16-Feb-2022

Encompass Health Corp. (EHC)

SVB Leerink Global Healthcare Conference

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Whit Mayo
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MANAGEMENT DISCUSSION SECTION

Whit Mayo

Analyst, SVB Securities LLC

Good morning or soon-to-be-afternoon, everyone. This is Whit Mayo, the healthcare provider and managed care analyst at SVB Leerink. It's my pleasure to have the team from Encompass Health joining us today. Representing the company, we have Mark Tarr, the Chief Executive Officer; Doug Coltharp, the Chief Financial Officer; and Mark Miller, who has recently joined the company in the last quarter or two, to spearhead the company's investor relations efforts and I've known Mark for a long time. So, happy that he's part of the team.

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QUESTION AND ANSWER SECTION

Whit Mayo
Analyst, SVB Securities LLC

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With that, we may just get right into the call. Doug, Mark, I think you have maybe a disclaimer you'd like to read, but maybe just – it'd be helpful to sort of the level-set the conversation now that you've reported your numbers for those that haven't had an opportunity to review some of the key highlights of the quarter, what sort of stands out to you as you sort of reflect back on the trends that developed towards the end of the year?

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

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Sure, we'd be happy to do that. And first of all, we're very excited to be with you today. Relative to a quick note on disclaimer and caution around any forward-looking statements and non-GAAP measures that we may refer to and caution around placing the undue reliance on these items apply here.

So, yeah, so let me start first with some highlights, and we do feel like we had very solid financial performance in Q4 that wound up what we considered to be a strong year, particularly in the difficult operating environment, dealing with Delta variant first and then Omicron in the – at the – towards the end of the year. But let me – just couple of highlights from Q4 first. We had solid – consolidated financial performance around revenue growth of 8.6%, consolidated adjusted EBITDA growth of 5.3%.

On the IRF side of business, we had a revenue growth of 11.7% with adjusted EBITDA growth of 8.4%. We had a record high IRF average daily census of 7,100, which resulted in a growth of 8.7% and then around the discharge growth on our IRF, we had 9.6% discharge growth with 6% of that coming from same store, so, really strong there, and 4.7% total admissions growth in home health, including same store home health admissions growth of 2.4%. And then, if you look at it for the year 2021, we had consolidated revenue growth of 2.3 %, 12.6% coming on the IRF side of the business, 2.6% on the Home Health and Hospice.

With regard to adjusted EBITDA, we had total consolidated growth of 19.5%, 16.3% on the IRF, 29.5% on Home Health and Hospice, and we had an increase of our total licensed bed count contributed through our eight de novo hospitals which account for 350 beds, that puts us just shy of 10,000 beds. We have 9,924 licensed beds, and we also added 117 beds to our existing hospitals last year.

Additional growth notes for Home Health and Hospice, we invested $102 million last year, and we also opened up three de novo locations and ultimately came in above our initial guidance in all three metrics despite, once again, a challenging environment around COVID. So, overall, we were pleased with the results.

Whit Mayo
Analyst, SVB Securities LLC

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Yeah, and all those results include expenses from COVID as I [indiscernible] (00:04:02).

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

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That's right.

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Whit Mayo
Analyst, SVB Securities LLC

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Well, great. Well let's just talk for a second about the pending spin transaction of Enhabit. The company's been rebranded, there's been an awful lot of internal work that has gone into this over the last year or more. Maybe not fully appreciated the level of work, but I guess the question is really the – thinking through the timeline now of some of the milestones that you need to hit, you need to get your K out, presumably there's another filing that is going on behind the scenes. So, anything, Doug, maybe to help investors sort of think through the timetables here?

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

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I think that's exactly it. There are several things that need to take place before we can effect spin. From a filing perspective, what you should assume is that we'll lead with the Encompass Health 10-K, that should occur in early March, and then by the end of the March, we would expect to form – file our initial Form-10 with the SEC. Some of the longer poles in the tents that lead us to target the – really the second order for the spin, one is Private Letter Ruling with the IRS to ensure that the transaction can be consummated on a tax-free basis to our shareholders. That is a process that has been underway since December, and we're confident that it will not be a constraint to the timeframe that we've laid out.

