CRH Medical Corporation

Third Quarter 2017 Results Conference Call

Date: **November 2, 2017**

Time: **8:00 AM PT**

Speakers: **Edward Wright**

Chief Executive Officer

Richard Bear

Chief Financial Officer

Jay Kreger

President, CRH Anaesthesia

Kettina Cordero

Director, Investor Relations

Operator:
Welcome to the CRH Third Quarter 2017 Results Conference Call. As a reminder, all participants are in 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. In the interests of time, please limit yourself to one question before re-queueing into the queue. 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 Operator, and good morning everyone. Today I am joined by our CEO, Edward Wright, our CFO, Richard Bear, and Jay Kreger, President of CRH Anaesthesia. Before we start, I would like to remind everyone 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 quarter ended September 30, 2017, and 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 Disclosure & Analysis for the quarter ended September 30, 2017 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.

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 Edward Wright.

Edward Wright:

Thank you, Kettina. We had an active quarter on the business development front. We announced a number of acquisitions: one in August and three more in September, bringing our total to six acquisitions so far in 2017, and 15 since we entered the anaesthesia space in December 2014. CRH Anaesthesia now services 35 ambulatory surgical centres in seven states and performs approximately 235,000 patient cases annually.

Acquisition spending in 2017 is in line with what we spent in 2016. Year-to-date, we've invested approximately $33.1 million. Jay will provide a more detailed account on our recent business development activities and our acquisition pipeline.

We are extremely disappointed that despite our recent acquisitions we have not seen a change in market sentiment for CRH. We believe that our share price does not reflect its true value, and therefore Board and Management are currently reviewing initiatives to address this situation.

During the third quarter, we generated $23.3 million in total revenue. We generated $7.8 million in Adjusted Operating EBITDA attributable to shareholders, and $6.4 million in free cash flow, while maintaining strong margins.

We completed the quarter in a strong financial position with $10.4 million in cash and $13.1 million in working capital. In addition, we have $35.8 million remaining on our $100 million credit facility at an interest rate of LIBOR plus 2.5%. This, combined with our quarterly cash flow gives us ample flexibility to grow our business without issuing stock and diluting our shareholders.

With that, I'll leave you with Richard who will discuss our financial performance during the recent quarter.

Richard Bear:

Thank you, Edward. Good morning everyone. I'd like to start by reminding everyone that in accordance with International Financial Reporting Standards, also known as IFRS, we report consolidated financial statements which means that our financial statements include those of the subsidiaries in which we

hold a controlling interest, such as the anaesthesia practices we own or in which we hold majority interest. This practice is in keeping with current accounting standards.

We reported total revenue of $23.3 million for the three months ended September 30, 2017, compared to $22.1 million in the same period in 2016. Year-to-date, we reported $67.9 million in total revenues compared to $52.5 million for the same period in 2016.

Anaesthesia revenue for the quarter was $20.5 million compared to $19.4 million for the same period in 2016. Year-to-date anaesthesia revenue was $58.5 million compared to $44.8 million for the same period in 2016. Anaesthesia revenue was positively impacted by growth in acquisitions, organic growth and revenue from our MAC development program. Anaesthesia revenue was negatively impacted by changes in payor mix and rates within our commercial payors, primarily at our GAA location, and by temporary clinic closures related to Hurricane Irma. Our payor mix is predominantly commercial, which was 61% of our patient cases in the third quarter. Federal patient cases, which include Medicare, Medicaid and other federally funded programs represent 39% of our patient cases.

For 2017, we have seen growth in both federal and commercial patient cases. Federal cases have grown at a faster pace than commercial patient cases, resulting in a change in our payor mix compared to prior periods.

Average revenue per case of $417 for the third quarter is consistent with Q2 2017. Changes in the payor mix and rates of practices acquired prior to 2017 have resulted in a decrease in average revenue per case of 10% when compared to the same period last year. Year-to-date, average revenue per case has declined 7.5%.

During the third quarter of 2017, we serviced 49,114 patient cases. Year-to-date 2017, we have serviced 137,664 patient cases.

Sales of our O'Regan system during the third quarter were $2.9 million, 5% greater than in the third quarter of 2016. Year-to-date, O'Regan sales were $8.4 million or 9% higher than last year. As of September 30, we have trained 2,620 GIs at 1,011 practices and the network of GIs and private

practices using our O'Regan system is still growing. We expect to continue expanding our product business at the same rates over the coming quarters.

Total Adjusted Operating EBITDA for the third quarter of 2017 was $10.9 million. Total Adjusted Operating EBITDA attributable to shareholders was $7.8 million, and total Adjusted Operating EBITDA for noncontrolling interest was $3.1 million. Out Total Adjusted Operating EBITDA margin for the quarter was 47%.

