked with Vizient for many of our supply chain strategies. Much of that was reordered out of necessity during COVID. So, we'll continue to keep an eye on that. But as of right now, we're anticipating any upward pressures that would influence our guidance.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Q

Great. No, thank you. One minute left. So, another topic or my interest around free cash flow, pretty good, right, and leverage is already low. So, how we should think about deployment? Obviously, you've increased your plans in terms of spending money on beds and de novos and such. But what else, I guess, you can do? And in terms of, can you also talk about the leverage targets?

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

A

So I think, we're an and story, not an or story, Joanna. So, 2.0x in terms of leverage rate that we're currently at right now, feels like the old 3.0x. I think that there is an appreciation within our investor class that we hear about frequently for maintaining a lower degree of financial leverage, and we're in a fortunate position to be able to do that, and not be constrained in terms of the capital that we can deploy towards our best use, which is expanding capacity of our systems from the de novos and the bed expansions. We talked earlier about the fact that we've raised that target. And we're now complementing that with share repurchases. In the first quarter, we repurchased $32 million of our stock. Interestingly enough, that was more than we had purchased in all of 2024, and we expect to continue pulling that lever.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Great. This is right on time. Thank you so much.

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

Great. Thank you, everyone.

Joanna Gajuk
Analyst, BofA Securities, Inc.

Thanks, everyone.

Brad Kennedy
Group President-South Central Region, Encompass Health Corp.

Thank you.

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