

12-May-2026

Encompass Health Corp. (EHC)

Bank of America Securities Healthcare Conference

CORPORATE PARTICIPANTS

Douglas E. Coltharp

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

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

OTHER PARTICIPANTS

Joanna Gajuk

Analyst, BofA Securities, Inc.

MANAGEMENT DISCUSSION SECTION

[Abrupt Start]

Joanna Gajuk

Analyst, BofA Securities, Inc.

...I cover healthcare facilities and managed care at Bank of America. And thanks so much for joining us. This is going to be an exciting conference, and we're starting now this session with Encompass Health. They are the largest operator of inpatient rehab facilities. And today with us, we have Doug Coltharp, the CFO; and Zabi Hotaki, who is the VP of Finance, but also Mark is here from IR. So, just in case you have any follow up questions, he's right there.

QUESTION AND ANSWER SECTION

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

So, thank you so much for being here today with us. We appreciate it. And I guess maybe we'll go right into Q&A, by the way. So, I want to start with volumes, because really, this is like an exciting part of the – of the story for this company, growing much faster than a lot of different provider types. So you guys are targeting 6% to 8% long-term discharge growth. Obviously, this quarter has some puts and takes. So, maybe just kind of refresh people where we stand, you know, as we think about Q1 and also how you're thinking about the volume growth for this year?

Douglas E. Coltharp

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

A

Yeah, absolutely. Thank you for hosting us, and thank you again for hosting the tour of our hospital yesterday, which was very well attended. In the way of further introduction, many of you may have not met Zabi before, so Zabi joined us about 2.5 years ago as the Senior Vice President of Finance and Strategy. His last stop before joining us was at Stericycle. But he's had some great experience, relevant experience beforehand, and he's becoming an increasing participant in our Investor Relations functions as well. So, glad to have him here today.

As Joanna mentioned, back at our Investor Day in the fall of 2023, we laid out a five-year discharge growth CAGR. And I say discharge growth because that is our primary measure of patient volumes in this industry. And that objective was to have a five-year CAGR of 6% to 8%. We attempted to be clear in our communications at that time, but apparently, have fallen short, that 6% to 8% was indeed meant to be a five-year CAGR and not a series of quarterly targets that would be 6% to 8% or series of annual targets. And so, if you wind the clock forward to the end of 2025, we would be three years into that five-year CAGR and we were fortunate that we had operated at the high end of that range with a 7.6% CAGR.

We'd said all along that there would be fluctuations, particularly from quarter to quarter, depending on things like the constitution of the calendar and what day of the quarter ends on, yes, that makes a difference because our discharge patterns based on the day of the week are a little different as well as things like the comp that you're up against from the prior period. And when you have new capacity rolling in, because we've been adding a lot of new capacity to our business, both in the form of opening up new hospitals and then adding beds to existing hospitals.

The last two quarters, our discharge growth has slowed from those levels a little bit, but it was readily explainable. And in particular, when we look at the first quarter, our discharge growth was 4.3%, and that was impacted by a number of factors. First, something that's a little bit anomalous in the business is between the second half of last year and February of this year, we closed four units that we were operating that were actually housed within joint venture, acute care hospital partners. And all of those were situations where we were operating – three of them were that, and one of them was the lone SNF unit, skilled nursing facility unit that we operated.

With regard to the three-unit closures, those were leased space within the hospital. They operated as remote locations. So, they were tied to the same Medicare provider number as a freestanding hospital that we operated in that market, and we operated those units, all of which ran at essentially a breakeven EBITDA as an accommodation to that acute care hospital partner. They were not strategic to us, they were not financially contributing.

And so, in each one of those cases, it was just coincidental that it happened within one year period of time. The host hospital wanted to take that space back for other purposes. We were glad to turn that back over to them. The aggregate impact of that, plus the we closed our one skilled nursing facility.

We have skilled nursing facility housed within one of our freestanding IRFs in Lexington, Kentucky. That was a facility that we acquired in 2014. Based on our relationship with the University of Kentucky, we agreed to continue to operate that skilled nursing facility, even though that too was not strategic for us for a period of time. They agreed that it was no longer necessary for us to do this. We closed that as well. All of those together constituted about 85 basis points of a discharge growth headwind but no impact to EBITDA. The second thing that we commented on and I'm going to ask Zabi to elaborate is we got a high-class problem, which is because of that rapid discharge growth that we experienced over the three years ending in 2025, our hospitals, even as we were adding capacity, filled up more quickly than we had anticipated. And so, we had about 35% of our hospitals in the first quarter that ran at an average occupancy rate of 95%. So, we've got some plans to address that in the future. And Zabi, maybe you just want to take a moment, comment a little bit more on the occupancy situation?

