CRH Medical Corporation

First Quarter 2017 Results Conference Call

Date: **April 27, 2017**

Time: **11:00 AM ET / 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 First Quarter 2017 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 Kettina Cordero, Director, Investor Relations. Please go ahead Ms Cordero.

Kettina Cordero:

Thank you Operator, 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 quarter ended March 31, 2017, 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 Disclosure & Analysis for the quarter ended March 31, 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 and to services related to gastroenterology such as anaesthesia for endoscopic procedures, and the abbreviation ASC to refer to ambulatory surgical centres.

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. Before we get into the details of another strong operational and financial quarter, I would like to address a fund's investor letter that was widely distributed recently. We, like most public companies, normally avoid comment on external reports. The problem with external reports is multi-faceted. They often contain opinion in which reasonable people can differ. They also have incomplete information or misconceptions, or they may be generated for undisclosed motives.

Although it is our practice not to comment on external reports, I would like to take this opportunity to clarify certain points raised in the document. The thesis of the report is that CRH's business risks have not been previously identified. The report identifies three principal themes. One, that anaesthesia reimbursement rates will be reduced by CMS. Two, that our labour rates are understated due to the use of CRNAs and that they will rise substantially when the laws change to disallow the use of CRNAs in the administration of anaesthesia. And three, that our billing practices are non-standard within the industry.

First, with respect to anaesthesia reimbursement rates, like other medical products or services offered in the United States, reimbursement rates can impact our business. With respect to GI anaesthesia, although the Centers for Medicare and Medicaid Services, known as CMS, has stated that it is re-examining the relative values of the primary billing codes used for anaesthesia furnished in conjunction with lower GI procedures, it's important to note that these rates did not change upon their initial review. CMS also stated that it will not propose any future changes to the valuation of these codes until it receives more input from its stakeholders.

The reason for the review of the codes is that there has been an increase in the frequency of anaesthesia services reported during various colonoscopy procedures, which is a direct result of changes in coverage and payment policies of CMS to encourage colonoscopies. Like many healthcare providers, the U.S. federal and state governments want to encourage people to get colonoscopies to improve patient care and save costs through the early detection and treatment of colon cancer.

We believe the re-examination of anaesthesia codes is positive. Standard of care in colonoscopies is changing and the use of deep sedation is part of that change. We expect that the full CMS examination process will result in no change to the reimbursement rates. Part of our expectation is based upon the work of the RUC committee, one of the primary bodies involved in the billing codes review process. This important committee is on record suggesting that the typical patient vignettes, which is the description of the work required before, during and after the procedure used to value the billing codes, are no longer representative of current medical practices for anaesthesia. For this reason, it recommends that the codes are resurveyed based upon updated patient vignettes.

With respect to the administration of anaesthesia by certified registered nurse anaesthetists, also known as CRNAs, the external report written about our company assumes that our labour costs will rise significantly when the federal or state governments amend the laws and mandate that only MD anaesthesiologists can administer anaesthesia. We believe such a move would be highly inconsistent with the federal and state government goals of increasing access for the early diagnosis of colon cancer. CRNAs are highly educated, skilled and licensed professionals. CMS's medical claims processing manual provides for payment to CRNAs under the Physician Fee Schedule. This provision has been in effect since 1989. Going back to a time where only medical doctors could administer anaesthesia would, we believe, not only increase the overall cost of colonoscopy but also reduce access to the current standard of care for colonoscopies.

Finally, with respect to our billing practices, we work very closely with our GI partners to identify key insurance companies to contract with in their local markets. Other insurance companies are managed through the radiology, anaesthesia and pathology benefits, also known as RAP, which are provisions already contained in the individual insurance plans and policies. This is a standard practice in the industry and allowed by most insurance companies.

The provision allows CRH's patients claims to be processed as if they were contracted with the insurance carrier while not requiring third party providers such as CRH to contract with every insurance company at every entity it serves. Such a requirement would significantly increase transaction costs for insurance companies and healthcare providers. This is a standard, appropriate and we believe sustainable practice throughout the U.S. healthcare system. This

standard procedure is widely accepted by insurance companies. There is nothing at all unusual in our billing practices.

Now, let me review our achievements during what was a great first quarter of 2017. We invested $7.4 million to acquire two anaesthesia practices, each with one ASC under contract. We funded these acquisitions through a combination of internally-generated cash and our existing credit facility. Today, we serve 27 ASCs in seven states and our estimated number of annual patient cases has risen to approximately 185,000.

