FINAL TRANSCRIPT

Medical Facilities Corporation

2017 First Quarter Conference Call

Event Date/Time: May 11, 2017 — 8:30 a.m. E.T.

Length: 30 minutes

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CONFERENCE CALL PARTICIPANTS

Lennox Gibbs
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Neil Maruoka
Canaccord — Analyst

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CIBC — Analyst

PRESENTATION

Operator

Good morning, ladies and gentlemen. Welcome to the Medical Facilities Corporation's 2017 First Quarter Results Conference Call.

Before the call is turned over to management, listeners are cautioned that today's presentation and the responses to questions may contain forward-looking statements within the meaning of the Safe Harbor provisions of Canadian provincial securities law.

Forward-looking statements involve risks and uncertainties, and undue reliance should not be placed on such statements. Certain material factors or assumptions are applied in making forward-looking statements, and actual results may differ materially from those expressed or implied in such statements.

For additional information about factors that may cause actual results to differ materially from expectations, and about material factors or assumptions applied in making forward-looking statements, please consult the MD&A for this quarter, the Risk Factor section of the Annual Information Form, and Medical Facilities' other filings with Canadian security regulators.

Medical Facilities does not undertake to update any forward-looking statements. Such statements speak only as of the date made.

Listeners are also reminded that today's call is being recorded for the benefit of individual shareholders, media, and other interested parties who may want to review the call at a later time.

I would now like to turn the meeting over to Mr. Britt Reynolds, President and CEO of Medical Facilities. Please go ahead, Mr. Reynolds.

Britt Reynolds — President and Chief Executive Officer, Medical Facilities Corporation

Thank you, Operator, and good morning, everyone. Joining me today is Tyler Murphy, our Chief Financial Officer.

Prior to market open today, we released our 2017 first quarter financial results. Our news release, financial statements, and MD&A may be accessed through our corporate website at www.medicalfacilitiescorp.ca, and were also released on SEDAR today.

For today's call, I will start my discussion with the results of the past quarter. Tyler will then review the financial results. I'll wrap up with some comments on our progress, after which we will open the call for questions.

It was a year ago today I first addressed you as the Medical Facilities Corporation's CEO. A great deal of progress has been made in the year, and I'm particularly pleased with the results of the past quarter.

A hallmark of our facilities and a testament to their quality and profile on the community is a continued growth in case volume. This was no different in the first quarter of 2017.

We had growth in surgical cases of 10.3 percent, which results positive contributions from all the one of our centres, including newly acquired facilities. There were two components to this growth that we should note.

First, a high proportion of those cases were for more complex procedures, which translates to higher revenue per case. Secondly, this case growth came predominately from commercial insurers and private payors. For MFC, this means that we received a higher margin for the procedures delivered.

The results on this past quarter are an indication of those we are striving to achieve going forward. And I am confident that we have put together pieces in place for substantial growth results as were defined in our strategic plan.

In line with that plan, we added a new member to our team to address our operations. Rob Harare (phon) joined us as Chief Operating Officer this month. Rob has over 25 years' experience in health care operations with some of the largest operations in the United States.

He will be responsible for working with our local leadership teams to operationalize performance, contain costs, and increase market presence, as well as negotiating with payors and integrating new facilities.

With this addition we now have a team with a full complement of skills to execute our growth strategy, and significantly, skills for our assets.

Now Tyler will provide more detail and insight for our financial performance for the first quarter of 2017.

Tyler?

Tyler Murphy — Chief Financial Officer, Medical Facilities Corporation

Thanks, Britt. As on our previous calls, I would like to note that all of the dollar amounts expressed in today's call are in US dollars, unless otherwise stated.

In Q1 2017, MFC had revenue of $89 million, a 17.2 percent increase over $75.9 million in Q1 2016.

Incremental revenue from acquired facilities was a main driver of growth, along with contributions from the new urgent care and ENT clinics at Black Hills, increased revenue from improved case mix, along with annual price increases. This is the seventh consecutive year-over-year increase in quarterly revenue.

As Britt mentioned, surgical cases increased by 10.3 percent overall in the quarter, with outpatient cases growing by 13.1 percent. Of the case growth, the majority, or 26.1 percent, came from commercial insurance and private payors, followed by Medicare and Blue Cross Blue Shield.

As a result of new acquisitions, depreciation and amortization increased by $1.7 million year over year thus moving income from operations to $13.3 million from $14.8 million in the first quarter of 2016.

Adjusting for depreciation and amortization, income from operations was $20 million in the first quarter of 2017 compared to $19.9 million in Q1 2016.

I will also mention that income from operations was impacted by about $2.4 million as a result of a temporary absence of a key physician at our Unity Hospital, which required the

rescheduling of several complex cases. I'm pleased to report, however, that the surgeon returned to work in late March at full capacity, and one other surgeon has also joined the team.

