FINAL TRANSCRIPT

Medical Facilities Corporation

2017 Third Quarter Results Conference Call

Event Date/Time: November 9, 2017 — 8:30 a.m. E.T.

Length: 36 minutes

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PRESENTATION

Operator

Good morning, everyone. Welcome to the Medical Facilities Corporation 2017 Third Quarter Results Conference Call.

Before turning the call 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 laws. 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 implied 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 securities 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, the 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. Robert Horrar, President and CEO of Medical Facilities. Please go ahead, Mr. Horrar.

Robert Horrar — President and Chief Executive Officer, Medical Facilities Corporation

Thank you, Sharon (phon), and good morning, everyone. Joining me today is Tyler Murphy, our Chief Financial Officer, and Jim Rolfe, our Chief Development Officer.

As you know, I have been with the Company since May as Chief Operating Officer. In that time, I have met with and worked with all of our hospitals and centres, and met with many of you in the investment community. I am very pleased to be taking on the role of President and CEO, where I will be able to continue to work with our teams driving growth and operational excellence.

I would also like to thank Jeff Lozon for stepping in as Interim CEO for the past several months. His guidance and leadership were invaluable, and I look forward to continuing to work with him and the entire MFC board. Now to the results of the third quarter.

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

For today's call, I will start by discussing the results of the past quarter, Tyler will then review the financial performance, and then I will wrap up with some comments on our outlook, which we will open to call [sic] with questions.

In the third quarter of 2017, we continued our consistent trend of year-over-year growth in surgery volume and revenue. This is a reflection of our nationally recognized quality and patient satisfaction scores and continuing success with organic growth initiatives.

Overall, surgical cases increased by 5.2 percent, largely driven by additions from Unity Hospital and Prairie States Surgery Centre. We also had strong growth of 12.6 percent in urgent care centre cases.

Offsetting this was a decrease in pain cases at our Oklahoma Hospital, and unfavourable case mix changes at Black Hills and Unity Hospital.

In the quarter we also continued to work with our local teams on organic growth initiatives.

The new physicians added recently at Unity continue to ramp up, and a new GI physician has joined our team at the surgery centre in Newport, California. We also signed an agreement with Ambulatory Innovation Associates to establish an urgent care centre at Arkansas Surgical Hospital.

Urgent care centres have been a successful strategy for us at Black Hills Surgical Hospital as a source of revenue and for expanding our access points in the community. We expect to have similar success with the centre at Arkansas, which is on track to open by the end of the year.

And has been the case since inception, in the quarter we continued to deliver reliable returns to our shareholders. In October, MFC shareholders received their 163rd consecutive dividend. In the quarter we also achieved a low payout ratio of 70.7 percent, ensuring continued reliability. Over the past four quarters we have maintained an average payout ratio of 66.2 percent.

Now Tyler will provide more details and insight into our financial performance for the third quarter of 2017.

Tyler?

Tyler Murphy — Chief Financial Officer, Medical Facilities Corporation

Thanks, Rob. 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 Q3 2017, MFC had revenue of 89 million, a 12.9 percent increase over 78.8 million in Q3 of 2016. The increase was driven by contributions from new acquisitions, as well as the new urgent care and ENT clinics at Black Hills and case growth at our existing facilities. This is now the ninth consecutive year-over-year increase in quarterly revenues.

For the nine months ended September 30th, revenue was 274.1 million in 2017, an 18.4 percent increase over 231.5 million in 2016. As a result of higher case load, operating expenses increased to 76.5 million in Q3 2017 from 64.6 million in Q3 2016.

Acuity and case mix shift had a significant impact at Unity, which incurred an operating loss of 1.6 million as a result of lower reimbursement rates. As of Q3, a new finance executive is in place at Unity who is focused on executing our operating expense and growth initiatives.

EBITDA in Q3 2017 was 19.3 million, a slight decline of 1.4 percent from 19.6 million in Q3 2016. The decline is the result of the lower operating income at Unity.

On a same-hospital basis, eliminating the results from Unity and Prairie States, EBITDA increased by 4.3 percent to 20.3 million from 19.5 million in Q3 2016.

For the nine months ended September 30th, EBITDA was 62.6 million in 2017, a 7.1 percent increase over 58.4 million in 2016.

