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# Encompass Health Corp. (EHC)

Q1 2026 Earnings Call

## CORPORATE PARTICIPANTS

**Mark Miller**

*Chief Investor Relations Officer, Encompass Health Corp.*

**Mark J. Tarr**

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

**Douglas E. Coltharp**

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**Patrick W. Tuer**

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## OTHER PARTICIPANTS

**Ann Hynes**

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**Matthew Gillmor**

*Analyst, KeyBanc Capital Markets, Inc.*

**Andrew Mok**

*Analyst, Barclays Capital, Inc.*

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## MANAGEMENT DISCUSSION SECTION

**Operator:** Good morning, everyone, and welcome to the Encompass Health First Quarter 2026 Earnings Conference Call. At this time, I'd like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] You'll be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may be disconnected this time.

I will now turn the call over to Mark Miller, Encompass Health's Chief Investment Relations Officer. Please go ahead.

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### Mark Miller

*Chief Investor Relations Officer, Encompass Health Corp.*

Thank you, operator. And good morning, everyone. Thank you for joining Encompass Health's first quarter 2026 earnings call.

Before we begin, if you do not already have a copy, the first quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website at [encompasshealth.com](http://encompasshealth.com). On page 2 of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release.

During the call, we will make forward-looking statements, such as guidance and growth projections, which are subject to risks and uncertainties, many of which are beyond our control. Certain risks and uncertainties, like those relating to regulatory developments, as well as volume, bad debt and cost trends that could cause actual results to differ materially from our projections, estimates and expectations are discussed in the company's SEC filings, including the earnings release and related Form 8-K, the Form 10-K for the year ended December 31, 2025, and the Form 10-Q for the quarter ended March 31, 2026, when filed. We encourage you to read them. You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented, which are based on current estimates of future events and speak only as of today. We do not undertake a duty to update these forward-looking statements.

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

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

With that, I'll turn the call over to President and Chief Executive Officer, Mark Tarr.

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### Mark J. Tarr

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

Thank you, Mark. And good morning, everyone. We are pleased with our start to 2026 as first quarter revenue increased 9% and adjusted EBITDA increased 11.2%. Based primarily on our Q1 results, we are raising our

guidance for 2026. Doug will review the details in his comments. We achieved these strong results while, once again, delivering outstanding patient outcomes. Compared to Q1 of 2025, our discharge-to-community rate improved 50 basis points to 84.5%. Our discharge-to-acute rate improved 30 basis points to 8.6%, and our discharge-to-SNF rate improved 20 basis points to 6.2%. Our performance on each of these quality metrics exceeds the industry average.

We continue to invest in our clinical staff by providing professional growth and development programs, such as our Career Ladder programs, providing nurses with support to attain certified rehabilitation RN certifications, and offering in-house continuing education opportunities. We've seen increased participation in and benefits from these development programs. We believe our success in these programs contributes to the continuing improvement in our clinical staff turnover trends.

Q1 2026 annualized RN turnover was 17.8%, down from fiscal year 2025's 20.2% and annualized therapist turnover was 6.4%, down from last year's 7.8%. This represents our lowest RN turnover rate since at least 2012, and helped drive a 9.4% decline in premium labor spend compared to Q1 2025. We also believe that our clinical advancement programs and reduced clinical staff turnover further enhance our abilities to serve high acuity, medically complex patients and increase patient satisfaction scores.

Demand for IRF services remain strong, and we are continuing to invest in capacity additions to meet the needs of patients requiring inpatient rehabilitation services. In Q1, we opened a new 49-bed hospital in Irmo, South Carolina, our 11th hospital in that state. We also added 44 beds to existing hospitals. Over the balance of the year, we plan to open seven more hospitals with a total of 340 beds, and add an incremental 100 to 150 beds to existing hospitals.

We continue to build and maintain an active pipeline of new hospital development projects, both wholly owned and joint ventures, while also executing on bed expansion opportunities as dictated by occupancy trends and market dynamics. Our pipeline of announced new hospital projects with opening dates beyond 2026 currently consists of 11 hospitals with 520 beds. And we anticipate additional projects, including small format hospitals, will be announced over the balance of the year.

We have previously discussed the innovation of our small-format hospital, which will serve to facilitate a hub-and-spoke strategy in large and growing markets. We're confident we will open at least one small-format hospital in 2027, with the potential to add more depending on the timing of pending real estate transactions. The small-format hospitals will operate as remote locations under the same Medicare provider number as an existing in-market hospital, and will share certain administrative services with that hospital. Small-format hospitals will complement our existing de novo and bed expansion strategies.

This was a particularly active year on the regulatory front with implementation of TEAM beginning on January 1, and the expansion of RCD into Texas effective March 1, and California beginning today. We will work to address these developments as we have the numerous other regulatory challenges we have successfully navigated in the past through extensive preparation and proactive refinements of our operations. This is not to say that we will be immune from short-term transitory impacts to our business. Nonetheless, the fact remains that demand for inpatient rehabilitation services remains considerably underserved and is growing as the US population continues to age. We are uniquely positioned to address this important societal need.

On April 2 of this year, CMS released the 2027 IRF proposed rule. The proposed rule included a net market basket update of 2.4%, which we estimate would result in a 2.4% pricing increase for our Medicare patients beginning October 1, 2026. We expect the IRF final rule to be released in late July or early August.

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

## Douglas E. Coltharp

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

Thank you, Mark. And good morning, everyone. Q1 revenue increased 9% to \$1.59 billion, and adjusted EBITDA increased 11.2% to \$348.8 million. The revenue increase was comprised of 4.3% discharge growth, inclusive of 1.6% same-store discharge growth, and a 3.7% increase in net revenue per discharge. Net revenue per discharge growth benefited both from patient mix and a favorable year-over-year comparison in the annual Medicare SSI adjustment. Bad debt expense increased 20 basis points to 2.2%, primarily as a result of writing off claims from 2013 associated with a legacy audit appeal.

As a reminder, since the end of Q2 2025, we have closed three IRF units hosted within acute care hospitals, as well as our lone SNF unit hosted within one of our freestanding hospitals. Together, these four units were essentially breakeven in terms of adjusted EBITDA. The unit closures impacted total and same-store discharge growth in the quarter by approximately 85 basis points. The impact on future period discharge growth will diminish as we consolidate this volume into other proximate hospitals and as we anniversary the unit closure dates. We expect to add 66 beds to our existing hospitals in these markets.

