CRH Medical Corporation

2016 Fourth Quarter and Year-End Results Conference Call

Date: **February 23, 2017**

Time: **8:00 AM PT**

Speakers: **Edward Wright**
Chief Executive Officer

Richard Bear
Chief Financial Officer

Kettina Cordero
Director, Investor Relations

Operator:
Welcome to the CRH Medical Fourth Quarter and Year End 2016 Results Conference Call. As a reminder, all participants are in a listen-only mode and the conference is being recorded. After the presentation, there will be an opportunity to ask questions. To join the question queue, you may press star, then one on your telephone keypad. Should you need assistance during the conference call, you may signal an Operator by pressing star, and zero.

I would now like to turn the conference over to Ms. Kettina Cordero, Director, Investor Relations. Please go ahead Ms. Cordero.

Kettina Cordero:
Thank you, Joe and good morning, ladies and gentlemen. I am joined here today by our CEO, Edward Wright, and our CFO, Richard Bear, who will briefly review our financial and business results. Before we start, I would like to remind our listeners that certain statements you will hear today constitute forward-looking statements within the meaning of applicable securities laws. For important assumptions, definitions, and cautionary statements relating to forward-looking information and the risks inherent to our business, please refer to the Cautionary Notes in our financial report for the year ended December 31, 2016, and to the Risks Factors section in our most recent Annual Information Form.

During this call, we will discuss non-IFRS measures as indicators of our performance. Please refer to our Management's Discussion & Analysis for the year ended December 31, 2016 for reconciliations of non-IFRS measures to reported IFRS measures. These documents are available on SEDAR and on the Investors section of our website.

Also, please note that we use the abbreviation GI to refer to gastroenterologists and to services related to gastroenterology such as anaesthesia for endoscopic procedures.

Finally, please be advised that our reporting and functional currency is the U.S. dollar. All dollar figures referenced today are in U.S. dollars.

Now, I leave you with Richard Bear for the financial highlights.

Richard Bear:
Thank you, Kettina, and good morning everyone. Yesterday, we reported total revenue of $78.4 million for the year ending December 31, 2016, a 70% increase compared to 2015. Anaesthesia revenue for the year ending December 31, 2016 was $67.8 million, an increase of 86% when compared to 2015. This increase is a result of the full year's contribution of the five transactions announced in 2015, and half a year's contribution by the three transactions announced in 2016.

In 2016, we invested $34.1 million in anaesthesia transactions, compared to $19.9 million invested in 2015. We have completed 10 anaesthesia transactions since we entered the space in December of 2014; this includes our latest transaction announced on February 1 of this year.

During 2016, product sales contributed $10.5 million to total revenues. This represents an increase of 10% compared to 2015.

Total Adjusted operating EBITDA for 2016 was $41.5 million, an increase of 73% compared to 2015. In 2016, total Adjusted operating EBITDA attributable to our shareholders was $32.4 million, and total Adjusted operating EBITDA for non-controlling interest was $9.1 million. Our 2016 total Adjusted operating EBITDA margin remained steady at 53%.

In 2016, we generated $23.2 million in free cash flow compared to $12.1 million generated in 2015. We define free cash flow as cash provided by operations, less payments made for interest and other finance expenses, less distributions for non-controlling interest. The increase in free cash flow is a result of growth in our anaesthesia business and the restructuring of our debt, completed at the end of 2015.

At December 31, 2016, we had $9.5 million in cash, and $26.3 million available on our revolving credit facility.

I will now turn the call over to Edward Wright to provide an overview of the business highlights of 2016.

Edward Wright:

Thanks, Richard. In 2016, we continued to focus on leveraging our relationships with the GI community to generate and seize opportunities for our anaesthesia business. On the O'Regan side of the business, we trained an additional 239 GI's in 2016. To date, we have trained a total of 2,414 GI's at 930 clinical practices in all of the lower 48 states.

During 2016, our O'Regan relationships continued to translate into growth for our anaesthesia business. We completed three additional transactions, all of which were in states where we had no previous anaesthesia presence. Two of these transactions were with existing O'Regan customers, demonstrating our ability to continue to leverage our existing GI relationships.