EBITDA margin for the past quarter was 21.7 percent compared to 24.9 percent a year earlier. On a same-hospital basis, EBITDA margin was 25.5 percent compared to 25 percent in Q3 of 2016.

Cash available for distribution in the quarter was 12.3 million Canadian, a 17.2 percent increase from 10.5 million Canadian a year earlier. On a per share basis, our cash available for distribution was $0.40 in Q3 2017 compared to $0.34 in Q3 2016.

As Rob mentioned, the resulting payout ratio was 70.7 percent for the quarter compared to 83.1 percent in Q3 of 2016.

With cash and short-term investments of 63.1 million and about 32 million available on our credit facility at September 30th, we believe we are well resourced to execute on our growth strategy. For additional detail on specific results for each facility, please refer to our MD&A.

Now Rob will provide some comments on outlook, and then we will take your questions.

Rob?

Robert Horrar

Thanks, Tyler. Overall, we are pleased with the third quarter results and the progress that we are making at executing growth and operational improvements.

Looking to the rest of the year and beyond, we will continue to focus on growth. In terms of organic growth, this means adding complementary facilities to our hospitals, as we did when we added Prairie States ambulatory surgery centre at Sioux Falls, as well as opening new urgent care centres, adding and enhancing service lines, and recruiting new physicians. Managing supply cost initiatives remain a priority, and we continue to make progress.

We are still highly engaged in making acquisitions and, in fact, are currently evaluating several accretive opportunities.

In keeping with our communicated strategic plan, our investment criteria for acquisitions of physician alignment, accretive earnings, and growth opportunity remains constant. And as such, we have walked away from several potential transactions that did not meet this criteria.

We'll also continue to navigate the changes in the US health care system as government and other payors endeavour to reduce cost through changing reimbursement rates and lower-cost settings.

An example of this is the recent announcement from the Centres for Medicare & Medicaid Services, or CMS, to remove total knee replacements from the inpatient-only procedure list and to allow certain of them to be carried out in an outpatient surgery basis.

Whether to carry out the procedure on an inpatient or outpatient basis is a medical decision, not a financial one, and is at the judgment of the physician. There is also a two-year period before these procedures will really be audited (phon) by CMS. This is a very recent development, and we are still considering the impact. However, we see both challenges and opportunities in this change.

An important consideration is that a total knee replacement procedure on an outpatient-surgery basis would not be recommended for all patients. Those patients that are elderly, or have complications and other medical complications may still require an inpatient stay so their recovery can be observed and managed. A significant proportion of Medicare patients will require inpatient stays.

We are confident that we will continue to successfully navigate the changes in the US health care system to the benefit of our shareholders.

With that, we would now like to open the line for questions.

Operator?

Q&A

Operator

If you would like to ask a question at this time, please press *, then the number 1 on your telephone keypad. If you would like to withdraw your question, press the # key. We will pause for just a moment to compile the Q&A roster.

Your first question comes from Ling Han from TD Securities. Your line is open.

Ling Han — TD Securities

Hi. Thank you for taking my questions. My first question is related to the CMS decision you just mentioned about the total knee replacement. So I'm just wondering, can you tell us about the orthopaedic outpatient capacity that currently exists in Sioux Falls and Black Hills and your prospects for increased outpatient capacity in those markets? Thank you.

Robert Horrar

Well, I'll begin—I'll take that on. So we know very well that the demand for knee replacements and hip replacements, especially due to osteoarthritis, is increasing at a rapid rate particularly among the Medicare population. So to your point, this is a growing service line, so total knee replacements are growing, and we do have capacity.

We have capacity, as we've mentioned, our acquisition of Prairie States Surgery Centre gave us additional capacity in Sioux Falls. So we do have capacity to add surgeries in these locations, so.

Ling Han

Thank you.

Robert Horrar

You're welcome.

Ling Han

My second question is related more to a more macro (unintelligible). So several of your hospitals and ASC peers have recently reported (unintelligible) related to the high deductible insurance plans and related to a deteriorating payor mix. So I'm just wondering, can you tell us about Med Fac's vulnerability to these trends? And if there's not much threat has been thought of, why not? Thank you.