We also – we've frequently been asked why we separated the announcement of our decision to proceed with the spin and the unveiling of the Enhabit name from our Q4 earnings report, because they were relatively proximate. And the primary reason for that is another long pole in the tent, is the various state and local regulatory filings that need to be done in order to change the name over to Enhabit. Some of those have a long lead time and as we made those filings, some of those had the potential to become public. So, before that got into the public domain inadvertently, we wanted to make sure that we alerted the entire investment community, and that's why those two announcements were separated.

Those would be the longer poles in the tent, but, all of the other things that need to be done to affect the spin in terms of preparations, the negotiation of transition service agreements and so forth, those are well underway. As you suggested, we've already been working on these for a very long time.

Whit Mayo
Analyst, SVB Securities LLC

Q

Got it.

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

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And I want to – [ph] a line that (00:06:31) I want to add, we provided a great deal of detail around and how that – and other details around the financials of it with regard to the Q4 earnings call slide. So I just want to remind everybody of that.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. As I think original combination of the original Encompass and the HealthSouth inpatient rehab business, you guys identified a number of opportunities to collaborate clinically and you laid out some targets and milestones. How do we sort of visualize the two organizations working collaboratively together going forward? Are there any things that changed between the two? Whether they can have their case management people inside

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your hospitals? How do the organizations either work together in a similar way or work together in a different way?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
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Whit, the two organizations will absolutely continue to work very closely together. There will be certain things that we have to change because we no longer have a common ownership, such as around the CTCs and them having an office within our hospitals and certain things, make sure that from a compliance standpoint we're on the right track. But, the focus and priority on having a smooth transition for our patients that discharge from our hospitals with Home Health, and keep in mind about 6% of our patients, at the time of discharge, go home at Home Health. That remains an absolute priority. So we want to make sure that our patients get great care from the best home health provider.

Keep in mind, we have 95 overlap markets that we have been standardizing what we've referred to as [ph] home (00:08:22) collaboration now for seven years. So, they have refined that, they've refined those relationships, and it's shown in the quality indicators. When you think about patient satisfaction with regard to communication, when you think about readmission rates, we have really proven that there are clinical benefits for collaborating closely. So, the two organizations will absolutely continue to work close together.

As you know, Barb Jacobsmeyer has a high level of knowledge, given her previous role on how this is supposed to operate, so, she'll be sensitive to making sure that the Home Health and Hospice segment provides that high level of care that we're expecting on the hospital side.

Douglas E. Coltharp
Chief Financial Officer & Executive Vice President, Encompass Health Corp.
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You know, a way to think about it, and to use to use bit of a cliché, with regard to Enhabit continuing to be able to successfully get referrals from Encompass Health IRFs, they're starting on third base. To begin with, you need to have a presence in the same market because of the efforts we undertook over the last seven years, as Mark just suggested, there is overlap in 95 of the IRF markets, the protocols have been in place in practice for the last seven years and importantly, the Home Health agencies – the Enhabit Home Health agencies in those overlapped markets have staffed up with the appropriate clinical complement, with an emphasis on therapy, to be able to service the types of patients who are coming out of an IRF.

Whit Mayo
Analyst, SVB Securities LLC
Q

Can we just spend a minute on the demand backdrop for the inpatient rehabilitative segment? I think it's always been unique, just the level of – just the non-discretionary inelastic nature of a lot of these services, and reflecting back on 2021, I think at the enterprise level, trends may have exceeded what expectations I may have had. Can you maybe just talk about some of the pockets of strength or weakness, when you look inside of each of the payer categories, whether it's stroke, brain injuries, joints, where are you – where were you excited? Where are some of the pain points? Just trying to sort of visualize how this – how the business has sort of changed in terms of the patient service lines?

Mark J. Tarr
President, Chief Executive Officer & Director, Encompass Health Corp.
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Yeah, we'd be happy to do that. First of all, think about the ageing demographic, the tailwind that that provides in terms of continuing to drive the demand for our services. Our average age patient is right at 76 in our hospitals.

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Almost 90% of our admissions to our rehab hospitals are with patients that come directly from the acute care hospital. So we treat medically complex patients, they have a lot of comorbidities – your comment about non-discretionary or generally non-discretionary, that's the case these patients aren't deciding whether they go home or go to a rehab hospital. They need a higher level of care, the complexity of the 24-hour care and an interdisciplinary staff, so, that leads to the non-discretionary nature of our patient.

