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Encompass Health Corp. (EHC)

BofA Securities Health Care Conference - Fireside Chat

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CORPORATE PARTICIPANTS

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

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

OTHER PARTICIPANTS

Kevin Fischbeck
Analyst, BofA Securities, Inc.

MANAGEMENT DISCUSSION SECTION

Kevin Fischbeck
Analyst, BofA Securities, Inc.

It's my pleasure to be introducing Encompass Health. Encompass is the largest operator of inpatient rehab facilities in the country. Presenting today we have Mark Tarr, President, CEO; as well as Doug Coltharp, who's the CFO. And I guess we'll jump right into...

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

Sure.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

...to Q&A.

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QUESTION AND ANSWER SECTION

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

All right. So I guess one of the things that we're still trying to triangulate into after Q1 is just kind of where volumes and demand, within the healthcare system broadly is today. I mean, how would you characterize, the volume backdrop today for...?

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

A

Yeah. Certainly. Q1 is a strong quarter for us. If you look at everything from geographic performance, all eight of our geographic regions had nice growth over prior year. If you look at it by program mix, we had nice growth in our stroke programs, other neurological, we had brain injury and debility where all programs that we saw double digit percentage growth. So not only the geographic coverage as well as the programmatic coverage was really an indicator of the strong need for our services across all of our platform.

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

A

And specific, when you look at Q1, there were two benefits in the quarter. First was the inclusion of Leap year and second is that the Easter holiday fell on the last day of the quarter. And when that happens, it tends to push some discharges that would otherwise have occurred in the first week of the second quarter and into last week in the first quarter.

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

A

So I think what you're seeing, Kevin is the continued demographic tailwind that we're experiencing. Our average age patient is right at 77. So if you think about the age cohort of the baby boomers, they're starting to move into that age cohort that we have in terms of our patient population. That plus just the fact that if you look at our performance going back to 2020 and COVID, when we were able to really show the types of outcomes we could get with a higher acuity patient, we've certainly been taking market share from other post-acute providers, including nursing homes and certain marketplaces competing.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

And I guess from a market share perspective, I guess we often hear you about adding capacity and doing de novos and things like this. We don't hear as much. Can you talk about because I don't hearing as much talk about taking share from other post-acute care sites of location or from competitors, I mean, how are you winning or where is this? You know, what's the strategy to get that volume to come to you versus wherever it was going previously?

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

A

Yeah, well, we lead with our outcomes and our quality as well as our sales and marketing staff, our nursing liaisons that are out there daily working with the discharge planners, acute case managers, referring physicians,

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and the acute care hospitals, making sure that we have work with them to identify those types of referrals that are appropriate for our intensity of care, and then make sure that we follow up in a prompt manner so that we can be a provider that's easy to refer to where they get good communication. And we are there to service the patients as well as the referral source.

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

And that plays into our clinical programs as well, making sure that we've got the clinical capabilities to take the most medically complex patients who qualify for inpatient rehabilitative services and to be able to take those patients quickly from the acute care hospitals. And that allows them to manage their length of stay and to turn the tables in the restaurant, if you will, faster at the same time not exposing them to additional rehabilitation or readmission risk. So whether it's something like the addition of in-house dialysis services or some of the other things that we can do so we can take that patient that might otherwise, if they were going to be discharged with SNIF require two or three additional days in the acute care hospital, which is very expensive. Instead, to safely transition into one of our facilities and begin their recovery.

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

Kevin, I think a big, big part of our ability to accommodate the increased volume was just what we've done on the labor side. We have done really a great job in terms of recruiting nurses. We consolidated centralized that function a couple of years ago so we could take that burden off the individual hospitals themselves. But by centralizing, we really have gotten a lot of expertise now and our ability to recruit RNs nursing staff across our platform make that easier for the hospitals. But if you look at our net new nursing hires, we've really had some impressive trends on that.

And then on the other side of that is we're really putting a focus now on retention of those nurses. So we wouldn't be able to handle the increased volume if we didn't have the staff. So it's really a two-pronged approach and making sure that we have the resources, the skilled resources necessary to take care of these patients.

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

And so the investment that we've been making in ensuring that our salaries are competitive across all markets, getting our staffing to the right level, providing the right degree of training and precepting and all of those things that are contributing to the improved retention is really showing up in the numbers as well. As we started on our Q1 call, if you annualized our first quarter of 2024 nursing turnover was at 21%, which is well below the industry average and is below where we were pre-pandemic. And on the licensed therapy side, it was a little over 5%. And again, well below the industry average better than we were pre-pandemic. So we're very proud of those numbers and those will pay long-term benefits.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

And where nursing turnover kind of peaked during COVID? Where nurse turnover peak during COVID in 2021 where were you?

