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# Encompass Health Corp. (EHC)

## Q3 2026 Earnings Call





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

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

# OTHER PARTICIPANTS

**Pito Chickering**
*Analyst, Deutsche Bank Securities, Inc.*

**Ann Hynes**
*Analyst, Mizuho Securities USA LLC*

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

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

**Morgan T. McCarthy**
*Analyst, Leerink Partners LLC*

**Ryan Langston**
*Analyst, TD Cowen*

**Joanna Gajuk**
*Analyst, BofA Securities, Inc.*

**Brian Tanquilut**
*Analyst, Jefferies LLC*

**A.J. Rice**
*Analyst, UBS Securities LLC*

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

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


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# MANAGEMENT DISCUSSION SECTION

**Operator**: Good morning, everyone, and welcome to Encompass Health's Third Quarter 2026 Earnings Conference Call. At this time, I would 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] Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Mark Miller, Encompass Health's Chief Investor Relations Officer. Thank you.

## Mark Miller

*Chief Investor Relations Officer, Encompass Health Corp.*

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

Before we begin, if you do not already have a copy, the third quarter earnings release, supplemental information, and related Form 8-K filed with the SEC are available on our website at 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 quarters ended March 31, 2026, June 30, 2026, and September 30, 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 will 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.

## Mark J. Tarr

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


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Mark, thank you, and good morning, everyone. We're very pleased with our third quarter results, as revenue grew 8.9%, adjusted EBITDA increased 15.5%, and adjusted EPS increased 23.6%.

For the first nine months of 2026, revenue rose 9.2%, adjusted EBITDA increased 11.9%, and adjusted EPS was up 17%. Based primarily on our Q3 results, we are again raising our guidance for 2026.

We achieved these results while once again delivering outstanding patient outcomes. Our Q3 discharge-to-community rate was 84.7%, discharge-to-acute rate was 8.4%, and discharge-to-SNF rate was 6.2%. Our performance on each of these quality metrics continues to exceed industry averages.

Our hospitals continue to be recognized for the outstanding clinical care we provide. Newsweek recently named Encompass Health as America's Most Awarded Leader in Inpatient Rehabilitation for the seventh consecutive year.

Also, NRC Health, a leading provider of patient experience data, recognized Encompass Health with the 2026 NRC Health Excellence in Patient Experience Award for the second consecutive year, placing us among the top three large health systems nationwide for patient experience.

Our investments in professional growth and development programs for clinicians continue to enhance our abilities to serve high-acuity, medically complex patients.

Encompass Health holds 408 Joint Commission Disease-Specific Certifications, including 150 Joint Commission Stroke Certifications. This represents approximately 65% of total stroke certifications among all providers.

In August 2026, the American Heart Association and American Stroke Association reaffirmed the importance of inpatient rehabilitation facilities in their updated 2026 stroke rehabilitation guidelines, recommending IRF care over skilled nursing facilities for eligible stroke patients when both settings are available.

The recommendation is supported by evidence showing greater functional improvement and higher rates of discharge back to the community following IRF care. We treat more stroke patients than any other inpatient rehabilitation provider.

Through the first three quarters of 2026, we treated 37,620 patients recovering from a stroke, comprising approximately 18% of our patient mix. We will continue to put our resources to work to help stroke and other vulnerable patients regain their independence and return to the activities that matter most to them.

Demand for inpatient rehabilitation services remains strong and is growing. We continue to invest in capacity additions to help address this underserved market. In Q3, we opened a new 50-bed hospital in Norristown, Pennsylvania, and added 31 beds to existing hospitals. Through the third quarter, we opened four hospitals with a total of 189 beds and added 85 beds to existing hospitals.

Earlier this month, we opened two additional 50-bed hospitals, one in Bangor, Maine, and one in San Antonio, Texas, and added 60 beds to existing hospitals. Over the balance of the year, we intend to open two more hospitals with a total of 100 beds and add up to 45 beds to existing hospitals.

We maintain an active pipeline of new hospital development projects while also executing on bed expansion opportunities as warranted by occupancy trends and market dynamics.


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Our pipeline of announced new hospital projects with opening date beyond 2026 currently consists of 15 hospitals with 654 beds. This includes our first two small-format hospitals, Conroe, Texas, and Richmond, Texas, both of which will be additive to our Houston market presence and serve as an exemplar of the hub-and-spoke strategy we have previously discussed.

We anticipate additional projects will be announced over the balance of the year. We also continue to expect to add 150 to 200 beds to existing hospitals in 2027.

On October 1, North Carolina's repeal of its Certificate of Need law became effective. As we have previously discussed, North Carolina has highly favorable population growth and demographic characteristics, and our assessment indicates a large underserved market for IRF services. We currently operate one hospital in North Carolina and have thus far prioritized 15 markets for development. We currently have six real estate parcels under contract.

Now, 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. The Q3 revenue increase of 8.9% was driven by 5.7% discharge growth and a 4% increase in net revenue per discharge. Net revenue per discharge again benefited from higher patient acuity.