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

Yeah. So, more than half of our high occupancy stores have bed additions plans over the next three years. And when we look at 2026, 70% of the bed additions coming online are earmarked for these hospitals. And then, as we move into 2027 and most of those bed additions are coming on in the back half in 2026, as we move into 2027, we're seeing about 90% of the bed additions in 2027 slated for these high occupancy stores, with more of those stores having bed additions in the first half than the second half. So, when we look at the next 15 months or so, we'll see a nice ramp of bed additions coming on, specifically addressing this high occupancy and alleviating some of these constraints and enabling discharge growth.

Douglas E. Coltharp

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

A

The last thing I would point to, and I don't want to make a litany of excuses because actually 4.3% discharge growth, we weren't disappointed, particularly given the EBITDA flow-through we had in Q1. But you may have heard from some of the upstream acute care hospitals that it was a particularly mild season for flu and respiratory illnesses, and we do get volume in the first quarter attributed to those. There's some seasonality. One of the proxies that we have, and it's not a direct correlation for what kind of volume we're seeing related to flu and respiratory is debility, which is one of the RICs that qualifies for admission into an IRF. And for the first quarter, our total debility growth was only 0.7%. It was actually negative 1.5% for the first quarter. That's again, just a seasonal thing that varies, and so it's not necessarily a carryover.

Last point on this, Joanna, because we take a lot of time to answer your first question, you said what about the rest of the year? And so, if you just go through our guidance assumption assumptions and pair those back and those were updated with our Q1 earnings report, it would imply volume growth for the full year between 5% and 6%. So, obviously, as we progress through the year, we start to anniversary some of those unit closures I had mentioned before and also consolidate some of the volume from those closures into the remaining capacity that we have in those markets. That impact will diminish and we're going to anniversary some of these other impacts, so we should see volume growth accelerating from the first quarter level through the balance of the year.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

And on disclosures, just to wrap it up, originally, you talked about 30 to 35 basis points, I think for the year headwind. So, remind us, are you on track with that? Because you also talked about the fact that you plan to sort of capture these patients somewhere else, right, in different locations. So, kind of walk us through the gross versus the net headwind?

Douglas E. Coltharp

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

A

Yeah. And in a couple of those markets, we need to add beds to the existing facilities to accommodate that demand. I think a reasonable estimate is that 85 basis point impact in Q1 drops by about 20 basis points in each of the remaining quarters in this year.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

And the...

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

The 30 basis points, by the way, is more back half heavy, not full year, because the first half is 85 basis points in Q1. And then, it starts to step down.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

As you kind of...

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

Yeah.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

...capture these patients.

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

Yeah.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

All right. And talking about these bed additions, so appreciate it. So, it sounds like you're addressing these high occupancy markets first, right, the next – like you said, the next 15 months. But you're also talking about now adding the small format hospitals, the large hospitals. So, I guess there's a lot of different options you have at your disposal. So, maybe walk us through in terms of economics, like, does it kind of change your ROIC metrics whether you do the large format, the regular or the small format?

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

Yes. So, just going back, we mentioned half of these hospitals have bed additions plans, the other half do not. So, the portion that do not have bed additions planned are typically landlocked hospitals or hospitals in competitive markets where they're best suited for a small format hospital. So, we're evaluating a dozen or so markets within this high occupancy cohort for the smaller format concept. And then, just another subset of this high occupancy cohort, we had, you know, some of these hospitals grow at a faster pace than we had anticipated. A portion of that had to do with some of the recent de novos that are just outperforming our original model. And we're addressing those in the next couple of years with bed additions. As far as just the economics and maybe I'll kind of run through the different modalities, you know, and at the top of that list, I would say I would put small bed additions at the top of that list as far as the returns, because it's the highest and best use of capital for us, typically returns on those bed additions are north of 30% and the average investment or cost per bed is about \$850,000.