During 2016, we strengthened our anaesthesia team with the addition of Jay Kreger, who was appointed as President of CRH Anaesthesia Management. Jay comes to us having gained valuable experience as an executive at the Ambulatory Surgical Division of Hospital Corporations of America, one of the largest hospital management organization in the U.S. Since joining us, Jay has made key hires in both operations and business development, establishing the infrastructure to position us for growth and ensure we provide exceptional service to our anaesthesia partners.

At the end of 2016, CRH had exclusive contracts to provide anaesthesia services to 25 ambulatory surgical centres in seven states, and we have built on this momentum with the announcement of the transaction in Decatur, Georgia, earlier this month. This most recent transaction brings the total number of ambulatory surgical centres under contract with CRH to 26.

Based on our current pipeline of opportunities, the relationships that we have developed through the CRH O'Regan System, the growing awareness of our anaesthesia offering, and the fragmentation of the GI anaesthesia market, we believe we will be able to continue to transact additional anaesthesia opportunities in 2017. We will maintain a disciplined acquisition strategy, maximizing shareholder value by identifying high quality anaesthesia practices where we can add value through our operational expertise.

An aging population and the increased focus on regular screening for the early detection of colon cancer will continue to drive demand for our anaesthesia services. The U.S. Census Bureau projects that the number of Americans between the ages of 50 and 75 will rise from 91 million in 2014, to 99 million in 2020. Today, approximately 66% of adults over 50 are up to date with their colorectal screening. The goal of the Centers for Disease Control and Prevention is to increase this number to 80% by 2018.

Additionally, the use of monitored anaesthesia care for endoscopic procedures has grown exponentially in recent years, from approximately 15% in 2003 to approximately 50% in 2015.

Performing outpatient procedures at ambulatory surgical centres is a cost-effective option for the healthcare industry. It is important to note that approximately 31% of all procedures performed at ASCs are related to GI cases according to the Medicare Payment Advisory.

We estimate that there are approximately 800 to 1,000 ASCs dedicated exclusively to GI procedures, all of which CRH is currently serving only 26. There is a substantial opportunity for growth and we will work diligently towards our goal of becoming the pre-eminent provider of GI anaesthesia.

At the end of 2016, our cash position plus the amount available on our credit facility was approximately $35 million. Based on our current business, we estimate that we will generate approximately $6 million in free cash each quarter, thus providing us with the necessary capital to further grow our business.

Finally, we continue our efforts to raise our company's profile in the Canadian and U.S. capital markets. Since our last quarterly financial report, Cantor Fitzgerald, Scotiabank, TD, and National Bank Financial have all initiated coverage of CRH. We continue to educate the investment community regarding our business through non-deal roadshows and other meetings. In the coming months, we have several initiatives scheduled, including participation at a number of Canadian and U.S. specialized healthcare and investment conferences.

I look forward to reporting on our progress as we execute our strategies and drive shareholder value. With that, I will turn it over to the Operator to open up for questions. Thank you.

Operator:
Thank you. We will now begin the question-and-answer session. To join the question queue, you may press star, then one on your telephone keypad. You will hear a tone acknowledging your request. If you're using a speaker phone, please pickup your handset before pressing any keys. To withdraw your question, please press star, then two. We will pause for a moment as callers join the queue.

The first question is from Richard Close with Canaccord Genuity. Please go ahead.

Richard Close:
Great, thanks. Congratulations on a great 2016. Want to just hit a couple of areas of interest here. First, on the price per procedure, obviously, that was really strong in the fourth quarter; payor mix plays a role in that but if you can just go over how you think about the price per procedure and maybe anything else that drove the fourth quarter strong number.

Richard Bear:
Good question, Richard. The fourth quarter—what we saw in the fourth quarter was the effective seasonality. We define seasonality two ways; first, seasonality is defined as the number of patient cases we perform each quarter, but also seasonality is defined as the relationship between commercial and federal patients that we see within those patient cases that we perform. In the fourth quarter, we saw a higher percentage of commercial payors than we did in previous quarters, and as we've talked about before, commercial payors reimburse at a higher rate than that of the federal payors, so that contributed to both strong revenues in Q4 and the strong revenue per case performance. As I look forward, I would look at the average revenue for the year per case, not just the revenue for the fourth quarter in terms of what 2017 would look like.