Bad debt expense in Q3 was 2.7%. The increase over last year is primarily due to a billing and collection disruption issue following a system conversion in Q2 of 2026. This was a one-off issue, and we expect bad debt expense as a percent of revenue in Q4 to normalize in the recent historical range of 2% to 2.5%.

Q3 Medicaid supplemental payments decreased by $10 million from Q3 2025. Recall that Q3 2025 included $10.8 million of net provider tax revenue owing largely to retroactive Medicaid supplemental payments.

In Q3 2026, we reversed $9.2 million of previously accrued supplemental payments within our other revenue category related to the anticipated approval by CMS of the Florida fiscal year 2026 Medicaid state-directed payment program.

The Florida fiscal year 2026 program is still pending approval from CMS, and as the fiscal year ended September 30, we deemed it appropriate to make this adjustment. We also reversed $3.4 million of accrued provider tax expense within our other operating expenses related to the 2026 Florida program.

Q3 adjusted EBITDA increased 15.5% to $346.6 million, even as we absorbed an $11.5 million year-over-year decrease in net provider tax contribution. Through the first three quarters of 2026, the adjusted EBITDA contribution from net provider taxes was $600,000, and that compares to $18.1 million for the comparable 2025 period.

In our Q2 update, we had revised our expectation for the 2026 net provider taxes contribution to our adjusted EBITDA to approximately $10 million. This was based primarily on the Florida fiscal year 2025 Medicaid state-directed payment program approved by CMS in May of 2026. Given the pending status of the fiscal year 2026 program and the related adjustments to our accruals, which I just reviewed, we now expect the 2026 net contribution to adjusted EBITDA to be approximately $3 million.


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Q3 SWB per FTE increased 3.8%, in part driven by increased participation in our career ladder programs, partially offset by declines in premium labor and medical plan costs. Premium labor costs, comprised of contract labor and sign-on and shift bonuses, declined $3.9 million from Q3 2025 to $23.1 million. This marks 16 consecutive quarters of year-over-year reductions in premium labor spend, even as capacity and patient volumes have grown substantially. Contract labor FTEs as a percent of total FTEs was 0.9%, an improvement of 30 basis points from Q3 2025 and our lowest level since Q4 of 2020.

Q3 net pre-opening and ramp-up costs were $4.9 million, flat from Q3 2025, and were $15.8 million on a year-to-date basis compared to $11 million through Q3 2025. Based on the incurrence to-date and our projection for the balance of the year, we now expect net pre-opening and ramp-up costs of $20 million to $24 million for 2026.

Adjusted free cash flow for the first nine months of 2026 was $634.2 million, an 8.9% increase from the comparable period in 2025.

During Q3, we repurchased approximately 495,000 shares of our common stock for a total of $57.9 million, bringing our year-to-date total share repurchases to approximately 1.91 million shares and $203.7 million. We also declared a cash dividend of $0.21 per share, which was paid earlier this month.

During Q3, we issued an incremental $100 million of senior notes as an add-on to our 5.875% notes due in 2034, bringing the total amount of that note series to $600 million.

Our leverage and liquidity remain very favorable. Net leverage at quarter end was 1.8 times, and we ended the quarter with approximately $870 million available on our $1 billion revolving credit facility.

As Mark mentioned, we have again raised our 2026 guidance as follows. We now expect net operating revenue of $6.45 billion to $6.50 billion, adjusted EBITDA of $1.395 billion to $1.415 billion, and adjusted earnings per share of $6.23 to $6.37. The considerations underlying our guidance can be found on page 11 of the supplemental slides.

With that, we'll open the lines for Q&A.


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# QUESTION AND ANSWER SECTION

**Operator**: Thank you. [Operator Instructions] And we'll take our first question from Pito Chickering with Deutsche Bank. Your line is open.

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

Good morning, Pito.

**Pito Chickering**
*Analyst, Deutsche Bank Securities, Inc.*
Q

Good morning, guys. Nice quarter. So I know you aren't giving out 2027 guidance yet, but can you help walk us through the known headwinds and tailwinds for next year as we do our modeling, specifically in areas like startup losses from the hospitals opening up, Managed Care pricing you just raised that this quarter, VA penetration, and then anything just around labor and turnover that we should be thinking about?

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

Pito, this is Doug. I'll start on that and then ask Mark and Pat to jump in as they see appropriate. I'd say, generally speaking, we think that things are setting up for another solid year in 2027. I won't hit these in the specific order that you mentioned, but I think some things to consider. I just went through quite a few adjustments, and we did the same in Q2 regarding net provider tax impact, predominantly related to the Florida 2025 rule proposal and then 2026 as well. And so, we're not going to have to repeat those same accrual adjustments in 2027, and that should present some upside there.

With regard to – about pre-opening and ramp-up costs, we've got a comparable number of new hospitals opening next year. I would say that we would expect that number to be plus or minus $20 million.

Some other things to consider is we'll anniversary the last of the four unit closures in late February of next year. On the labor perspective, we're going to start to anniversary the impact of the increased career ladder participation on SWB. By the same token, and I've said this a couple of times before, at some point we're going to start to realize diminishing returns on the reductions that we've made in premium labor. But we continue to see some opportunity there.