On the small format hospitals, you know, we're expected to generate a return somewhere between 20% and 25%. And the average cost per bed, there is about \$1 million. And then as we look at de novos, historically, that has generated returns somewhere between the low- to mid-teens and the cost is about \$1.2 million. You mentioned the larger format hospitals. In theory, a larger hospital, so 60 beds or greater, would generate a slightly better return than, say, a 50-bed de novo if all things are equal. But there are so many different variables that go into that depending on the ramp-up of the demand, the patient payor mix, the cost per bed, whether we have a partner or not. So, I wouldn't necessarily classify these 60 bed hospitals that we're doing into a new category. I'd probably put them in that de novo return category of low- to mid-teens.

Douglas E. Coltharp

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

A

And Joanna, I don't want to assume that everybody in our audience today knows what a small format hospital is because it's a relatively new concept for us. We've had a chance to explore that with you previously, and so historically, our methods for increasing capacity in our business have been twofold. Since 2021, we have been opening a greenfield basis, eight new hospitals per annum. And not surprisingly, because there are great economies of scale to standardization, those hospitals have followed a pretty standard format. So, essentially, what we have looked to do to create the best labor efficiencies because labor consumes about 54% [indiscernible] (00:12:47) one of our revenue dollars, is we would go out and we would acquire depending on the specific topography, anywhere between 5 and 7 acres of land. And we would start with typically a 50 all private room, single-story building supported by administrative areas and a large therapy gym and dining facility and so forth. And on that acreage, there would be capacity, again, depending on the specific topography, to increase with future period, bed additions of anywhere between 10 and 30 beds, so up to about 80 hospitals. And the effect of those subsequent period bed additions, as Zabi mentioned, was to turbo boost the overall return because you're bringing on new capacity at 30% plus return.

What we found is we've moved into more dense markets, is that finding a 5 to 7-acre piece of land can be challenging and can be expensive. And if we fill those up as we've been able to do, and the opportunity to serve that market typically means that we need to move to another location. And sometimes, the market dynamics, if you think about a Dallas or Houston are such that between traffic patterns and the movements and the migration of population, you don't want to be in the same location. You want to put the beds more proximate to where the patients and the attending physicians are. And so, we've spent about three years developing this concept for small format hospital. So, what does that mean?

The prototype is going to be 24 all private rooms. It's going to be a single-story. It'll sit on 2 to 2.5 acres of land. It's going to have a smaller amount of the square footage devoted to administrative space because you have fewer patients, the dining facility will be smaller and the therapy gym will be smaller. But importantly, this only works to the extent that these small format hospitals are set up as a remote location, and remote is a defined term on under the Medicare regulations that says it's going to operate under the same Medicare provider number as an existing hospital in the market. And that allows us to get economies of scale by sharing leadership functions, by sharing a marketing team and other administrative services. And for example, in the small format hospitals, we're not going to be doing on-site food preparation. So, the food will be prepared and then brought over to that facility either by the host hospital or by a third party in the market.

So, we are really excited about this. The first of these is going to open up in 2027. It really gives us another important arrow in our quiver to address the high-class problem of higher occupancy, and it gives us a hub-and-spoke strategy. A lot of the denser markets that we're serving, they're seeing a pretty significant growth in the age population over 65.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

Right. And since you mentioned that kind of underlying demand, right, the population growing pretty robustly here, but also another dynamic in the market is around Medicare Advantage, like that growth clearly slowed down this year. So, the penetration seems like maybe that's going to stall. I mean, we don't know what's going to happen afterwards. But can you talk about your experience in your markets? And I guess what implication does that have to your company?

Douglas E. Coltharp

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

A

So, we had a great run up into through the third quarter of last year with regard to Medicare Advantage growth. And you know, I think from 2021 through the first three quarters of 2025, we had seen something like a 9% CAGR in Medicare Advantage. And as a percentage of our payor mix, Medicare Advantage grew from just under 9% to a peak of about 17%.

And over the last two quarters, we have seen some more challenging pre-authorization requirements from the Medicare Advantage plans, even on higher acuity patients. And so, our growth has slowed in that category. In fact, in the first quarter, it was 0.6% in total, and it was negative on a same-store basis.

Now within that, the units that we closed that I mentioned before, particularly the SNF, were actually much more heavily weighted towards Medicare Advantage. So, if we factor out those units, we had a positive same-store growth of I think, 0.6% and a total discharge growth in Medicare Advantage of 1.9%. We've got a specific strategy that we began rolling out on a pilot basis at the end of February to try to address this. I'm going to ask Zabi to talk about that in just a moment. But I do want to comment that the fact that the MA plans are pushing more self-pay back on the patients, that they're reducing benefits in part in response to the medical cost increases that they're seeing and the level of increases that they've been getting from Medicare and that they're so stringent on preauthorization is starting to show up in enrollment.