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

It was north of 30%.

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

Yes.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

Okay. And what kind of wage growth are you looking for, over the next couple of years?

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

So we think that SWB this year is going to be up a total of 4% to 5%. You know, underlying that is an assumption of kind of core wage growth. It's probably in the 3.5% to 4% and then you're getting another percent just based on the fact that we had a very favorable year last year with regard to benefits. And we expect some mean reversion this year.

Moving forward, we'd like to think that that settles in closer to kind of the 3.5% range. But it's tough to have complete visibility into that right now. It does feel like labor market conditions are calming down a bit. We see that certainly in the improvements that we've made in the premium labor categories, most notably continuing to see compression in the rates for contract labor. And we've been able to manage that contract labor as a percentage of total FTEs in around 1.5% for the last several quarters, having peaked at 2.4% in the first quarter of 2022. It's still higher than we were pre-pandemic, which was just below 1%. Again, if we continue to make the strides that we are making with regard to new hires that Mark referred to and keep the retention rates in this level, we'll see that contract labor number come down even further.

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

We've been very aggressive at making sure that our rates were at market and where we didn't slip behind the market, which led, could lead to turnover. Our thought is that we're better off making sure that we keep up with the market versus falling behind the market because the experience has been that it costs more to catch up once you have fallen behind versus making sure that you have periodic market adjustments to keep you at the market where you need to be, particularly for RNs and therapists.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

Okay. Great. And then when you think about the growth that you guys are looking for kind of longer term in that 6% to 8% number, how much of that is going to be predicated on building new capacity? Is the capacity has to keep growing 6% to 8% over time to be able to do that, or is there an opportunity within the quarter today?

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

We're still seeing organic or same store growth within the legacy base as well. And so that will certainly be a contributor. The balance of that 6% to 8% CAGR between new store and same store is going to vary from period to period based on when new capacity come online. The ramp up of that new capacity. And then also from a same store perspective, what you're up against from a comp perspective, you tend to see that kind of back and forth where you're up against a good comp, your same store growth is going to be a little bit more muted, but then

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you're up against an easier comp the next year and so it can be a little bit higher. But we like having the balance of both organic growth opportunities without adding capacity expansions, augmented with capacity expansions.

And through our de novo program, we get the turbocharger of subsequent period bed expansions and that strategy has played out really well. In a typical de novo and the prototype that we're using right now is 50 all private rooms. We are acquiring enough land and usually have the flexibility to increase those up to about 80 beds. And it's unusual for a new de novo not to see the need for its first bed expansion within the first three years.

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

If you look at just the occupancy rate and our complement of private versus semi-private rooms, clearly all the new hospitals we're building and the beds that we're adding are private rooms. But when you do that, you can run almost a 100% occupancy versus complement of semi-private rooms where you may have reasons for isolation or gender pairing, where you're not able to run that higher occupancy that you can in a hospital that's all private rooms. So that's also a factor in our ability to grow as we move forward and sustain that 6% to 8% discharge growth.

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

And within our maintenance CapEx, when we're doing large remodels or significant remodels of some of our legacy hospitals that have a high complement of semi-private rooms, we're looking for opportunities while we're in there to convert more of that space to private rooms, which increases the occupancy and allows for more organic growth in those facilities. And so the combination of the new capacity being brought on in the manner that Mark referenced earlier and that remodel activity has served to take the balance of semi-private versus private rooms from about 60/40 as recently as the end of 2018 to a number that's pretty close to 50/50 right now, and that'll continue to trend up towards more private.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

And can you just remind me how many facilities you have in your de novo pipeline and then maybe kind of break it out between what's done from us? So ownership versus a JV relationship.

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

We have about 40 in the pipeline right now. And I would say about a third of those, a third to half are joint ventures.

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

And what we would expect out of that is because joint ventures, particularly if it's the first time that you're joint venturing with a new partner and if it's a not for profit system that may not have a lot of experience in terms of joint venture relationships, we would expect out of that that 40 or so in the pipeline that maybe it's a third that are identified as joint venture opportunities right now. By the time we get to opening those facilities, about half of them will be. And so our overall portfolio mix, we are about 40% joint venture right now. But based on that 50/50 composition within the pipeline, we're going to see that inching up over time as well.

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And it's really consistent with the overall trend that you've seen in terms of licensed beds in the US over the past 12 years. If you look back over the last 12 years, in spite of increasing demand for our services, which have been largely tied to demographics, and there specifically, we would note that the age demographic north of 65 years old in the US has been growing at low to mid-single digits for the last 12 years, while the overall US population has been growing at less than a 1% CAGR. But over that entire 12 year period, this is not a CAGR, this is the total growth in licensed ERF beds is only up about 1.5%. And that's because of the largely because of the model that we've been pursuing, which was one way to do a joint venture transaction.