Robert Horrar

Well, I think it's just helpful to understand that our model, typically, is that on of elective-surgery basis, so patients that come to our centres it's not an emergency situation, but rather an elective situation. So they're preauthorized, pre-certified, and those insurance questions have been addressed up front. So I'm not saying that we don't have some sensitivity.

Clearly, all providers are better with more covered individuals, but from an exposure standpoint we would be less so because of that elective nature. And again also, we are also looking forward to we typically see the fourth quarter is one of our higher seasonal times of the year as patients have met a lot of these deductibles, so.

Ling Han

Well, thank you for answering my question.

Robert Horrar

Does that answer—yeah.

Ling Han

Yeah. Thank you.

Operator

Your next question comes from Neil Linsdell from Industrial Alliance. Your line is open.

Neil Linsdell — Industrial Alliance

Good morning, guys.

Robert Horrar

Morning.

Neil Linsdell

I was wondering with the Unity Hospital, so you had the increased expenses. Can you give us a little bit more colour about what's going on there if you expected it to be more expensive or take more time to get things going? And what kind of initiatives you're putting in place to get that in line with the other pieces of your business?

Robert Horrar

Yes. Well, I'll take that as well. Overall, we've seen our volumes actually grow here quarter over quarter—third quarter over third quarter. The issue at Unity is one of a payor mix and acuity, so the volumes that we've seen aren't of the same acute nature and under different payors the shift is. So we have made some progress there since acquisition. We've added a number of physicians, I believe four physicians, that continue to ramp up. And clearly we've said in previous calls, this is a growth platform.

We have a lot of opportunity to add a significantly increased number of physicians to this platform. So it's—we think that we're in a good position to do that and to execute that growth strategy. So most of it's just on the revenue side and the growth, and we think we'll make good progress here. As far as the expenses go—

Neil Linsdell

—time line?

Robert Horrar

So we've got … we have several large opportunities in this market. And those take time to develop, so I wouldn't give you a specific time line, but I tell you our time line is as soon as possible, so.

Neil Linsdell

I appreciate that. So are there any specific initiatives you can tell us about? Or is it more just ongoing; it'll come as it comes?

Robert Horrar

Well, the initiatives are, like I said, to add physician participation to this centre. It is—got a good platform to grow and expand, and there is a lot of that opportunity to attract partners to this … to the centre. So that's our primary driver.

As Tyler mentioned in this call, we hired a new chief financial officer in this area, and we continue to manage expenses. Our supply initiatives are in place, we continue to see the benefits of

that, and also managing productivity in our labour: our salaries, wages, and benefits. So we do … we are focused on all fronts, but clearly the most significant opportunity in this market is to grow. And we have a number of those initiatives in place.

Neil Linsdell

Okay. All right. So ...

Tyler Murphy

Yeah. And I would just add to that, Rob, there's a large number of unaffiliated physician groups in that market. So those are the groups that—that's why we feel so good about that market. We think we can get some of those aligned with our hospital.

Robert Horrar

Right.

Neil Linsdell

Okay. So within that context as well then, if I look at the broader—so all your facility, all your geographies—can you talk about how the acquisition pipeline might be developing, the number of acquisitions, how long you've been talking to a lot of these guys, and if things are moving quicker or slower and with management getting solidified at MFC?

Robert Horrar

I'll let Jim Rolfe talk about that.

Jim Rolfe — Chief Development Officer, Medical Facilities Corporation

Yeah. Yeah. Hey, Neil. Good morning.

Neil Linsdell

Hello.

Jim Rolfe

Yeah. We have been very busy since the first of the year. And as Rob talked about, our two major charges coming onto MFC were to grow our current portfolio and, of course, to grow through acquisitions, right? So we've had a pretty robust and very active pipeline from … since January. So we've looked at a lot of deals. We've actually had advanced discussions with several. And as Rob said, we walked away.

We've got five hospitals and one ASC, so we have to be very selective in making sure that the assets that we look at are high quality, good margins, and make sure they have good management and a good growth potential. And if they don't have those, then were small (phon) that we have to walk away. So we actually walked away from a couple. We are in advanced discussions with several, several of these opportunities that meet our adjacent core business of the high quality and accretive and good growth opportunities. And so we're … we are still very, very optimistic on these discussions that we're having now.