So, Medicare Advantage enrollment and penetration look like that for a long period of time. And it appears that it has now peaked at about 52% of Medicare beneficiaries and that it's actually started to recede a little bit more. And in fact, if you look at the 12-month period from March 2026 through March 2025, 20 states had a decline in MA penetration. We have hospitals in 12 of those, and 54 of our 148 counties saw a year-over-year decline in

Medicare Advantage penetration. It doesn't mean it's necessarily going away, but I think it is showing up how beneficiaries choose a particular plan. Zabi, you want to talk about [ph] the net appeal (00:18:32)?

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

Yeah. So, we're taking several steps to counteract some of the MA denials, the aggressive MA denials, and that includes maintaining active communication with the subject plan, highlighting our value proposition. We're also informing CMS of non-compliance with Medicare coverage criteria. We're making sure on our end, our clinical liaisons are responding timely to referrals, but we also have this admit-and-appeal strategy that we implemented this past quarter where we will admit MA patients that were denied through the preauthorization process that we believe meets CMS criteria, and we have strong clinical support for admission. And then, we're following up with a formal appeals process on those. And so, nine hospitals are part of a pilot that we kicked off a couple of months ago.

Early outcomes from that are very promising, but it's not to say we are done. I think we'll let this play out over the next six to nine months and understand kind of the end-to-end process of appeals and what the full effect of this program is and our success rates as far as what gets overturned. But early outcomes look, look good.

Douglas E. Coltharp

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

A

There are five different levels of appeal, and the first two happened very quickly. So, the first is called an expedited appeal. And essentially, as soon as you get a denial in the pre-authorization process, you fill out a form which we've been using AI to help us do and flip that back to the plan to see if the plan will overturn it based on that. We've actually seen, as you know, almost a 30% success rate on just flipping it back and saying, take another look. The second level of appeal is with a fiscal intermediary that is employed by CMS. That happens automatically if you get a denial and the turnaround is very quickly, and then, it moves to the ALJ and things slow down. So, it's going to take us a little while to develop an experience curve on this.

Our historical practice, by the way, because we have to compare this to what we were doing before is because there was sufficient patient flow within basically all payor classes, we got a pre-authorization denial for an MA patient unless there were really extenuating circumstances. We let it go and we moved on to the next patient. But as we've seen, their conversion rates drop so dramatically over the last two quarters, we felt the need to take a more aggressive approach, really advocating for the patients. And we're hopeful that this will change behaviors in two ways. One is that we're going to be successful on those that we're admitting and appealing. But the second is that the plans are going to wake up to the fact now that we're just not accepting their initial decision. And so, they'll start approving more of those appropriate patients on the front end. More to come on that in the future.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

But do you see, because it sounds like there was the issue with one particular payor, which is nationwide, but has that spread to other payors?

Douglas E. Coltharp

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

A

It has not. It's been disproportionately concentrated with one large player.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

Okay. And are you seeing any I mean, maybe different actions from other players? Because obviously, we hear across the board kind of providers talking about kind of your experience in terms of pre-authorization increasing and sort of more pushback from the payors? So, just curious if there's anything else?

Douglas E. Coltharp

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

A

We really haven't.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

Okay, that's good.

Douglas E. Coltharp

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

A

Yeah, that's good.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

But overall, I guess...

Douglas E. Coltharp

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

A

We also want to remind everybody we'd like to be able to serve the Medicare Advantage beneficiaries at the same rate that we do Medicare beneficiaries fee-for-service. There are plenty of patients out there, again, nationwide, just as a proxy for the unmet demand in this business, 60% of patients admitted into any IRF, ours included in a particular year, have to have as a primary diagnosis, 1 of 13 categories established by CMS called CMS-13.

We have the ability through the Medicare database to look upstream at all of the discharges coming out of acute care hospitals in the US on an annual basis. And we look at those that are coded CMS-13. We look up to the acute care hospitals because 93% of the patients who come into an IRF come from an acute care hospital, and only 14.5% of patients coming out of acute care hospitals with a CMS-13 diagnosis, wind up in an IRF bed. And so, that just tells you how much room there is to expand that. In many of the markets in which we operate in an existing hospital and we track that same conversion rate, we're able to move that up north of 20%.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

And I guess also maybe finishing up on the Medicare Advantage dynamics, because it is important payor, right.