We previously announced the closure of our 18-bed unit hosted within our acute care hospital JV partner in Evansville, Indiana. This closure will occur in early 2027 and represents another market consolidation opportunity. We are in the process of adding 40 beds to our existing freestanding hospital in this market to support the consolidation and future growth. These incremental beds are expected to be operational in late 2026.

Following the Evansville unit closure, we will have nine remaining hospital-in-hospital locations with no further closures currently planned. The hospital-in-hospital format remains a viable strategy to capitalize on market opportunities. Over the next two years, we expect to open three additional hospital-in-hospital locations in existing markets. These three projects are already in our bed addition assumptions and will address needed capacity in these markets.

Q1 SWB per FTE increased 3.7%, driven in part by the increased participation in our Career Ladder programs Mark discussed earlier. Greater participation in Career Ladder programs leads to more of our clinical staff obtaining higher licensing and compensation levels. Over time, we believe this drives financial and operational benefits, primarily in the form of reducing turnover and premium labor costs.

Premium labor costs comprised of contract labor and sign-on and shift bonuses, declined \$2.7 million from Q1 2025 to \$25.9 million. Contract labor FTEs as a percent of total FTEs was 1.2% in Q1, down 10 basis points from Q1 2025. Net pre-opening and ramp-up costs were \$4 million. We continue to expect net pre-opening and ramp-up costs of \$18 million to \$22 million for the full year 2026.

We continue to generate significant free cash flow. Q1 adjusted free cash flow was \$194 million. Our primary use of free cash flow continues to be capacity expansions. During Q1, we repurchased approximately 708,000 shares of our common stock for a total of \$71.6 million. We paid a \$0.19 per share cash dividend and declared another \$0.19 per share cash dividend that was paid in April. Our leverage and liquidity remain well-positioned. Net leverage at quarter-end was 1.9 times.

Based primarily on our Q1 results, we have raised our 2026 guidance as follows. We now expect net operating revenue of \$6.375 billion to \$6.470 billion, adjusted EBITDA of \$1.35 billion to \$1.38 billion, and adjusted earnings

per share of \$5.89 to \$6.11. The considerations underlying our guidance can be found on page 11 of the supplemental slides.

And with that, operator, we'll open the line for Q&A.

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## QUESTION AND ANSWER SECTION

**Operator:** Thank you. [Operator Instructions] In the interest of time, we ask you please limit yourself to one question and one follow-up. And we'll pause for just a moment to allow questioners a chance to enter the queue. And we'll take our first question from Ann Hynes with Mizuho Securities. Please go ahead. Your line is open.

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**Mark J. Tarr**

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

Good morning, Ann.

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**Douglas E. Coltharp**

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

Good morning, Ann.

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**Ann Hynes**

*Analyst, Mizuho Securities USA LLC*

Hi. Good morning. Yeah. Thanks for the question. So, I know your organic volume discharge growth was impacted by closures. Do you have a number of what that would have been, if you exclude the closures?

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**Mark J. Tarr**

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

Yeah. As I mentioned in my comments, the impact of the closures was approximately 85 basis points, and that would be the same for both total and same store. And again, we would anticipate that that impact will diminish through the course of the year because we're going to be consolidating some of that volume and in certain instances adding beds to those markets, to the existing hospital in those markets, and then we'll also be anniversaring the closure date.

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**Douglas E. Coltharp**

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

And Ann, just a reminder, take note, there's no impact on EBITDA. That was the discharges only.

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**Ann Hynes**

*Analyst, Mizuho Securities USA LLC*

Yeah. And then just your comments around nursing. You have the lowest nursing turnover [ph] since (00:15:54) 2012, which is very impressive. What do you think is driving that? I'm sure there's internal factors and external factors like inflation, but any observations you can provide on why you think that's so low?

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**Mark J. Tarr**

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

A

And I'm going to ask Pat Tuer to weigh in on that.

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

So, Ann, the – a couple things on that. We talked about our centralized talent acquisition team before and they have done a great job bringing talent into our organization. Net hiring for the quarter was higher, in fact, than the first two quarters combined last year on the same-store basis. And on the turnover front, our ladders are really starting to take hold. So, we have about 35% of our nursing staff is now on clinical ladders. That's up about 300 basis points from last quarter. Turnover, if we can get a nurse on the ladder, in Q1, the turnover for that group was a little over 2%. It was 2.6% compared to 20.7% for non-laddered nurses. So, really our hospital teams are doing a great job engaging our staff to become more organizationally rooted and get into these ladder programs, and as a result, earn more compensation. I would say, more broadly, the dynamics around the labor environment can be unpredictable, but we have seen a lot of positive momentum from a hiring and retention standpoint.

**Mark J. Tarr**

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

A

And as Pat noted, having that centralized talent acquisition here in Birmingham frees up the local hospital staff then to do nothing but really focus more on retention. So, there's a lot of other programs involved. But certainly clinical ladders are an important part of the tools they've added in the last couple of years.

**Ann Hynes**

*Analyst, Mizuho Securities USA LLC*

Q

Great. Thank you.

**Operator:** Thank you. We'll take our next question from Matthew Gillmor with KeyBanc. Please go ahead. Your line is open.

**Mark J. Tarr**

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

A

Good morning, Matt.

**Matthew Gillmor**

*Analyst, KeyBanc Capital Markets, Inc.*

Q

Hey. Thanks for the questions. Hey. Good morning. Maybe following up on Ann's line of questioning on the same-store volumes. The 2.6% number, if you adjust out to 85 bps, is still a pretty healthy number, but slightly moderated from the trends you saw in 2025. Curious if there were any other sort of puts and takes to think about, and how you're sort of thinking about same-store volume performance for the balance of 2026?

**Douglas E. Coltharp**

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

A

Yeah. And, Matt, we don't want to make it sound like a litany of excuses, but since you've asked for further insight on volume, I think we would cite four factors in the first quarter. The first was the unit closures, which we've already covered. The second is occupancy levels, and I'll go through that in more detail in just a moment. The third is something that you've heard from the acute care hospitals reporting, which was, it was a relatively light, meaning, low severity flu and respiratory season. And the fourth is some continuation of the MA trends that we experienced in Q4.