As a result of the amendment to our credit facility at the end of June 2017, and the extinguishment of the Crown debt, we have significantly reduced our quarterly interest expense. During the third quarter, we recorded interest expense of $270,000 compared to $1.1 million in the third quarter of 2016. During the third quarter 2017, we generated $6.4 million in free cash flow. 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.

As of September 30, 2017, we had $10.4 million in cash and $13.1 million in working capital. In addition, we have $36 million available on our credit facility to fund future growth.

With that, I will leave you with Jay for his update.

Jay Kreger:
Thank you, Richard. Last quarter I spoke of the groundwork that we've laid at CRH Anaesthesia to assemble a professional team and create an efficient organization that's capable of supporting our growing business. That groundwork became even more important in the third quarter, as we saw increased activity on the deal front.

We completed four acquisitions to further expand our presence in Florida, Texas, North Carolina and Colorado, respectively. As we briefly discussed on last quarter's call, on August 1 we announced the acquisition of a 55% interest in West Florida Anaesthesia Associates for $5.8 million. West Florida services one ASC and has estimated annual revenue of $3 million.

On September 11, we announced the acquisition of a 51% interest in Central Colorado Anaesthesia Associates in Denver, Colorado for $7.9 million. Central Colorado serves three ASCs and has estimated annual revenue of $5.6 million.

On September 20, we announced the acquisition of a 51% interest in Raleigh Sedation Associates in North Carolina for $7.2 million. Raleigh serves three ASCs and has estimated annual revenue of $5.3 million.

Then finally, on September 28 we announced the acquisition of 100% of Alamo Sedation Associates for $3.5 million. Alamo serves one ASC in San Antonio, Texas, and has estimated annual revenue of $1.8 million.

Consistent with recent past acquisitions, we financed these acquisitions through cash on hand and funds from our credit facility. Additionally, we paid multiples that were in line with past acquisitions, which are also reflective of current industry developments. As Edward stated earlier, we've now invested $33.1 million in acquisitions year-to-date, which is comparable with what we spent in all of 2016, which further confirms our capacity to leverage our relationships and have a strong pipeline during a changing environment.

The implementation of our MAC program with Puget Sound Gastroenterology in Washington State is progressing well. We anticipate exercising our option by mid 2018. Again, our people and processes here are working diligently to ensure a successful launch.

As I've said before, I'm confident that we will be able to expand this program to other practices in future quarters as new groups adopt MAC as their standard of care. The timing of these opportunities will in part depend upon payer adoption in various regions around the U.S.

Our focus remains on efficiently managing our business and creating future growth opportunities through a robust pipeline. I look forward to providing you with the year-end update at our next conference call, so I will now leave you with Edward for his closing remarks.

Edward Wright:
Thanks, Jay. As we evolve our business in a changing environment, we continue to post strong operational results and maintain a solid financial position. For the remainder of this year we are focused on integrating our most recent acquisitions, leveraging our pipeline and increasing value for shareholders.

With that, I'm going to turn it over to the Operator to open up the call for questions.

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 are using a speaker phone, please pick up 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 comes from Doug Miehm of RBC Capital Markets. Please go ahead.

Doug Miehm:
Thank you. Good morning everyone. Two questions. The first question maybe for you, Richard, or Jay. Just with respect to the changes that we observed in your split of business between commercial and government pay, it seems that the numbers have changed year-over-year. Maybe you could, number one, explain that, and part B to that question would be given that, should we be using the Q1 and Q2 numbers that were provided or will they have to change in addition to last year's Q4?

Richard Bear:
Good question, Doug. I'll take the question. What we did during Q3 is we just took a hard look at how we're reporting commercial and federal because of the focus on payor mix. There's a couple classic federal plans, Medicare, Medicaid, etc., and then there's some sort of crossover plans such as CHAMPS and TRICARE that, honestly, were inconsistently recorded as commercial versus federal. They're federally funded plans and actually act very similarly to Medicare plans. So, the information that we provided in our financials are really based on the corrected reclassification of payor mix and I can

share with you or anybody else who sends me an email the breakdown by quarter historically, which tie into the year-to-date historical numbers that we've provided.

Doug Miehm:

You'll provide the same thing for Q4 last year as well? If that has changed.

Richard Bear:

Yes, sir.

Doug Miehm:

Okay, great. Then the second question just has to do with the outlook. Now, I think we've all seen what's happened to, I wouldn't call them competitors but people or companies that we use to benchmark you, I guess. Recently commentary over the last day or two is that the seasonality effect that we might normally see, they're not seeing in their numbers so far. Can you give us any indication of what you're seeing? If you can't, I guess my other question would be if you're not able to provide that information, what differences in systems do you have relative to what they have that would prevent you from doing that? I'll leave it there. Thanks.