We also announced our first monitored anaesthesia care development program, known as MAC or deep sedation development program, in the state of Washington. This is a novel initiative where we are developing and managing a deep sedation program for a leading GI anaesthesia practice in the greater Seattle area. The MAC program agreement gives CRH the option to acquire a 51% interest in the new anaesthesia practice after at least one year, providing us with an excellent vehicle to develop future acquisition opportunities.

Sales of our O'Regan system continue to meet our growth expectations. We've now trained almost 2,500 GIs in approximately 960 practices, and we expect that to continue.

Our first quarter financial and operating results demonstrate the health of our business is solid and that the fundamentals of our investment proposition are sound. Our goal is to become the pre-eminent provider of GI anaesthesia and since 2014 we have completed 11 transactions and have expanded our network to 27 GI ASCs in seven states.

Through years of development of our O'Regan business, we have built strong relationships with the GI community which we're leveraging in the expansion of our GI anaesthesia business. The two acquisitions we announced in the first quarter of 2017 were with existing O'Regan clients. The anaesthesia partnerships we have built are based on trust that is predicated on our expanding service and product excellence. This is an invaluable advantage that cannot be acquired overnight.

The addition of the MAC development program will allow us to tap into a market of around 400 GI ASCs that currently do not do deep sedation as a standard of care, thereby expanding our entire acquisition pipeline.

The dynamics of the GI anaesthesia market haven't changed and we have a scalable growth strategy focused on consolidating a very fragmented market.

In summary, we have solid relationships with the GI community that are feeding a strong acquisition pipeline, the operational and financial capacity to execute on our growth strategy and a capable management team with the business acumen to achieve our ambitious goals.

With that, I'm going to turn you over to Richard to review our financial results and look forward to the Q&A after Richard speaks.

Richard Bear:

Thank you, Edward. 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. This means that our financial statements include those of the subsidiaries in which we own more than 51% and have controlling interest. This practice is keeping with the most current accounting and auditing standards.

Yesterday, we reported total revenue of $22.5 million, a 63% increase compared to the first quarter of 2016. Total revenues included anaesthesia revenue of $19.8 million, which was an increase of 73% year-over-year. Anaesthesia revenues rose as a result of additional revenues contributed by the three transactions announced in June of 2016 and the two acquisitions completed in February and March of this year. There were no material changes to anaesthesia reimbursement rates during the first quarter of 2017, however there was a change in the payor mix at our GAA business as a result of the usual annual health insurance renewal process. As a result of this change, the average revenue per case at GAA declined 12% compared to Q1 2016, but it was offset by an 8% increase in patient cases.

It is worth noting that the payor mix change at GAA relates to a single insurance provider and we don't expect material changes from this payor after this year.

Total adjusted operating expenses were $11.5 million compared to $7.1 million during the same quarter of 2016. The increase was directly attributable to the growth of our anaesthesia business already discussed.

Total adjusted operating EBITDA for the first quarter of 2017 was $11 million, 63% more than the first quarter of 2016. Total adjusted operating EBITDA attributable to our shareholders was $7.7 million, and total adjusted operating EBITDA for non-controlling interest was $3.3 million. The adjusted operating EBITDA margin for the quarter was 49%.

During the quarter ended March 31, 2017 we generated $3.2 million in free cash flow. We define free cash flow as cash provided by operations less payments made for interest and other expenses, less distributions for non-controlling interest. Free cash flow was impacted by seasonality, similar to our operating margins and income. Free cash flow is usually lowest in Q1 and highest in Q4 of each year.

At March 31, 2017 we had $9.2 million in cash and cash equivalents, and $9.9 million in working capital. In addition, we had $22 million available on our revolving credit facility to fund future growth.

With that, I would ask the Operator to open the call for questions.

Operator:

Certainly. 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 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.

Our first question comes from Richard Close of Canaccord Genuity. Please go ahead.

Richard Close:

Great. Thank you for the questions. Just want to dig into GAA a little bit deeper, Richard, if I can. You had the 12% decline in price here in first quarter 2017 but you also had that in the first quarter 2016, obviously partially offset by better procedure growth or year-over procedure growth, but can you just walk us through the reason for those price changes? Explain to us why this is not maybe an example of contracts being adjusted and just so we can get a better feel there, and then why you're confident that won't happen again.

Richard Bear:

Good question. First I would just kind of—if you don't mind I'll just kind of correct the question because we're not seeing price changes; we're seeing payor mix changes. So let's just assume for simplicity that we only have two payors in GAA, Payor A and Payor B, and last year Payor A and Payor B each equalled 50% of the commercial business. Payor A paid 25%, 30% more than Payor B. In simple words what's happening is Payor A is losing market share to Payor B. We still have the patient volume but that volume is being paid at a rate that's lower than what we were paid in the previous year.