To dive a little bit deeper on the occupancy story, our Q1 average occupancy of 78.7% was essentially flat with our record-high levels in Q1 of 2025, and that was up 200 basis points from Q1 of 2024 and up over 500 basis points from Q1 of 2023. And that's reflective of our strong growth. And as Mark pointed out, the underlying demand for inpatient rehabilitation services.

And to meet that demand, we've obviously been adding beds via de novos and bed additions, and we've been seeking opportunities to convert semi-private rooms to private rooms. That's something we've talked about quite a bit before. At the end of the first quarter, 58% of our beds were private, and that compares to 41% being private at year-end 2020.

But in spite of those efforts, occupancy has become a bit of a constraint in certain markets. In Q1, approximately 35% of our hospitals had occupancy in excess of 90%, with that cohort having an average occupancy of 95%. A subset of that group is comprised of relatively recent de novos that have been growing quickly, and they crossed the 90% threshold in Q1.

More than half of our hospitals within Q1 that had occupancy in excess of 90% are slated for bed additions between 2026 and 2028. And we're anticipating adding more of those hospitals to the list, as well as introducing small-format hospitals per Mark's discussion in certain of those markets. So, we probably fell a little bit behind because the growth was faster than we anticipated, but we've got a plan to address that.

Just a little bit more commentary on the flu and respiratory season. Debility for us is a proxy for the severity of the flu season and also for respiratory illness. And as you know, as you've heard from the acute, Q1 2026 was relatively light in that regard. Debility is approximately 11% of our patient mix, and it only grew by 70 basis points in total for the quarter and actually declined 1.5% on a same-store basis. That's purely a seasonal item, and it's going to fluctuate from year to year.

And then again, MA continued to be a bit of a struggle as we moved into the quarter. You know, I'd probably there point to some things on a longer trend. We can talk about, obviously, the success that we're having with regard to the admit and appeal strategy that we began implementing at the end of February. That's very early on. It's only in nine hospitals, but we're seeing some good traction there. But some of the things that you've probably been hearing nationwide on an MA basis that are worth underscoring is that nationwide MA penetration appears to have peaked at approximately 52%, and it's now actually receding slightly. And as a matter of fact, if you look at the year that ended in March of 2026, 20 states experienced the decline in MA penetration from the prior year. And we have hospitals in 12 of those states. And if you drill down even further to our home counties, 48 of our 154 home counties, or 31% had a year-over-year decline in MA penetration.

So, we're not necessarily saying that there's going to be a wholesale abandonment of MA, but what we would point to is there continues to be a very large population of Medicare fee-for-service patients that continues to grow, that remains considerably underserved.

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

Just to...

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**Matthew Gillmor**

*Analyst, KeyBanc Capital Markets, Inc.*

All right.

Q

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

...add a little bit to that, Matt. This is Pat. Doug talked about how half of the hospitals are being – have capacity expansion plans underway. You know, that could beg the question, what about the other half? And those are all under evaluation as well. Some of those are landlocked. Some of those are in competitive markets where it makes more sense for us to consider a small-format hospital. But we're looking at a lot of options in those markets as well.

In addition, one of the things that we've found is, we have ramped up in many of these markets faster than anticipated. And as a result of that, we've historically talked about how we have looked at hospitals to have an occupancy between 80% and 85% for us to start the – that expansion process. Well, that worked for a long time. But what we're seeing now is that the process can take a little longer. The permitting process takes longer than it used to. The regulatory process can take longer than it used to. So, we have lowered the threshold internally where we're now looking at 70% to 75% from a occupancy standpoint. And that what we're hoping is going to allow us to time these capacity additions a little better, so that when the capacity is available, when the occupancy is reaching to the point where we actually need it.

The other thing that I'll mention is, we typically build a 50-bed hospital. And, we've been talking internally about, in some markets, should we be looking at larger footprints? And that's something that we're also evaluating currently. So, we have several plans to address these occupancy challenges and constraints moving forward.

**Mark J. Tarr**

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

A

I will say with regard to occupancy, it meets the definition of a high quality problem.

**Matthew Gillmor**

*Analyst, KeyBanc Capital Markets, Inc.*

Q

Yeah, I agree with you. Thanks for all those details. That's great. Let me try one follow-up on the Medicare proposal. You know, within that proposal, there was an RFI to potentially make some adjustments to the payment model. You know, from our perspective, it seemed pretty neutral. But I was curious if you all had any initial reaction, or maybe it's even too soon to kind of give an educated guess. But any perspective there would be great.

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

Yeah. This is Pat again. And, I think we're aligned with your – some of the points you made in your question. So, this is a concept. At this point, it's not a proposal and it lacks many of the details necessary for us to model out what the particular impact could really look like. But it's not any sort of site neutral concept. And in fact, it would look more to change the SNF PDPM buckets to account for the unique and more complex patient populations that are treated in IRFs. And that new process would ultimately be based on ICD-10 coding for both levels of care. So, it's more just trying to make things uniform from how things are coded and classified, rather than any type of site neutral push. But too soon to tell. Not really a concern for us right now.

**Mark J. Tarr**

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

A

Matt, we – as we always do, we'll be responding to the proposed rule with our comments as a company, as well as working closely with the trade associations to contribute to the feedback to CMS.

**Matthew Gillmor***Analyst, KeyBanc Capital Markets, Inc.*

Q

Okay. Thank you.

**Operator:** Thank you. We'll take our next question from Andrew Mok with Barclays. Please go ahead. Your line is open.

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

A

Good morning, Andrew.

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

A

Good morning, Andrew.

**Andrew Mok***Analyst, Barclays Capital, Inc.*

Q

Hi. Good morning. I just wanted to follow-up on those comments around MA trends. So, you previously called out aggressive, utilization management from a large national Medicare Advantage payer. Is this issue broadening out to other payers or is more of the MA drag that's coming from the higher fee-for-service volumes? And if the latter, why is that the case?

