# CRH Medical Corporation

# Second Quarter 2019 Results

# Conference Call Transcript

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**Time:** 9:00 AM ET

**Speakers:**

**Dr. Tushar Ramani**
Chief Executive Officer and Director

**Richard Bear**
Chief Financial Officer

**Jay Kreger**
President, CRH Anesthesia

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**Operator:**
Welcome to the CRH Medical Second Quarter 2019 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. 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 Richard Bear, Chief Financial Officer. Please go ahead.

**Richard Bear:**
Thank you, Operator, and good morning, everyone. I am joined today by our CEO, Dr. Tushar Ramani, and the President of CRH Anesthesia, Jay Kreger.

Before we start, I would like to remind everyone that certain statements you will hear today constitute forward-looking statements within the meaning of the applicable security laws. For important assumptions, definitions and cautionary statements about forward-looking information, and the risks inherent to our business, please refer to the cautionary notes in our 10-Q for the three and six months ended June 30, 2019.

During this call, we will discuss non-GAAP financial measures as indicators of our performance. You can refer to our Management's Discussion & Analysis for the three and six months ended June 30, 2019 for reconciliations of non-GAAP measures to reported GAAP measures. These documents are available on SEDAR, EDGAR, and the Investor section of our website.

In addition, please note that we use the abbreviation GI to refer to gastroenterologist.

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

With that, I will now leave you with our CEO, Dr. Tushar Ramani.

**Dr. Tushar Ramani:**

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Thank you, Richard. Thank you, also, to everyone on this morning's call for your interest in CRH. I would like to start with just a quick recap of my time here so far, a little over 90 days now. I've taken time to assess our current operations and understand our opportunities. I've met with our O'Regan and our Anesthesia Team. I've had important discussions with several of our GI partners across the country, and I've attended the International DDW Conference where II interacted live with the GI community, including current and prospective CRH customers. Additionally, I've had the opportunity to meet or speak with many of our key shareholders as well. All my work thus far confirms for me that CRH enjoys a great reputation and customer satisfaction in both our current business lines, that there are worthy growth opportunities and leveraging the work done thus far in both of them, and that our positioning in the GI community has set us up well to add to the ways that we serve our GI partners and customers in the future.

Much of this time was also spent strategizing with the leadership here on identifying and developing three material growth opportunities. We think that one of these is already in-house; namely, the CRH O'Regan system for rubber band ligation of hemorrhoids. As I mentioned on this call last quarter, the treatment of hemorrhoids is starting to get significant attention as an important, but neglected and undertreated, medical condition. As the leader of the most effective treatment, the time is right for us to be making a significant and renewed effort to educate the medical and patient communities that hemorrhoids are imminently treatable and that gastroenterologists should be the ones to do it, and that the O'Regan system is the safest, fasted, easiest way for them to do so. We think the ultimate opportunity here could be an order of magnitude greater than what we've created so far.

The second line is anesthesia for endoscopies, which is our largest segment, and one where the GI community already recognizes CRH as the far-and-away market leader in terms of clinical and business management. We've demonstrated continued success at this and we see a long runway of M&A opportunities. We've also got some plans here that will help us expand our opportunities that help us engage with a wider group of GI practices.

Then, we see a third segment forming, where CRH will be able to, in a similar way to our anesthesia offering, bring or optimize certain ancillary lines of patient care to the GI community. This is still in the conceptual stage, but my earlier conversations lead us to believe that there could be a receptive market out there for a company with a strong expertise in managing the clinical and business aspects of certain patient care offerings that many GI practices can't or won't fully invest in themselves.

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Now, regarding our 2019 second quarter results, we're pleased overall with the substantial year-over-year gains for total revenues, coupled with the adjusted shareholder EBITDA of $9.7 million. We're proud of these results, in that the continued double-digit level of growth, quarter after quarter, continues to substantiate our business model. While we're not satisfied that we've optimized the opportunities that come from our market leadership in the GI support space, as I suggested above, CRH will now be actively working to find new strategies which will help further accelerate our growth and continue to drive shareholder value.

I will now hand it off first to Jay, and then to Richard to review the second quarter in more detail.