The typical way that that will come about is we will identify a market that based on its demographics and the underlying supply of providers we think is very attractive in terms of building new ERF capacity. We'll then look upstream and identify a quality acute care provider that in many cases is operating an ERF that appears to be inefficient and underutilized. We'll approach that partner with a proposition that says, we will come into this market and build a new freestanding hospital on your campus or proximate to your campus, if you will go ahead and convert that ERF unit within your hospital to something that you can generate a profit on, like general medical and surgical services, and sign a non-compete for ERF services that we can in exchange for that non-compete give you an in-kind equity interest in the new Joint Venture Hospital. It's a double win for you because that space within your four walls that was previously unprofitable is now profitable. And yet you'll still be able to represent to your constituents that you're in the ERF line of business and you'll actually be making money based on your minority interest in our facility.

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

Another part of our partnership growth has been multiple hospitals with the same partner. A good example of that is Piedmont Health in the state of Georgia, and we're now up to six hospitals with that system. That's a growing system as they have grown. It's provided opportunities for us to grow with them and add new rehabilitation hospitals in marketplaces that they're growing into as well. We're seeing that same dynamic with Barnes-Jewish Christian and the St. Louis market. We've had we have a number of other providers that are partners that we built second or third hospitals with as well.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

Okay. Great.

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

And the Piedmont Partnership is particularly important because for a long time Georgia, the state of Georgia, was a bit of frustration for us. It's our neighbor immediately to the east. And yet our ability to establish any kind of significant presence had been somewhat limited by CON laws. We had acquired the Walden facility in Augusta, Georgia, which was very profitable and well run. But getting into some of the markets, particularly in the Atlanta metro market, had proven more challenging and the partnership with Piedmont has really opened up a lot of doors for us.

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

So this business model of having partnerships, we've done this now for 34 or 35 years. So about a third of our portfolio are joint ventures and we're very proud. We've never had a JV unwind in that 34 years. So we think know

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how to be a good partner. Those good partners lead to new future partners because they always call each other for reference on Encompass Health.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

And I know you kind of mentioned this a little bit earlier, but it just does seem like you're opening up a bunch of new facilities. It seems like the bed capacity is growing. I mean, how many markets are there for this type of development? How long can you keep growing 6 to 8 facilities?

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

A

I think the runway in front of us is pretty substantial. And so, yeah, we made the decision towards the end of 2018, beginning of 2019, to start ramping up our de novo building program. It took about three years to bring that into fruition because we had to hire the right internal resources and build the capabilities. There's nothing easy about building a new hospital and opening it successfully. And so the first year really saw that roll through the pipeline was 2021. We opened up eight de novos. The previous high that we had done in any single year had been four. We followed that with nine in 2022 and then an additional eight in 2023. Certainly some of that building has been facilitated by the removal of the CON requirement for ERFs in the State of Florida. Prior to the CON being revoked in the State of Florida, we had operated 11 legacy hospitals, but we had known for a long period of time just reading the political tealeaves that there was going to come a day when that CON restriction would be a requirement would be removed. And so we already scouted out the markets that we wanted to move into another 15 markets, which are definitely supported by the population.

We were to some degree fortunate that the removal of the CON really coincided with COVID because a lot of other parties who might otherwise have moved into the state with new capacity, particularly some of those that are PE-sponsored just decided to hold back on any capital commitments during the midst of COVID. We had enough flexibility in the balance sheet, enough confidence in the model to push forward. We further enhanced our first mover advantage. But I don't want to suggest that the opportunities for continued ERF development are just limited to the state of Florida and for the state of Texas. I mean, if you look at the capacity that we're bringing on in just the second quarter of this year, we've got openings that are happening in Atlanta. We did open up another one in Florida in the Orlando area, and we've got an opening coming up in the near term, which will be our first facility in the state of Rhode Island. We've got another facility that's opening up in Louisville, Kentucky.