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

A

I'm not sure I fully understood the second part of your question. The first part of your question, has it extended to other payers? No, the trends from Q4 to Q1 remained pretty consistent. And again, I want to highlight that, as we mentioned last quarter, we did begin implementing a strategy for MA patients in certain markets of admit and appeal. And as a reminder, whereas previously, for a very high percentage of the patients on which we received an initial denial, we would simply not admit the patients and move on and not attempt to take that any further.

Towards the end of February, in nine of our hospitals thus far, certain MA patients, where we believe we have a very strong case that a referral is appropriate, we are now admitting those patients even with an initial denial, and taking them through the five various levels of appeal. We've started to see some positive results there, and we anticipate rolling that out further. It's important to note that that is not targeted at any one particular MA plan. That is based more on the specific patients and not the plan. Andrew, could you help clarify me on the second part of your question regarding fee-for-service?

**Andrew Mok***Analyst, Barclays Capital, Inc.*

Q

Yeah, I think, you made a comment that the slower MA membership growth, industry membership growth is creating maybe like a little bit of a volume drag. I guess, why is that the case if fee-for-service penetration is a little bit higher?

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

A

No. I was going the opposite. I think, for many years what we were observing is that an increasing percentage of newly minted Medicare beneficiaries were signing up for MA. And so, the total MA penetration of the MA beneficiary population had been increasing, but it appears that it peaked at about 52%, and it's actually backing up now. And I was giving some specificity about how MA penetration in some of our home markets has receded, which means that a higher percentage of those patients are fee-for-service, which, generally speaking, is a good thing for us.

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

Just to add to that...

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**Andrew Mok**

*Analyst, Barclays Capital, Inc.*

Got it.

Q

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

...Andrew. This is Pat. Sequentially, our conversion rate with MA actually went up, but it was down versus Q1 of prior year. And just a little more color on Doug's comment around the admit and appeal strategy. It is way too early to form an educated opinion about this, but in the nine markets that we are piloting this, we have seen, some nice improvement in the approval rate of claims that we submit for authorization. So, we're encouraged by what we're seeing. We have a number of cases that are pending and admitted in ALJ hearing. And you know, we'll wait until we have several of the decisions around those before we make a decision on when and if to scale this up further.

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**Andrew Mok**

*Analyst, Barclays Capital, Inc.*

Got it. Okay. And then as a percentage of revenue, it looks like SWB is the lowest levels we've ever seen, which is even more impressive given 1Q SWB tends to be the highest in the year. Beyond low turnover, is there – are there any other factors driving the strength in SWB this quarter? And how should we think about sort of the seasonal progression from here given that starting point?

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**Douglas E. Coltharp**

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

Yeah. I mean, you had a couple of things, depending on how you're looking at it as a percentage. First of all, we had a pretty significant increase in state-directed payment revenue because that included some out-of-period stuff. Now, we believe that the net provider tax impact on EBITDA for the quarter had some seasonality to it and we continue to believe that for the full year it's going to be relatively flat with last year. And then also, part of our pricing increase, as I mentioned in my comments, was a favorable year-over-year impact from the Medicare SSI adjustment. And so, you're pulling in incremental pricing revenue without any labor required to offset that.

A

You know, there's always some seasonality in our labor first quarter just because of the higher occupancy rate tends to be one of the more efficient quarters. It's also going to be impacted by the timing of de novos, when the net capacity comes on. And as was the case last year, we're pretty back-end loaded this year.

**Mark J. Tarr**

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

A

One other comment on that. On the same-store basis, and we don't give out same-store EPOB, but to Doug's point, the ramping de novos and the timing of de novos can really impact EPOB, and we look really good for Q1. But on the same-store basis, we are showing incremental improvement year-over-year. And that's just a product of us continually working to make sure that our hospitals are as efficient as possible without sacrificing any type of clinical or quality outcome. And you know, with an organization of our size, you'll have some variation from hospital to hospital or region to region. And those are the markets that we work to get in line with our expectations.

**Douglas E. Coltharp**

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

A

The last thing I'd point out that had an impact there, Andrew, is that the closures had a favorable impact on that because, as we mentioned, we were taking out the revenue and the volume, but they were breakeven from an EBITDA perspective, which leads you to conclude that the SWB associated with that volume was a substantially higher percentage than we run on average.

**Andrew Mok**

*Analyst, Barclays Capital, Inc.*

Q

Great. Thank you.

**Operator:** Thank you. We'll take our next question from Pito Chickering with Deutsche Bank. Please go ahead. Your line is open.

**Douglas E. Coltharp**

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

A

Pito.

**Mark J. Tarr**

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

A

Good morning, Pito.

**Pito Chickering**

*Analyst, Deutsche Bank Securities, Inc.*

Q

Hey. Good morning, guys. Thanks for taking my questions here. Shockingly to you, guys, I want to go back to that occupancy question. You gave some good details around the facilities that are capturing occupancy with half of those you can expand the next few years and half of them you can't because they're landlocked, what do you think is the ceiling for same-store discharge growth over the next year or two until these beds are getting added just because you're capped in occupancy?

**Douglas E. Coltharp**

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

A

Yeah, I want to be clear, and I think Pat elaborated on this, we've identified bed expansion opportunities for half of that cohort. It's not that we can't do the other half. Some of those just moved into that category faster than we anticipated, so we're evaluating those. And even in those where we are landlocked, there's a good chance that

we'll be able to solve for that equation with a small-format hospital. So, I would actually anticipate that for those high occupancy markets, there's only going to be a relatively small percentage that over time we can address with incremental capacity in some way.

In terms of a theoretical cap on discharge growth, again, this is another reason and the introduction of the small-format hospital goes into this category, where we believe it is increasingly irrelevant to think about the breakdown between total discharge growth and same-store discharge growth, because you're going to have buckets that move in and out. So, with regard to total discharge growth, it's just a matter of, how quickly can we add new capacity and continue to fill in and boost the occupancy rates as we do so. And we certainly believe that that number is greater and perhaps substantially greater than that, which we posted in the last two quarters.

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

Pito, if you look at the track record of our real estate and our design and construction team, I'm very proud of the way they've been able to bring these projects on plan, on schedule and within budget. So, we've got a lot of confidence in the team that we have in place here will help us to address the occupancy and capacity issues.