So yes, it's been active since January, and it remains active right now currently.

Neil Linsdell

Okay. I'll leave it at that then. Thanks.

Jim Rolfe

Yup.

Operator

Once again, if you would like to ask a question, please press *, then the number 1 on your telephone keypad.

Your next question comes from Endri Leno from National Bank. Your line is open. Endri Leno, your line is open.

Endri Leno — National Bank

Hi. Sorry. I had a muted line. Thanks for taking my questions, guys, and good morning.

Robert Horrar

Good morning.

Endri Leno

I just have a quick question. If you can talk a little bit to the urgent care centre in Little Rock, Arkansas how is that going? And you said it's on track to open at the end of the year. What kind of traction did you expect on it? And, yeah, I mean just to talk a little about the development.

Robert Horrar

Sure. Be happy to. As we mentioned earlier, the urgent care centre strategy for us is very positive. It expands our outreach. Our arrangement with American Innovations is a platform deal for

us. This is going very well. We do anticipate being open at the end of the year and with opportunity to do more, not only in about the Little Rock area, but throughout our company.

So we think this is a good strategy. It's been positive for us particularly in Black Hills, and we see this as a platform to continue to add complementary facilities organically.

Endri Leno

Thanks. And if you had to prioritize between these types of organic developments and acquisitions, which one would you preferably go for?

Robert Horrar

Well, we wouldn't necessarily exclude one or the other. I think both are important. Our stated strategic plan is organic growth and external growth, so we're focused on both.

Endri Leno

Oh, great. Yeah. Thanks. That's all the questions I had. Thank you.

Robert Horrar

Thank you.

Operator

Your next question comes from Doug Miehm from RBC Capital Markets. Your line is open.

Doug Miehm — RBC Capital Markets

Good morning, everyone.

Robert Horrar

Good morning.

Doug Miehm

A couple questions; maybe this first one for Tyler. I'm just trying to reconcile how on a US dollar basis anyway distributable cash could have risen 23 percent when EBITDA was down year over year?

Tyler Murphy

Yeah. It's because you have to factor in taxes and other things go into that calculation. So it's not just a straight EBITDA calculation.

Dough Miehm

No, I understand that. So I'm just trying to understand maybe some of the timing issues then that are associated with this because if we were to simply to take the lower EBITDA, and we can use over a year, all things else being equal, if we look at the accruals, the taxes, and working capital. I'm just thinking that—is it correct to assume, or are you getting some benefit in working capital somehow that in a specific year if EBITDA is down, distributable cash should be down?

Tyler Murphy

Not necessarily, again, because of the other factors, as I just talked about income taxes. There's times where we get recoveries that aren't necessarily really period-specific and other working capital things like that. So I can run you through a calculation off-line.

Doug Miehm

Yeah. Yeah. Okay. I think it was mentioned earlier in some of the prepared comments just about when you were talking about total knees and the potential for a greater proportion of patients could be on Medicare that would need to stay as inpatient; that makes sense. But does that mean that going forward a greater proportion of the patients that you are doing work on in terms of total knees are going to be at lower reimbursement levels because they are Medicare patients?

Robert Horrar

Well, it's a more complicated response than that. And so for—the total knee final rule basically just removes total knee replacement from the inpatient-only list. And it also, I'll just make a note, does not approve them for the ambulatory surgery centre list.

So if there is a Medicare patient that can qualify, a physician feels and the service is available and the patient can meet the criteria and you have the care patterns established in your facility, and can be done on an outpatient basis, then the reimbursement is less. But that's a very large filter to go through.

So as I said earlier, we see the demand for the service continuing to grow. And for the most part, there are very, very few outpatient total knees done today. There's zero for Medicare today. And single digit on the commercial side.

Doug Miehm

Okay. Perfect. No, that makes sense. And then I just wanted to go back a little bit to Unity. I know that you've not had this on your books for very long, but it appears to be … their business

appears to be quite variable. So if we were to—forget about Q1 because we had one of the key doctors gone—but if we look at Q2 versus Q3 and the dramatic variability between those two quarters, I think you indicated that this was largely due to I think it was payor mix and acuity. How can we be confident that things are going to stabilize? Like this swing of several million dollars in EBITDA potentially at this facility is a little disconcerting.