From an overall pricing perspective, as we move into Q4 of this year, we're lapping some of the increases that we've seen based on higher patient acuity on revenue per discharge. That's not to suggest that there isn't more room to go, but last year in Q4, our net revenue per discharge was at 4.1%, and it stayed right around 4% for the last four quarters. I think those are the primary things that come to mind in terms of considerations.

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

Yeah, Pito, it's Mark, I would just say as we noted in my comments and as we've made a general theme now for the last couple of quarters, adding capacity is a big focus for us. So bringing on the additional projects not only in Q4 of this year, but then as it carries over into 2027 with additional beds coming on to existing hospitals, we're


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going to bring on the first small-format hospital next year that we talked about, as well as additional de novos. So that will be a common theme that will go into 2027 that we carried out in 2026.

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

Hey, Pito, this is Pat. Just a couple of points on VA and then hiring and turnover. VA continues to be a big positive for us. We've now hit our sixth consecutive quarter of at least 20% growth in that segment. We hit 21% growth in Q3. That's on top of 26.4% growth in Q3 of 2025. As well as that's going, there remains a lot of upside. There's a lot of variability between region-to-region and hospital-to-hospital in terms of capture of the VA population. So that's something our operators have done a great job with and continue to focus on.

You didn't ask about this, but as I think about 2027, one of the things that I think deserves to be called out is the success that we've had in the MA admit and appeal strategy and how we're thinking about expanding that. So far, relatively small n-size, we've had 294 claims go through. 87% of those have been overturned in our favor. 81% are being overturned before they go to the ALJ. So a lot to like there.

And if we think about discharge growth in that population, the MA growth in those nine markets for MA was 36%. And then we've talked about how that has endeared us to the referral sources. They also saw total growth of about 9.5% with another benefit of 6.6% growth in Medicare.

So we have just completed educating all of our hospitals on expanding that pilot across every hospital, every payer. For stroke specifically, we've increased the number of total pilot hospitals from 9 to 13 as well. So I think we'll start to see that incrementally tick up in Q4 and certainly in 2027. And then we'll evaluate how this goes. The next two diagnoses that we would likely scale up through the organization is brain injury and spine, which we're having a lot of success with as well.

And then just on the hiring and turnover front, turnover did tick up slightly in Q3 to 20.7%, but that remains below our historical levels. In the 10 years from 2014 to 2023, we averaged about 24.2%. Even if you back out the COVID years, the five years before COVID, 2015 to 2019, we averaged about 23.2%. So well below historical levels there.

And hiring has continued to remain robust. We have more full-time net RN hires through three quarters of this year than we've had in the last five calendar years on an individual basis, but the high-water mark there was in 2023. So again, a lot of things to be optimistic about from a workforce perspective as well as the other two buckets that I mentioned.

**Operator**: We'll take our next question from Ann Hynes with Mizuho. Your line is open.

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

Good morning, Ann.

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

Hey, Ann.


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**Ann Hynes**
*Analyst, Mizuho Securities USA LLC*

Q

Good morning. Thank you. So just on the capacity thought, I know that your capacity is running very high, and I think you said like 35% of your hospitals may be running at 85% capacity. Can you update that stat for us? And when do you think those capacity constraints could be freed to really accelerate same-store discharge growth? Thanks.

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

A

Yeah. So it is a factor. It's not the only factor. And generally speaking, when you're running at high systemwide occupancy rates, that's a really high-class problem. Specifically, we called out a cohort of hospitals that have been running at greater than 90% capacity with an average capacity – an average occupancy of 95%.

And so in Q1, we identified that there were 65 hospitals in that cohort. In Q2, the number dropped to 60, and in Q3, the number dropped further to 58. Across those three quarters, there have been 49 hospitals that have been present in that cohort for each of those three quarters. 19 of those will have bed additions between now and the end of fiscal year 2027. So that'll help greatly in that regard. And as Mark mentioned earlier, we're excited about the addition of these small-format hospitals. It's really going to help us address those in some markets where there are physical limitations on our ability to expand.

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

A

Ann, this is Pat. Just in addition to what Doug has shared and what Mark has mentioned as well, we're really excited about our development pipeline. Both our development team, our operators, and others at the home office have done a lot of work thinking about capacity expansions and how do we continue to take advantage of the demographic tailwind that is in front of us. And our pipeline from a de novo and small-format hospital perspective is larger than it's ever been. And we're working hard to figure out how do we – we guide to 6 to 10 hospitals a year with – inclusive of North Carolina, we think we can get to the top of that range. And potentially in the outer years be above that range. So we're working towards that and really excited about the pipeline both from a de novo and small-format perspective.

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

A

And the demand is there to support it. If you look just at the counties in which Encompass Health has a presence, from September of 2025 to 2026, in those counties, there were almost 500,000 more Medicare beneficiaries. And roughly 50% of those, a little bit more than 50%, were fee-for-service versus Medicare Advantage. So you've got an underserved population that continues to grow, and I know you've heard the mantra from us frequently, but the demographic tailwinds are still very much there.