Richard Close:
Okay, but if we look at the third quarter, I think the payor mix was pretty similar, if I'm not mistaken, yet the price is a lot higher, so just…

Richard Bear:

No, our fourth quarter had a stronger commercial payor mix. I mean so you got two factors. You got both the—you got a strong commercial payor mix and the number of cases, so there were more commercial patients with cases in fourth quarter as compared to third quarter.

Richard Close:
Okay. With respect to the calculation of the non-controlling interest, can you just go over that a little bit and what the delta was really between third quarter and fourth quarter and then thoughts on how we should look at that as you go through 2017?

Richard Bear:
Sure. So, non-controlling interest obviously is the share of our income related to our partners, anywhere from 35% to 49%. That number is primarily driven by the revenue estimates for each of those partnerships. We true-up or we refine our estimated revenue on a monthly/quarterly basis. It takes about four to six months of operations to really get a true indication of what the realized revenue per case is going to be. For all those acquisitions we did in June, that four to six months occurred in the fourth quarter so we were able to update our revenue projections for those. That resulted in an adjustment to our estimates, not material enough to change anything in our financials but material enough to impact the relationship between income, Adjusted operating EBITDA attributable to shareholders and Adjusted EBITDA attributable to non-controlling interests. So, going forward, I would look at the relationship for the second half of the year in terms of how that relationship would look going forward. If you use Q4 your NCI number will be too high; if you use Q3 as a marker your NCI number going forward will be too low.

Richard Close:
Final question for me would be how you think about same store growth going forward; whether you factor in any price increases or volume growth for the centres that you have contracts with, how you think about that going forward. Then also any update on maybe managed care pricing as we enter the new year.

Richard Bear:

So, in terms of when we talk about organic growth we always speak to it in terms of patient cases because that's the easiest thing to measure and to get indicators from our partners for the upcoming year. If we look at the business that we had for all of 2016 and all of 2015, which would be GAA, the patient—the organic growth there in terms of patient cases was 6%. As we look forward into 2017, based on the size of the business that we're managing now, we would expect that number—we expect organic growth but to be at a lower rate than what we experienced in 2016. In terms of managed care contracts, we believe that the revenue per unit per case or per patient, per payor, that we've been experiencing in 2016 will continue into 2017. We're not aware of any changes.

Richard Close:
Okay. Thank you.

Operator:
The next question is from David Novak with Cormark Securities. Please go ahead.

David Novak:
Good morning. Thanks for taking the questions, and again, congrats on 2016. So, first, on the acquisitions you've made in June 2016, both AGAA and Arapahoe have materially outperformed your revenue estimates for these businesses, both at the time of acquisition and even as of last quarter, Q3, when AGAA was noticed to outperform. Now, I'm all for upward surprises but I was just wondering if there was anything Management is contemplating that could perhaps increase the accuracy of predictions relating to how these businesses will perform following an acquisition.

Richard Bear:
Good question, fair question, David. It's a bit of a science. We go through a significant due diligence process to understand what these businesses would look like under our control. A lot of our analysis is kind of I would call more defensive analysis, making sure that we've caught everything in terms of what potential risks are. It's a little bit more difficult to forecast all the upside until we're actually doing the billing and seeing the records and getting reimbursement from the payors, especially in markets such as Denver and Texas where we had no operations before. Each state, each payor, although we work with Aetna, United, Humana, etc., across the country, the reimbursement levels are different in each

state so it's difficult for us to really predict what is going to occur until we actually see the billing. We were pleasantly surprised by both Austin and Arapahoe; each of them outperformed for different reasons, and we'll continue to look to refining our processes going forward.

David Novak:

Thank you. That's quite helpful. Just following on with acquisitions, specifically with respect to historical acquisitions, as the years roll by and CRH acquires more and more businesses, it will become more difficult for us analysts to track the performance of businesses acquired in prior years; years prior to the current reporting year as disclosure requirements only really cover current reporting year acquisitions. As of now, it kind of appears to us after backing out historical acquisitions that some of the businesses acquired in the past may be slightly underperforming our personal expectations. I was wondering if you could share any commentary around what you are seeing with respect to businesses acquired in 2014 and 2015, and also, is there anything that you can do going forward to help analysts track this performance of historical business combinations?