Richard Bear:

We've always seen seasonal growth. In talking with our GI partners and looking at the schedules, we will see growth in patient cases in Q4 vis a vis Q3. We get information on a weekly basis. We get only information on claims processed because that's the most accurate information for us, so it typically lags. We haven't seen anything that would tell us that we won't see an increase in Q4 vis a vis Q3.

Doug Miehm:

But will it be of the same amount that you've historically seen?

Richard Bear:

Last year we saw, if we look at Q3 and Q4, that the bucket of properties in each quarter was identical because all of our acquisitions closed in Q2. We saw 7% increase in cases between those two periods. I would say that we are expecting somewhere between 5% and 7% this year.

Doug Miehm:
Okay, great. Thank you.

Richard Bear:
You're welcome.

Operator:
Our next question comes from Lennox Gibbs of TD Securities. Please go ahead.

Lennox Gibbs:
Good morning. Thank you. The first question is for Edward. Just in the prepared comments, you alluded to initiatives that may be under consideration by the Board and Management with respect to market sentiment. Can you discuss the scope of those initiatives?

Edward Wright:
Not at the moment, Lennox. We're evaluating a number of possible options and those are things that we will inform the market or inform everyone when we make some decisions. There's a variety of things that are under consideration.

Lennox Gibbs:
Okay. All right. Second question: what's your working assumption with respect to the current macro environment and the likelihood that these headwinds continue into 2018? Then as a part of that, can you discuss potential countermeasures that you might implement, that might help to improve performance in this environment?

Richard Bear:
You're defining headwinds as the …?

Lennox Gibbs:
Payor mix, the high deductible, the shift towards higher deductibles.

Richard Bear:
Yeah, I mean and again we'll see where things go. I haven't seen any data yet in terms of what the insurance premium market looks like for 2018 compared to 2017. I can say for CRH and it's a positive for everyone that we saw less than a 1% increase in our healthcare costs, so we did not change our plan construct. Going forward, I hope that everybody has that same opportunity so that we don't see plan constructs change.

We're looking at a lot of different areas. We're looking at valuation techniques that we're using. We're looking at utilization at different centres. We're looking at how payor contracts go up, what we can do from a market perspective to adjust those. There's a lot of different things that we are looking at as we go forward and manage these trends.

Lennox Gibbs:
Just taking a look at the margin performance and the slide that we've seen there, are there cost reduction measures that might be of use that might be a lever to you going forward?

Jay Kreger:
Lennox, this is Jay. I think we look at staffing optimization and staffing models that we can undertake to affect our cost levels. The cost side of the business is something that we are trying to take a close look at, but it's also very much market driven. When you talk about macro level dynamics from a cost side, we're in a supply and demand issue with a limited number of CRNAs and anaesthesia providers, but I think there are some things we can do going forward.

Lennox Gibbs:
Thanks, Jay. Thanks very much.

Richard Bear:
Thank you, Lennox.

Operator:
Our next question comes from Richard Coles of Canaccord Genuity. Please go ahead.

Richard Close:

Great. It's Richard Close; I'm not sure what that was. Question, with respect to the activity on the acquisition front, spanning several different states. I know you have Florida in there and the demographics might be a little bit different. Can you talk a little bit about the payor mix associated with the acquired properties so far this year? How should we think about maybe those acquired entities' payor mix and how that blends into the existing company?

Richard Bear:

Let me start with that just from a numerical standpoint. If we look at our acquisitions, if we just look at Q3 2017 as an example and we look at all of our acquisitions prior to 2017, our commercial federal split of our base acquisitions are 62.5% commercial and 37.5% federal. If we look at our payor mix of the 2017 acquisitions, it's around 53% commercial and 47% federal. If we look at those acquisitions, we had West Florida and the acquisition in Osceola. Those two are going to have a higher percentage of federal than what we acquired in Raleigh, San Antonio, Colorado and Atlanta. But remember, we are valuing those—although those will have an impact on our revenue per case and our margins just because of the profile of those properties, please keep in mind—and this is critically important—that we value the business based on what we see in those. So, those have lower EBITDA profiles going in so, our cost on those would be lower, so our valuations are all in line with the value of the business that we're acquiring regardless of the payor mix.

Richard Close:

Okay. Then that feathers into my question with respect to the revenue per case I guess was relatively flat from second quarter to third quarter. Typically your seasonality is greatest for the fourth quarter in terms of procedures and as we think about people meeting deductibles and what not, I suspect that you would see a bump in the commercial procedures in the fourth quarter. Just so we manage expectations here, what should we be thinking about in terms of a revenue per case for the fourth quarter as to not get too far ahead of you guys?