So, taking that to what we're seeing in GAA, there are a large number of payors and we have patients distributed amongst all those. There is difference in how those payors reimburse us. What we've seen happen at GAA is we had a payor that was one of our stronger payors from a reimbursement standpoint who appears to be continuing to lose market share, shifting those patients to payors who are more in the average range which has lowered our revenue per case but the individual revenue, the payment we get from each payor per case has not changed. We believe that 2017 will be the end of these payor mix changes because this payor who was a dominant reimburser in that market has now been reduced to a very minimal player.

Richard Close:

Okay. Thanks for that. With respect to non-controlling interests, that increases percentage in the first quarter, that's obviously bouncing around quite a bit based on the acquisitions that you're completing, but can you give us I guess a little bit more guidance or directionally where you expect non-controlling interest to be, maybe in the second quarter and through the second half of this year?

Richard Bear:

I will first comment more on our base of business that we are managing today and the relationship between operating EBITDA, adjusted operating EBITDA non-controlling interest to total adjusted operating EBITDA was something I would—that relationship we've seen in Q1 is the relationship that I would expect to see going forward this year on the base business.

Keep in mind, just to remind you, that our business model is to partner with GIs in their anaesthesia business, so all of our transactions going forward will be partnerships which will increase, just based on the accounting, that non-controlling interest, and since that non-controlling interest is a smaller number than the interest associated with shareholders you will see that that non-controlling interest is going to grow faster, but again, it's how we value … We only value these businesses based on the income attributable to our shareholders. It's the accounting that drives the non-controlling interest.

Richard Close:
Okay. My final question would be as we think about the second quarter Adjusted EBITDA, I think the Street is looking for a nice sequential increase in Adjusted EBITDA to common. If you could just comment, you know, do you have any—can you sort of give us a range in terms of where you expect Adjusted EBITDA to be in the second quarter?

Richard Bear:
I think if you ran your models and looked at the seasonality, you know, you know that our seasonality in Q1 is low in terms of patients and also low in terms of revenue per case because although our government cases don't vary much quarter-over-quarter, the commercial cases do with the highest percentage of commercial cases coming in the fourth quarter. So as commercial increases quarter-over-quarter so will our revenue per case and which is driven by seasonality. So I think if you run out your models, you come up with your revenue, come up with your EBITDA, expenses are pretty fixed because it's primarily people, and you use the ratio of non-controlling interest to total EBITDA for Q1, you'll get to your Q2 numbers. Sorry for the non-financial people on the call.

Richard Close:
So you're saying use 30.1% in terms of non-controlling interest as the number for second quarter.

Richard Bear:
Assuming—yes, with the base business and then whatever assumptions you've made for strategic planning.

Richard Close:
Okay. Thank you.

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

Lennox Gibbs:
Good morning. Thank you. So your GAA business appears to have been fairly heavily weighted to the payor in question. Are there payors in other state markets to which you have similar revenue exposure? If so, where?

Richard Bear:
No. No, I would say the GAA scenario is a one-time situation.

Lennox Gibbs:
Okay. Then secondly with respect to CRNAs, have you ever experienced pushback from payors regarding your use or your leaning to CRNAs, a pushback either by way of rejected claims or pushback in the context of contract negotiations?

Edward Wright:
Categorically no.

Lennox Gibbs:
Are you aware of any sort of—any recent bump in terms of noise on the policy front with respect to reimbursement of CRNAs on an equal basis to anaesthesiologists?

Edward Wright:
No.

Lennox Gibbs:
Then finally, just with respect to Kissimmee and Decatur, the recent acquisitions, can you tell us what the staffing complement was at those two facilities at the time that you acquired them, and what, if any, changes you've made to the staffing complement or what, if any, changes you intend to make to the staffing complement?

Richard Bear:
Osceola—Kissimmee is what's called the MD supervisory model where the rooms are staffed by CRNAs and those are the MD anaesthesiologists that would be doing pre and post op. That was the model that we acquired. That was the model that is comfortable to the doctors in that ASC. That's how we valued it. That model will continue. At DDAB, a slightly different model where the MD actually participates in the room with the CRNA during procedures. It's actually the only ASC that we serve that has that specific model. It's the model that doctor in that site is comfortable with. It's how we value the business and it's how that business will continue to be staffed.