**Jay Kreger:**

Thank you, Tushar. Our anesthesia revenue grew to $28 million for the second quarter, and to $55.7 million year to date, representing increases of 14% and 17%, respectively, over 2018. Our growth continues to be driven by our acquisition strategy, which included one transaction in the quarter. In this transaction, we expanded our footprint in Georgia, acquiring 55% of a group running two locations. In the first two quarters, we've now completed three transactions, not including the subsequent Florida acquisition that was completed and announced in July. Including that transaction, CRH has now spent $11.4 million on acquisitions year to date, which still does not include our MAC development program in North Carolina, which we expect to transact in the fourth quarter. We still expect to hit our previously stated spend target of $35 million. While the timing of our transactions is behind pace, our funnel continues to widen and we have line of sight to meeting our goal. In fact, we have more groups at a meaningful deal stage than we've ever had and, therefore, remain optimistic about this year, as well as any future runway.

We are now proudly serving 52 ambulatory surgery centres, and 333,000 patients each year. This national footprint and scale has coincided with the ongoing development of our operations T\team, as we systematize our organization. This starts with recruiting and attracting only the best anesthesia providers, which results in one of our other differentiators, our quality of service and outcomes. Our documentation practices and subsequent reporting ensures that we are not only maximizing our reimbursement, but that we also have insight into the outcomes that we are delivering around the country. Our vast footprint further allows us to benchmark within our organization, as well as against any national standards.

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Finally, the recognition we're gaining as a provider of choice in GI anesthesia will ultimately be the catalyst for our future growth, both for anesthesia, as well as with our O'Regan customers, which do overlap.

I'll now turn it back to Richard for his commentary.

**Richard Bear:**
Thank you, Jay. I'd like to start by reminding everyone that beginning December 31, 2018, and on a retrospective basis, our financial reports are prepared in accordance with U.S. GAAP. We also report consolidated financial statements, which means that our financial statements include those of the subsidiaries in which we hold a controlling interest, such as anesthesia practices that we own or in which we hold a majority interest. This practice is in keeping with our current accounting standards.

During the second quarter of 2019, we reported total revenue of $30.5 million, a 12% increase, compared to the second quarter of 2018. Anesthesia revenue for the quarter grew nearly 14% year-over-year to $28 million. During the second quarter of 2019, we provided serviced 84,656 patient cases, which is a 27% increase over the same period in 2018.

Sales of the O'Regan system during the second quarter were $2.5 million, compared to $2.7 million for the same period in 2018.

Total adjusted operating EBITDA for the quarter was $13.3 million. Total adjusted operating EBITDA margin for the quarter was 44%. Adjusted operating EBITDA attributable to shareholders was $9.7 million for the three months ended June 30, 2019.

For the three months ended June 30, 2019, net cash flow from operating activities was $9.6 million, and free cash flow, defined as net cash flow from operations less distributions to non-controlling interest, was $5.4 million. Free cash flow for the six months ended June 30, 2019 was $13.8 million. As of June 30, 2019, we had $2.6 million in cash, $14 million in working capital and $33 million available on our credit facility. Our acquisitions continue to be financed through these internally generated cash flows, along with the $100 million credit facility, which currently has an interest rate of LIBOR plus 225 basis points.

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I will now turn it back to Tushar for his closing comments and questions.

**Dr. Tushar Ramani:**
Thanks, Richard. I would just like to thank our hard-working team here at CRH for another good quarter, and I want to reiterate that we remain very optimistic about our future for CRH.

With that, we'll open it up for questions.

**Operator:**
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 speakerphone, please pick up your handset before pressing any keys. If you wish to withdraw your question, please press star, then two.

Our first question comes from Tania Gonsalves with Cormark Securities. Please go ahead.

**Tania Gonsalves:**
Good morning, gentlemen. Just a couple questions from me. It was a pretty good quarter, it seems like. Just on the M&A front you touched on the fact that your pipeline is still looking good, you've reiterated the $35 million of deployment, which is great. Is there any reasoning why the first half of the year was as slow as it was? I know the summer tends to be the busiest in terms of acquisition activity, and we've only got two months left, so what makes you so sure that you are going to hit that $35 million deployment forecast?