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**Pito Chickering**

*Analyst, Deutsche Bank Securities, Inc.*

Q

Yeah. These are all pretty high quality problems to your point. I guess, a follow-up here from a CapEx question then, what's the right level of CapEx in order to keep on filling this demand? You know, does CapEx as a percentage of revenue go up as demand is going faster than you guys think, or is this sort of the right level of CapEx as percent of revenue? Thank you.

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**Douglas E. Coltharp**

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

A

You know, I think, it's going to increase as a percent of revenue relatively modestly over the next two to three years, and peak at probably about 15% and then start to recede back towards the, call it, 10% to 12%, which is probably going to represent a longer term run rate.

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**Pito Chickering**

*Analyst, Deutsche Bank Securities, Inc.*

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Great. Thanks so much, guys.

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**Mark J. Tarr**

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

A

Thank you.

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**Operator:** Thank you. We'll move next to Whit Mayo with Leerink Partners. Please go ahead. Your line is open.

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**Douglas E. Coltharp**

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

A

Hey. Good morning, Whit.

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**Mark J. Tarr**

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

A

Hi, Whit.

**Whit Mayo**

*Analyst, Leerink Partners LLC*

Q

Hey. Good morning. Hey. Douglas, the Medicaid DPP, the supplemental known when you gave guidance, I believe that it was? And then just how much more incremental directed payments do you have within your plan for the rest of the year? And then are there any states that you're looking out for that may not be in the plan?

**Douglas E. Coltharp**

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

A

Yeah. So, we're not aware of any new states coming on line. Q1 was larger than we anticipated, largely due to a significant portion being out of period and we called that out, the EBITDA impact from the out of period was about \$4.2 million. In our Q4 call, we suggested that we anticipated for this year that the EBITDA impact from net provider taxes would be roughly flat with last year, which was \$21 million. And we continue to believe that the increase in Q1 was really a timing issue and that the full year will be in that range. As a reminder, the peak that we had in last year was in Q3, where we had a \$10 million favorable impact from provider taxes at the EBITDA level, and \$6 million of that was out of period. So, again, we just think that's a flow between quarters and that the EBITDA impact should be flat on a year-over-year basis.

**Whit Mayo**

*Analyst, Leerink Partners LLC*

Q

Okay. And then my follow-up is I just wanted to kind of take your temperature on buybacks again with leverage now drifting to probably 1.5 times soon just seems like, you could add a half turn, maybe a full turn of leverage in the next year or two, deplete a lot of the market cap, maybe move the investor focus away from EBITDA to EPS. So, just wanted to hear the latest thinking about the longer term buyback strategy.

**Douglas E. Coltharp**

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

A

Yeah, I'll leave it to you guys to decide whether you want to move the focus from EBITDA to EPS. We do feel like using some of the capacity in our balance sheet and buying back shares, particularly at the levels we've been trading at here more recently, represents a really attractive complement to our overall strategy. And so, if we just do some math around that and you look at the guidance assumptions that we've included in our supplemental slides, the midpoint of our free cash flow estimate for the year is roughly \$818 million.

And what's not included in that number? And by the way, the reason that the taxes went up was predominantly, as you can see from that end note, was predominantly because of the proceeds we received on the sale of the Gamma Knife, and then also on the receipt of legal proceeds or legal fees in the Delaware litigation. That adds another \$40 million of cash. And so that would take you to cash available for investment of roughly \$858 million. The midpoint of our growth CapEx estimate is \$725 million. You hold the dividend constant, that's \$77 million. So, at those levels, even without utilizing any capacity in the balance sheet, you've got roughly \$56 million that would otherwise be available.

If you look at the end of the first quarter, our funded debt was roughly \$2.575 billion. And the midpoint of our EBITDA range based on the updated guidance is \$1.365 billion. If you simply took the leverage up to 2 from 1.9, that would suggest total incremental capacity of \$212 million for share buyback. We did \$71 million in the first quarter, so you've got at least \$140 million available. Then you could do the math in a similar fashion if you

decided that you wanted the leverage to flow between 2 and 2.5 times. So, I mean, that's the simple way that the math works. And we believe that share repurchases will continue to be part of our allocation of free cash flow.

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

Hey, Whit. This is Pat. Just going back to the state-directed payment question for a second. We do think this represents an opportunity for us in certain states to work with our acute care partners to get additional Medicaid volume. There's about 20% of our markets are in states that have a pretty attractive Medicaid reimbursement structure, that on the surface, it doesn't look like it covers our costs, but when you factor in the other dynamics, it does. And that represents an opportunity for us on the volume growth side as well.

**Whit Mayo**

*Analyst, Leerink Partners LLC*

Q

Thank you.

**Operator:** Thank you. We'll take our next question from Joanna Gajuk with Bank of America. Please go ahead. Your line is open.

**Mark J. Tarr**

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

A

Good morning, Joanna.

**Joanna Gajuk**

*Analyst, BofA Securities, Inc.*

Q

Oh, hi. Good morning. Thanks – hey. Thanks for taking the question. So, I just want to follow up on the discussion around the proposal. So, thanks for sharing your initial views about this RFI that CMS included in the proposal. I know it's early to know details, but also in the document, CMS actually quote MedPAC analysis and they talk about like the mix varies by the ownership, and they talk about, aligning payments with costs. So, what are your thought processes there? Like what exactly CMS is trying to kind of allude here to? And would you expect, something specific they have in mind? Are they thinking about, 2028, because I think in 2027 like they cannot add anything? But like, I guess in a year from now sort of, would you expect something in that proposal?

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

Hey, Joanna. This is Pat. It's hard for us to tell and to discern the – you know, for a long time, what has been issued by MedPAC has not historically been followed or given much attention. So, the fact that something was quoted now, it's hard for us to be able to speak on that intelligently.

What I can tell you is this proposed rule is relatively benign. There's some pieces of the proposed rule that could create some minor burdens from a logistics perspective. I'm not really sure what it does to help patient care, but you know, in any case, we will provide comments by June 1, as Mark said. And we will adapt and be prepared to meet any changes that are included in the final rule.