**Ann Hynes**
*Analyst, Mizuho Securities USA LLC*

Q

Great. Thank you so much.

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


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

A

Hey, good morning, Andrew.

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

Q

Hi, good morning. Just wanted to follow up on the managed care pricing. The guidance assumption increased 125 basis points at the midpoint to a new range of 3.5% to 4%. Would love to hear what's driving that increase. Is the admit and appeal strategy part of that? And can you also confirm that that's unit pricing only and does not include shifts in acuity? Thanks.

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

A

It does include shift in acuity, and it's benefiting from that. The biggest driver there is something that Pat mentioned before, which is – that is – in that category we include our VA CCN volume, and that's been growing consistently at north of 20%. And as a reminder, that pays at the fee-for-service rate. So, the reason that we adjusted it up for the full year is because of the favorable performance we've had for the first three quarters of the year. Medicare Advantage is not included in that bucket. And again, that has skewed upward in acuity in part because of the more stringent pre-authorization that we've been facing and the fact that we've been able to replace some of the lower acuity patients there with higher acuity, specifically the stroke example that Pat gave earlier.

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

Q

Got it. Okay, that's helpful. And then maybe just to follow up on the small-format hospitals. You mentioned that you have two in the pipeline, but I believe only one is expected to open in 2027. Can you confirm that one is still the expectation? And just given the smaller format and presumably faster speed to open, why isn't that a bigger number in 2027? Why can't you accelerate that? Thanks.

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

A

So, I can confirm that our expectation is that one will open in late 2027. The best explanation I can give you on why we're not moving faster right now is that small-format hospitals are not only new to us, they're new to the communities in which we're introducing those, which have their own licensing and permitting aspects to them. And so in some of those instances, it doesn't fit. The small-format hospital doesn't fit neatly within the definition of either an acute care hospital or more of a subsidiary type of arrangement. And so we're having to spend a little bit more time on the front end through the permitting and licensing processes so that there's a greater understanding of what requirements really need to be contained within the remote location versus those that are provided by the host location.

I think the good news is really on a state-by-state basis once you have cracked the code of the initial time, the template is set, and we'll be able to go much faster. And it's that aspect of it that gives us a lot of confidence that as we get rolling here, we're going to be able to accelerate that pipeline pretty significantly into 2028 and 2029. The design is there, we're confident in the design, we've got the capacity with our general contractors, and there's no capital constraint either.


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

I would add to that that just from the market identification standpoint, our operators and development teams have identified about 200 locations where this potentially could happen. As Doug mentioned, we really think that we're going to be in a position to ramp this up in 2028 and 2029. I think we would all be collectively disappointed if we're opening less than six of those a year by that point.

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

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

Morning, Matt.

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

Hello, Matt.

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

Hey, good morning, everyone. I wanted to ask about the RCD expansion. I think you indicated 75 more hospitals will be subject to RCD in 2027, and at least when we look at the CMS reports, it seemed like the affirmation rates with Palmetto have been improving. Just wanted to see if you had any comments in terms of what to expect as that gets rolled out to additional hospitals next year?

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

Yeah. So I'll start by saying that with regard to the expansion into Jurisdiction JJ, which does include 75 more of our hospitals, we are having ongoing discussions with both Palmetto and CMS to understand specifically how it's going to work. Our greatest concern is whether or not Palmetto is going to be able to handle this administratively. Palmetto's involvement in RCD thus far has been limited to the state of Alabama, and seven of our hospitals are included there. But the expansion into Jurisdiction JJ is going to increase the volume that they're going to have to process by more than 10 times.

It's a requirement that during Cycle 1, which is slated to begin on January 1st and extend through June 30th, all providers will be on a 100% prepayment claim review. There's no option out of that in Cycle 1. So that's going to be a real burden on Palmetto, and we just want a greater understanding as to how they're going to be able to process that.

That said, to the extent that we progress through Cycle 1 and the hospitals exceed the target affirmation rate of 80%, which we would have a high degree of confidence based on our experience to-date, they will. And beginning July 1st, one of the options we would have is to move from the 100% prepayment claim review to a 5% spot check. We have just moved into Cycle 2 for the 24 hospitals that we have in Texas, where we performed very well and above the target affirmation rate, and we've made the decision to move to the 5% spot check there. And I think it's our anticipation that we'll avail ourselves of the same opportunity as it arises in other RCD markets.


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

Q

Great. That's helpful. And then maybe just one follow-up on the bad debt expense. You called out some impact from I think a system conversion. I was just hoping you could explain what happened there.

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

A

Yeah. So, really about two-thirds of the increase was due to the system conversion. I'll probably give you more detail than you would want. But in Q2, we converted our patient billing system from a legacy system that was called Patcom to the Oracle module. And we did so because Patcom was essentially being sunsetted and the Oracle module has enhanced functionality as well as greater comparability with our Fusion ERP. When we initiated the cutover, the pending claims that were left in the legacy system required a more manual processing. And at the same time, we were shifting some of our resources in that area over to processing claims under the new system. As these claims were pending, they became subject to our aging-based reserve methodology.