**Jay Kreger:**
Hi, Tania. Thanks for the question. I think you touched on it. Historically, the second and third quarters are always the busiest of the year, and not only closing deals but also getting deals set up to close. I think, as I mentioned, we've got a line of sight of what we expect to close here either near the end of this quarter, third, or early in the fourth.

**Tania Gonsalves:**

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Okay, perfect. Then, secondly, there's been a big push to introduce legislation that would end surprise billing in the U.S. What, if any, impact will this new legislation have on your anesthesia business?

**Dr. Tushar Ramani:**
Tania, it's Tushar, I'll take that, and thanks for that question. The surprise billing, you know, it's a little bit murky, right, and really ultimately it depends on where any successful legislation ends up setting the reference level payment for these non-contracted services. We saw that there was a Senate proposal, that was clearly too low and that didn't get advanced. I've seen some provider proposed levels that I think better reflect the cost of us providing services. We know that the House is looking at something that's arbitration-based for these reference payment levels, but then the White House has already stated that they were opposed to an arbitration-based solution. I don't know that there's a real consensus there, and so there's  a lot that remains to be seen and what ultimately happens.

I guess, regardless, if it's passed in some form, we think that there's going to be an increase in the level of work and the costs that CRH and others have to incur to get our claims paid, or repaid, I guess, at acceptable levels for these non-contracted charges. There's just going to be rounds of effort to do that. But, we think that at our size that we can withstand those costs, and now, at our scale, our breadth and volume, we believe has an economic benefit in payer contracting. So, now we're going to actively look at ways that we can engage with payers to access upper tier contract rates for our services that are more commensurate, I think, with an organization of our current size and quality now. The benefit of this should be that we'll reduce our non-contracted exposure, our out-of-network exposure without impact to profitability, and also without an impact to our ability to attract quality providers.

If you think about that, a lot of the smaller GI practices that are not affiliated with us, they're going to see substantial reductions in their anesthesia payments for these non-contracted cases, and they will not have, I think, the experience, the size, or the market influence to get the kind of rates that we'll be able to achieve here. So, maybe one interesting by-product of all this, especially given our current drive to get more contracted, is that these affected GI practices may be even more willing to transact with CRH as they see their own anesthesia revenues decline.

Long answer, but I think the summary to your question is that there will be some impact, but we'll be able to change ways that we do our business and, ultimately, with a maybe more favourable result, and at the end, it may ultimately end up improving our anesthesia business opportunities.

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**Tania Gonsalves:**

All right, excellent, I appreciate that. Then, finally, you mentioned—you touched on some ancillary lines of business that you could move into as your third growth strategy. Are you able at this time to provide any more colour into possible examples of these ancillary services?

**Dr. Tushar Ramani:**

Yes, I just thought about that as I was getting prepared for this conference call, and I think that, in the interest of just market competitiveness, as well as trying to avoid maybe incorrect investor speculation, it's probably best that we wait until we're further along on some of these.

**Tania Gonsalves:**

Okay, that's fair. That's all for me. Thank you so much.

**Operator:**

The next question comes from Lennox Gibbs with TD Securities. Please go ahead.

**Lennox Gibbs:**

Good morning, thank you. I'm hoping that you can share your latest intelligence on the colonoscopy market; specifically, the latest data with respect to growth rates in the number of colonoscopy procedures, and also the kind of momentum that you're seeing with respect to MAC penetration, whether or not you're continuing to see growing MAC penetration into those colonoscopy procedures, is the first question.

**Jay Kreger:**

Hey, Lennox, it's Jay. Thanks for the question. With regards to the second part of that, there's still no new data, as far as from a national scale, of where the standard of care is in adopting MAC. However, we are still seeing regional pockets, and I think we've touched on this before, but regional pockets that are increasingly using propofol, and picking it up more so. We're talking about the West Coast, of course. We continue to see anecdotal evidence of at least nominal increases, while we don't have any national data to prove that out, but, like I said, anecdotally, everything looks positive.