Richard Bear:

What we've seen is fairly flat commercial quarter-over-quarter, as we've stated. We've seen growth in both aspects of our business, commercial is growing, federal is growing. Federal is growing faster which has resulted in this evening of our payor mix. Historically, you're right. We always see a higher percentage of commercial cases in Q4 as compared to previous quarters. I'm assuming a slight uptick when I look at our internal forecast but I'm not forecasting any hockey stick-like effect because it's not responsible, so you might consider a slight uptick applied to the case increases that we'll see, but I wouldn't go crazy, Richard.

Richard Close:

Okay. You had mentioned organic when you were making your comments earlier. You know, growth through acquisitions, growth organically. Can you provide any details on what the organic or same store growth was in the third quarter?

Richard Bear:

Generally, we guided that we see 3% to 5% organic patient growth at the sites that we serve, both for year-to-date, September 30, 2017, and quarter-to-date when I look at it, it is right there in that 3% to 5% range.

Richard Close:

Okay. My final question would be you've done a handful of transactions here over the last couple of months. Can you talk a little bit about the pipeline and where that stands and maybe how potential targets have changed in terms of thinking about? Are they more eager to sell? Are they less eager to sell? Thoughts in and around that.

Jay Kreger:

Sure, Richard. It's Jay. I'll answer that. So, as far as the acquisitions we did this year, it's always interesting because these things are not timed. Ideally we always talk about how it'd be nice to do a couple of acquisitions each quarter, and just like 2016 when we closed three acquisitions in one month, we had a very busy third quarter this year, and I would suspect that that will always be the case. Not

necessarily three in one month but where we don't time them. We may go three months without and then do two real quick. We may do one a month; we just don't ever know.

Doctors who are partnering with us are incented or make their decisions on their own personal factors: age of the practice, age of the individuals, where they are. I don't see the macro developments as we've talked about being the thing that makes a doctor want to do a joint venture with us or not. They do it because they see value in the proposition that we are showing them.

Whether or not that changes next year after these expected cuts come through, we'll see. That said, I don't see any difference next year in the amount of activity that we have for the year. We should be at a comparable level of activity or higher, and that's how we're looking at 2018. We're very bullish on our pipeline as we go forward, especially now that we've gone through our pilot, if you will, on the MAC development program.

Richard Close:
Okay. Thank you.

Operator:
Our next question comes from Noel Atkinson of Clarus Securities. Please go ahead.

Noel Atkinson:
Hi, good morning. Thanks for taking my questions. Just to follow up to the last question, do you see an opportunity, however to hold off on additional acquisitions until the CMS rate changes do take effect and maybe there is a little bit more pain felt in some of those smaller practices?

Jay Kreger:
I think that there is an opportunity there, however, we've not held off our level of activity. We've taken into account what we believe will happen from CMS into our modelling, and as Richard mentioned earlier, our return on investment, regardless of the payor mix, regardless of the cuts, should remain consistent with past acquisitions. So, that is already taken into account in the valuations that we're currently using.

As I mentioned, once they feel the pain of those cuts within their own anaesthesia practices, that may lead some to want to partner with us, but what I'm hearing is most of them do understand and believe that the cuts are going to happen, and so it's not that they're holding out waiting to see.

Edward Wright:
Noel, this is Edward. Just to add a little bit to that, keeping in mind that what we're bringing forth as an opportunity is a new proposition to GIs. Jay would tell you that as he's assembled his team and they've gone out and worked the leads that are primarily still within the array in customers that we have, this is still a new idea. So, of all of the acquisitions that we've done to date, 15 of them—I believe 13 if I'm not mistaken are O'Regan customers—and 14 of the 15 have been a result of us going out and educating people.

What I'm excited about is some of the deals that happened in this last quarter, these were people that we talked about quite some time ago and the sales cycle sometime is a little bit slower than what we might like but that's because there's a long time education process involved with many of the practices. I don't know if you've got anything to add to that, Jay.

Jay Kreger:
No, I think what we've seen is the typical sales cycle from the time we first propose our value proposition is close to a year, and so that is why we can say with some level of confidence that next year looks good because of how many conversations we've started in 2017.

Noel Atkinson:
Okay. So the San Antonio acquisition being a 100% acquisition, do you see that being a bit of an outlier? That you still intend to continue to do primarily the joint ventures.

Jay Kreger:
I think that the primary is to go to joint ventures still. That was a particular case where that's what they felt comfortable with and we did as well because it was in line with everything else we include in our transactions.

Noel Atkinson:
Okay. Can you talk a little bit about the hiring environment and sort of the cost environment for the CRNAs? Is availability changing and is daily rate that you have to pay changing? Are you expecting any meaningful cost increase to your existing portfolio of CRNAs in 2018?

Jay Kreger:
Good question. In general, salaries have been and remain to be flat, but that is market by market. For the most part we are contracting people on 1099s and those contracts are renewed automatically where there is not an adjustment. Unless the market dynamics would dictate otherwise, we don't adjust those, but again, it's market driven by supply and demand.