By the end of Q3, we were essentially caught up on our Medicare billing and collections. But the queue had not been cleared out for our managed care and our Medicare Advantage. And those payers typically run at a higher bad debt expense than Medicare fee-for-service, and they also generally require higher patient copays, and we can't bill for the copays until the payers process our claims. So it creates this backlog. Now we expect that queue to be fully cleared by the end of the year. And it is important to note that all claims since conversion are processing through the Oracle module without an issue. So this is really a one-time situation.

**Operator**: We'll take our next question from Whit Mayo with Leerink. Your line is open.

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

A

Morning, Whit.

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

A

Morning, Whit.

**Morgan T. McCarthy**
*Analyst, Leerink Partners LLC*

Q

Hey, guys, good morning. It's Morgan McCarthy on for Whit.

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

A

[ph] Morning, Morgan (00:34:23).

**Morgan T. McCarthy**
*Analyst, Leerink Partners LLC*

Q

Morning. So, your unit costs per discharge were effectively flat on a year-over-year basis. Is there anything to call out, whether it's this year or in prior years, related to provider taxes or any other cost items that might skew that metric?


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

Yeah. So the net impact from provider taxes was actually going to be a negative on that. But where we had some gains, again SWB was very favorable. That was driven by lower group medical expense in the quarter and then also just by the lower overall turnover. EPOB was favorable for the quarter. Length of stay was favorable for the quarter. I will note that we had a benefit in supplies. You may recall that in Q3 of 2025, we called out the fact that we had advanced some purchases of supplies in advance of the Fusion conversion in order to avoid any disruption. And obviously we didn't have to replicate this year. But generally when you've got a pricing increase in the 4% range, the flow-through and the efficiency there tends to be high.

**Morgan T. McCarthy**
*Analyst, Leerink Partners LLC*
Q

Thank you.

**Operator**: And we'll take our next question from Ryan Langston with Cowen. Your line is open.

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

Morning, Ryan.

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

Morning, Ryan.

**Ryan Langston**
*Analyst, TD Cowen*
Q

Great. Thanks. Hey, good morning, guys. I appreciate the questions. You had some really nice acuity pickup recently that's carried through to the third quarter. I guess, is that acuity lift a durable opportunity into 2027? And might RCD expansion impact the acuity of the patient transfers from the acute care hospitals?

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

I'll start there. And acuity can shift or RIC mix can shift on a quarter-over-quarter basis, but we do think that some of the trends that we're seeing are sustainable. We talked last quarter about the shift in acuity, and I'll call out a couple of diagnosis categories where we saw some really nice growth that are driving that again. We had 9.3% growth in our neuro RIC, 5.1% growth in stroke, 5.7% in brain injury, and then major trauma was up 10.3%. Some of those had a softer comp last year, but even if you look at it on a two-year stack from a same-store basis, brain injury was up 9.8%, neuro up 8.5%, stroke and major trauma up 5.7%.

And that mix is gaining because lower acuity conditions like lower extremity joint replacements are down. So, in Q3 same-store lower extremity joint replacements were down 5.3%. On a total store basis, they were down 0.7%, and we were able to backfill that volume with those higher acuity conditions. Not only are we seeing an increase from a RIC perspective, the percent of patients that come to us with comorbid conditions also continues to increase. And then we're getting the benefit on the pricing side as well from the outcomes that we're seeing. So, even though we're seeing higher acuity conditions, we continue to do a better job of getting those patients home, and that has a favorable pickup on the pricing line.


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

We don't anticipate that RCD expansion will have any impact on patient acuity. We believe we are admitting appropriate patients and providing the appropriate documentation for those patients.

**Ryan Langston**
*Analyst, TD Cowen*
Q

Got it. And then, sorry if I missed this in the supplemental payment commentary, but is there any update on the potential tax waiver program in Florida? And can you remind us if there's any impact plus or minus to guidance for 2026? Thank you.

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

Yeah. So, we went through the fact that we reversed the year-to-date accrual through the first three quarters. And that is because fiscal year 2026 ended on October 1st for Florida without a decision positive or negative from CMS on proposals set forth by Florida. The proposals set forth would include waivers for many of our hospitals in that state. If that were to come through in the fourth quarter, it has a potential favorable increase to EBITDA of about $8 million, which would be the sum of the roughly $5.5 million net impact that we reversed in our Q3 earnings plus the pickup we would get for Q4.

As we look into 2027, again, if it's approved with the waivers in it as submitted, that would be a positive. And again, on a year-over-year basis, we took that $11.5 million hit related to the fiscal year 2025 Florida plan in the second quarter, and we're not anticipating that we would replicate that.

**Operator**: We'll move next to Joanna Gajuk with Bank of America. Your line is open.

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

Morning, Joanna.