Cash available for distribution in Q1 2017 was C$10.8 million, a 9.6 percent decrease from $11.9 million from a year earlier related to the increased maintenance capital expenditures at the centre level.

On a per share basis, our cash available for distribution was C$0.348 in Q1 2017 compared to C$0.384 per share in Q1 2016. The resulting payout ratio was 80.9 percent for the quarter compared to 73.2 percent for the previous year.

We had cash and cash equivalents of $60.6 million and about C$42.5 million available on our credit facility. We believe we are well positioned to execute on our growth strategy.

For additional detail on the specific results for each centre, please refer to our MD&A.

Now Britt will provide some comments on our strategy, and then we will take your questions.

Britt?

Britt Reynolds

Thanks, Tyler. As we discussed on several previous calls, the new management team at Medical Facilities Corporation has an increased focus on growth both through acquisition and organically.

Before I close, I would like to briefly discuss our current facilities and core strength of our operations.

As you know, we have six facilities, five specialty surgical hospitals, and one ambulatory surgery centre. What's important to note is the operational high quality of these facilities. Our surgical facilities are all top-rated by national and local market surveys on quality and patient satisfaction.

For example, our Black Hills Surgical Hospital in South Dakota has a positive referral rating where patients are asked if they would refer their family members and friends, which has a 92 percent rating. The national average is only 72 percent.

The Unity Medical and Surgical Hospital in Indiana is in the top 1 percent of hospitals in the US for patient satisfaction. And Arkansas Surgical Hospital was recognized recently as one of the top 36 US hospitals with the lowest readmission rates for patients needing high and new replacement surgeries.

What does this mean for MFC shareholders? It means that our facilities have a substantial competitive advantage on their markets.

As patients continue to be more active in their health care services, our strength to provide surgical care will have a positive influence on these centres positively in the future.

This high quality is also a key factor in physician recruitment and retention. The health care system in the US is competitive and facilities compete on all fronts.

This dynamic has been the case during the entire … during my entire career. With the MFC hospital portfolio and the operational skills of the best facility executives in the industry, I am totally confident about our ability to compete and succeed in the markets.

With that, we would now like to open the line for questions and—about our operations.

Q&A

Operator

And if you would like to ask a question, please press *, followed by the number 1 on your telephone keypad. Again, that's *, 1 in order to ask a question. And we'll pause for just a moment to allow people to queue.

And our first question this morning comes from Lennox Gibbs from TD Securities. Please go ahead.

Lennox Gibbs — TD Securities

Good morning. Thank you. Other than Sioux Falls and Black Hills, are you facing prospects or are you aware of any prospects of significantly intensified competition in any of the other … in any of your local markets? And if so, can you step us through what may or may not be unfolding?

Britt Reynolds

Yeah. I would tell you that there are no recent developments, Lennox, on anything in any of the other markets. I would also tell you both to the existing markets in South Dakota that you're

referring to, we have to be prepared for competition at all times. So there's existing competition in our market—it's just not more recent—and then as you're alluding to, some more recent press around market growth in the South Dakota market.

So we're prepared, but nothing new or developing that we're aware of.

Lennox Gibbs

Okay. And then just more broadly and more of an industry question, I guess, is what we're seeing in Sioux Falls, Black Hills is some sort of more aggressive stance on the part of the general hospitals trying to capture some higher-value procedures and higher-value operations? Is that kind of maybe I shouldn't say leading edge, but is it part of a broader trend? And this isn't necessarily just a Med Fac question, an industry question. Is that part of a broader trend? Or is that more isolated? How would you characterize it?

Britt Reynolds

Well, I would tell you, as I've discussed before, we're going to be in both the acquisitive, and so it would naturally apply to our organic markets. We're going to be in markets where there is competition. We really don't want to be in what I would call the lower tier or very small market base; it's really not where Jim and the team is focused on from an acquisition standpoint.

So to be absolutely transparent, we have to embrace competition, Lennox. It's going to ebb and flow on any given market whether they want to develop something new or they have recruited a specialty base. So we're going to be in a constant state of moving back and forth.

And quite candidly in my 31 years, the element of competition is present in every market that we're in. So it's more about how we respond and continue to keep our strong positions we talked about.

Lennox Gibbs

Okay. Thank you.

Operator

And as a reminder, that's *, 1 on your telephone keypad in order to ask a question.

And our next question comes from Neil Maruoka from Canaccord. Please go ahead.

Neil Maruoka — Canaccord

Hey. Good morning, guys.

Tyler Murphy

Good morning.

Britt Reynolds

Hey. How are you doing?

Neil Maruoka

Good, good. Just had a question on Unity; you'd mentioned—I missed the number in your comments—but you said that your income from operations was impacted by just over 2 million due to the rescheduling of … an injury to a surgeon and a rescheduling there. Could you provide a little bit more colour on that how that impact worked through? So was that revenue or income from

operations? And then you also mentioned that you had added a new surgeon. Could you provide a little bit more detail there and maybe an update on your recruitment efforts at some of the other facilities?