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As far as the volume of colonoscopies, every single physician—and again this is anecdotal, but every physician I speak to on a daily basis is looking to recruit new doctors. There's actually a shortage of doctors, or seems to be, to treat the patient load that is out there, which tells me that colonoscopies are not shrinking, and while the—you may recall, we talked about it last quarter—the American Cancer Society put a new guidance out that 45 was maybe with a new age for starting colonoscopies, that hasn't been adopted by the other associations, but I think the awareness that it brings does enlighten people that a colonoscopy is something that they should be doing at some point by age 50, at least.

**Lennox Gibbs:**
Okay. Is there any reason to believe that the growth rate in the number of colonoscopy procedures is any different from the sort of high single-digit, low double-digit that I had last seen reported around two, three years ago?

**Jay Kreger:**
None that I have seen.

**Lennox Gibbs:**
Okay. How does your own organic growth in procedural volume compare to market growth?

**Richard Bear:**
Our organic growth rate, we've always guided that it's around 1% to 3%. I'd say that we're on the—so far in 2019, that we're on the upper end of that, and we see that's fairly consistent with what we're seeing in GI endoscopic ASC's, from the due diligence work that we do. How that compares to other ASC's, I wouldn't be able comment on.

**Dr. Tushar Ramani:**
Lennox, I think we're diversified enough now throughout the country and throughout multiple sizes and types of practices that we pretty much experience the same tailwinds that the GI industry experience.

**Lennox Gibbs:**
But, it doesn't seem to—I mean, we're talking low single-digits versus high single-digits as the reported numbers for the number of—in terms of procedural volume growth. It doesn't look like a match. Just help me understand that.

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**Jay Kreger:**

High single-digit growth in colonoscopies versus lower single-digit growth in cases, is that the question?

**Lennox Gibbs:**

That's the question. Are you keeping up to overall market growth?

**Jay Kreger:**

Lennox, keep in mind we're working within a practice. For instance, if a practice has ten physicians, those physicians will maintain a patient roster that they're seeing every five years, or what have you. They're going to grow through new patients only based on their capacity. An existing practice will only grow as they add doctors, and as I mentioned they're trying to recruit doctors to meet that demand. I think what you've got is the higher digits are coming in by way of either new practices or practices that are growing at a higher rate. While our overall average may be 3%, for instance, we've got groups that are growing faster than others because they're recruiting doctors. That's what's feeding the higher numbers that you're seeing.

**Lennox Gibbs:**

Right. So, therefore, it's possible, then, that, overall, the ASC's that you serve are not necessarily matching overall market growth in terms of colonoscopy procedures. Is that a fair comment?

**Jay Kreger:**

I don't agree with that, actually, because I think the growth is coming from new practices as opposed to organic growth within an existing practice.

**Richard Bear:**

I think said another way, Lennox, as Jay stated, many of our practices are recruiting new doctors, so we have the opportunity to continue to grow and hopefully increase that organic growth percentage that we've seen historically.

**Lennox Gibbs:**

Okay, I'll move on. Just with respect to the ancillary services that you referenced in the introductory remarks, I noted that you don't want to disclose what they are at this time, but can you give us a sense

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as to the timeline in which you could see actually launching into some of these ancillary services, and perhaps give us a sense, as well, as to whether or not this is a new therapeutic area that you might be referencing or if—or remind me if you said it was in the context of GI.

**Dr. Tushar Ramani:**

Lennox, it's Tushar. It will be in the context of GI. It's unlikely to be something new. We think that maybe the most optimal way to do this will be to take something that's a tried-and-true service or offering for patients that's currently out there but maybe it's not being done to the level that GI's could or should do it, and we'll help them do it better, much like we did with anesthesia. As far as specifics or timeline, though, I think that we're not prepared to do that yet.

**Lennox Gibbs:**

Okay, all right. Thank you very much.

**Operator:**

Our next question comes from Noel Atkinson with Clarus Securities. Please go ahead.

**Noel Atkinson:**

Hi, good morning, and thanks for taking my call. On the first thing, I was wondering if you could talk about the 2020 proposal for the Medicare Physician Fee Schedule, and sort of any positive/negative impact you see on CRH. Specifically, they talk about CRNA's now being able to do some assessments on patients that previously physicians were able to do only.