**Joanna Gajuk**
*Analyst, BofA Securities, Inc.*
Q

Oh, hi. Good morning, thanks. Hey, good morning. Thanks so much for taking the question. So, I guess, first on the small-format hospitals, was very exciting, I guess, type of development there. But can you remind us, I couldn't remember whether you talked about the returns on these projects versus, say, your typical 40-, 50-bed hospital, because I guess you're leveraging some of the local costs in there, right? So can you remind us how that progresses I guess, when you have a small format versus just a regular hospital [indiscernible] (00:40:22)?

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

Yeah, absolutely. So we have been targeting and realizing returns – IRRs on our de novo program in the mid-teens, and that's based on maintaining a cost per bed which we feel some degree of confidence in moving forward of roughly $1.25 million per bed. Bed expansions to existing hospitals offer the greatest leverage opportunity and then also the highest returns. We are at 25% or higher with regard to the IRR on bed expansions at existing hospitals, and the average cost per bed there tends to be right around $850,000.


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The small-format hospitals are going to fall right in between. We're estimating the cost per bed on those will be right at $1 million, and we're targeting an IRR of about 20%. You identified the ability to get some efficiencies by sharing certain components of the administrative staff with the host hospital. And as a result, whereas we run on a corporate-wide basis an EPOB of just under 3.4 times, we think there's an opportunity for the small-format hospitals to have an EPOB below 3 times, and that's a highly sensitive metric with regard to the P&L and therefore flow-through to returns.

**Joanna Gajuk** Q
*Analyst, BofA Securities, Inc.*

Okay. Yeah, that's great. Thank you for that. And I guess the other question that I had in terms of this acuity-driven pricing, seems like it's very sustainable there, and thanks for breaking out the volume growth by the different categories. So anything to call out that would suggest somehow things could slow down in the next year? I know it's volatile quarter-to-quarter, but if we think, say, the next 12 months or so, anything that would say, hey, like things should slow down or change versus your trajectory? Thank you.

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

Other than to recall that at least some of the increase in acuity that's flowing through in the pricing growth is attributable to the trends that we've been seeing within Medicare Advantage and the increase in pre-authorization denials that skewed us towards a higher acuity within our MA book of business first became really prevalent in Q4 of 2025. So if you looked at Q4 of 2025, we had a 4.1% net revenue per discharge. Our MA discount for that quarter – and it tends to widen out from Q3 to Q4 because MA price increases on a calendar basis and fee-for-service increases on a fiscal year basis was 2%. And so as we anniversary those higher increases, even if acuity is maintained at the current levels, the year-over-year pricing change is going to be less pronounced.

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

**Brian Tanquilut** Q
*Analyst, Jefferies LLC*

Hey, good morning, guys.

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

Good morning, Brian.

**Brian Tanquilut** Q
*Analyst, Jefferies LLC*

Good morning. Congrats on the quarter.

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

Thanks, Brian.

**Brian Tanquilut** Q
*Analyst, Jefferies LLC*


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Good morning. Yeah, so maybe, Doug, my first question, your contract FTEs this quarter showed some pretty good improvement, and I know in Q2 you said that the gains were getting smaller. So just curious what you're seeing there on the permanent side hiring, retention, and the career ladder grads that you're putting out there, and how that's translating into contract labor?

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

I'm going to toss that one over to Pat because it's something that he spends a lot of time focused on.

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

Yeah. And Doug continues to challenge us on the operations side by talking about the diminished returns that we're going to see in reducing contract labor and premium pay, and there's a truth to that. But this was another really strong quarter. And I highlighted some of the hiring and turnover dynamics earlier in the call, but we still have – if you look at contract labor, extra shifts, sign-on, overtime, and you normalize that by a per patient day basis, we still have a couple dozen hospitals that are over $100 per patient day in spend. So there still is juice for us to squeeze there, and we've had a lot of success working on those higher-spend hospitals to bring that number down.

Again, just to reinforce what I said earlier, net RN hires and therapy hires has not been better in years. Even if turnover ticked up a bit, the hiring dynamics have certainly overcome that, and turnover on a historical basis is still very strong.

From a ladder perspective, we are up to 55% of eligible nurses are on the ladder. That represents about 31% of all of our full-time nurses being on the ladder. They have to be here for a certain period of time to move up into the ladder. So there's some upside there. Again, we had a big bolus in 2026 of the ladder, and we're going to anniversary some of that. So any of that upside within the ladder, we will be able to take those dollars and not be as pronounced as they were in 2026. But our largest bucket of opportunity is non-certified, non-laddered nurses, which represents about 60% of our full-time nurses.

And again, we have some variation from region-to-region that we're working to improve upon. And I think if we can continue to do that, we're going to continue to see improvements not only in turnover reduction in the premium pay bucket, but also in the continued sustainability of the higher acuity patients that we've been able to bring in.

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

Brian, you've heard us say before relative to contract labor, we've given our operators the green light. If they've got the volume and need to have contract labor to accommodate that volume, they need to go ahead, and we'll take the hit on a short-term until we can work it back out of the system. But we are not being throttled on our volume because of the focus on eliminating contract labor.

**Brian Tanquilut**
*Analyst, Jefferies LLC*
Q

Maybe my follow-up, just as I think about the hospitals that you've opened in the first half of the year, how are they tracking in terms of hitting break-even in your typical ramp? I mean, just curious how this class of new openings are performing. Thank you.