Richard Bear:

When we look at the acquisitions in 2014 and 2015, from our perspective based on – I don't have the luxury of seeing the detail of your models; I do have the luxury of seeing the detail of our models – they are performing in line with expectations. In terms of disclosure, we're constantly looking at our disclosure, David, to make sure that we're providing disclosure that is meaningful and that we can maintain. So, as we look at down the road and there's 20 of these opportunities, identifying - you're talking about revenue and past performance on 20 becomes more difficult but we'll continue to look at continuously improving our disclosure.

David Novak:

Great, thank you. That would be helpful. Finally, just kind of a macro question. I haven't personally heard you guys say this but I've been relayed from some institutional investors that on your more recent road shows CRH has been talking about an uptick in the use of deep sedation on the West Coast and Management believes that that could potentially create an opportunity. While your focus is really still east of the Mississippi, it's an interesting jurisdiction. So, while that would be fantastic, when we started to look at the West Coast, particularly California, what we noticed was certain payors such as Anthem,

Alliance, etc., are now requiring prior authorization for the use of deep sedation with an endoscopic procedure. Does this change your view about the West Coast at all? Furthermore, do you believe that this could foreshadow other payors in other states making this same requirement in the future and would that impact your business?

Richard Bear:
I think what you're seeing in the West Coast, David, is what you would — if you went back historically on the East Coast you would see that as payors become more comfortable with anaesthesia-assisted endoscopy it starts with prior authorizations and then it goes to — then it evolves to where we're at today, primarily in the Southeastern part of the United States and East of the Mississippi. We are seeing in pockets of the West Coast where the acceptance by payors has continued to increase. The first one was Colorado; our business is doing well there. I think we'll continue to see an increase. I mean if you talk to the GI community, they don't understand why it's not 100%; they believe GI anaesthesia could get up to 100%, so it's just going to take some time.

David Novak:
Got you. Excellent. Well, thank you very much Richard. That was really helpful. Appreciate it.

Richard Bear:
No problem, David. Thanks for the questions.

Operator:
The next question is from Alan Ridgeway with Scotiabank. Please go ahead.

Alan Ridgeway:
Hi. Good morning, guys. Thanks for taking the questions. I guess, first, just to sort of follow up on something that Richard was asking a little bit earlier. As far as the timing of the contract renewals with managed care and with the payors, when do those renewals usually come in and when do you guys know that your rates will be set for 2017 and then for 2018, etc.?

Richard Bear:

The relationships with the payors vary. Some are annual, some are two years. Some of the rates are set for longer periods than that, so again it varies. Most of what's typical in managed care contracting is these rates roll over unless one or the other parties wants to renegotiate. We believe the rates that we are getting are fair in most cases. We're always looking to improve, so unless the payor wants to renegotiate, they typically roll over and that's what our experience has been in the past.

Alan Ridgeway:
That happens throughout the year, or is it typically sort of (inaudible 22:41)?

Richard Bear:
Yes. I mean it happens throughout the year because they just —as we've talked about before, any time we do a transaction, in most cases we set up a newco so that newco has a new tax ID and a new billing ID number and the process starts and that, since we do transactions throughout the year, those — in the cases where there's contracts – those would be spread out throughout the year for a variety of the different entities.

Alan Ridgeway:
Right. I also have a question just on the profitability of some of the joint ventures, comparing them to each other. If we look at, I think it's Note 14, it's pretty clear that some of the centres are doing quite well but then the profitability of the Arapahoe community in Macon appears to be a lot less. Is there anything going on specifically at those three centres? Is there a reason why those centres aren't as profitable and are there things you can do to improve those centres?