As we go forward, more and more often hospitals are now starting to utilize CRNAs instead of anaesthesiologists in order to drive their costs down, but what it also does is it reduces the amount of supply that's out in the marketplace. Just like nursing, there is a shortage and so we're subject to that same shortage on the CRNA front, which makes the salaries somewhat inelastic.

So, as we go forward, the pay per CRNA will be driven by the market more so than by us increasing or decreasing pay amounts.

Noel Atkinson:
Okay, great. Two more quick ones here, in terms of procedure volumes, in the imaging, medical imaging side, there is a push by the federal government in the U.S. to—I'm sorry—by insurers in the United States such as Anthem to push volumes of outpatient procedures for medical imaging from the hospital into freestanding centres. Are you seeing anything like that where there's starting to be any sort of initiatives by insurers or hospitals or anything like that to kind of push things out?

Jay Kreger:
You're speaking specifically of GI? My stance is that most of the GI has already been pushed out of the hospitals other than those who are employed by the hospitals. If you go by the endoscopy suites within the hospitals, they're generally not very busy and those doctors are not owners of ASCs that would be

able to drive that business outside. So I don't think we'll have the same type of movement going forward because I think they've already been migrated out.

Noel Atkinson:
Okay. Then finally, it looks like the O'Regan, the number of O'Regan trained docs went down sequentially in Q3. Can you talk to that?

Richard Bear:
Yeah, I'll speak to that. That was a error, unfortunately, in our Q2 MD&A that was not caught. We reported that there was 2653 trained docs. There was a transposition there; it should have been 2563. We didn't think it was material enough to issue a restated financials.

Noel Atkinson:
Okay, great. Thanks very much.

Operator:
The next question comes from David Novak of Cormark Securities. Please go ahead.

David Novak:
Good morning. Thanks for taking the questions. This is the first time I've heard you guys talk about commercial rate pressures in providers acquired prior to 2017. Could you elaborate a little bit on this? Would this be changes to contracted commercial rates or just changes in UCR rates? Anything you disclose on that, that would be great.

Richard Bear:
Hey David, how are you? Most of the changes that we're seeing still relate to the payor mix issues at GAA that we previously disclosed. But as we round the corner from the 2016 acquisitions, meaning that we've had those for a full year, as we acquire those businesses we are running RAP on everyone and it takes a little bit of time to get those key payors that we bring in under contract in contract, so when we have the comparable periods we're just seeing differences in some of those net realizable rates just because of the timing of those contracts.

David Novak:

Great. I guess just looking at GAA specifically again and drilling down a little bit on the same contract per patient encounter revenue, back in 2014 we know GAA took a bit of a hit as it contracted with United. Since that time has GAA contracted with any other major commercial carriers? Would that be a material event that you would press release?

Richard Bear:

The contract with United in 2014 would have been prior to our acquisition. That was May of 2014. Our acquisition date was December of 2014 and we assumed that contract rate in our valuation for GAA. There has been no other changes in our payor relationships at GAA, and if we contracted GAA and it had a material impact on our financials, we would need to consider how that information was disclosed and the timeliness of that disclosure.

David Novak:

Okay, great. Just looking at your commercial volume for the nine months year-over-year, there is a slight uptick of about, call it 0.8%, I think, in the MD&A, yet same contract revenue decreased about 9%, so I just really want to make sure I understand this. By the commercial payor mix explanation, are we to assume then that this is really entirely the result of patient volume shifting between various commercial carriers and not the result of a change in contract status between any of your providers and the commercial carriers?

Richard Bear:

Yeah, it's primarily the result of changes within the commercial payor matrix.

David Novak:

Okay. Just one final question on commercial patient volumes. Looking at that patient volume's segment specifically, what percentage of cases have you successfully collected the co-pay element of the bill from?

Richard Bear:

I don't have that data in front of me. I mean these are all processed, contracted and RAP are processed as if they're in network, so we bill the insurance companies, we get back an explanation of benefits that shows what they allow. They send us a check for what they pay. The patient portion is then billed to the patient. We send approximately six statements out to the patient and then follow it up with letters, and then working with our partners who it's really their patients, the GI's, we determine what level of those claims would go to a third party collection agency.

David Novak:

Okay, great. Then just one final two-parter on the CMS proposed rule changes, just so I can kind of think about my forward estimates. When you press release your analysis of the changes, does your analysis assume code 8X2 is associated with four base units or three base units?

Richard Bear:

Four base units.

David Novak:

Four base units. Okay. Finally, in our discussion with investors, we've noticed that there seems to be a little bit of inconsistent information out there on the Street with respect to what your assumed code utilization rate as a percentage of your total annual patient volume would be. I was wondering if have that information, would it be possible to clear that up here by providing your assumed utilization rates for 7X1, X2, and 8X1, X2 and X3?