Tyler Murphy

Yeah. Good morning. It's Tyler. Yeah. As you can see if you look in the MD&A, we were down about—for income from operations at UMASH was down about 2.7 million. About 2.4 million of that is related to surgeries that were put off from the first quarter, and in many cases will hit in the second quarter.

Due to an injury we had a surgeon who was out and he could not operate during that period. He came back at the end of March and has ramped back up, and many of those cases that had been put off are now getting scheduled in and actually performed.

And I'll let Britt to give you some commentary on the recruitment.

Britt Reynolds

Sure. We were actively recruiting. This is our—Neil, this is our most productive and really strong surgeon in the UMASH marketplace. So it was significant for us, but we're pleased. It's totally full recovery, everything's good, and he was actually seeing patients by the end of the first quarter to tee up (phon), as Tyler said, readdressing procedures in the second quarter. So that's all good in the macro view.

As far as recruiting physicians, we had actively been pursuing a local surgeon there to complement this individual. And he has been in the marketplace between six and seven years; highly reputable; actually offers a few service dynamics that we don't offer at the facility. And he has been active starting right at the beginning of Q2 as well.

So we feel good about that particular service line now being absolutely shored up and not dependent if there were to be something of the same in the future.

As far as other physicians go in terms of recruitment, I'm going to make a blanket statement because it would be a slightly different commentary at each location, but the theme is the same. We are working with local leadership who are keen on developing leads on physicians that want to join our facilities. Also our local medical staff have great insight as to other people in the marketplace that they're familiar with that would have an expressed interest.

Jim is in his development role is actively working with our facilities and recruiting physicians. So I will make a blanket statement. Hopefully it doesn't sound too blanket that every one of our facilities have active physician recruitment and interaction in place and has had for several months at a minimum.

Neil Maruoka

Okay. Great. And could you comment a little bit maybe on the specialties that you're looking at? Or how you kind of looking at the individual facilities in terms of bringing in different specialties that might be complementary or that maybe better margins or how you might be viewing that?

Britt Reynolds

Sure. As you know, the orthopaedic and neurosurgical is the bread and butter. It's the high margin, high complexity service lines that our company was frankly built upon, and we continue to grow those even all the way up to the newest people that have joined us. So those are always going to be in the wheelhouse for any new acquisition, or in some of our markets where there's actually a need expressed by our physician colleagues where we need more services and more physicians there. So that's always on the radar.

The second piece is we're looking into what I would say regional—reasonable, excuse me, margins of other services that we could provide and would be either complementary to, or are situationally based on each individual market. There may be a group in cardiology; there may be a group in oncology that might make sense for one of our facilities, but might not make sense across the entire portfolio.

So it's a very custom-tailored approach to each one of those, but I would tell you the services we think that have appropriate margin are ortho, neuro, oncology, cardiac services in certain locations.

And then as we go into the ambulatory surgery space with our Sioux Falls acquisition last year, at the ambulatory surgery space since it's not an overnight stay, you get a lot more of slightly lower margin, but you get a quicker turn and you don't get an overnight stay. So you would see ENT procedures there and general surgical procedure. So it's really custom tailored, but our primary

criteria is can we deliver good care that people want to come back to? And can we deliver to a margin and a price that make sense for us?

We don't want to just grow something to grow it.

Neil Maruoka

Okay. Great. Thank you.

Britt Reynolds

Thanks.

Operator

And our next question comes from Prakash Gowd from CIBC. Please go ahead.

Prakash Gowd — CIBC

Thanks. Good morning, gentlemen. I have two questions; first probably for Tyler on the issue of costs. They appeared to be higher as a percentage of revenue across all of your cost categories, especially with respect to drugs and supplies and G&A. Can you comment in terms of is this increase more of a onetime issue in Q1? Or do you see this sort of as a trend for the course of the year?

Tyler Murphy

Yeah. On the G&A, the largest portion of that increase was the amortization that comes along with the acquisitions. So that's—it's not necessarily an ongoing thing. Drugs and supplies, I mean we've talked about it. Obviously I've only been here a couple quarters, but that is something that we are actively looking at with Rob on board. He and I are going to really continue to try to look

at different ways we can help the facilities get aggregated purchasing and really try to combat these rising prices. And so that's industry-wide across the US.

I mean everybody's doing the same thing, and so we just need to—we've done a good job finally getting aggregate data of what all our facilities are spending, and now we can try to go to the distributors, GPOs, and whatnot and try to drive some savings out of that. But that's a continued battle in US health care across the continuum.