Richard Bear:
The profitability is going to be primarily driven by payor mix, that relates to between commercial and federal. Profitability is going to be driven by just what the payor strategy is in each state in terms of reimbursement on the commercial side. Payor mix is going to be driven by productivity. We can only do as many cases as — our CRNAs (phon 24:12) can only do as many cases as the GIs want to do. We are — as we've talked about before – our role in the process is to serve demand created by GIs. The GIs do the cases and we serve them, so there are always going to be differences on margins at each of those locations depending on those factors, and those, the margins we see today, I would assume that

those are the margins that we're going to be seeing in the future. Keep in mind from a valuation perspective we value these — all these entities are valued on a multiple of trailing 12-month EBITDA so the cost structures and the efficiencies and the payor mix and the productivity are all included in the historical financials and that's how we value the properties.

Alan Ridgeway:
Right. No, absolutely. I was just wondering if there was maybe something inherent in those practices that you guys could step in with some of your experiences from some of the other places. One follow-up to that and then I'll jump off though. When you mention the payor mix differences, you're talking blended between commercial and government, I assume, and not differences in network versus out of network, is that correct?

Richard Bear:
Yes, the primary drivers of profitability would be the ratio between commercial and federal, which drives —t hat would be the biggest driver of profitability when you're comparing partnerships against each other.

Alan Ridgeway:
Okay. So, the more profitable ones don't have higher mixes of out-of-network or anything like that.

Richard Bear:
No. No, it's almost all attributable to the percentage of commercial compared to federal payors.

Alan Ridgeway:
Okay, great. Thanks, guys. I appreciate it.

Richard Bear:
No problem. Thanks, good questions.

Operator:
The next question is from Lennox Gibbs with TD Securities. Please go ahead.

Lennox Gibbs:

Good morning, thank you. So, there's been some commentary from industry observers to the effect that the hot anaesthesia consolidation trend may be cooling. Do you agree or disagree with that observation? Then secondly, can you share the extent to which you think that CRH's expansion strategy, that is the GI-focused ASCs, is coupled or maybe decoupled from the broader industry consolidation trend?

Richard Bear:

Sure. I'll take the first part and then I'll let Edward take the second part. I think the first comment relates to the broader market which is the Team Healths, the Mednax, the Sheridans of the world who are acquiring large physician-owned anaesthesia practices that serve hospitals and there's been —over the last number of years there's been significant number of transactions and I don't know how many more deals those guys can do. So, when we talk about it's slowing I think that's a fair statement. Our business model is drastically different than theirs and I'll let Edward talk about why we think our trends, our opportunities will continue to grow.

Edward Wright:

I think that particularly due to the fact, Lennox, that what we're partnering with GIs that are in private practice. They own, as you know, either all or a portion of the ASCs where they operate, and those are the places where we've built these relationships over the last number of years. So, because of that, the relationships, because of the deal size, if you look at the average price that we're paying for these opportunities in comparison to the companies that Richard just stated and the figures that are associated with those deals, they obviously don't move the needle for those folks.

So, we're in a very enviable position with the fact that we've got these relationships with these GI docs all over the country. The deal size is perfect for us because these are amounts that we can transact quickly on. We don't have a lot of competition, as you know, in these opportunities, and to date, it's a new offering. It's a new idea in many ways that we're bringing to these people, so we don't — we see a great appetite to talk to us and to learn more about our offering is, at the moment. We have lots of

people that we're under discussions. If I take a look back at since we started this, there certainly is many or more people that we're talking to today that than we ever have been in the past.

Lennox Gibbs:
Thanks very much.

Operator:
The next question is from Prakash Gowd with CIBC. Please go ahead.

Prakash Gowd:
Thanks. Good morning everybody and congratulations on another strong quarter. I have just a couple of questions on acquisitions. First of all, historically, if you look at the acquisitions that you've done to date, can you talk a little bit about any trends that you've seen specifically around timeline to deal execution and what you've been seeing as the rate-limiting steps and perhaps how that's changed over time?

Richard Bear:
Sure. Time is interesting, Prakash. I would say time from when it may be we get a buy-in from the group that want to go forward, that can be done quite quickly. That can be executed in I would say a six- to eight-week period. Probably eight weeks would be the shortest; in most cases, a bit longer than that depending on the complexity, the size, the number of doctors involved.