Lennox Gibbs:
Thanks very much.

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

David Novak:
Good morning. Thanks for taking the questions. A couple from me. I'll try to get through them relatively quick. First off, it looks like within your Q1 payor mix, you're seeing an uptick in commercial versus federal paid, so this makes sense in terms of the increased EBITDA margin attributable to non-controlling interest. However, could you help me understand why, if we're getting more commercial pay, is overall anaesthesia EBITDA margin down both quarter-over-quarter and year-over-year?

Richard Bear:

Okay. Hi David, how are you? So, year-over-year, let's go over that one. Year-over-year it's down primarily as a result of the payor rate, the payor mix change at GAA. If you compare Q1 to Q4, Q4 is always going to be our highest revenue per case because the commercial mix, which I believe if you look at our Q4 reports was closer to 75%, is higher and commercial pays on average three times more than federal, so you're going to see much better margins in Q4 than you'd see in Q1?

David Novak:

Perfect. That's great, thank you. Next, if you look at your payor landscape now, specifically as it relates to some of your larger service providers like GAA or AGAA, what would be typical delta between the payor that reimburses at the highest revenue per case versus the mean?

Richard Bear:

The typical delta, if there's such a thing, the typical delta it could be $100 to $150 per case.

David Novak:

That's the difference between the mean and the top payor?

Richard Bear:

That's the spread between …

David Novak:

Ballpark.

Richard Bear:

Yes.

David Novak:

Okay, great. Then looking specifically at your commercial patient volume, and I know we talked about this in past so you might not be able to answer, but what proportion of the volume would be covered by contracted or in-network payors versus those that are out of network or those that are reimbursing you at a preferred rate through their RAPs provision?

Richard Bear:

Yes. Being reimbursed via RAP doesn't mean you're getting reimbursed at preferred rate. It is really just an administrative designation. If you think about all the entities that we serve and all the insurance companies related to those entities, we would have to prepare like 1,000, contracts which is just not administratively feasible. So, RAP does not necessarily mean we're getting more or getting less; we're getting what the insurance companies pay us, which sometimes is more or sometimes it's less, sometimes equal. We don't feel that that level of disclosure is necessary to understand our financials, so we can't answer that question.

David Novak:

Fair enough. Let me just kind of spin this a different way as well because I know I'll get asked this. Of your total anaesthesia service revenue then, could you kind of guide to what proportion of that would be paid via contracted rates versus non-contracted rates?

Richard Bear:

I will tell you that if you look at our revenue, if you look at the source of our revenue, greater than 90% of our revenue comes directly from insurance companies and the remainder, that smaller percentage coming directly from patients. That's how I'd answer that question.

David Novak:

Okay. Last question, just turning to the cash flow for a moment. Looking at the distribution to the non-controlling interest as a percentage of operating cash flow, we've seen this has grown from about 30% in Q4 to about 50% in Q1, so I think actual free cash flow if you want to call it in this quarter was about $4 million. I don't think this is a result of DDAB or OGAA as the revenues of the non-controlling interest was in line with my estimates personally, so my gut tells me it's likely a result of AGAA continuing to succeed in getting relatively high levels of reimbursement. Can you touch on this a little bit?

Richard Bear:

It's a good question. All things being equal, distributions in Q1 that we report in our statement of changes, relate to activities in Q4 because we pay Q4 in Q1. So if you look at the EBITDA attributable to non-controlling interest in Q4, it was roughly $4.2 million. If you look at the payout that we did in Q1, it's around $4 million. You've got a bit of a timing difference. That's

why in the prepared remarks I referred to how seasonality impacts us because we're seeing that fourth quarter, which is the strongest quarter, income attributable to NCI being distributed in the first quarter.

David Novak:
Okay. So I mean, if AGAA, specifically is a bit of an outlier in terms of average reimbursement per procedure, do you anticipate or do you believe there could be any payor pushback in the future at that specific service provider?

Richard Bear:
No.

David Novak:
Okay. That's it for me. Thanks so much, Richard.

Richard Bear:
Yes.

Edward Wright:
Yes.

Richard Bear:
Thank you, David.

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

Noel Atkinson:
Hi, good morning. Thanks for taking my call. I was wondering if you could talk about the proportion of your anaesthesia revenue that you're getting from Medicare and Medicaid. You break it out in the filings in terms of percentage of patient cases, but could you give us a sense of what it is in terms of percentage of revenue? 2016 is fine, if you have these…?