One of the things that really gives us confidence is this supply demand imbalance that's been created by that dynamic that I referenced earlier, which is the supply of ERF beds is just been relatively static for the past 12 years, what the underlying population has been growing and the incidence of maladies that require treatment in an ERF have not declined or changed materially within that age demographic that we serve. So there's a lot of unmet demand out there. As a proxy for that, we're able to look upstream to the acute care hospitals. As a reminder, more than 90% of the patients who come into an ERF come from an acute care hospital and just look at the CMS 13 eligible discharges, which are only required to be 60% of the patients that we treated in ERF. How many same as 13 eligible discharges are being discharged on an annual basis from those acute care hospitals. And what percentage wind up being admitted to an ERF? And it's a large pool and currently only 13% are winding up in an ERF bed. So that number shouldn't be 100%, but it should be a whole lot larger than 13%. And a primary reason why it's not is because there just isn't ERF bed availability in a lot of markets that can support it.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

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Yeah. It seems to me like the volume support is quite strong. I think there's a risk that I focus on is on the reimbursement side. Talk a little bit about the outlook for rates over the next few years.

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

Well, we've got 2.5% to 3% out there is kind of what our expected range is CMS. We're not seeing anything from a sheer regulatory front that would be a cause in the near term to significantly impact rates in terms of some major regulatory change in the way they do reimbursement from a broader perspective. Also, we're always quick to say if you look at the history with our company and our ability to respond to significant regulatory changes that are rolled out by CMS, we've really done a great job on evaluating and figuring it out, mitigating the impacts. And then, it has also led to some periods of significant growth for us. As these impacts have impacted us in a negative way. They're hurting our competition or smaller providers in a much more significant way. So it's been an opportunity for growth and acquisitions when these regulatory changes are rolled out.

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

And regulatory changes and reimbursement scheme changes notwithstanding, the underlying demand for the services we provide is only continuing to grow in this population and well into the foreseeable future. And someone has to be available to meet the needs of those patients when there is a regulatory change that creates a period of disruption, typically very temporary within the industry and the benefits attendant to scale become even more pronounced in those types of periods of disruption. We simply have more and better resources available to be able to confront those changes than any other competitor. And so that typically means we emerge from that with market share gains, and we have demonstrated that time and time again the threat of a regulatory or reimbursement change is almost always overstated in terms of its impact on us and our ability to deal with the changes underestimated. And you can go back and you can look at the Affordable Care Act, the Budget Control Act of 2012 that led to sequestration, BPCI, CGR, Section GG and most recently RCD.

Kevin Fischbeck
Analyst, BofA Securities, Inc.
Q

So I guess the one that people have been scared about every April for the last few April has been this transfer policy to home health. So it was brought up I guess three times ago, but for the last two it hasn't been brought up. Do you feel like that is now kind of behind you or is that something that CMS is still working through? Do you have any?

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

No. We've not heard from CMS on that. But our take away from that is clearly it's not a priority for CMS. It was almost three years ago, I guess, that did the request for information. And then there's been two subsequent rulemaking periods where it's not been mentioned. So certainly doesn't seem to be a high priority for CMS.

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

We do know that following the receipt of comments, one of the CMS administrators did publicly make the statement that one of the things that they were concerned about with regard to any form of the home health transfer policy was the impact it would have on access to care for the Medicare beneficiary population, which they consider to be a highly vulnerable population.

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Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

If I may, I guess, can you remind me kind of what that impact would be? I guess, since there is a home health transfer policy for an acute care hospital; why would that not also logically apply to ERF as well?

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

A

I think one of the reasons and this is something that the industry really hit hard with CMS, is that this is sending a patient home with home health is not a substitution of care, it's a progression of care for a rehabilitation patient. They get their intensity of 3 hours a day of therapy. They progress to the point where they're ready to go home, then they get transferred home. The average length of stay for the industry has not changed in almost four years. So if the industry was looking for an opportunity to condense the length of stay in order to send patient home early to kind of game the system, the numbers don't show that.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

Okay. And I guess the other thing that comes up from time to time is MedPAC, always kind of focuses on the margin of the freestanding facilities versus the hospital-based units and then kind of wonders is there some change there that could happen that would maybe normalize that too, and, if you would take rates down for stroke or something that was done more often in a freestanding facility and raise rates on the other rates, would that be like disruptive to your business? Is there a way that that could, move money around to be a problem for you?

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

A

It's interesting because the units where the acute care hospitals already get reimbursed by Medicare more for similar patients than we do. And it's because there are cost inefficiencies in the way they account for their costs lead to more high cost outliers, which is a very small percentage for us. So Medicare is already paying them more than they're paying us to treat a patient with similar conditions and similar acuity. And yet we're producing continuously better outcomes. So it seem a perverse set of circumstances to attempt to penalize us simply because we run a more efficient business. There's just no precedent for being able to separate how you pay one set of providers because they happen to be housed within an acute care hospital versus a freestanding inpatient setting. It's not like the difference between an inpatient setting and an outpatient service.