But where we are in the process with many of these opportunities is initially talking with a lead doctor that is, or a doctor for that matter, who's part of a practice that we've known for some time in most cases, unless it's an inbound – somebody that's coming to us who wants to learn more. So, we have a conversation with that physician. From there, what we're trying to do then is go and meet with their executive group, make a presentation about our offering and then it would go from there to their broader group.

We've seen situations last year where we spoke to somebody six months or a year before and then they came back out and said, "Okay, we're ready. Come and speak to us again now." So, it's very

difficult to predict from an initial discussion to when will be the exact date of the transaction. There's many of these conversations that are in play, and keep in mind what we're doing is bringing something relatively new in this partnership agreement on the anaesthesia.

Timing? It takes time and primarily because doctors are busy during the day, and a lot of the discussions that we have with them are in the evenings or on weekends initially. So, I don't—that's a bit of a vague answer in terms of exactly how long it takes but hopefully that adds some colour around the process.

Prakash Gowd:
That's helpful. I was just wondering if you've seen rate-limiting steps change over time.

Richard Bear:
Not

Edward Wright:
Well, I wouldn't say there's any rate-limiting steps that have changed over time.

Prakash Gowd:
Okay. Then in terms of the future, I'm trying to understand what opportunity there is to target GI practices that don't currently use deep sedation. Can you give me an estimate of how many of your O'Regan customers currently don't use deep sedation? Just to give us some sort of a sense on how large that opportunity might be, and is that something you might consider targeting in the future?

Richard Bear:
Yes. I mean so first question is, we would assume and based on data that we have that our customer base for O'Regan follows the national trends where 50% of them are using deep sedation in their facilities and 50% are not.

We're looking at different models. There's a model from the ASC world where the ASC organization like AmSurg or HCA or Tenet will go out and help a practice develop the ASC because the practice doesn't

have the financial wherewithal or the expertise to build their own ASC with the ability then to acquire a majority over time. We're looking at models like that but nothing at this point to announce.

Prakash Gowd:
So, there's still plenty of opportunity with those who are already using deep sedation is what you're saying?

Richard Bear:
Yes.

Prakash Gowd:
All right, that's great. Thanks very much.

Operator:
The next question is from Noel Atkinson with Clarus Securities. Please go ahead.

Noel Atkinson:
Hi. Good morning. Well done in the quarter guys.

Richard Bear:
Thanks, Noel.

Noel Atkinson:
Just a couple of quick ones. So, some of these massive megamergers in health insurance in the U.S. look like they're not going to go through. Do you see that that has a beneficial effect on your business, having a larger pool of insurance providers to work with?

Richard Bear:
Yes. I think it's beneficial to everyone. I mean, you know, the mega guys can — don't necessarily have cost efficiencies, so with power they could drive prices down for providers and drive prices up for consumers. So, I think it benefits all that those megamergers weren't approved.

Noel Atkinson:
Okay. Then this is a follow-up from an earlier question. AGAA (phon 34:28), at the start of 2016 there was a shift in the commercial payor mix, so are you saying that you haven't seen anything of that sort, either positive or negative, so far in 2017?

Richard Bear:
It's really too early to tell. I mean it wasn't — we didn't have a clear picture of what was going on in 2016 until we got through the first full quarter, so we don't have — no comment either way right now, and again, we won't have a clear picture until the end of first quarter 2017.

Noel Atkinson:
Okay. All right, thanks very much.

Operator:
The next question is from David Martin with Bloom Burton.

Antonia Borovina:
Good morning. Antonia Borovina on the line for Dave. Just a quick question from us. Did you have any ASC contracts up for renewal in Q4 and just subsequent to that, and if so, did those contracts roll over?

Richard Bear:
Great question. In Q4, I think the contracts — the ASC contract is just one component of our transaction. So, the ASC contracts associated that we acquired and associated with Knoxville (phon 35:55) would be annual agreements that auto-renew, which auto-renewed in Q3. The Macon one is a little bit longer, but again, as we've talked about before, there are other provisions in the purchase agreement that we leverage to ensure the longevity of those agreements that are more important than that exclusive contract.

Antonia Borovina:
Okay, thanks.

Operator:
The next question is from Doug Miehm with RBC Capital Markets. Please go ahead.