Richard Bear:

Yes. I mean I would give you some data points. Because that's not something that we have currently disclosed so I can't disclose it on this call, but I think we've commonly said that commercial can be 3 times or more than that of government. Government represents, call it roughly 30% of our business, so that 30% of cases would translate into something around 10% of revenue, if you did the math, if I did my X's and Y's correctly.

Noel Atkinson:

Okay, great. Can you talk a little bit more about the acquisition pipeline activity? It's been pretty quiet across the industry so far in 2017 for acquisitions.

Richard Bear:

Yes. I'll let Edward address that one.

Edward Wright:

Okay. Noel, what I would say there is that when I look on a daily basis where we are with this process, I'm excited for what 2017 holds. I remind everyone that when we hired Jay Kreger as the President of CRH Anesthesia with oversight for our operations and for business development teams, his initial stages were spent more on existing operations, getting to know our customers and building his team. As we're out today educating GI practices about our offering, I believe that 2017 will turn out to be a very good year for CRH.

I remind you again that one of the nice advantageous positions that we're in is that most of these business that we acquire, in fact all but one to date have not been for sale. So, there's an education process that's involved in terms of what we're doing. Obviously, as time goes on word-of-mouth with the doctors and the practices that we've already transacted is very positive. So at this point in time, knowing where we are in the process, you saw it last year in June where it was very lumpy and three of them came together all of a sudden. We would prefer that it didn't happen that way, but at the same time, where we are in discussions and what I see for the year ahead in the pipeline looks very good.

Noel Atkinson:

Okay, great. Just a couple more quick ones. You talk about the 8% growth year-over-year at GAA per patient volumes. Can you talk a little bit about the patient volume trends that you're seeing across the rest of your portfolio?

Richard Bear:
They would be consistent to what we've discussed previously in that expectation based on historical of around 3% to 5%.

Noel Atkinson:
Okay, great. Then finally, did you see any daily rate increases for the contracts for your CRNA's or MD anaesthesiologists at the start of 2017 that would be more than normal?

Richard Bear:
We did not.

Noel Atkinson:
Okay. Okay, great. Thanks very much.

Richard Bear:
You're welcome.

Operator:
The next question is from David Martin of Bloom Burton. Please go ahead.

David Martin:
Good morning. I'm wondering, the payor that lost market share in GAA, is this the same one that lost market share last year and caused the same dip in the revenue per procedure and they just took another step down in market share, or was this is the different one?

Richard Bear:
It would be the same payor, David.

David Martin:

Okay. So before this happened, what percent of total revenues for your anaesthesia services businesses did they represent? Then what's the next largest payor in your network as a percentage of revenues?

Richard Bear:
I appreciate the question, David, but you know we don't get down to that level of detail. They represent a much smaller percentage than they did two years ago, I'll answer it that way.

David Martin:
Is the next largest payor anywhere near closer to their size or much smaller?

Richard Bear:
From a revenue contribution standpoint, there is no dominant player in that market anymore.

David Martin:
Okay. The GAA procedure increase of 8%, is that sustainable? Will it generally be higher than the 3% to 5% across the rest of the network, or should it come in line with the 3% to 5%?

Richard Bear:
We would suggest that using a smaller percentage growth rate going forward would probably be more reasonable and more sustainable.

David Martin:
Okay. Then Puget Sound, have you finished developing the anaesthesia program there now and are you managing it? Have you made that transition? What kind of we revenue should we expect from the relationship as you go from developing to managing the business to potential 51% ownership?

Richard Bear:
Yes, so I would just remind everybody, Puget Sound Gastro was our first MAC development program whereby we are assisting Puget Sound Gastro in converting from a conscious sedation standard of care to a deep sedation standard of care. Puget Sound Gastro has four ambulatory surgical centres in the greater Seattle area. Our agreement is that we will help them develop

the business, then we'll help them manage the business. In return, we receive the option to purchase 51% of that business a year later.

The development fees and the management fees are just not material enough to discuss. We're not in it for the development and management fees. We're in it for the opportunity to acquire 51%. Our operations there—they have four centres. Our operations began at the first centre in April, this month. They're going very well and every 45 days to 60 days we will be adding additional centres up to the max of four and would expect a transaction in and around May of 2018.

David Martin:
Will they convert everything to deep sedation, or will the patients be given a choice?

Richard Bear:
The standard of care for anaesthesia is driven by the doctor and the ASC. So all the ASCs that we serve today, they either do deep sedation—I mean they all do deep sedations. Obviously, there are very small percentages that may not tolerate deep sedation, but it's less than 1%. So when we talked about converting the sites, it's converting all their sites and all their patients.