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

A

A part of our margin that comes with scale and the efficiencies you get from the larger scale versus the smaller units. So you have to kind of dig into it, look at the different layers that go into margins and what leads to higher margins than others.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

And then these other aspect of reimbursement is just Medicare Advantage, that's growing. And I know that with a lot of the sectors within post-acute the reimbursement for Medicare Advantage is much lower than it is for fee for service. It sounds like you guys have been successful in kind of narrowing that rate differential, but it still does seem like MA uses ERFs less than fee for service, generally uses ERFs. Is there a reason why you would you know, point to that?

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

A

Well, there is. And there's still a much more stringent authorization process for patients. And if you look at the most recent MA rule, CMS even called the Medicare Advantage plans out on that. They noticed the very large distinction between the utilization of ERF services for Medicare advantage versus fee for service. And they saw no reason in within those underlying populations why that difference should exist other than the denial of access to care which they believe is impacting patient quality, patient outcome quality. And so, CMS had stated that they're going to hold MA plans more to account for that. We'll see if that ultimately translates into having any teeth. But that just for us. It looks like a further opportunity with MA plans. We're very proud of the progress we've been making in terms of underscoring our value proposition to Medicare Advantage plans. It's been an initiative that's been underway for more than a decade. We still have to do it on a daily basis.

It where you really start to see the progress that we're making show up is in, two or three different statistics. First is we're now at the point where 90% of our Medicare Advantage revenues are under contracts that are paid on an episodic versus a per diem basis. The overall payment differential between our Medicare Advantage Book of Business and our fee for service book of business is about 3% right now, which is considerably narrow. It was it was significantly higher even just five years ago. And the patient mix for Medicare Advantage for us has broadened from an initial very high concentration in just stroke and debility, the highest levels of acuity. It's broadening. It's still doesn't match our fee for service patient mix, but it is progressing in that direction. And we've been able to do all of that while seeing Medicare Advantage as a percentage of our overall payer mix over the last five years more than double from 8% to 17%.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

And so, I guess, still below where, it was like a 50/50 fee for service versus Medicare Advantage still below. What that would imply is to get to that number. Or has the growth that you've already shown, is that a function of signing more contracts and going in network with more MA plans? Or is that a function of you already have the contracts, it's just not actually sending patients to you? So you would have to just convince them to send more patients.

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

A

I think it's been a combination of both. And Doug mentioned the value proposition and that has taken a while. But we've gotten some traction now because we can show the outcomes and they've seen the benefits of having some of these patients, particularly higher acuity strokes and have would perform better and have better outcomes coming from our hospitals versus being sent to another setting.

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

A

But ultimately there's an opportunity in improving the admission to referral rates for Medicare Advantage. It remain substantially higher for a fee for service patient in terms of the number of referrals that we ultimately convert to an admission and so that opportunity is there, but we feel very good about the progress that we're making.

You know, in terms of getting to 50/50 too, Kevin, is a point you and I have discussed before, which is I'm not convinced that if you look at our specific demographic that it's at a 50/50 enrollment. There is evidence that suggests that in the older cohorts, in the average age of the patient that we treat in our facilities is 77, you still got a much higher balance of fee for service versus the Medicare Advantage. Medicare Advantage tends to grab a

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higher percentage of newly minted Medicare beneficiaries who are more accustomed to transferring off of an employee-sponsored plan.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

Q

And maybe just the last question here is we're getting out of time, free cash flow. I mean, for the last several years, a lot of that, all your free cash flow has been geared towards building more facilities started generating free cash flow. Now how should we think about that? Should we think about 6 to 8 moving to 8 to 10 as you get bigger? You know, the pipeline should also get bigger and we shouldn't expect free cash flow because you've got great returns on these things. Or is there an ability to, you could open these sites and still have capital for share repurchase or what have you?

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

A

So, we've got that target out there, 6 to 10 de novos per year and we've been hitting that bid. It feels like a pretty good place to be right now because there is a lot of complexity to successfully opening up new hospitals. It's not to say we won't, if the opportunities arise, go above the high end of that, but generally speaking, we're going to stay in this range and cost per bed seem to have stabilized at about $1.2 million. So we do find ourselves in a position where the leverage feels very appropriate at 2.5 times on a net basis at the end of Q1. And we feel like we're going to continue to generate excess free cash flow in the days ahead. The most likely utilization of that is to complement the capital spend with increase in shareholder distributions and there's likely to be some balance. This is all decisions that the board will be making between modest periodic increases in the dividend and some share repurchase activity.

Kevin Fischbeck
Analyst, BofA Securities, Inc.

All right. Great. That's all we have time for. Thank you very much.

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

Good. Thank you.

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

Thank you.

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