Douglas E. Coltharp

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

A

Yes.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

Especially as you think about the penetration. And you guys like, you mentioned, you did a good job growing that penetration inside your business, right? But also, can you talk us and remind us where you stand in terms of the rates from these payors, right? Because historically, there was a bigger discount. It sounds like on average, you're kind of closing the gap, so kind of – is there...

Douglas E. Coltharp

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

A

Yes.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

...more room to close that gap or are we kind of where we should be on the rate?

Douglas E. Coltharp

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

A

So, there are positive aspects and there are concerning aspects around closing the gap between the two. So, if you roll the clock back 10-or-more years ago, the payment gap between fee-for-service and Medicare Advantage for our IRF services would have been as large as 25%. For the first quarter of this year, it was 1%. And that is a result of two things. One is, over time, as we've been able to demonstrate our value proposition, we have converted over 90% of our MA contracts from being paid on a per diem basis to being paid on a per episodic basis tied to the fee-for-service rate. And so, that has helped close the gap significantly. But the gap that we're talking about also is not acuity neutral. So, within both payor classes, reimbursement is tied to acuity, and we skew higher in acuity, not surprisingly, for Medicare Advantage.

And for instance, just a comparison, one of the most medically complex conditions that we treat in our facility. And we're better than anybody else in the world of doing that, patients that are recovering from stroke. And so, within our fee-for-service book of business, about 14% of our patients are stroke patients. Within Medicare Advantage, it's 35%. So, as we're seeing these more stringent pre-authorization requirements for Medicare Advantage, we're also witnessing is that we're retaining the higher acuity patients and we're losing some of the more – some of the still IRF appropriate but lower acuity patients. And so, that's closing the payment gap between them. But it's impacting volume. So, ultimately, you know, I would rather see that payment gap open up a little bit because the MA acuity spectrum is broadening.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

And maybe, we have a couple of minutes left, but I want to touch on the fee-for-service reimbursement. So, we got the proposal, I guess, that was very benign, I think, in there. I mean, there's some language around CMS looking at some things and they quoting netback analysis. So, maybe how we should think about the reimbursement outlook? I mean, we kind of have a view of 2027, right, but I'm thinking about could there be something else that could happen in the future? Because obviously, there's a lot of discussion in DC around fraud and abuse and, you know, going after certain providers. I mean, there's nothing out there that would suggest that, you know, inpatient rehab is being targeted. But I'm just kind of putting out there in terms of how you're thinking about the bigger picture kind of reimbursement changes in the future?

Douglas E. Coltharp

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

A

Yeah. I think the greatest comfort that everyone in this room should take around fraud and abuse in the IRF sector is the extension of RCD, Review Choice Demonstration. So, when the providers in the space are having 100% of their claims reviewed by a Medicare fiscal intermediary on the front end and still prevailing rates of 98% and higher in states like Pennsylvania and our early experience in Texas has been the same. That should be very comforting. And it's not our reviewer, that's their reviewer, and it's a 100% on a pre-claim basis. The proposed rule was relatively benign. The market basket update and pricing increase were a little bit lower than we anticipated. We had been anticipating 3% for the fiscal year that will begin October 1 of this year. It came in at 2.4%. That impacts our fourth quarter revenue and EBITDA by about \$7 million. We absorbed that within our guidance and still increase those guidance ranges.

There are a couple of provisions that are operational components about just including functional status within the pre-screen about when you have to initiate the initial team conference and so forth. Some of those don't make a good deal of sense. And so, as we normally do during this comment period, we will be providing comments to CMS both as an individual company as part of the trade association.

There was one RFI in there that has confused a lot of people because it talked about within certain patient categories wanting to basically converge coding of those patients between the SNF system and the IRF system. We do not believe that that is any kind of step disguised or otherwise towards site neutrality. And we really think that that is just an attempt to reconcile some coding differences on similarly situated patients.

Zabi Hotaki

Senior Vice President-Finance, Encompass Health Corp.

A

And the intent is to be budget neutral with those changes. So, as we see some of these categories maybe moving down – other categories moving up, it would potentially have a net offset.

Douglas E. Coltharp

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

A

And we saw that when Section GG was initiated in the IRF payment system in 2019. We just moved the pieces around the chessboard and wound up in the same place. And by law again is, as Zabi mentioned, CMS cannot promulgate any changes that are not budget neutral for the industry.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

And maybe the last question on capital deployment and I guess leverage and kind of your targets there, because I guess clearly your leverage is now below 3 times.