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

Yeah, so remember we're heavily skewed towards the back end of the year, with four hospitals, four of the eight opening up in Q4. That said, we think that these are tracking in accordance with our recent historical performance. And just as a reminder there, generally what we have been seeing is that our de novo hospitals are achieving a four-wall positive EBITDA by about month six, and they're climbing over a 70% occupancy by about month 10, and then they're achieving what we would suggest is full maturity and typically qualifying for a bed addition sometime between year three and year four. So we have no reason to expect that the performance of the current class is going to be any different from that recent historical.

**Operator**: We'll take our next question from A.J. Rice with UBS. Your line is open.

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

Good morning, A.J.

**A.J. Rice**
*Analyst, UBS Securities LLC*
Q

Hi, everybody. Yeah, first question on the discharge growth on the same-store basis. There's been a lot of focus on that. I wondered if you would just offer us any comments. I think you mentioned that you had the final four closures will anniversary in February of those, and then you've obviously had the pacing on the new facilities. Anything to call out in the way to think about same-store discharge growth over the next number of quarters here, where there's any challenges or where there's some easy comps? I know you've got a long-term target of 4% to 6% growth on that.

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

Yeah. So, actually I think our total discharge growth from 2023 to 2027, the target that we put out there was 6% to 8%. We didn't break that down between new store and same-store. This won't surprise you, A.J., but I'm going to start with my usual disclaimer that we think it is increasingly less relevant to think about the distinction between new store and same-store, that what really matters most is total discharge growth and the capital that's required to generate it. Having now said my piece with regard to the disclaimer, I'm going to take you through five factors that we think are relevant to looking at same-store.

The first, that you mentioned, was the impact from the four unit consolidations. That impact on a net basis we estimate for Q3 was about 40 basis points. That's down from 70 basis points in Q2 and from 90 basis points in Q1, and that will be fully lapped in Q1 2027. And as a reminder, the reduction in the volumes related to those unit closures carried no impact to EBITDA.

The second is something that I mentioned earlier, which is that cohort of high-occupancy hospitals, 65 above 90% in Q1, 60 above 90% in Q2, 58 above 90% in Q3, 49 hospitals consistent through all three of those quarters. 19 of those will have bed additions coming on board prior to the end of the year in 2027.

The third factor I would mention was the change that we saw in MA pre-authorization denials beginning in Q4 of last year. If you look at total MA discharges in Q3, it actually declined 1.1%. Adjusted for the unit closures, which


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were disproportionately high in Medicare Advantage for the patient mix, especially the sole SNF unit that we closed, we would have been up 1%. Still not the height of our aspirations.

As Pat mentioned earlier, in the nine admit and appeal pilot markets for the quarter, total discharge growth was up 9.3%. So what we've demonstrated is that pilot is working, and as Pat outlined, we're looking forward to extending that across stroke in all of our hospitals and then bringing more hospitals into the fold from a pilot perspective.

In terms of bed additions and new hospitals, as we mentioned previously, bed additions in 2026 were also heavily weighted towards the second half of the year. Q3 benefited from only 54 beds added to existing hospitals in the first half of 2026. And also we only had one de novo, and that was Loganville, Georgia, that moved from new store to same-store in Q3. I'll note that we have 90 beds moving into same-store in Q4 and another 150 in Q1 of 2027.

And then something we haven't talked about a lot, but it's evident I think to some degree in our overall patient mix, is there is some impact that is happening across the 89 TEAM markets. And so in Q3 we saw knee and hip replacement actually decline 3.6%, and these are small categories for us, and cardiac declined about 0.7%. Now not all TEAMs markets are reacting the same, and in those markets we're having a lot of success substituting higher acuity and/or VACCN patients for these lower acuity patients that may be subject to TEAM. And while it may not be a one-for-one change from a volume perspective, what we're seeing in those markets is that the move to the higher acuity patients and the move to the VACCN patients is generating higher revenue and EBITDA.

**A.J. Rice**
*Analyst, UBS Securities LLC*

Q

Okay, that's great. Thanks. I would maybe as my follow-up just ask, I know you're now down to 1.8 times net leverage. I think you previously said it wouldn't necessarily make sense to go below 2 times. Should we think of capital deployment from here leaning into share repurchases, dividends, anything else? Any comment you want to make along those lines?

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

A

Yeah, I think that the capital allocation framework is going to be relatively consistent. You'll probably see modest, occasional, or periodic increases in the dividend, so that's not going to consume a lot of that capacity. Pat mentioned earlier that as we think about an accelerating pipeline for both small-format hospitals and for de novo openings, particularly with the attractiveness of North Carolina as just an example that we're likely to see our discretionary CapEx begin to increase. And that's still going to leave capacity while maintaining a very favorable leverage target for increased share repurchase activity. So we like the combination of those things.

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

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

A

Good morning, Jared.

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

A

Good morning, Jared.