**Dr. Tushar Ramani:**

Just our quick run through—it just came out—we didn't see anything in there that impacted our services. Rates are stable, as we expect them to be from now on in terms of the CMS rates. They did several years of study and adjustment in the last few years, so we think that this is a settled issue.

With regards to the CRNA and assessments, it will not change our practice or our overall economics in any way. It might improve some of the efficiency on the ground, but I don't think that's a material change for us.

**Noel Atkinson:**

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Okay, great. Can you also remind us about sort of Q3, Q4 seasonality and whether you expect it to be any different this year versus prior years?

**Richard Bear:**
Yes, I'll take that question. We haven't seen anything in Q1 or Q2 that suggests that seasonality, both in terms of volume of patients and payer mix, will be any different in Q3 and Q4 than it has been in previous years.

**Noel Atkinson:**
Okay, great. In terms of sort of in that work or non-contracted discussion, just following up on a prior question, have you seen historical precedence in either your business area or sort of a similar practice area in U.S. medicine where there would be opportunity to move to higher tier payments and to be able to sort of offset this as you go in network?

**Dr. Tushar Ramani:**
Historical precedence?

**Noel Atkinson:**
Like, have you seen it with any other business lines in the U.S. where folks that, as they gain scale, were able to go to higher tier payments, and then as they shifted to a network, that they were able to offset any associated price decline?

**Dr. Tushar Ramani:**
Oh, absolutely. That's one of the benefits of scale at the healthcare organization, is that you have a different level of discussion with payers. If I'm an independent, small, single practice negotiating with a payer, I don't have the leverage or the experience to demonstrate the quality of care that we provide and the systems that we have to back up that quality of care, which allows me to ask for a higher rate. I mean, that's sort of a tried-and-true model.

**Noel Atkinson:**
That's something that you folks achieved, for example, at Team Health in the past?

**Dr. Tushar Ramani:**

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Exactly.

**Noel Atkinson:**

Okay, perfect. Also, the credit facility was extended from June 2020 to August 2020. Was there any reason for that and were any other terms changed?

**Richard Bear:**

No other terms were changed. It was really extension out of convenience, so we wouldn't have to classify it as current in this quarter's financials. We'll be working over the next couple of months, prior to the Q3 financial release, to secure a new and improved, more competitive credit facility.

**Noel Atkinson:**

Okay, great.

**Richard Bear:**

I'm not speaking of what we hope to accomplish, the process is pretty far along, and we expect to decide on a bank by the end of this month.

**Noel Atkinson:**

Okay. Then, finally, as we were talking about these sort of non-contracted payments and that sort of thing, can you talk at all about the percentage change in commercial cases that are in that work now, as of Q2 this year versus the prior year period?

**Richard Bear:**

Yes, As you know, we do not disclose the percentage of in contract versus out of contract. I think the comment Tushar made to an earlier question, is really the important piece that we believe now, with our scale and with the expertise that Tushar brings to the organization, that we have the ability to accelerate that transition without any impact on our revenue per case.

**Noel Atkinson:**

Okay, great. Thanks very much for taking my call.

**Operator:**

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Our next question comes from Richard Close with Canaccord Genuity. Please go ahead.

**Richard Close:**
Yes, thanks. Just to follow up on getting scale and negotiating better rates for yourself, as I think about you guys, you know, your practices are not concentrated necessarily in one area, although you do have some spots, like Atlanta, where you have some size there. Are you really able to negotiate rates on a national level, do you have the scale? Just thoughts in and around that that you can provide.

**Dr. Tushar Ramani:**
Some of our early conversations here, I think give us confidence that we'll be able to do that. There are not just four payers, there are many, many smaller payers that are regional, and those cases certainly will be able to bring a level of sophistication to the contracting process that's better than individual practices. For the larger national payers, four or five of them, we think that we're now—maybe we weren't a year or two ago, but we're now at a point where we can have those conversations.

**Richard Close:**
Okay, that's helpful, thanks. Then, Jay, maybe on the acquisition pipeline, can you go into maybe a little bit more detail with respect to do you see new states in there, are these trending towards more 100% ownership or, you know, co-ownership models, thoughts maybe around the details on the acquisition opportunities that you're seeing?