David Martin:
Okay. So again, during this period of building up to the four centres and potentially buying the 51%, we shouldn't expect material revenues, although there will be a bit.

Richard Bear:
Exactly.

David Martin:
Okay. Then the last question I have is, on Medicare and Medicaid patients, do you profit on those patients? Like as far as looking at the exposure to the reimbursement possibly coming down, is there an argument that those patients aren't profitable already?

Richard Bear:

Yes. Medicaid we won't even talk about because no one makes money off of Medicaid. That's one of the challenges with our healthcare system. In terms of Medicare, when I look at our data and I consider ourselves fairly productive compared to most because we're single specialty focused on providing anaesthesia services to highly productive ASCs doing 8 to 10 cases per day per CRNA. When I look at our cost and I look at our revenue, it's at best a couple of percentage points profitable. In some cases, in more rural areas it may not be profitable. So, that's one of the things that gives us comfort that this won't change because you won't have accessibility to these services which will impact the number of people getting colonoscopies which is completely counter to the direction of CMS, Medicaid and all the commercial providers.

David Martin:
Got it. Thank you.

Richard Bear:
You're welcome.

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

Alan Ridgeway:
Hi. Good morning, guys. Most of my questions have been asked already but I did want to just circle back on the GAA volumes. So, they're up 8% in Q1, and then you guys have already answered a question about the sustainability. I just want to understand a little bit how they did—why they were up so much and why it may not be as sustainable going forward. Did these guys doctors expand their facilities at all during 2016, which ended up with maybe higher volumes in the back half of last year on a comparable basis that we won't see repeatable?

Richard Bear:
The group that we serve in with GAA is a very sophisticated, large practice in Atlanta that is constantly adding doctors and, as needed, adding facilities. There's always plans on the board for as they grow. They're a very business-minded organization and they will continue to grow, maybe not at these levels but we would see continued growth because they will continue to expand.

Alan Ridgeway:

That's interesting. As they expand facilities, do you guys automatically get those contracts, or are they up for potential competition, I guess, or is it just sort of like an auto renew or an auto add on to your deal?

Richard Bear:

Not yet. To date they've just been added onto our existing agreements.

Alan Ridgeway:

Okay. On Puget Sound, how much volume would those four centres do?

Richard Bear:

You know, we haven't disclosed the volume but I think that if you took the 27 centres we had today, divided—took our case counts divided by the 27 centres and multiply it by four for the four centres of PSG, you'd probably be pretty close.

Alan Ridgeway:

Okay, so sort of average versus what you guys already have?

Richard Bear:

Yes.

Alan Ridgeway:

Just to clarify, during the year while you're administrating, is it the doctors that are making the reimbursement then?

Richard Bear:

Yes. So the practice owns the entity that was created, Lake Washington Anaesthesia. They benefit from that and then our option is to acquire 51% of Lake Washington Anaesthesia, and it's our option. All the documents related to that option and all the purchase agreements, all the supporting documents were negotiated on the front end, not on the back end.

Alan Ridgeway:

So, basically the price is set based on a certain amount of …?

Richard Bear:

The multiple is set, yes.

Alan Ridgeway:

Okay, and its flowing through your billing group, or the billing group you guys use?

Richard Bear:

Yes.

Alan Ridgeway:

Okay. All right. That's all for me. Thanks, guys.

Richard Bear:

Thanks.

Operator:

The next question is from Prakash Gowd of CIBC. Please go ahead.

Prakash Gowd:

Thanks, and good morning everyone. Most of the questions have been asked; I just have a couple of small ones. First on the acquisition front, you've previously talked about expectations of allocating equivalent capital to acquisitions this year as you did last year. Is that still valid this year? Any comments on that?

Edward Wright:

Yes, exactly Prakash. We feel very strongly that that is still something that we're going to do,

Richard Bear:

Yes.

Prakash Gowd:

Okay. Then lastly, Exact Sciences reported some strong numbers and they seem very bullish on Cologuard going forward this year. We still see a lot of confusion with investors about that product and where it fits in terms of the diagnostic and treatment paradigm for colorectal cancer. Clearly, you're on the ground discussing with GIs on a daily basis and in those discussions I'm just wondering if you can maybe highlight what the specialists think about the product and the basically where they might position it vis-a-vis colonoscopy.

Richard Bear:

They see it as increase to access to colonoscopy. I'll take you back to a prior life of ID Biomedical; we were developing a nasal flu vaccine. All of our models, we were never going to taking away from the injectable market because there are people that just were freaked by a needle and nasal flu vaccine expanded the market. This is a very similar situation where you've got capsule endoscopy and Cologuard that expand the market. There are some people that, believe it or not, don't want a device inserted into their body and so they want to go to an alternative method.