I think that, when you think about the various settings of post-acute care, COVID really helped to better differentiate the quality of care and the severity of the types of patients for the complexity of patients' acuity that we can treat in an IRF and clearly Encompass Health stood out above the others in terms of taking these COVID patients, sick patients and doing very well on them.

As you know, we've put a great focus on the stroke population and developing our stroke programs in our hospitals over the past seven years. So, when you think about strength that we have and this treating a high level of acuity, I think about stroke, other neurological types of ailments that patients have typically that you would see in an aging generation, we're doing a great job with spinal cords and brain injuries. Hip fractures are another pocket of strength for this.

If you look at what we've seen a decline and it's kind of just a natural decline in the lower acuity scale with large extremity joint replacements, knee replacements, if we get those types of patients now in our hospitals, it's because they have a lot of other comorbidities, could be obese or otherwise, but that counts for somewhere between a 2% to 3% of our total discharges now, where in the past, it was much greater.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. Is there, Doug, any way to frame organically, maybe how some of those higher acuity patient categories have been growing? I don't know if you've shared that or not or could share, but just thinking about stroke and brain injury and some of the more intense categories, at least anecdotally?

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

A

I think the very good news is that even as we've demonstrated those high levels of ADC growth and discharge growth, from a mix perspective, the percentage of our patients falling into those two categories of stroke and neurological have stayed relatively constant. They comprise almost 40% of our total patients mix. It's also stayed relatively constant across all parameters even as we've seen outsized growth in the Medicare Advantage book of business, and that's all extremely encouraging.

It means that we're gaining market share in each of those two important high acuity categories and that's important as well because that really is a bit of a competitive moat. It takes a lot of refinement of clinical protocols to be able to really develop the treatment procedures that create the most efficacy around those very complex patients. And when you think about it, just from a pure numbers perspective, we see more stroke patients in the course of the year than any other provider in America and we're able to build on that data to have a strategy of continuous improvement in terms of how we're addressing those patients.

It's encouraging that that value proposition has become increasingly clear to Medicare Advantage. Again, Medicare Advantage, for the last four or five years has been growing for us at a rate greater than fee-for-service. And yet, if you look at what's happening in terms of our overall reimbursement, because we've been successful in converting so many of the Medicare Advantage contracts to CMG from a per diem basis, we're not experiencing any kind of increase in the discount.

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Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. Just to maybe close the loop out on stroke, years ago – I mean, you guys had – and I'm not going to call it a partnership and an affiliation with either the American Heart Association, the American Stroke Association, but, I think the important thing here is that you guys, as you continue to grow, you have more data and more analytical resources that you can deploy into the field to continue this education and try to almost drive like this clinical flywheel with a physician and provider awareness. Is there anything to elaborate on that's new in terms of those initiatives today?

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

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So, Whit, you're right, we have a co-sponsorship with the American Stroke Association and that extends out through 2024 and maybe beyond that we've had a really good success story with working with them. We've had great exposure and the ability to reach people out in the various marketplaces, just do the collaborative nature of this and [ph] cobraining (00:16:13).

They work on the stroke prevention, our message is surviving with stroke and living with stroke, you know, it really pairs well and it has led towards additional name recognition with literally thousands of individuals that would have otherwise not known the Encompass Health name, nor would they even think about where they might get care or their loved ones would get care if they had a stroke. So, we'll continue on with that. I think that when you think about how we keep improving our clinical outcomes and our clinical protocols, it's using what now is 400,000 discharges that we have as part of our electronic medical record, that we can utilize for predictive analytics. We're using it now around – we're piloting a fall prevention model that's out there that we're seeing great resolve in preventing falls for our – for more patients that have shown a higher risk versus other patients, of which stroke patients are certainly part of that.

We did the same thing historically with the readmission back to the acute care and preventing those – the need for patients to be sent back to the acute care hospitals, and maybe having a medical emergency of some sort. So, all those tie us closer with referral sources, they tie us closer to working with the physician community, develops our reputation. We've got the statistics now and the scale to show how our protocols are superior to those of our competitors. Matter of fact, we get almost 81% of our patients now go back home into the community after they've been cared for in our hospitals or have had stroke.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. I want to shift to just the payer mix conversation. I mean, none of this is new, right? You guys have done an exceptional job narrowing the gap on the in-patient rehabilitative side between fee-for-service and MA, for all the reasons that you've already discussed. But there's been this very wide gap on the home health side. And, again, none of this is new and we know a lot of the factors that have influenced and drive the differential and rates that I think you have sort of summarized, Doug, as – call it 40% or so on a affected basis.