**Jay Kreger:**
Yes, thanks Richard. I think, as far as the states that we go to, there will be definitely be new states that we enter into, and I think that's really just more of a matter of us being out there and people knowing who we are, and reaching more people. As I was mentioning, our line of sight—the way we give status to our pipeline, we've got people at different stages with different models, both 100%, as well as joint ventures. The two that we announced most recently, of course, were joint ventures, whereas last year I think three of the five were 100%. I see that remaining. It will be a mix based on the goals that our physician partners are trying to achieve, where they are within their practice lifecycles. I continue to see that as a mixed bag, so to speak. The states we go in to will be opportunistic, because, as Tushar touched on, our national scale allows us to be successful in every state, so long as they have adopted MAC as the standard of care. As far as different models, and we haven't talked about this a lot, but I think some of the larger platform plays that will want our services will be an opportunity for us in the

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future, when maybe it hasn't in the past because we've stuck with an acquisition-only model. So, again, the larger we get and have more resources, we're able to serve more groups without a one-size-fits all business model.

**Richard Close:**

Okay. With respect to the De Novo program, I think you have an option on the one that you started last October, if I'm not mistaken. What's the thoughts on the timeline of bringing that into the ownership status? I think Puget was 18 months or 16 months, 17 months, something like that, from the start until you actually exercised your option.

**Jay Kreger:**

Yes, the ramp-up on the current one has been much shorter just because it was a smaller practice and, therefore, we believe it will transact in Q4.

**Richard Close:**

Okay, and I guess my final question here would be on O'Regan. That decrease year-over-year in the second quarter, you talked about it being a growth area. Any thoughts on does O'Regan return to the 10% growth level, any timeline with respect to return to growth there?

**Dr. Tushar Ramani:**

Richard, it's Tushar. We've got a couple of initiatives underway right now, and we'll be able to see what the value of these initiatives are going forward, but we've renewed our focus on that business with a number of things. We're going to increase our—and we expect that this will increase sales soon, and then over time in a more sustainable manner. Early indications seem to be positive for us. We're leveraging the GI community's increasing awareness of the need to treat the hemorrhoids. GI literature is actually independently supporting this, and so there's a tailwind for us. The time just seems absolutely right to be leaning into this right now.

We're also supporting the development of a training curriculum for GI fellowship programs. It's actually not part of the GI core training to identify and treat hemorrhoids. Given the current academic focus on it, it seems like that's something that should develop, and that obviously will be beneficial to us, as well. We've got some additional practice support initiatives. We have a higher emphasis on re-training physicians, where usage may have decreased.

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Then, resource-wise, we're looking at internally what's the optimal efficacy of the current team and sales size that we have, and we wanted to figure out what's the best way to deliver sort of the continual contact that this market seems to require in order to maintain and grow these usage lines.

So, a lot of stuff that we're attacking, all different angles, but I think that ultimately will all be successful in helping achieve, as I said before, I think is a full order of magnitude of opportunities.

**Richard Close:**
Okay, thank you.

**Operator:**
Our next question comes from Doug Cooper with Beacon Securities. Please go ahead.

**Doug Cooper:**
Hi, good morning. I just want to stick on the O'Regan for a second. Can you just maybe talk about how big an opportunity you think is there? Is it possible to talk about what percentage of the hemorrhoid market it is serving today and what you think it could get up to with better education to the GI's?

**Dr. Tushar Ramani:**
If you look at what the headline opportunity is, the literature now, the recent literature seems to support that there's about 1.5 million newly diagnosed hemorrhoid patients just in the employer insured market alone. There's probably another 1.5 million or so in Medicare and non-employer-insured markets. You're talking about 1.5 million to 3 million new hemorrhoid patients per year, and rubber band ligation, it turns out it's probably the most effective, safest, fastest, probably lowest cost treatment available. So, you have to believe that the lion's share of those patients should be treated, or could be treated with rubber band ligation.