Doug Miehm:
Okay. Good morning. Two questions. One of them has to do with capacity utilization at the sites. Were there any sites given the number of procedures that were done in the quarter operating at what would effectively be at 100% capacity utilization, I guess is the first question.

Second question just has to do with very strong numbers and excellent drop to the EBITDA line, but what I did note is that it seems relative to the EBITDA to shareholders that was less of a contribution that I would have expected relative to the margins typically associated with your business at 50%. Because it looks like on a $2 million outperformance relative to our numbers on the revenue side, the outperformance on the EBITDA to shareholders was only $600,000 when you would have expected a million or perhaps even more given how much more was added on just as straight EBITDA.

Edward Wright:
Doug, I'll take the first question regarding utilization and then Richard can address your second one. In terms of utilization, there's different aspects that go into play there. Clearly there is the ability for the ASC to be able to see as many patients as possible. There's also a limitation in terms of the number of physicians and how many patients that they can see. So, when we take a look at 2016 and we look at Q4 and particularly December across the network, what you'll see many days during those days, because we look at it every day by location, if you look at it from that sense, there's very little more that can be done in certain locations on many days in December just because the physicians that are in those particular locations are not able to see any more patients and it would be challenging for them to bring on more doctors just at that place in time. What we tend to see in December, in that latter part of December in particular, is really most physicians working to see as many patients as they possibly can.

When we look at and we speak to our partners and we ask them to give us forecasts for the year ahead and break it down, depending on what their plans are for expansion, for hiring doctors so that we can get a better idea forecasting, that's really how we look at utilization.

There are many of these centres that have been built with expansion plans for the future. So, they may have, it could be a three-room centre that may only be using two rooms currently, so there would be lots of opportunity there, but until the physician, or until the practice decides to hire another physician and whatever their plans are, then we're not really in a position obviously to service those patients.

So, it's something that we, from a utilization point of view, we're forecasting. We're working closely with the partners to discuss with them what are their plans so that we can really understand what that's going to look like in the months or the quarters ahead. Does that help, or do you want some more clarification around that?

Doug Miehm:
No, that's very helpful. I guess in particular we did see the outperformance at AGAA and Arapahoe, I guess it is, relative to what we were thinking. I'm just wondering at those types of sites essentially, certainly in December it looks like you were at 100% capacity but there may be the opportunity to build out those sites so that you're not capped at that level in the future.

Edward Wright:
Yes, absolutely. We're in constant dialogue about, or visiting, in terms of what are the plans for hiring additional doctors, maybe expansion of sites. A lot of it has to do with how many cases can they actually see, and that's what we're trying to get visibility to. I'll let Richard answer the second question that you had.

Richard Bear:
Doug, good question and I think you must have —I 'm guessing you came on a little late. Did you join the call late?

Doug Miehm:
I did, sorry.

Richard Bear:

Okay.

Doug Miehm:
Maybe you touched on this already.

Richard Bear:
No worries. No worries. Yes, this question came up earlier and the answer to the question is there are—as you know we use estimates to record revenue and those estimates are something that we are finetuning every month, every quarter. It takes about four to six months of operations of the new entity before we really have a high degree of accuracy in terms of what that realizable revenue rate per unit is per payor. We achieve that with those three acquisitions that we did in June. So, in December we made some adjustments to revenue, primarily for those entities that we have non-controlling interest in, Austin, Arapahoe community, so that impacted the revenue a little bit in Q4, but that would have totally impacted the — would have had a significant impact on the non-controlling interest for Q4.

What we've — going forward, we would suggest that you use the combination of Q3 and Q4, the second half revenue as a rate — in the ratio of those non-controlling interest to shareholder — to interest attributable to shareholders as your benchmark going forward. If you use Q4, your NCI would be too high. If you use Q3 your NCI would be too low.

Doug Miehm:
Got it. Okay. Makes a lot of sense. Thanks.

Richard Bear:
Thanks.

Operator:
As a reminder, analysts who wish to ask a question, please press star, then one on your touch-tone phone. The next question is from Richard Close, a follow-up, from Canaccord Genuity. Please go ahead.