**Mark J. Tarr**

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

A

Joanna, just in general, as you know, we're always quite active in DC and have our own resources up there and remain part of the discussion with CMS and members of Congress and others about just making sure that people understand the value proposition that comes with inpatient rehabilitation. And we are the leader within that sector. So, we'll always be part of those discussions. There will be thoughts that are shared from CMS and other types of proposals. As you know, a lot of times these things are discussed, but actually implementing them is a major challenge. So, we'll be part in those discussions and give our feedback, and I want to make sure that we're ahead of the curve.

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**Douglas E. Coltharp**

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

A

And we do believe that the CMS is aware and is sympathetic to the amount of change that they're inflicting on any one particular sector at a time, and it's not lost on them. That TEAM implementation began on January 1, and that RCD is being extended this year in a significant way, as well as some of the specific provisions in the proposed rule regarding the therapy evaluations and treatment, the pre-admission screening, and then also the integration – the timing of the disciplinary team meeting. So, there's already a lot underway.

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**Joanna Gajuk**

*Analyst, BofA Securities, Inc.*

Q

Thank you so much.

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**Operator:** Thank you. [Operator Instructions] We'll take our next question from A.J. Rice with UBS. Please go ahead. Your line is open.

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**Mark J. Tarr**

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

A

Hi, A.J.

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**A.J. Rice**

*Analyst, UBS Securities LLC*

Q

Hi, everyone. How are you guys? So, obviously you've had a nice pacing of your JV opportunities. I wondered if you'd update us on how that pipeline looks. Is it still pretty plentiful? And obviously you're leading peer and competing for those JVs is in the midst of going private. Does that maybe even create more opportunities, maybe the potential partner is a little hesitant because of that, or maybe they're just pulling back because they're going to focus their cash flow elsewhere? Any thoughts?

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**Mark J. Tarr**

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

A

Well I – look, we've had this business model in place now for well over 30 years in terms of joint venturing with acute care hospital systems. As I noted in my prepared statements, we have a nice mixture of both wholly owned and joint venture projects that are in the pipeline. I like our chances if we – when we go out with other providers as we show what we can do, and the fact that we have about a third of our overall hospitals are partnerships, we have a lot of partners that can validate what a great partner we are and what a great manager we are. So, A.J., I'm not concerned about what others are doing, but I am very confident in our ability to move forward.

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**Douglas E. Coltharp**

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

A

You know, if you look on slide 18 of the materials we distributed this morning, we note that we have 18 IRF development projects underway. Now, only one of those is currently identified as a joint venture opportunity and that's our Loganville, Georgia hospital, which will open as part of our partnership agreement with Piedmont. But as you've seen with us over the last several years, as we've extended the learning curve with regard to de novo development, we've gotten increasingly comfortable going ahead and forging ahead on an individual basis in a market, even as discussions with potential joint venture partners are underway. So, I think, there's a better than even prospect that some of the development projects that are listed on that page will ultimately turn out to be joint ventures.

With regard to Select Medical, we don't expect any change in their appetite for incremental growth. Their strategy is somewhat different from ours in that they are 100% JV focused, and they tend to focus a lot on HIHs as well. So, we would expect them to continue to be a viable competitor. But the pool is big enough for both of us.

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

A.J., I think one of the trends we do see within our joint venture partners is building multiple hospitals within that partnership. Piedmont is a prime example of that. We've done that at Vanderbilt, we've done that at BJC, and a number of other providers where we are building multiple hospitals within that same partnership.

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**Mark J. Tarr**

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

A

The last thing I would say there and this also relates back to some of the high occupancy doors. Some of those are joint ventures. And as we have gone back to some of our joint venture partners and introduced them to the potential for a small-format hospital, we're getting a very favorable reception.

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**A.J. Rice**

*Analyst, UBS Securities LLC*

Q

Okay. Then my follow-up I wanted to ask you about the small-format hospitals. Is the ROI on those materially different than the regular size facilities? Is there any ability to get around certificate of need or more flexibility on certificate of need with the small-format hospitals? And just how are you going to think about those versus the traditional size?

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**Douglas E. Coltharp**

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

A

Yeah. So, the ROI falls squarely between bed expansion, which is our highest ROI, and a de novo. So, better than the de novo, not quite a bed expansion because of the infrastructure leverage. In CON states, the addition of beds is almost always subject to CON requirements. Because you're operating under the same Medicare provider number and because you're dealing with less than a number of beds associated with the de novo, that tends to be a – not always, but it tends to be a lower hurdle to get over. It is not a substitute for a de novo hospital. It is a complement to de novo hospitals, and it is a bit of a substitute for a bed addition at an existing hospital.

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**Mark J. Tarr**

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

A

A.J., just in terms of how we're thinking about the scale of this opportunity, you could have markets that have three or four of these, at maturity. You could have markets that have one or two, and some markets won't have any. It gives us a lot of flexibility in how we approach markets. But we are currently evaluating dozens of markets

and building out a robust pipeline similar to what we've done with our bed expansion process and our de novo process. We're doing the same thing for small-format hospitals.

**Douglas E. Coltharp**

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

A

And we are actually developing an enhanced market analysis tool that includes all aspects of the market, including projected growth and real estate aspects, in conjunction with Palantir that's going to help us be a lot more prescriptive when we're entering in the new market about what should be the initial size and location of the de novo that's going to anchor that market, and then what would be potential sites prioritized in terms of timing for augmenting that with small-format hospitals. So, that's going to allow us to be much more proactive with regard to our real estate strategy. And hopefully, even as occupancy ramps up quickly with new capacity coming onboard, it's going to alleviate some of these concerns we have when we've fallen behind with regard to bed expansions.

**A.J. Rice**

*Analyst, UBS Securities LLC*

Q

Okay. Great. Thanks so much.

**Operator:** Thank you. We'll take our next question from Brian Tanquilut with Jefferies. Please go ahead. Your line is open.

**Mark J. Tarr**

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

A

Good morning, Brian.

**Douglas E. Coltharp**

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

A

Hey, Brian.

**Brian Tanquilut**

*Analyst, Jefferies LLC*

Q

Hey. Good morning, guys. Maybe, Doug, since you mentioned Palantir, so when I look at with your hospital, the acute care hospitals are doing, rolling out a lot of AI here, just curious, I mean, what are the initiatives that you're doing right now? And then when I think of where something like a Palantir can come in and play, I look at your length of stay at 12 days right now, is there a room for AI or analytics to improve, in the clinical and operational side, beyond just kind of like back office stuff?