Douglas E. Coltharp

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

A

Yeah.

Joanna Gajuk

Analyst, BofA Securities, Inc.

Q

So now, kind of as we're thinking about kind of the...

Douglas E. Coltharp

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

Below 2 times.

A

Joanna Gajuk

Analyst, BofA Securities, Inc.

Below 2 times, actually [indiscernible] (00:29:18). Thank you.

Q

Douglas E. Coltharp

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

It's a good place to be. One of the real attributes of our business is we generate really high and sustainable levels of free cash flow. And so, we've been in a position last several years where even as we've ramped up CapEx to address these occupancy issues and add more capacity, we're funding that almost exclusively with internally generated funds because EBITDA been growing in the low-double digits for the last several years, the leverage has been coming down. And so, that's been giving us capacity to augment the capital that we're deploying for growth in the business with an increase in share repurchase program.

A

There was a time when we said our target leverage was about 3 times and we'd go up and above and below that, the last several years in speaking with our investors and it's just we've observed the overall environment, it feels like 2 to 2.5 is the new 3 to 3.5. We're at 1.9 times. It doesn't mean that we're capped there, but I think you're going to see us because we can do this without sacrificing the opportunities we have to grow the business and buyback shares. And I think you're going to see us probably hover in that 2 to 2.5 range for the foreseeable future.

Joanna Gajuk

Analyst, BofA Securities, Inc.

All right. That's all we have today. Thank you so much, everyone. Thanks so much as well and enjoy the conference.

Douglas E. Coltharp

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

Thank you.

Disclaimer

The information herein is based on sources we believe to be reliable but is not guaranteed by us and does not purport to be a complete or error-free statement or summary of the available data. As such, we do not warrant, endorse or guarantee the completeness, accuracy, integrity, or timeliness of the information. You must evaluate, and bear all risks associated with, the use of any information provided hereunder, including any reliance on the accuracy, completeness, safety or usefulness of such information. This information is not intended to be used as the primary basis of investment decisions. It should not be construed as advice designed to meet the particular investment needs of any investor. This report is published solely for information purposes, and is not to be construed as financial or other advice or as an offer to sell or the solicitation of an offer to buy any security in any state where such an offer or solicitation would be illegal. Any information expressed herein on this date is subject to change without notice. Any opinions or assertions contained in this information do not represent the opinions or beliefs of FactSet CallStreet, LLC. FactSet CallStreet, LLC, or one or more of its employees, including the writer of this report, may have a position in any of the securities discussed herein.

THE INFORMATION PROVIDED TO YOU HEREUNDER IS PROVIDED "AS IS," AND TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, FactSet CallStreet, LLC AND ITS LICENSORS, BUSINESS ASSOCIATES AND SUPPLIERS DISCLAIM ALL WARRANTIES WITH RESPECT TO THE SAME, EXPRESS, IMPLIED AND STATUTORY, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, ACCURACY, COMPLETENESS, AND NON-INFRINGEMENT. TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, NEITHER FACTSET CALLSTREET, LLC NOR ITS OFFICERS, MEMBERS, DIRECTORS, PARTNERS, AFFILIATES, BUSINESS ASSOCIATES, LICENSORS OR SUPPLIERS WILL BE LIABLE FOR ANY INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL OR PUNITIVE DAMAGES, INCLUDING WITHOUT LIMITATION DAMAGES FOR LOST PROFITS OR REVENUES, GOODWILL, WORK STOPPAGE, SECURITY BREACHES, VIRUSES, COMPUTER FAILURE OR MALFUNCTION, USE, DATA OR OTHER INTANGIBLE LOSSES OR COMMERCIAL DAMAGES, EVEN IF ANY OF SUCH PARTIES IS ADVISED OF THE POSSIBILITY OF SUCH LOSSES, ARISING UNDER OR IN CONNECTION WITH THE INFORMATION PROVIDED HEREIN OR ANY OTHER SUBJECT MATTER HEREOF.

The contents and appearance of this report are Copyrighted FactSet CallStreet, LLC 2026 CallStreet and FactSet CallStreet, LLC are trademarks and service marks of FactSet CallStreet, LLC. All other trademarks mentioned are trademarks of their respective companies. All rights reserved.