Richard Close:
Great, thank you. Edward, you mentioned you are having many more discussions and I'm curious whether you think that's a function that you have a dedicated team in place, Jay, and I think you mentioned he hired some people as part of the Operations and Business Development team. Is it just that you guys are knocking on more doors or is there a movement towards more businesses, seeing what you guys have done so far over the last two years and that's spurring higher interest in selling to you guys?

Edward Wright:
Yes, so I'll address the question maybe at a little bit more of a macro level, Richard, first of all.

When I say more conversations, it's on both fronts. I'll get to the BD side in a second but it's also on the operational side. Some key hires, while we haven't hired many people, we certainly had some key hires like a VP of Operations and a VP of Business Development, and the Operations role is really important because with 26 ASCs in seven states, we have to be certainly meeting — my preference is exceeding — customers' expectations. Because these relationships are going to be the best conduit for us for future growth on the Business Development side by word of mouth amongst gastroenterologists. So, that's been really key there.

Then if we go to the BD side, I'd like to pay a real credit to Mr. Kreger. He's been a wonderful addition to our team. In his role, he has oversight for Operations and for Business Development. But where Mr. Kreger has assisted us greatly, and I would say really towards the end of 2016 and going into 2017, is on the BD side. When he first joined us he was very focused on the operational side of our business, and I asked him to do that and make sure that he met all of our customers. He's now spending more time on the BD side and there is certainly some inbound interest, but clearly, we're still in our infancy here in the processes that we've developed for outreach primarily to O'Regan customers, but its expanding beyond that now is proving fruitful. Mr. Kreger is spending a tremendous amount of time as is some other people that work closely with him in terms of travelling and educating people about what our offering is.

So, we're very much still in a stage of travelling around the country and ensuring that the GI practices understand what our opportunity is. So, when I say many more, yes, absolutely. In terms of we have people now that are dedicated to this, there's a strategy, there's processes in place. It's been integrated within our organization, so that's something that is going well.

Richard Close:
Then do you envision as we think about 2017 that the free cash flow generated throughout the year you'll fully use that with respect to acquisitions?

Edward Right:
I would say that that would be something, Richard, that I wouldn't feel comfortable boxing us in by making a statement like that. We're going to continue to be really prudent. I mean it's great that we're generating approximately $6 million a quarter and what we're going to do is continue to be disciplined in our approach. We've got a very strong checklist of what it is that we're looking for before we transact on an acquisition. One would not know — we don't announce LOI so one would not know when they don't meet our criteria and we walk away from them, but we want to ensure like we've done to date, that when we execute on something that it's going to have a meaningful benefit for the shareholders. That's how I would answer that question.

Richard Close:
Thank you.

Operator:
The next question is from Endri Leno with National Bank Financial. Please go ahead.

Endri Leno:
Hi, good morning. I just have a couple of quick questions. One is if there is a centre — I mean you mentioned that a lot of the sort of legacy acquisitions (inaudible 47:49) they're performing according to your expectations. If they weren't, have you put any consideration into disposing any of them, or would you?

The other question is more kind of a housekeeping; what you expect for corporate costs for 2017? Thank you.

Richard Bear:

No. Disposing of any — I mean there's still — I mean these things are still highly profitable and highly effective. I don't know why we'd ever dispose of them, so that's not something we've ever considered. In terms of corporate expenses, corporate expenses, they'll be — as we get bigger corporate expenses will continue to increase slightly. We don't have significant hires on the corporate side but as we get bigger our legal expenses, our regulatory expenses, our audit expenses tend to increase, so you won't see — it's just going to be more of the same if you compare cash items over cash items from 2016 to 2015 and then translate that into 2017. Just based on the accounting of stock comp, there's always variability there but all the other stuff will kind of grow based on historical rates.

Endri Leno:

Thank you.

Operator:

This concludes the question-and-answer session. I would now like to turn the conference back over to Mr. Wright for any closing remarks.

Edward Wright:

I'd just like to thank everyone for taking time to participate in the call and we look forward to updating you on our Q1. Thanks very much.

Operator:

This concludes today's conference call. You may disconnect your lines. Thank you for participating and have a pleasant day.