Richard Bear:

Yeah. About currently 25% of our coding goes to 740; 75% of our coding goes to 810. Seven forty is being split into two codes, 7X1, 7X2; 7X1 has a base unit value of 5; 7X2 has a base unit value of 6. 7X2 is actually for ERCP which is done in the hospital so for that 25% currently coded as 740, there is no change.

Seventy-five percent of our coding goes to 840. Of that 75% of our coding that goes to 840, 15% of that are for 'doubles' where it's both a upper and lower done at the same time. So, 15% of the 75% will see

no change in base rate changes. Of the remaining 85% of the 75%, which is 63.75%, we see that equally split between 8X1s and 8X2s.

David Novak:
Excellent. Thanks so much, Richard. That's been really, really helpful. Appreciate it.

Richard Bear:
Great questions, David. Thank you.

Operator:
Our next question comes from David Martin of Bloom Burton. Please go ahead.

David Martin:
A couple of questions following on some of the others. The government cases groing faster than commercial, is that because of the new acquisitions or on a same storefront basis is that also happening? Why is that happening?

Richard Bear:
The first question is easy. It is on the same store basis. If you go back and look at 2015 and prior acquisitions, and we look at our 2016 acquisitions because that's where we have year-over-year comparisons, in both cases commercial and federal are growing, but in both cases federal is growing faster.

Why that's happening? That's a more difficult question. We've been monitoring what Envision has said, what Mednax has been talking about and other hospital groups, and they're seeing similar things and they're talking about changes in the exchanges and as we talked about before, we have very little exposure to Affordable Care Act patients because of the GIs in private practice primarily don't participate on those plans. There's also been discussions about other comments on how that impacts this.

Very few questions that I don't think we have the answers for in this one. We're pleased to see growth and our business is strong. Why one is growing faster than the other will be something that we'll be able to address once we have a full year's data at the end of Q4.

David Martin:
Okay. Second question: At Puget Sound, you mentioned that this model you can expand to others depending on payor adoption. How has payor adoption been going in your experience at Puget Sound? Is that what you're waiting for? For more payors to come onboard before you exercise your option there?

Jay Kreger:
David, this is Jay. With Puget Sound the payors for the most part in that market had already adopted deep sedation as a standard of care, and in fact that's one of the reasons why we were able to go into that market. It's other markets that we're talking about where the payors either have not adopted or not all of the payors have adopted it yet. For instance, you may be at a centre in certain parts of California where half the payors are paying for deep sedation and half are not. We are talking with those GIs, looking at the market and deciding if and when it makes sense to go in to those markets and it's worth it for everyone involved.

With regard to Puget Sound, the reason why we have not transacted yet, as we laid out at the beginning when we first announced the MAC development, is we always wait a year. Not only to ramp up the business but also for the physicians to take advantage of long-term capital gains.

David Martin:
Okay. Jay, this one's for you, too. In response to one of the questions about the targets that you're approaching and what their expectation is as far as the cuts, the Medicare cuts, you said that they're all generally expecting that the cuts are going to happen. Are you referring only to the 2018 cuts or are people building in expectations that there'll be that extra cut to the screening colonoscopy in 2019?

Jay Kreger:
Generally speaking, no one is of the opinion that additional cuts will happen beyond the one unit cut down to four base units, as Richard laid out earlier.

David Martin:
So they don't have an opinion yet, or they do have an opinion and they feel it won't happen.

Jay Kreger:
They do have an opinion, and like our opinion they don't believe it will happen.

David Martin:
What's the basis for feeling it won't happen?

Jay Kreger:
I think the general feeling is that the amount of the cost, if they were to lower it any more, it would be basically at cost, and so the idea, from a reasonableness standard is that they would only lower it to the point where there is a reasonable margin, and going below that would in fact not be reasonable.

David Martin:
Okay. Okay, great. Thanks.

Operator:
Our next question comes from Alan Ridgeway of Scotiabank. Please go ahead.

Alan Ridgeway:
Good morning, guys. Thanks for taking the questions. I just wanted to circle back on the CRNA because we have heard from some other companies that they are facing pressure there on the employment. I just wanted to circle back with Jay on the contracting with them. How long are the contracts that you guys sign with the CRNAs and sort of what percentage of CRNAs in your business are sort of up for renewal on a yearly basis?

Jay Kreger:

I think of our—we have over 200 anaesthesia providers that are either employed or under 1099 independent contractors. Roughly 75% of those, maybe 80% are 1099s, and those contracts are usually only one or two years in length with automatic renewals. As the market may dictate, we'll review those contracts only upon renewal to determine whether or not there should be an adjustment, up or down. Otherwise, they just auto-renew and we just keep on going.