**Douglas E. Coltharp**

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

A

Yeah, I think, there's a lot going on. Pat, do you want to speak to maybe some of the clinical and operational aspects of it?

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

Yeah. The first thing I would say in regards to Palantir on the length of stay front, we're not actively trying to get our length to stay down further. You know, what we're trying to do is make sure that each patient has an appropriate care plan for their needs. That just happens to average around 12 days. And again, we're not trying to

pressure our hospitals to get that down. So, we're really focused on appropriate patient care for each patient. But we are on the same note looking for opportunities to make sure that our care plans are as efficient as possible.

You know, we've talked about our partnership with Palantir on pre-screen narratives, appeal letters, but we are looking at and have – are in various stages of implementation of documentation efficiency for our physicians and providers around histories and physicals, face-to-face notes, discharge summaries. And, you know, we're evaluating other opportunities as well. And this is all in an effort to give our physicians and our clinical staff time back so that they can do direct patient care instead of documenting. And I think, there's going to be operational benefits that come along with that. And we're excited to see where that goes. We're really encouraged by some of the things we're seeing and how efficient it is allowing our providers to be.

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**Douglas E. Coltharp**

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

A

I would further say, just kind of in summary. In the queue with Palantir, we have the real estate analysis and the market analysis project I mentioned before. We've got a substantial CRM opportunity. We've got a revenue cycle management opportunity, and we've got a clinical staffing opportunity as well. Those are all in the queue.

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**Mark J. Tarr**

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

A

Brian, just as a follow-up on the length of stay discussion. You know, we've seen our length of stay over the years come down from 14 to 12 days, as Pat noted. And you get to a point where you want to be careful on pushing it down much lower, because some of these quality metrics that I mentioned in my opening comments, relative to the ability to have 84-plus percent of our patients go back on the community, have very few of them go back to the hospital on the acute care transfers or skilled nursing discharges. Those are all kind of tied to that length of stay. So, we're very careful in terms of, trying to really push that down.

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**Douglas E. Coltharp**

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

A

You know, I think, it's important to note that much of the reduction from 14 days to 12 days had less – that was much more to do with removing the friction on the discharge process than any change to the care that the patient has been treating, the volume and the intensity of it while in our facility.

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**Brian Tanquilut**

*Analyst, Jefferies LLC*

Q

No, that makes a lot of sense. And then maybe, Doug, last one from me. So, when I think of \$4 million of pre-opening costs in the quarter, is that kind of in line with expectations? And how should we think about the back half given the timing of bed adds? And then maybe just in the same vein, the free cash flow guidance was revised down, just curious, what we need to be thinking about as it relates to that adjustment? Thanks.

---

**Douglas E. Coltharp**

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

A

Yeah, absolutely. So, with regard to the pre-opening, we – \$4 million for the quarter, we anticipate for the full year is going to be \$18 million to \$22 million, midpoint of that \$20 million, going to be a little bit more heavily weighted towards Q3 and Q4, probably following a little bit of the same pattern that we had last year. Q3 will probably be the most significant on that. You know, the free cash flow came down because of upward revisions in two items. One was interest expense, which moved up by about \$5 million. That's simply reflective of the fact that as we're – as our CapEx is rolling out and as we're spending a little bit more money on share repurchases, we're carrying a

larger balance on the revolver, but not overly significant. The second piece is that cash taxes went up. That estimate went up solely because of the tax payments that are due against the gain on the sale of the Gamma Knife, and also the taxable portion of the recovery of legal fees on the Delaware litigation.

As I mentioned previously, what you don't see from an accounting perspective in that table is the \$40 million benefit from the receipt of proceeds. So, net-net, the actual cash available for us, in spite of the increases in those two categories, actually increased for the year.

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**Brian Tanquilut**

*Analyst, Jefferies LLC*

Q

Awesome. Thank you.

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**Operator:** Thank you. We'll take our next question from Jared Haase with William Blair. Please go ahead. Your line is open.

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**Douglas E. Coltharp**

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

A

Hey, Jared.

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**Mark J. Tarr**

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

A

Hey. Good morning, Jared.

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**Jared Haase**

*Analyst, William Blair & Co. LLC*

Q

Hey. Good morning. Appreciate all the details thus far. Maybe I'll take a step back for a little bit of a bigger picture question on the market landscape. But you know, obviously a lot of what you've messaged today is demand clearly remains very strong and you're seeing that show up in all of the occupancy dynamics. But I'm curious just, as we think about this long term kind of structural thesis that you've had around capturing some share away from skilled nursing facilities over time, moving that volume to IRFs, are you seeing some of these competing SNFs in your market, increasing their investments around clinical capacity, programs, other services that would help them, move further into higher acuity patients?

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**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

A

This is Pat. You know, I think much like every level of care is probably trying to improve what they do and how they operate. I'm sure the SNFs are doing the same thing, but it's an entirely different level of care. You know, they don't have the staffing intensity or the clinical oversight that we do, the investment that we have in our programs, technology. It's just apples and oranges. And there's a time and a place for skilled nursing facilities.

But you know, I've talked before on these calls that, across the country in markets that we're in, patients are still twice as likely to end up with a CMS 13 diagnosis to end up in a nursing home. And you know, we have an opportunity to continue to add capacity to address that. You know, our average age patient is around 78 years old. The oldest baby boomer turned 80 in January. There's a few years of baby boomers that haven't even hit Medicare eligibility. So, there's a lot of volume dynamics for a long period of time that we can serve. And, again, I still see a lot of opportunity for us to continue to capture market share away from SNFs.

**Jared Haase***Analyst, William Blair & Co. LLC*

Q

Okay. That's really helpful. And then, this is admittedly a small nuance here, but I thought I'd just clarify, it looks like there was a slight change in your guidance assumption for the bed expansions that went from approximately 175 to now, 150 to 200. And so, I guess, obviously, just in light of everything you've shared with what's going on from an occupancy perspective, just, is there anything we should be thinking about as to why maybe a slightly lower end is implied here for bed expansions this year? Is that mostly just a timing dynamic?