Good news actually, for us, because a capsule or Cologuard cannot clip a polyp, and in a lot of cases a colonoscopy results in the clipping of a polyp and the biopsying of that polyp. So if more people are getting tested, either via capsule endoscopy or Cologuard, it's positive because if they have a positive result they have to come in for a colonoscopy.

Prakash Gowd:

That's great. Thanks for clarifying.

Richard Bear:

Yes.

Operator:

The next question is from Endri Leno of National Bank. Please go ahead.

Endri Leno:

Good morning, guys. Thanks for taking my questions. First one, it's on the distribution to non-controlling interest on the cash flow statement. Does it include any earnouts or is it purely distributions?

Richard Bear:

Purely distributions. Earnout would be—you'd see earnout handled a different way on the cash flow. We have two earnout obligations: one being with AGAA Austin Gastro, and one being with GAA. There would be a scheduled $800,000 payment in June of this year related to AGAA and then the earnout related to GAA we expect to be paid out during the fourth quarter of 2018.

Endri Leno:

Great. Thank you. The other question that I have, ' primarily relating cost in the individual segments. The cost per case for anaesthesia was the highest in the last five quarters. I was wondering if that is related at all—I mean is it seasonal or is it related at all to employee costs which were also significantly higher in Q1 versus—I mean for as long as this has been in your company?

Richard Bear:

Just a clarification: are you looking at adjusted operating expenses or total operating expenses?

Endri Leno:

I am looking at adjusted, so it's anaesthesia service is the cost. I'm just stripping out depreciation out of there and dividing it.

Richard Bear:

The cost per case, if you think about going back to the seasonality comments before, we have the lowest level of anaesthesia cases in Q1 and the highest level in the case in Q4. We service 27 ambulatory surgical centres, each averaging, call it three rooms. Each of those rooms has to be staffed each day. We have the highest productivity of CRNAs in Q4, the lowest productivity in Q1 just by nature of the patient cases. Our people costs are relatively fixed. We can't tell people—the model is to pay people. If they're salaried, the get paid a salary; if their contracted, they get paid a per day rate. That's just how the industry works. So, if they're only working six hours in a day versus nine, they still get paid the same. So those employee costs remain

steady. If you look at our anaesthesia costs between Q4 and Q1, Q4 the anaesthesia cost is 9.5 and Q1 they're 9.5. So as cases increase, those costs don't increase, and you'll see that improve.

Endri Leno:

Great. Thank you. The other questions I have, on the flipside the product costs and support for the product segment was lower than—I mean we have seen since you had the product. Does that indicate sort of any change in strategy and to focus less o to that statement, or is it just a one quarter kind of thing?

Richard Bear:

Product cost in Q1 was $1 million and its right around $1 million every quarter. I mean sometimes in varies depending on the conferences that we're attending and the size of those conferences, but the group that we have servicing that business has remained fairly statistic for the last six, eight quarters. Although we continue look for ways to invest in that business to increase adoption and to get more doctors trained, the costs are not going to grow substantially.

Endri Leno:

Okay, great. That's all questions I had. Thank you.

Richard Bear:

Great. Thank you.

Operator:

The next question is from Richard Close of Canaccord Genuity. Please go ahead.
Pardon me. The next question is from Doug Miehm of RBC Capital Markets. Please go ahead.

Doug Miehm:

Thank you. Just a couple of housekeeping notes, Richard. Medical supplies year-over-year were basically flat even though we had a dramatic increase in the number of procedures that were done. Why is that?

Richard Bear:

Because in the early days, in our early agreements we paid some of the medical supply cost. In all of our later agreements we've basically—it's not natural for us to buy the supplies because we don't control the ASC, so in later agreements we put that responsibility into where it should be, which is the ASC. So, we don't have that expense in all of our later agreements.

Doug Miehm:

Perfect. Then as we look at, let's say I guess we'd call it same-store sales or organic growth or those sorts of things, it was hard to tease out exactly what that number was this quarter. But I guess in the language of the quarter, you indicated that all the growth was associated with acquisitions year-over-year. So, if we take into account the sort of losses in revenue that we saw associated with GAA, what would be the growth of the rest of the business? Would it be in line with the 3% to 5%?

Richard Bear:

Yes, it would be. I guess that's drafting. When we look at quarter-over-quarter, the primary driver to our increase in revenue is going to be the acquisitions that we did post March 31, 2016 that wouldn't be in that comparable quarter.