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

Q

Morning, thanks for taking all the questions here. Maybe I'll ask one on the current mix of your beds between single occupancy and double. I know you kind of had this shift towards more single over the last couple years. Just wanted to get an update on where that stands today, and then based on what you have in the pipeline, where you think that could trend over the next couple of years.

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

A

Yeah. So at the end of the third quarter, we were at 58%. That compares, if you go all the way back to 2020, at 41%. 58% were private. All of – essentially all of the capacity that we're bringing on in all three modalities, bed additions, de novos and small-format hospitals is going to be 100% single occupancy. So that number will continue to push up, and we'll get some benefit of that here in the fourth quarter because of the number of bed additions and new hospitals that we have coming on board. So that number will be higher when we report it for Q4.

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

Q

Okay, very helpful. And then I appreciate all the details on the Medicare Advantage admit and appeal strategy. I realize it's still relatively early with the pilots, but just given the success you've seen so far and then your thinking around how you can expand that to other conditions and other hospitals across the portfolio, I guess when we think about the impact to the model, are there any guardrails that you would sort of frame for us in terms of what the actual net impact could be on conversion rate or I guess, ultimately volume growth within that cohort over the next several years?

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

A

Well, generally speaking, we think it's positive, a, because we're anniversarying the more challenging pre-authorization from the MA plans that began in Q4 of last year, and this has proven to be an effective tool, and because even beyond what we were experiencing in these categories with regard to denial rates pre that dip in Q4 of last year, we're seeing higher success rates. All of that said, it's not going to happen in a vacuum. And so we believe it is a tailwind, in terms of quantifying it, that's yet to be determined.

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

A

Hey, Jared, this is Pat. We're in the process now of we've added resources since we've started the pilot. We're adding a good number of FTEs that are going to help us as we scale this throughout the organization. But we're putting the structure in place to be able to go a little bigger here.

**Operator**: We'll take our next question from Raj Kumar with Stephens. Your line is open.

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

A

Good morning, Raj.


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

Q

Hey, good morning. Maybe I just wanted to touch back on RCD. As I look at the Alabama cycle-through reports, the claims activity coming down by 25% to the pre-RCD baseline, but looking at your guys' results, fee-for-service still pretty strong. So would love to reconcile your experience in that Alabama program across these three cycles, and more specifically, I guess, where your initial affirmation rates are, maybe where your appeal rates are as well, and maybe helping us extrapolate to this more expanded RCD program. Any details there would be helpful.

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

A

Well, it's hard to extrapolate any of our experience across the expanded program because Palmetto in particular has never been asked to handle this volume of claims. And so we don't know if it's going to be the same reviewers, we don't know if it's going to be under the direction of the same medical director, we don't know whether they're going to be using subcontractors, we don't know if the program is ultimately going to be phased in, et cetera.

What we do have a high degree of confidence in is that there's – that we are admitting the right kind of patients and we are providing the appropriate documentation. And again, as this extension begins on – assuming it begins across all of these 75 hospitals on January 1, we will be prepared administratively to do our part. And the target affirmation rate in Cycle 1 is going to be 80%, and we have a very high degree of confidence that all of our hospitals are going to get over that 80% target affirmation rate.

And if they do, beginning July 1, we can move to a 5% spot check. That is not something that we have experience with to-date because to this point, either because we were in Cycle 1 in the other states that just came out, which was a requirement like California and Texas, because we elected to stay for various reasons on 100% prepayment claim review. In Alabama, we haven't had experience with the 5% spot check. But the math will tell you that the impact is going to be less and the administrative burden will be less.

And so again, we think if there's volatility in the bad debt number that arises out of the rollout to these 75 incremental hospitals, it's going to be contained, and it's likely going to be contained in the first half of the year. And it's important to note none of the coverage requirements, none of the patient criteria under RCD are any different than they have been under the audit programs that we've been subject to for an extended period of time and that have informed our historical bad debt in this recent range of 2% to 2.5%. So there's no reason to believe that things settle in – that we're going to settle in at a bad debt number that differs in any material way from that which we've experienced historically.

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

Q

Got it. Maybe just following up on that, I guess when I think about maybe some of the more independent IRFs and maybe some behavioral changes around maybe not appealing or not admitting IRF-eligible patients that might be on the fringe of eligibility, I guess have you maybe experienced any market share gain dynamics from that or any favorability, as I think about your administrative working power versus maybe an independent mom-and-pop IRF?

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

A

We don't think we're admitting patients who are on the fringe of eligibility. We think that the patients that we admit clearly meet IRF admission requirements.


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### Patrick W. Tuer

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

A

Yeah, this is Pat. I would just add, I sit on the board of AMRPA, which is the trade association for inpatient rehab providers, and I think not only Encompass but the other providers within AMRPA have all done a really nice job with RCD, and it hasn't shifted our admission practices. I mean, we're taking the same patients that we did before, and to my knowledge, the other providers are as well. So I think if anything, administrative burden aside, we're proud of the fact that this has demonstrated such a strong record of compliance within our company and the industry.

**Operator**: Thank you. At this time, there are no further questions in queue. I will now turn the meeting back 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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