What does it really take to narrow this gap and if this isn't something that can be accomplished in the next few years, how do we think about like the margins in the businesses? Is this something that you can overcome? It just seems like it's a ongoing secular challenge that the industry is going to continue to face. But I'm not so sure what the solution is here.

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

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Yeah, I think you're exactly right. Well, if you look at the Delta on a revenue per visit basis between episodic, which is almost entirely Medicare fee-for-service, and non-episodic, which is heavily skewed towards the per visit payments under Medicare Advantage plans, it increased 44% in the fourth quarter, which is just huge. And at the same time, we were seeing our SWB per FTE over the back end of last year increased by 8% to 9%. And so, what was already a poor margin on that, non-episodic volume shrunk even more.

Historically, the way that the MA plans have been able to continue to price that way is because you had such a large and fragmented home health industry that there was almost always a provider in a market who was willing to accept visits at that price under the assumption that they were going to get volume eventually be able to see the prices improve or at least justify it from a contribution margin perspective. And that was coupled with the fact that the M&A plans by and large simply did not differentiate based on quality, which is a little bit perplexing, it didn't really take time to understand how effectively is this provider initiating a timely start of care. What are the outcomes for this provider?

We think both of those things are going to change in the near-term, and perhaps there's a silver lining in the kind of rapid inflation which we believe is somewhat transitory that we've all witnessed on the labor side. Is this going to force the issue and it's going to force the issue in two ways, for the smaller, less efficient home health firms that have been taking some of that volume. If you think about the cumulative impact that they've experienced over the last three years, starting with PDGM, two years of COVID, and now that escalation in labor costs, were just going to have to throw in the towel. So, capacity is going to exit the business. Some of that will be done by acquisition. Some of it is going to be simply by closing up shop, but capacity will come out of the business, and at the same token, for Medicare Advantage plans, we have – are seeing increasing numbers of beneficiaries come to the plant, they want to be able to ensure access to care. They're going to have to pay up for those services. So, I think those forces are coming to the table very rapidly and it's not going to be a matter of three or four years, it's really going to be a matter of 18 months to two years before you start to see some meaningful movement.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. I mean, you had a very I guess we'll call it a large contract with a large payer. I can't remember if you said the name. I think he probably did and you've now revisited that contract and going back to a per visit type of rate structure. Any back story around how this came together or the decision to revisit and going back to a non-episodic type of a payment rate?

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

A

Certainly. So, it's a – it is a large national contract with an MA plan. We were already serving a very large number of these payers, patients across our platform. But there were only a limited number of mortgage where we were actually classified as in network. Somewhat ironically, in the times to find logic, we were treating a patient in network, we were paid a relatively low revenue per visit on that basis. If those patients came to us out of network, they were episodic patients and [indiscernible] (00:22:55) Medicare fee for service rate. We did our best over a multi-year period of time in spite of request from that payer to move into a national contract to avoid doing so. They essentially drew a line in the sand last December, and said, we got to have you come in or we will stop all referrals to you outside of the network as well. They were constructed in those discussions and suggested that as we work together over time, there would be opportunities to look at the value that we were contributing and the

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quality of our services versus other providers, and that that would lead to discussions regarding future price increases.

So, we made the tough decision. We moved in-network. And if you look at the strong episodic or non-episodic growth that we experienced in 2021, about 50% of that was directly attributable to converting episodic to non-episodic visits under that one contract. But also the balance of that really pointed to the fact that you had things moving in opposite directions in 2021, largely due to the course of the pandemic. And that is episodic volume which is where a lot of elective surgeries continues to fall for the population that we address with our home health business was down through the course of 2021, because of the disruptions to many healthcare systems, and non-episodic was up [indiscernible] (00:24:27) continued increases in enrollment in the MA plans.

Whit Mayo
Analyst, SVB Securities LLC

Q

I want to shift for a second just to their IRF development pipeline. I mean in the last, got it, I think it's been more than two years. But just – it's just interesting to me the velocity of press releases that you guys have continued to pump out over the last year or two, which is either a signal that the market is just so under bedded relative to the growth or there's just so much more interesting opportunities you find with health system partners. Just what do you attribute the growth in the pipeline? Where is this coming from? And there's a couple of different directions, I want to take this.