Then, within the ligation space, we believe there's really only one player. The O'Regan device or the O'Regan system has been now used over a million times and we've trained over 3,000 gastroenterologists. It's the largest installed device, certainly. We currently do about $10 million in sales into that market. If we were just roll out what our device cost is and sort of multiply it by the number of patients, it's well north of a couple hundred million.

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**Doug Cooper:**

Can you just remind us, the sales, is it one use and then they have to re-buy it, one use per patient?

**Dr. Tushar Ramani:**

Correct, and the typical patient—patients have three haemorrhoidal veins and so usually all three of those need to get treated.

**Doug Cooper:**

Okay. Moving on, just on the shareholder EBITDA , $9.7 million versus $8.7 million in the prior quarter, can you just talk about why the—partly, it was driven by the purchase of the 100% of the anesthesia practice in April, but is there something else going on to drive the shareholder EBITDA higher? Like, was the 100% owned practices doing better than the other ones?

**Richard Bear:**

Yes, great question. First off, we did acquire the remaining 49% of Arapahoe in early April, so we had the benefit of owning that entire piece of business for the entire quarter, which had no impact on revenue or expenses because it's already consolidated, but did impact shareholder EBITDA and lower non-controlling interest EBITDA. In addition to that—we talked earlier on this call about growth rates and different growth rates in different markets—we're seeing some of our strongest growth rates at markets that are 100% owned, large markets 100% owned, or markets that we own even greater than 51% in more the 65% range, are where we're seeing our largest growth rates. So, it makes sense to us that shareholder EBITDA came in at those levels.

**Doug Cooper:**

Okay. You bought back just under 500,000 shares at an average price of CAD$3.82, stock currently trading below that level. So, I would say, if you thought it was good value in the last quarter, and now the Company, by my calculation, is probably trading at its cheapest level maybe in—well, I'd have to go back and check the numbers, but it's trading about 6.5 times trailing 12-month EBITDA, by my calculations. Will the company continue to be active on the buyback?

**Richard Bear:**

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Yes, we continue to remain active on our normal course issuer bid, and we would continue to acquire shares at these levels, like we did at the higher levels you noted earlier in that question.

**Doug Cooper:**

Right. Okay, that's it from me, everything else has been asked. Thanks very much.

**Richard Bear:**

Thanks, Doug.

**Dr. Tushar Ramani:**

Thanks, Doug.

**Operator:**

Next question comes from Doug Miehm with RBC Capital Markets. Please go ahead.

**Doug Miehm:**

Yes, just a couple related questions as it relates to the potential ancillary business. I'm just wondering what the potential CapEx roll-out cost notionally might be, are they significant or are they next to nothing; and a related question, do you need to license products or technology to roll out this type of new business? Thanks.

**Dr. Tushar Ramani:**

Sure, Doug. A couple of the things that we've looked at—now, anesthesia was a fairly widely adopted service, and so our model there was to do serial acquisitions, and then we've added to that some De Novo business. I think in some of the ancillaries that we're looking at, it's less complete, and so in many cases, these will be new services that we would bring to practices. How we go about initiating base service or a new line remains to be seen. Whether we do a buy-and-build scenario or whether we try and bring in expertise and start from scratch, I don't think we've decided that yet.

**Doug Miehm:**

But, are we talking the same sort of CapEx that would be involved in the GI side of your business, the anesthesiology, or something that's materially more or less?

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**Dr. Tushar Ramani:**

I would estimate less, because I don't think that we'll be doing serial acquisitions and using capital the same way that we  always are in anesthesia strategy.

**Doug Miehm:**

These new services, do they require new technology that needs to be licensed?

**Dr. Tushar Ramani:**

It might. That is one of several things that we're looking at. I hesitate to get too much more specific here.

**Doug Miehm:**

Yes, that's fair. Thanks very much.

**Operator:**

This concludes the question and answer session. I would like to turn the conference back over to Richard Bear for any closing remarks.

**Richard Bear:**

I just want to say thanks everyone for attending our Q2 conference call. We look forward to discussions in the future and our upcoming Q3 conference call in November. So, everybody have a great summer.

**Dr. Tushar Ramani:**

Thank you all.

**Jay Kreger:**

Thank you.

**Operator:**

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

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