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

A

It's exactly that. So, the midpoint of 150 to 200 beds is obviously the 175-point estimate that we used previously. We've got two fourth quarter projects with both – which have the potential just based on timing and weather conditions to flip over into the first quarter of next year. And so, we just hedged a little bit with the range.

**Jared Haase***Analyst, William Blair & Co. LLC*

Q

Okay. Make sense. Thank you.

**Operator:** Thank you. [Operator Instructions] Our next question comes from Raj Kumar with Stephens. Please go ahead. Your line is open.

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

A

Good morning, Raj.

**Raj Kumar***Analyst, Stephens, Inc.*

Q

Hey. Good morning. Yeah, maybe just kind of thinking about, sticking to the kind of MA versus fee-for-service dynamic. You know, you typically called out that, your MA patients tend to exhibit a – just a higher average acuity versus your fee-for-service population. I guess, given more payer intervention or just kind of more stringency around that, have you seen that kind of acuity gap grow maybe over the past couple years? And then I guess maybe also on the kind of the admit and appeal strategy, I would be curious on kind of what the win rate target is or what that's kind of demonstrated early into the program?

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

A

Yeah. So, I'll start and I'm sure Pat will want to chime in as well. We have seen more of a concentration within MA in our highest acuity categories. In the first quarter, stroke was almost 36% of our MA volume. That's not surprising. Those tend to be non-jump ball cases as well. And so, the favorable aspect of that is because reimbursement across all payers is tied to acuity, the average reimbursement gap between Medicare Advantage and Medicare fee-for-service shrunk to 1% for the quarter. So, we continue to think that there are opportunities and necessities for us to service a broader spectrum of acuity of MA patients.

With regard to the appeal and admit strategy, again, we are seeing favorable results even at the first level of appeal, which is an expedited appeal right back to the plan itself. We don't have enough of a universe yet to

understand how we're going to succeed at the various levels of appeal beyond the Maximus decision, which tends to be a bit of a rubber stamp, but there's reason for optimism.

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

Hey, Raj. This is Pat. Just a couple points. So, on MA, this remains grossly under penetrated. And you know, if the dynamics around that ever change, we'll have a lot of opportunity to continue add even more capacity. Is the higher acuity dynamic of the MA patient? I don't necessarily view it as a positive. You know, it's great from a revenue perspective. But what that signals to me is there's a lot of other patients that should be coming to us that just aren't given the opportunity to do so. And that's something we'll continue to focus on.

On the admit and appeal strategy, we really got that up and going kind of mid-February. March, we started to see some significant improvement in those markets. We did have – Doug talked about Maximus, we did have our first overturn at the Maximus level. So, that's encouraging. And it's probably going to take us about six to eight months to really get our arms around and have a better sample size of what our success rate is at the ALJ level, what – you know, if we want to take cases beyond that, that could extend the time a little further. So, I would say six to eight months, we'll be in a better position to, make a decision on scaling up or increasing the size of the pilot and probably, within a 12 to 18 months, we'll have a lot of clarity around this.

**Douglas E. Coltharp**

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

Yeah. And just to, maybe dimensionalize this as well with regard to MA, you know. By 2030, it's projected that 20% of the US population is going to be aged 65 and older. So, that means 70 million Americans by 2030 will be Medicare beneficiaries. If you assume for a moment that the MA penetration rate based on recent trends stabilizes at around 50%, that means that you've still got 35 million Medicare beneficiaries who are not MA patients, which means that they're likely to be fee-for-service. That's a total addressable market. Some portion of those are going to be CMS 13 eligible of 35 million individuals. Our total discharge is on the last 12-month basis for 266,000. So, there's a really big pond out there for us to fish out of.

**Raj Kumar**

*Analyst, Stephens, Inc.*

Great. And maybe as a follow-up, just kind of going back to Pat's comment on the kind of Medicaid side of the business and, with the funding environment being supported there. And then I think, outpatient visits for the first time in a while grew positively year-over-year. And so that kind of thing about that business, even though it's a smaller part, just kind of thinking about, if the 1Q is a good baseline for that business kind of going forward from a volume perspective, just given how the funding environment has been kind of supportive to – from an economics perspective as well?

**Patrick W. Tuer**

*Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

Hey, Raj. This is Pat again. I wouldn't read too much into the outpatient volume in Q1. It's really not a core business of ours. And we've continued to ramp down the number of outpatient clinics that we have. I would anticipate that we'll continue to assess the clinics that we're in. And if they're not profitable or not – there's not a good business case for them to be in operation, we'll continue to look at opportunities to further bring that count down.

And then the – what was the second part...

**Raj Kumar***Analyst, Stephens, Inc.*

Medicaid.

Q

**Patrick W. Tuer***Chief Operating Officer & Executive Vice President, Encompass Health Corp.*

Medicaid. Yeah. Medicaid is – you know, this is a newer opportunity for us. I know it's been a big tailwind for the acute providers, and it just has not been a big focus for us. And we are starting to see some of the benefits in those states. So, we are like we do anything else developing strategies around how we can serve those patients more effectively. And I'm excited about some of the early progress that we're seeing.

A

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

And on that point, Raj, what's really changed there is if you rolled back the clock as recently as maybe three or four years ago, on an annual basis, our net provider tax impact to EBITDA was essentially zero. It would, be plus or minus \$1 million. And with the implementation of new programs by states over the last several years, that's increased to the point, again, where we're estimating \$21 million this year. That's obviously not evenly distributed across all states.

A

So, when we look at some states where historically the – on its base rate that we were paid for IRF services didn't cover our variable costs. If you include the directed payment portion of that with the actual reimbursement that we get, it puts in a position where in some of those states it is a profitable patient for us to treat. And so, we'll look at handling those referrals, perhaps in a slightly different manner.

**Raj Kumar***Analyst, Stephens, Inc.*

Great. Appreciate it the color.

Q

**Operator:** Thank you. This does conclude our question-and-answer session. I'd like to now turn the call back over to Mark Miller for any additional or closing remarks.

**Mark Miller***Chief Investor Relations Officer, Encompass Health Corp.*

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

**Operator:** Thank you. This brings us to the end of today's meeting. We appreciate your time and participation. You may now disconnect.

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