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

A

Yeah. Whit, see you named a couple of them, [indiscernible] (00:25:15) one we've got an unabated universe to work from and the demographic tailwind of the aging population and older people get, the more likely they're going to have issues that lead towards inpatient or [indiscernible] (00:25:34) hospitals. And then you have acute care hospital systems that are wanting to have a presence and relocation and post-acute, they may or may not have a rehab unit now that is underutilized or doesn't get the attention, and they otherwise should from a capital standpoint or just an expertise standpoint. So, we have inbound calls, we reach out to them. That has been a great part of our business model and historically, we now have 54 of our hospitals are partnerships. And so, that's part of what led us to having a record year last year with eight de novos. We have 10 coming on this year. We've already announced 10 for next year as well. So, it's the combination of our existing expertise, our existing partnerships that lead to other partnerships because they all network closely together to keep your hospital systems when they call each other to look for a good partner and rehabilitation.

And quite frankly, I'll get our team here credit as well, our development team here, of which we have staffed up to help us go out and identify marketplaces and search out opportunities have – it's really been clicking for the past several years.

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

A

I would just add to that from 2010 to 2018, we kind of steadily opened three to four new de novos a year. And over that time, we ascended a pretty significant learning curve, both with regard to efficiencies around constructing those facilities, but also in terms of our market analysis and really understanding what kind of critical mass of Medicare eligible patients, so what was required [indiscernible] (00:27:23) an IRF. And so, we were able to further refine our models the same time that we were getting validation about the returns that were being generated by the previously opened de novos and that led us to believe that there were many more markets in the US than we may have previously thought that were really in need of a new facility, and perhaps is – as further

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validation of that, the ramp up that we saw from the units that we opened up in 2021 was the most rapid ramp up that we've seen of any prior [indiscernible] (00:27:55).

Whit Mayo
Analyst, SVB Securities LLC

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Yeah. So, I'm going to go right to sort of two things there. Number one, when I look at the pipeline today that what you've announced is coming online over the next year or two. What percent of those inpatient rehab hospitals will be in a joint venture today or how many do you think will be in a joint venture rehab and identified one. So, that's kind of a two-part question. Actually, I'll just stop there, and then I'm going to go to one more, one other question.

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

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The pipeline is a mixture of wholly-owned and partnerships, and I would say that roughly maybe a third of the projects we've announced are partnerships and two-third wholly-owned.

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

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Yeah. I think that's right in there. What we've also gotten – more comfortable doing is entering a market on a wholly-owned basis, and then allowing for discussions with JV partners to take place after that. Whereas previously, we were more inclined to make sure that we had a JV agreement hammered out before we plant a flag anymore.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. And Doug, you talked a little bit about some of the efficiencies you found on the construction side. And I go back to the Analyst Day, I think you guys had March 2020, I remember very vividly you and I were in New York together, this whole COVID thing started. But there was a – there was an entire little section of your Analyst Day that was spent discussing the efficiency opportunities that you had around [indiscernible] (00:29:20) procurement, but just in national contracting, maybe just elaborate on one, two or three things that can help investors understand a little bit better how you've been able to really drive the significant level of efficiency around you build the staffing and the nurse centers and everything inside of the construction process.

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

A

Yeah. So, you're leveraging a – by virtue of the fact that we have a prototype even though it requires modest modifications based on specific land and market that you're going to. A big part of the design process and the materials that you're ordering for one facility versus another are very similar. Also, when we know that we are going to be opening 10 facilities in one year and 10 facilities the next year, our ability to bulk order things like steel in advance and that that generates efficiencies as well. And then the last thing that I would point to is just an example is very much like HCA. We've been using a company that [indiscernible] (00:30:20) based here in Birmingham called BLOX, B-L-O-X, and we've been doing modular prefabricated bathrooms that speed the time for which we can [indiscernible] (00:30:32) facility. And when you're speeding your construction timeline that means you get to cash generation and the return sooner in the process. So, this would just be three example on [indiscernible] (00:30:43).

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

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And the quality on that prefabrication and our operators were skeptical at first until they saw how seamless these things go together. It's really – it's not your – it's not what you thought about pre-manufactured housing several years ago. I mean this is really very well done in a high-quality fashion which Doug alludes, it gets us up and running faster than we otherwise would.