Doug Miehm:

Okay, fine. Then I guess the final question is just with respect to margins. It looks like, no surprise, over time GAA has lost margins from around 60% to—I don't know—something perhaps in the range of 45% to 50%. Today, outside of GAA it looks like on average the rest of the business is doing probably 55% or even better. What gives you the confidence that you're going to be able to maintain the margins in that other part of the business outside of GAA?

Richard Bear:

Margin is driven by two functions. Margin is driven by, one, the reimbursement rates that we're receiving from each payor, and again, we haven't seen any material changes in those rates. Two, the payor mix. If you look at our MD&A Page 9, it has a table that shows the payor mix and it compares the payor mix in March 31, 2016, of those properties that we owned at that point, to March 31, 2017. It shows basically the difference between those two would be the 2016 acquisitions, and you can see that Commercial and Other is 6.5 to 7 points higher, and the

higher the Commercial, the higher the revenue. Costs are not any different, so therefore, higher the margins.

Doug Miehm:

Okay. So I guess over time you're still very confident you're going to be able to maintain those sort of …?

Richard Bear:

In those, yes. Every acquisition is different. I mean the profile of the 2017 acquisitions could be 60% Commercial, 40% Federal; we value it based on that weight. As we sit here—if that's the case, we're going to sit here a year from now and you're going to be saying, "Why has it gone down?" and my answer is going to be the same because of just nature of the acquisitions that we're adding on. Each one is individually assessed and valued, and each one is going to have a different profile.

Doug Miehm:

Perfect. Thank you.

Richard Bear:

You're welcome.

Operator:

The final question is from Richard Close of Canaccord Genuity. Please go ahead.

Richard Close:

Great, thanks. Just curious, Edward, if you could comment or elaborate on your comment earlier on the RUC committee and the vignettes you were talking about previously are no longer relevant, relevant to current procedures. How do those get changed, do you know? Will that be looked at going forward? Just any insight there.

Richard Bear:

Yes, I've done some research on this, Richard; if you don't mind, I'll answer that one.

Richard Close:

That's fine.

Richard Bear:

Those vignettes, as they're defined, the RUC would be looking at the American Society of Anesthesiologists, the RUC will talk to the ASA to update those vignettes, and then the RUC will use those updated vignettes to make recommendations to CMS.

Richard Close:

Okay. But you don't know whether that's occurring now or not?

Richard Bear:

It's not. It hasn't. To the best of our knowledge there has been no work done on those updated vignettes.

Richard Close:

Okay. Then if you just could help us out. I know in Canada, obviously, deep sedation is not necessarily a practice that's employed up there. It's clearly growing in the U.S. Can you just talk a little bit why it's been adopted or it continues to be adopted in the U.S.? Obviously you're playing off this increased adoption with your MAC program or de novo program. Just talk a little bit how those conversations go with GIs that you're looking at in terms of developing this program. Just maybe the difference in terms of perception between the Canadian healthcare market and the U.S. healthcare market.

Richard Bear:

Okay. First off, one is for-profit and one is not, so that's always going to be the biggest—that's going to be a difference in the markets. We're not driving the change in the standard of care and the adoption of deep sedation. That's really being driven by the two factors: one, the GIs. Remember the GIs create demand, we serve demand. GIs want to be on the cutting edge of providing the best care to their patients. They see that anaesthesia-assisted endoscopy or deep sedation is that best care, so they decide to bring that into their ASC, and then they decide how to do that and hopefully they decide to do that with us. This is also driven by—you know, going back to the CMS issue, CMS back in 2015 eliminated the co-pay for deep sedation as it

relates to colonoscopies. This frequency change is a result of them wanting to increase access to colonoscopies because, again, colonoscopies is still the gold standard to detect and prevent colorectal cancer, and it drives cost out of the future system.

We're not driving these changes, we're facilitating these changes. So when we're talking to GI practices that are currently not doing deep sedation, they want to know how to do it. They don't really have an idea. They want to do it right and then they want a partner no different than they partnered with their ASC's with Amsurg and HCA and others.

Richard Close:
Okay. Thank you.

Operator:
This concludes the question-and-answer session. I'll now turn the call back over to Edward Wright for closing remarks.

Edward Wright:
Yes. Just again, thank you for joining us and we look forward to continuing to update you. Thanks very much.

Operator:
Ladies and gentlemen, this concludes today's conference call. You may disconnect your line. Thank you for participating and have a pleasant day.