Richard Bear:

I'll add one thing. There is a big difference for a CRNA in working for a hospital—and I don't know what you're referring to in terms of what you're hearing—than working for an ASC in that there's significant advantages like work/life balance primarily in working in an ASC versus a hospital. So I'm not sure there's going to be a direct correlation between increases on the hospital side and increases on the ASC side just because of the work/life balance opportunities we provide vis a vis the hospital.

Alan Ridgeway:

Right. So if you look at your business, across sort of your footprint, are the CRNAs in the different sort of geographic regions, are they making similar salaries, or is there a geographic difference across the board?

Jay Kreger:

I would say there's probably a 20% range but it's not necessarily in line with what you might think of as a typical cost of living increase, so there is a much smaller range than the cost of living range.

Alan Ridgeway:

Okay. They just on the payor side—we'll stick with contracts for my questions. Richard, you mentioned that when you first start billing, you're billing under RAP and it takes some time to sort of come in as to which ones are contracted and what the ultimate payments you guys are able to move forward with and your estimates. How long does that period usually take, and then how long are these contracts typically for? Are these typically two to three year contracts and so you've got sort of 30% renewing on an annual basis? How should we think about the contract risk on the payor side.

Richard Bear:
Typically it takes 60, 90 days to get contracts in place with the major players that we do in each market. It could be up to 120. It really depends on the payor. What we're trying to do is we're trying to achieve contract rates that are in the best interest of our partners and to the best interest of our shareholders, so sometimes that takes longer because we want to get those strong rates.

When we do sign contracts, the typical length of the contract is three years and with automatic escalators in each year and those escalators probably range from 3% to 7% each year. As contracts come up we either choose, depending on the rates, to automatically let those evergreen, or if we believe the rates are not at market, we will then open up negotiations through all the data we have about the value of these services and what we see these services being paid. That usually results in a better rate for us and our partners.

Alan Ridgeway:
Right. Just in order for us to get a good feel as to how much volume or how many contracts are in place, how much of your business would be specifically contracted with the higher volume payors at your ASCs, versus those where you're billing under RAP because it's just not worth the time or effort on your side and probably also on the payor side to sit down and negotiate every little tiny contract?

Richard Bear:
As we've previously stated, our primary strategy is to contract with the major payors and then remain and utilize RAP for non-major payors. Just please keep in mind that from a RAP perspective the patient is treated as if they're in-network. The payments are processed as if they're in network and as represented by our days outstanding, which was 39 this quarter, 38 last quarter, ticked up because the new entities that came on that we hadn't collected money on yet.

We don't report specifically on that breakdown. That would be the answer to that question.

Alan Ridgeway:
Okay. Well then maybe I'll ask it a slightly different way. Are the contracts under RAP, do they have escalators too or no?

Richard Bear:
Under RAP we're not putting a price, it's not a contracted price to the payors. The payors are paying us based on their internal payment schedules.

Alan Ridgeway:
Okay, so it doesn't necessarily have an escalator on it.

Richard Bear:
Doesn't necessarily have an escalator on it; but think about it this way: when we want to go in network or when we get approached by one of those RAP relationships to come in network, our goal is to utilize the data that we have and what they've been paying us to maximize the value of that contract and we've been successful doing that.

Alan Ridgeway:
Right. Okay. That's it for me. Thanks, guys.

Richard Bear:
Thanks, Al.

Operator:
Our next question comes from Endri Leno of National Bank Financial. Please go ahead.

Endri Leno:
Hi. Thank you for taking my questions. I just have a couple quick questions. First one: are you seeing any of the cases that were cancelled because of Hurricane Irma—are you seeing any pickup in Q4, or do you expect any of those to be rescheduled in next year?

Jay Kreger:
It think at the time that they were cancelled, within a very short time they were all rescheduled and we believe all of them will be rescheduled by the end of first quarter of 2018.

Endri Leno:
Thank you. The next question I have, it's on acquisitions pipeline. I think in the prepared comments, Edward, you mentioned that one of the goals for the rest of the year is to integrate the existing acquisitions. Are we to interpret that there are potentially not as many or fewer, or none at all perhaps, acquisitions in Q4?

Edward Wright:
That will remain to be seen. In terms of integrating the acquisitions, although one could say that it's seamless after having completed 12 before the 3 last month, there's still a fair bit of work to be done in terms of with Jay and the operational team, in terms of getting all of the providers up to speed with what we're trying to do in terms of best practices and integrating the relationship between CRH and that practice. That'll take a fair bit of time, but we'll still be active on the business development front, and as Jay alluded to earlier, there is a pipeline here, which is robust and Jay and his group are very much active out in the field talking to people. Whether those get across the finish line before the end of the year, that will remain to be seen.