Whit Mayo
Analyst, SVB Securities LLC

Q

Yeah. I want to [indiscernible] (00:31:11) couple of things in the remaining time that we have left. Doug, have we – when we think about the leverage of RemainCo. And presumably there'll be a little bit of leverage that you put on the SpinCo as well to make this maybe a little bit more leverage neutral. But what's the optimal leverage ratio? How does the board sort of revisit or rethink what the targets are today? Maybe I'll just stop there and just have you respond.

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

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So, thinking about Encompass Health post the spin-off of Enhabit, I don't think the leverage profile is going to change from what it historically has been. And what we've historically said is [ph] run rate (00:31:54), we think three times is about the right efficiency. If you drop much below that, we probably got some ability to increase the leverage to improve the overall weighted cost of capital. We can do that through various means of capital deployment whether it's further opportunities on the development side or increased shareholder distributions. We have said if we get the right kind of opportunity given the strength and the consistency of the free cash flow generation coming out of this business that we're comfortable levering up. A good example is when we acquired the Encompass Home Health business and also the Reliant Hospitals and CareSouth in same year. We took the leverage up to just over 4.5 times, but we did so, saying that, we believe that within a year, we'll be able to have this back down under 4 times and pretty rapidly to 3.5. And within 15 months, we were 3.5 just based on cash flow generation. So, there's a lot of flexibility here. Out of the gate, we anticipate coming in a little bit higher than three times, but our long range target would be right around that three times.

Whit Mayo
Analyst, SVB Securities LLC

Q

I've got a couple of questions here from the audience since I haven't addressed the 800-pound gorilla in the room around labor. And Doug, I think you laid out a pretty thoughtful response on your conference call to the – how you envision or visualize the shape of the labor trends playing out. Maybe just remind us what you've seen so far through the first quarter that you did share anything on the call that you're willing to share and sort of what your expectations are or what gives you confidence that we should begin to see some of the waning pressures around chip bonuses and sign on bonuses and contract labor?

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

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Yeah. So again, the same issues hit our two business segments a bit differently in the second half of the year. And it's really because of the nature of the businesses, one being a facility base and the other one being a really a mobile workforce. So, on the IRF side, the great news is the volume continued to stream in. And so, this was a matter of making sure that we can procure adequate staffing to service those patients at a time when we were seeing staffing constraints based on a large number of clinicians having to be out for a period of time on quarantine or because at their particular market, perhaps there were school closures or other facility closures that

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caused those nurses to be home for childcare or eldercare issues. And so, the way that we solved for that problem was through additional agency staffing and both the utilization and the rate were substantially elevated in the second half of last year, and then paying incremental shift bonuses to our existing clinicians to take on more time and sign on bonuses. Those things totaled for the IRF business about $50 million in Q4. That was an annual run rate in 2019 previously, so roughly a 4 times increase.

On the home health side, yeah, we had the elevated rates as well. But really the staffing constraints meant that we weren't able to accept the volume that we knew was out there based on the referrals we were getting. So, it showed up not only in a higher cost per visit, but at lower volume growth that we were anticipating. Our expectation is that those things are largely correlated to the current status of COVID, and as COVID and specifically Omicron begin to recede, those will get better. The first quarter is probably not going to look entirely different from that perspective than the fourth quarter. But there are reasons to believe that it will start to look a whole lot better based on COVID receding and based on all of the new hiring initiatives that have been underway in both of our businesses really beginning in Q3, and those new hires ramping up to the full level of productivity. We anticipate and embedded in our guidance is that, in the second half of the year, we're getting the benefit of both a more normalized labor environment and the fact that we anniversary these extremely elevated levels again for both businesses, SWB per FTE up 8% to 9% in the second half of the year last year was simply not going to see that level of increase again.

Mark J. Tarr

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

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It's also – it's also important to note that, you know, some of this wage inflation has occurred because of some of the stimulus funds and care fund dollars that, that were out there helping to drive up the rates for nursing that will burn off with time. So, I think we all – all the operators and service providers feel that hopefully that will burn off sooner than later.

Whit Mayo

Analyst, SVB Securities LLC

Yeah, I agree. Well, we've gone over our allotted time. I could go on for another two or three hours with you guys peppering me with a ton of questions. But I really appreciate you joining us today. If anyone has any questions, please feel free to reach out to myself or my team. And our guys, thanks again for participating, and I hope to see everyone soon.

Mark J. Tarr

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

Thanks Whit. It was great [indiscernible] (00:37:14) with you.

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