Robert Horrar

Right. Well, I will tell you that all of our attention is on this facility, and we're equally concerned about the shift. However, as I've said, there's a whole lot of very good underlying supportive strategies that have been implemented and have taken hold. We've mentioned the organic growth with physicians that we've brought to the centre and continue to do that. We mentioned implementing our supply costs, and we're seeing traction on that. I mean those are right now going to take some time to germinate.

Those larger opportunities that Tyler and Jim mentioned in this area with large unaffiliated groups, we have a lot of room that we can grow this centre. And we're focused right now, particularly our new CFO, on operating what we have.

Doug Miehm

Okay. Perfect

Robert Horrar

So I think the future will be good for this facility and all these things.

Doug Miehm

Okay. That's good. You mentioned that the unaffiliated doctor groups that could join with you. Would there be any cost? Do you have to buy them? Or would they just be working with you?

Robert Horrar

It could be—they could be investors in our facility or just working with us, either one.

Jim Rolfe

Yeah. And, Doug, Jim here. A lot of times when we look at a large group to invest in our hospital, a lot of times we'll do an in-kind transfer. For example, if they have an ASC that we are interested in acquiring as well, possibly trading that acquisition for acquisition into shares into our hospital, so it's kind of a combination of both. If it's singles, yes, they'll buy into our hospital. If it's a large group, then we look at doing some trading, if you will.

Doug Miehm

Perfect. Okay. Those are my questions. And if Tyler could follow up with me, that would be great, on the distributable cash.

Tyler Murphy

I will do.

Doug Miehm

Thank you, sir.

Operator

Your next question comes from Neil Maruoka from Canaccord Genuity. Your line is open.

Neil Maruoka — Canaccord Genuity

Good morning, guys.

Robert Horrar

Good morning.

Neil Maruoka

Just a—I apologize, I missed the first part of your conference call, but just on Black Hills and the margin that we're seeing there, can you talk about what kind of pressures you might be seeing in that environment? And what might have contributed to the weaker performance for Black Hills in the quarter?

Robert Horrar

Yes. So again, nothing that's not unusual in this market. I think we did have a neurosurgeon that left town at the very end of the second quarter. That was part of it. We had just some, again, some payor mix and acuity shifts in this market. I think that this is, again on a year-to-date basis, Black Hills has performed fairly well. And I don't see that as inherent of any competitive threat, or issues, or weaknesses there.

Neil Maruoka

Okay. Nothing that you can't address going forward?

Robert Horrar

No, that's right. That's right.

Neil Maruoka

You had mentioned kind of an ASC acquisition strategy. Can you talk a little bit more what you're seeing out there on the ASC front? And how you're looking at potential acquisitions of ASCs or groups of ASCs? Just any commentary on the M&A side?

Jim Rolfe

Sure. Yeah. Neil, Jim here. We're looking—yeah. That's part of our core business. As mentioned all throughout the year, we're looking at an ASC strategy, but also a surgical hospital strategy. So again, a lot of comments here (phon); a lot of things are moving to the—or not moving—but are addressed in a low-cost providing area like an ASC, we are—that's part of our charge and my charge is to go find either a platform ASC or to find individual ASCs around our current centres. And so, yeah, we're full steam on that for sure from the ASC side.

Neil Maruoka

Okay. And just finally on maybe just shifting back to Black Hills and some of the other markets where you're seeing increasing competition out there, can you describe how that's shaping up? And what you're doing to preemptively deal with additional hospitals that are being built in some of your markets?

Robert Horrar

Sure. So nothing is open yet. This is—again, I'll reiterate in both cases; I think we've talked about this in previous calls—not a new competitor. It's a new building with an existing competitor that's not open yet.

So we continue to stay focused on all of our opportunities, our organic growth strategies. We're going through our strategic planning process now, and identifying areas where we can continue to capture more market share. We've seen these markets are attractive, all growth, service line growth opportunities are there organically, and we continue to execute those strategies well in advance of that.

We're going to stay focused and eye on the ball.

Neil Maruoka

Okay. Great. Thank you.