Britt Reynolds

If I could add to Tyler's comment, I think we absolutely are confident that we can working with our local leadership teams and medical staff members that we can make a dent into it. I don't want to sit on every quarterly conference call and say, we get it, we want to make progress on it, but we're not quite there. So I want to be very transparent.

We know the issue. We are blessed with revenue growth and case growth right now. I mean it is very, very comparable—I mean it's very, very impressive compared to any leg of the industry, be it acute care or our comparable lines of business.

So our focus, just to put it straight out there and put us on the spot, is these three to four areas of expense management, which we think we can do by greater aggregation, as Tyler said, of services. Or even in some cases maybe we outsource the whole process to somebody who can give us an aggregate cost differential that's better.

Tyler Murphy

Yeah. And just to add, the last point of that is you got to remember also that we have the Unity Hospital and operating expenses this year that was not there last year. So that—those operating expenses obviously increased, and we've already talked about their issues in the first quarter bringing the margins down. But that will, again, not repeat itself.

Prakash Gowd

Okay. No, that's great. So just if we look more at a steady-state situation, is for the category of drugs and supplies would a 30 percent of revenue be reasonable as a go-forward assumption?

Tyler Murphy

I'm not sure that—I mean I think where it is right now is drugs and supplies, the costs are not going to go down, but it's—they were, yeah, 29.9 percent up from 29.3 percent, so I mean there was not a large increase. So I think you are in the right range.

Again, we're going to—we hope to continue to grow revenue as we bring additional cases and physicians into our facilities. And so hopefully every time that percentage doesn't go up as we attack it from both the revenue and the cost sides.

Britt Reynolds

And we made this comment earlier, but it really does have an impact. And that is part of this really impressive growth that pleases us is in higher-acuity caseloads. And in those really high-acuity cases, which we want—so let's make no mistake about it—they have disproportionately higher drug utilization.

So the process that I discussed earlier is really where we're going to make the input. But all day along we love—we'll still take the higher case volume and the higher acuity.

Prakash Gowd

Okay. Great. That's fine. And just quickly, any commentary you can make in terms of the acquisition pipeline; the status of that; the size of acquisitions you're looking for; and kind of some sort of guideline on timing?

Britt Reynolds

Yeah. So as I think as we discussed and we shared at the last board meeting following our strategic planning process really that solidified where we would make some slight modifications and where we would continue to stay true to the direction, there are a lot of opportunities in the pipeline that Jim Rolfe, our Chief Development Officer, and I following him are working on. There's at least a meeting or two with an entity every week, so just to give you some level of magnitude.

It covers a broad spectrum. It covers a broad spectrum from singular ambulatory surgery centres to organizations of 10 to 20 ambulatory surgery centres to just like with USMASH last year a lead on a very attractive or positive to us surgical hospital, and that is attractive. And we're entertaining some corollary services very discreetly if they really would complement our existing market.

So in a nutshell, I would say there is a lot of ripe activity out there. There's a number that I won't try to quote to you because I'm not sitting in front of it, but suffice it to say the punch line is

the ambulatory activity and the opportunities this year have bested last year's actual acquisitions. And that was besting year over year over year. So you can see that it's really growing as opposed to going away. And that really excites us as we're putting our team together.

Prakash Gowd

Okay. And just to follow up on that, have you seen any impact on those discussions and negotiations from the potential repeal and replace of Obamacare and any future initiatives that the Trump government might implement? Has that had any impact on it?

Britt Reynolds

Yeah. We really haven't seen anything from outside commentary that we would view as peer information that would be helpful to us. So we come back to really our own thought process about that. And it's really just not predictable, and I hate to sound like we can't give you an answer, but it really is not.

The one thing I do want to keep sharing, because I think it's important for our analysts and our investors base to know, is that our services are discretionary by the surgeons—not meaning whether the case needs to happen or not—but they are bringing those cases to their hospitals. And that is a very, very different dynamic than if you're an acute care facility where you have a 25-bed operating—excuse me, emergency department and an ICU and a lot of the other margin-depletive services.

We are just different. And I want to keep making that point, and I will keep making that point is because we have selection ability in that. And we have a higher percentage of good and commercial paying and other payors in that wheelhouse.

So we have greater control. So we might get lumped because we're health care providers with acute care hospitals. But I will keep pushing to distinguish us that we are not exactly like acute care hospitals, and we definitely aren't in these two arenas.

Prakash Gowd

Okay. That's great. Thanks very much.

Operator

And we have no further questions in queue at this time. I'll turn the call back over to Mr. Reynolds for closing remarks.

Britt Reynolds

Yes, ma'am. Thank you. Thank you all for participating on today's call and for your questions. We appreciate those, and for your continued interest in MFC.

We look forward to reporting our progress during the next quarter and going forward as we see you in the marketplaces during our visits.

So thank you for your time today. We appreciate it.

Operator

This concludes today's conference. You may now disconnect.

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