Jay Kreger:
I'll also just add that we have proposals out all the time, at all times of the year. Our activity does not slow down because of integration going on, however, the activity on the doctor's behalf and how much attention they can put forth towards a possible transaction is always going to be a little bit slower during the holidays, and as we've noted, the fourth quarter is always the busiest month or the busiest quarter of the year for the physicians, so their attention to any proposals we may have out is usually less during this time of year. I think that's in line with what our expectations are.

Endri Leno:
Thank you. That's all the questions I had.

Operator:
Our next question comes from Prakash Gowd of CIBC . Please go ahead.

Prakash Gowd:

Thank you very much and good morning, gentlemen. Just a few questions. First probably for maybe Jay. I'm wondering if you could talk a little bit about the macro environment for GI ASCs and looking over the last, say 12 months or so, have you seen new ASCs specialized in GI emerge as new competition in the relevant areas of your current business, and if so, is that a potential avenue for loss of private pay cases in your existing business?

Jay Kreger:

We've estimated that there are roughly 800 to 1,000 GI-specific ASCs in the United States, and that number has been flat for some time. What we're seeing on a macro level is a consolidation within the GI speciality and that continues to go on. I think how that affects our opportunities, it doesn't necessarily change it other than the fact that there may be larger groups in which we could transact with as opposed to more that are smaller. At the same time, sometimes the largest value we can provide is for a smaller group of GIs, and so I think those opportunities remain. But I think the overall market remains the same in terms of the number of ASCs that we can transact with.

Prakash Gowd:

Okay. So, no new GI ASCs in the relevant business areas.

Jay Kreger:

I don't believe so. I mean we've seen, for example, since the GAA acquisition that was announced on December 1, the practices that we serve under that first acquisition, originally it was 9 ASCs and it's currently 13 ASCs due to growth. Our Knoxville acquisition, with a new centre they've built probably increased capacity by 50% to 75% in terms of total rooms. We know other practices are considering new ASCs or expanded ASCs, so we are seeing growth from that standpoint and that's that growth that we see and those partners that we choose to do deals with that fuel the organic growth that we are seeing year-over-year.

Prakash Gowd:

Okay. I was just actually more curious about whether or not there's new GI ASCs that are coming up that are not part of your system.

Jay Kreger:

There seem to be more of a replace and enlarge type of motivation on behalf of the doctors as screenings have become more commonplace. The existing physician groups that are out there are just expanding their own opportunities and their own capacities, which certainly, as Richard pointed out, that's what drives our organic growth but doesn't necessarily create a new ASC that we can contract with.

Richard Bear:

Not to beat a dead horse on this one, but just keep in mind, so the GIs create the demand that the ASC companies and anaesthesia companies serve, so you're not seeing new GI groups come up that would then drive new independent ASCs. You're seeing GI groups actually get larger and more powerful within those markets and expanding their ASC facilities to meet their needs.

Prakash Gowd:

Okay. Second question is on reimbursement rates. Since CMS approved the lower reimbursements for 2018 back in July, what discussions have you had with private payors as they're reviewing their current reimbursement rates and into 2018? Are you involved in any negotiations? What's the nature of those discussions? Anything you can share on that front?

Richard Bear:

With the insurance companies, it's not a code-based discussion. We're not negotiating for reimbursements for Code 740 or Code 810. What we're negotiating for is a reimbursement per unit. So, our contracts are not impacted by any changes in the billing codes used because it's just that our per unit rate will be applied to those new billing codes. As we begin the process or as we continue process of negotiating contracts or contracts are up for renewal, our goal is going to be work as hard as we can to mitigate any changes with the CMS code changes by increases in rates but we can't guarantee that we'll be able to achieve that.

Historically, anaesthesia contracting is code independent and it's always on the rate. Just because the codes change doesn't necessarily mean that we're going to be able to use that as a means of

increasing our contract rates, but we will use all of our efforts to make sure that we're getting fair value for the services that we're offering.

Prakash Gowd:
Okay. Thanks, Richard. Then lastly, and I'm sorry if you might have addressed this earlier—I got on a little late. It seems you remain optimistic on future acquisition opportunities. It looks like you've got visibility there as well. Can you provide any intentions or expectations for acquisitions in 2018, perhaps in terms of dollars invested, much as you did for 2017?

Jay Kreger:
As we noted, we've spent $33.1 million in 2017 and we expect that that number should be comparable or better next year. Now that our de novo, our MAC development program is online, we should start to see some fruit from that in 2018 and beyond.

Prakash Gowd:
Okay, great. Thank you very much.

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

Edward Wright:
Thank you to everyone for joining us. We appreciate you taking the time and we look forward to talking to you as we progress through Q4. Thanks very much.

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