Operator

Once again, if you'd like to ask a question, press *, then the number 1 on your telephone keypad.

Your next question comes from Prakash Gowd from CIBC. Your line is open.

Prakash Gowd — CIBC

Thank you, and good morning, everybody. First question is what are the factors that influence case acuity mix? And are you actively either advertising, promoting, or patient targeting to make that more favourable?

Robert Horrar

Well, clearly we do. I mean what affects acuity is case mix. I mean it's the type of intensity of service. A spine case will be more intense than a knee replacement which will be more intense than, say, an ENT procedure. So when you're looking at total case counts, you really—and you look at acuity, you look at case mix in terms of what drives that. And then beyond that as well, it's the acuity under which payor mix and which payor contracts.

We've talked about payor—governmental payors pay typically less than commercial. So those types of dynamics are not controllable, and yes, we do have a very good marketing strategy in all of our markets. And they do a very good job, and we continue to evaluate ways to improve that.

Prakash Gowd

Okay. If you look on a year-over-year basis, what changes have you seen in private payor reimbursement for orthopaedic procedures?

Robert Horrar

Tyler, you want to take a shot at that?

Tyler Murphy

Yeah. I don't think there's been significant changes in the reimbursement. I think it goes back to what Rob just said. It's more of the acuity of what type of patients there have been. Obviously, implant costs continue to go up. That's something we are on at all of our facilities trying to get the best deals we can from an implant-cost perspective at our different centres.

So that's the important part is more the kind of the expense than there's been a wholesale change on the reimbursement side.

Robert Horrar

Right. And we continue—I'll just add to that—we continue to negotiate with our commercial insurers under contract to get our 3 to 5 percent rate increases that we think is very doable for us. Medicare just announced as a part of the final rule that it announced that brought to us the total knee another, what, I think it's a 1.9 percent increase on outpatient prospective payment. So overall the reimbursement rates are trending up, if that's helpful.

Prakash Gowd

Okay. So just so I understand, you mentioned that the changes are not significant. I guess what is the minimum, say, reduction in a reimbursement that you would consider to be significant that you may need to actually disclose?

Tyler Murphy

I'm not sure that there would be a minimum. To Rob's point, we negotiate these contracts when they come up, and continue to try to get some type of 3 to 5 percent increase of reimbursement rates to kind of keep up with the cost of living and things like that. So we're not seeing wholesale cuts in our rates anywhere.

Prakash Gowd

So are you saying that the average revenue per ortho case has actually increased year-over-year?

Robert Horrar

Well, you're talking about reimbursement rates, reimbursement rates have increased slightly. But when you're looking at revenue, I mean again that's impacted, as I've said, by payor, mix, and acuity. So if you're looking at an overall service line per case, the answer is acuity dependent. And I think we've highlighted some issues with acuity in the third quarter that have caused some of that to be less on the orthopaedic side.

Prakash Gowd

And is the—

Robert Horrar

So when—

Prakash Gowd

Yeah. Is the change in acuity simply meaning that the higher acuity cases are not coming to you anymore and are going somewhere else?

Robert Horrar

Not necessarily. It just means that for whatever reason the level of service that was done was not as intense as it had been historically. It doesn't mean it's not going to return, and again, there might be some element of seasonality to that. We typically, along with our other health care

operators, see the fourth quarter as a higher seasonal time for us due to the meeting of deductibles and coinsurance co-pays.

Prakash Gowd

Okay. The last question is if you look, say, through the course of 2017, how many physicians have actually left your system or retired?

Robert Horrar

Well, I'm not sure we publish that, but I will tell you that we do track our physicians that we've added on a quarter-by-quarter basis, and we've added around 19 physicians for the Company overall through year to date.

Prakash Gowd

So from the beginning of the year you have 19 more—

Robert Horrar

Yeah.

Prakash Gowd

—physicians than you did?

Robert Horrar

That's correct.

Prakash Gowd

Okay. Okay. Thank you very much.

Robert Horrar

Okay.

Operator

At this time, I will turn the call over the presenters.

Robert Horrar

Okay. Thank you very much. Thank you for participating on today's call, and for your continued interest in MFC. We look forward to reporting on our progress next quarter.

Thank you.

Operator

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

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